SUMMARY PLAN DESCRIPTION OF THE

NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND

I.B.E.W. LOCAL 104 PLAN OF BENEFITS

AS RESTATED AND AMENDED THROUGH SEPTEMBER 2023

Dear Participants of I.B.E.W. Local 104 Plan of Benefits:

We are pleased to provide you with this updated Summary Plan Description ("SPD") for the New England Electrical Workers Benefits Fund, I.B.E.W. Local 104 Plan of Benefits. 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 IBEW Local 104 Plan of Benefits. If a benefit, treatment, coverage, or other related item is not specifically described in this document, it is not covered by the Plan.

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 a continuation of income during periods of total disability and to have life insurance. However, many of us would find the cost 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 available in this Plan of Benefits only if you are aware of all of the provisions of the Plan and the wide scope of services the Plan covers. This SPD furnishes a description of the benefits to which Participants 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 Plan or to construe and interpret the terms of the Plan or the Fund, including ambiguous or disputed terms and meanings, and any other instruments or policies of the Plan or 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 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 Benefits 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, how 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 this Plan of Benefits provided by the 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 Benefits 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 Plan, contact the Benefits Fund Office for assistance.

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

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BASIC INFORMATION

NAME OF FUND

New England Electrical Workers Benefits Fund

ADDRESS OF FUND

c/o Zenith American Solutions
P.O. Box 5817
Wallingford, CT 06492-7617
(800) 832-6538

EMPLOYER IDENTIFICATION NUMBER / FUND NUMBER

06-0860627 / 501

FISCAL YEAR OF THE FUND (FUND YEAR)

January 1 through December 31

PLAN SPONSOR

The affiliated I.B.E.W. Locals and the signatory 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. Under 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 consisting of six Union Trustees and six Employer Trustees. The Board of Trustees is governed by the Trust Agreement established and maintained in accordance with Collective Bargaining Agreements.

The Benefits 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 Plan are self-insured. A few of the ancillary benefits, including life insurance coverage, are provided under policies purchased from insurance companies and are "insured benefits."

BOARD OF TRUSTEES

Union Trustees (listed alphabetically)	Management Trustees (listed alphabetically)
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. Thomas Adamson** Custom Electric, Inc. 52 Main Street Manchester, CT 06042 Phone: (860) 643-7110 Fax: (860) 647-1660
Mr. Daniel McInerney I.B.E.W. Local Union No. 488 721 Main Street Monroe, CT 06468 Phone: (203) 452-7679 Fax: (203) 459-2553	**Mr. Larry Egan** Collins Electric Co., Inc. 53 2nd Ave Chicopee, MA 01020-4697 Phone: (413) 598-1001 Fax: (413) 592-4157
Mr. Brian Murphy I.B.E.W. Local Union No. 104 900 S Main Street Mansfield, MA 02048 Phone: (508) 660-3900 Fax: (508) 660-0986	**Mr. Michael Gilchrist** Northeastern Line Contractors Assoc. NECA 700 White Plains Road / Suite 271 Scarsdale, NY 10583 Phone: (914) 723-2527 Fax: (914) 723-2536
Mr. Michael Nealy I.B.E.W. Local Union No. 35 208 Murphy Road Hartford, CT 06114 Phone: (860)525-5438 Fax: (860) 278-4372	**Mr. Spencer Marks** Rhode Island & SE Massachusetts Chapter, NECA 300 Centerville Road Suite 450 Warwick, RI 02886 Phone: (401) 738-0222 Fax: (401) 738-0223
Mr. Douglas Nelson I.B.E.W. Local Union No. 223 475 Myles Standish Blvd Taunton, MA 02780 Phone: (508) 880-2690 Fax: (508) 880-2994	**Mr. Michael R. Moconyi** Connecticut Chapter, NECA 144 Webster Square Road Berlin, CT 06037 Phone: (860) 259-5340 Fax: (860) 635-1119
Mr. Michael Treadwell I.B.E.W. Local Union No. 42 20 Craftsman Road East Windsor, CT 06088 Phone: (860) 646-7297 Fax: (860) 643-7092	**Ms. Jessica O'Neill** Northeastern Line Constructors Chapter, NECA 700 White Plains Road, Suite 271 Scarsdale, NY 10583 Phone: (914) 723-2527 Fax: (914) 723-2536

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 Benefits Fund Office:

New England Electrical Workers Benefit Fund
c/o Zenith American Solutions
P.O. Box 5817
Wallingford, CT 06492-7617

Telephone Number: (800) 832-6538
Fax Number: (203) 284-8656

The Benefits Fund Office is open Monday through Friday, excluding holidays, from 8:00 a.m. until 4:30 with limited access until 5:00 p.m. However, you can access your claim information at any time by visiting the Benefits Fund Office's website: **www.zenith-american.com**. "Login to your account", then choose Participant (under "Participants") as the "Account Type" and enter your "Username" and "Password". Call the Benefits Fund Office between the hours of 8:00 A.M. and 4:30 P.M. with limited access until 5:00 P.M., Monday through Friday at (800) 832-6538 if you need assistance with your online login.

AGENT FOR THE SERVICE OF LEGAL PROCESS

New England Electrical Workers Benefit Fund
c/o Zenith American Solutions
8 Fairfield Blvd, Suite 105
P.O. Box 5817
Wallingford, CT 06492-7617
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

COLLECTIVE BARGAINING AGREEMENTS

This Fund is maintained under various Collective Bargaining Agreements. You may obtain copies of the most current versions of these Agreements upon written request to the Plan Administrator for a nominal charge or from your Local Union. They are also available for examination at the Benefits Fund Office.

Participants in the Plan can receive from the Benefits Fund Office, upon written request, information as to whether a particular employer is a Contributing Employer to the Plan, as well as the Contributing Employer's address. Participants can also receive from the Benefits Fund Office, upon written request, information as to whether a particular employee organization participates in the Plan, as well as the employee organization's address.

FUNDING MEDIUM

The Trustees hold the assets of the Benefits Fund and the investment earnings on such assets 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 Plan and the eligibility rules, even for eligibility periods that have already been accumulated. The Board of Trustees also reserves the right to change or increase the cost of coverage charged to all Participants or any class or classes of Participants.

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 terms of the Trust Agreement, which establishes and governs the Benefit Fund's operations;
5. Are subject to applicable law;
6. Are subject to the provisions of any group insurance policies purchased by the Board of Trustees.

The nature and amount of benefits under the Plan are always subject to the actual terms of the Plan 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.

GRANDFATHERED STATUS UNDER THE AFFORDABLE CARE ACT OF 2008 ("ACA")

This plan is a Grandfathered plan under the ACA.

IMPORTANT: ANY BENEFITS NOT DESCRIBED IN THIS DOCUMENT AS AMENDED FROM TIME TO TIME ARE NOT PART OF THE I.B.E.W. LOCAL 104 PLAN OF BENEFITS.

BENEFITS AND ELIGIBILITY RULES DESCRIBED IN THIS DOCUMENT AS AMENDED FROM TIME TO TIME ARE THE ONLY BENEFITS, AND ELIGIBILITY RULES THAT APPLY TO PARTICIPANTS, INCLUDING ELIGIBLE DEPENDENTS.

From time to time, you may receive a "Summary of Material Modifications (SMM)" whose purpose is to provide you with notice of amendments that 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

EMPLOYEES IN COVERED EMPLOYMENT

Employees in Covered Employment may become eligible for coverage if the required contributions are paid to the Benefits Fund on their behalf for the amount of required contributions to establish or maintain eligibility for different types of employees in Covered Employment.

An employee in Covered Employment is:

1. an employee of Contributing Employers performing work or entitled to pay under a Local 104 Collective Bargaining Agreement that requires the Employer to make contributions to the Benefits Fund on his or her behalf;
2. an employee of employers in the jurisdiction of another local union performing work or entitled to pay under a Collective Bargaining Agreement with that local union that requires the employers to make contributions on his or her behalf to a health and welfare fund that has entered an agreement requiring reciprocation of such payments to the Benefits Fund; or
3. an employee of Contributing Employers obligated to contribute on his or her behalf under the terms of a Participation Agreement between the Employer and the Board of Trustees

After your coverage becomes effective, your eligibility shall continue during each calendar month for which sufficient contributions are made to the Benefits Fund on your behalf or during which hours from your Bank of Hours are available.

ELIGIBLE DEPENDENTS

1. The term "Eligible Dependent" shall mean lawful spouse of either gender of the employee in Covered Employment 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 you present a valid marriage certificate to the Benefits Fund Office within one (1) year of the date of marriage. If presented more than one year from the date of marriage, your spouse will be covered no more than 12 months before the receipt.
2. The term "Eligible Dependent" shall also mean all-natural or legally adopted children of the employee in Covered Employment under 26 years of age.
    a. Newborn children are covered as part of the mother's coverage for the first thirty (30) days of the newborn's life. After the first thirty days, a valid birth certificate must be presented to the Benefits Fund Office, listing the employee in Covered Employment as the child's parent. The birth certificate must be presented within one (1) year of the child's birth to avoid a gap in coverage for the child. If presented more than one year from the date of birth, your child will be covered no more than 12 months before the receipt.
    b. Children of an employee in Covered Employment for whom the employee acknowledges paternity will be covered following the receipt by the Benefit Funds Office of the Certified Birth Certificate of the child.
3. The term "Eligible Dependent" shall also mean any child under 26 years of age for whom the employee in Covered Employment has legal guardianship. The effective date of such child's

enrollment will be the first day of the month following the presentation to the Benefits Fund Office of a certified or attested copy of the order of a court of competent jurisdiction appointing you guardian of the child. The Participant must immediately notify the Benefits Fund Office in the event the appointment is no longer effective, is revoked or modified, or if the employee in Covered Employment is no longer the legal guardian of such child. Copies of pertinent papers or other sufficient proof must be sent to the Benefits Fund Office.

4. The term "Eligible Dependent" shall also mean any Stepchild of an employee in Covered Employment under 26 years of age. A Stepchild is the child of the spouse of an employee in Covered Employment, and the spouse must be listed as the parent of the child on the child's Birth Certificate. The Stepchild will be covered from the date of your marriage (or later if the Stepchild had other coverage), provided that you present a valid Birth Certificate to the Benefits Fund Office within one (1) year of the date of marriage
5. An "Eligible Dependent" shall also mean a child 26 years of age or older who is unmarried and who is unable to earn a living due to a physical or mental incapacity and who is dependent upon the employee in Covered Employment for support. Proof of the continued existence of such incapacity and of the employee's support must 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.
6. The term "Eligible Dependent" shall also mean a child under the age of 26 years of age who is placed with an employee in Covered Employment for adoption by a legally licensed adoption agency before being formally adopted by the employee. Such child must not have attained age 26 as of the date of placement for adoption. Also, the employee 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 adoption. The Plan considers the child's placement with the employee to terminate upon the termination of such legal obligation.
7. The term "Eligible Dependent" shall also mean a child under the age of 26 years of age for whom a Participant is required to provide coverage pursuant to a Qualified Medical Child Support Order.

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

- Marriage Certificate
- Birth Certificate showing both parents' names
- Court documents from a court of law showing legal guardianship/adoption
- Documentation of other insurance coverage either through an employer, a school, or from any other source, including by not limited to Medicare or Medicaid.
- 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 showing that a Dependent child who cannot maintain self-supporting employment is financially dependent on the employee in Covered Employment.
- 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 Benefits 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); however, information about such coverage must be provided to the Benefits Fund. Also, when enrolling a Dependent, the Benefits 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. If a Dependent's eligibility is based on receipt by the Benefits Fund Office of a birth certificate or a marriage certificate, in no event will such Dependent be eligible for benefits more than 12 months before the Fund Office receives such documentation.

Dependent children under the age of 26 of employees or former employees in Covered Employment who are actively working or available for work in Covered Employment (under the rules and policies of the Local Union), who lose coverage due to no longer meeting the Eligibility Rules for Dependent Children, will be offered all others Subsidized COBRA rate. Dependent children who turn age 26 may be eligible for the full Non-Subsidized COBRA rates if requested at the time of loss of coverage.

COLLECTIVELY BARGAINED EMPLOYEES' ELIGIBILITY AND BANK OF HOURS

The basic rules for Coverage of Collectively Bargained Employees and their dependents:

- Eligibility begins after the receipt by the Benefits Fund Office of **500** hours on behalf of the employee in covered employment within a 12 month period.
- Eligibility continues as long as you have **150** hours in your Bank of Hours.
- If you no longer have **150** Hours in your Bank of Hours, coverage will end.

There are other rules regarding eligibility in certain circumstances. The rules are explained more fully below.

WHEN COVERAGE BEGINS

An employee in Covered Employment will become eligible on the first day of the month following the receipt of 500 hours of contributions made on his or her behalf within the previous 12 months.

The eligibility of Eligible Dependents is generally based on the eligibility of the employee in Covered Employment. An Eligible Dependent becomes eligible for benefits when such employee becomes eligible unless documentation required to establish the dependent's eligibility (see above) is not provided, or the dependent qualifies as an Eligible Dependent at a later date.

BANK OF HOURS

The employee in Covered Employment will be credited with one hour in his or her "Bank of Hours" for each hour contributed on his or her behalf by a Contributing Employer under an agreement requiring such contributions.

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

CONTINUATION OF COVERAGE

Contributions by Contributing Employers are required to be made monthly, in the month following the month in which you worked as required by the Collective Bargaining Agreement. 150 hours will be deducted on the first of the month from your Bank of Hours for each month of coverage. If the Benefits Fund receives more than 150 hours in a month, 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 of Hours falls below 150 hours after you have established eligibility, these hours in your Bank of Hours 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 of Hours. You are only entitled to one Skip Month in a row. You are entitled to two Skip Months in any consecutive 12-month period. These Skip Months cannot be consecutive.

"BUY-IN" OF COVERAGE

If your Bank of Hours falls below 150 hours after you have established eligibility, but you have at least 110 hours in your Bank of Hours, 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 an employee in Covered Employment working towards reinstatement.

You may not use this provision more than six times in any 12 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 in Covered Employment pursuant to the rules and policies of the Local Union, you forfeit your Bank of Hours. You will be offered COBRA coverage immediately at the non-subsidized rates.

Please note that this forfeiture *does not apply* to Participants unable to work due to a disability, the Family Medical Leave Act, or military service.

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

ELIGIBILITY WHILE DISABLED

If an employee in Covered Employment is disabled and receives Weekly Disability Income Benefits from the Plan, or is disabled on the job and receives benefits under Workers' Compensation (or similar law) and the Benefits Fund is not receiving contributions on his behalf, the Benefits Fund will freeze his Bank of Hours for the period of time he is receiving either Weekly Disability Income or Workers' Compensation benefits up to a maximum of six months. His eligibility will be maintained during this period, up to a maximum of six months, but no hours will be taken out of his Bank of Hours. If he is still disabled after six months, the Benefits Fund will begin deducting 150 hours per month from his Bank of Hours. Once his Bank of Hours has been exhausted, he 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 that have been reported to the Fund by the Employer, 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 have exhausted your Bank of Hours and have worked at least 110 hours but fewer than 150 hours, you can "buy-in" additional hours.

EMPLOYEES OF PARTICIPATING UNITS WITH NEGATIVE BANKS

The basic rules for coverage of employees of bargaining units with "negative Bank of Hours" and their dependents:

- Eligibility begins the first of the month after you are hired with a "negative Bank of Hours."
- Eligibility continues as long as you have **150** hours in the month before the month of coverage.
- If you no longer have **150** hours accumulated each month until your "negative Bank of Hours" becomes positive, coverage will end.

There are other rules regarding eligibility in certain circumstances. The rules are explained more fully below.

WHEN COVERAGE BEGINS

An employee of a "negative Bank of Hours" bargaining unit that is newly participating in the Plan will become eligible on the first day that the "negative Bank of Hours" bargaining unit's participation begins if he or she had health coverage on the day before the "negative Bank of Hours" bargaining unit began participating in the Plan. You will begin your participation in the Fund with a "negative Bank of Hours" of 500 hours. A newly hired employee of a 'negative Bank of Hours" bargaining unit will become eligible on the first day of the month following the month that he accumulates 500.

BANK OF HOURS

For each week you work or are entitled to pay, hourly contributions will be made by your employer at the rate established by the Trustees on your behalf.

The negative Bank of Hours will be reduced each month by the hours contributed by your employer in excess of the hours required to maintain Continued Eligibility (150 hours per month). Until you have "repaid" your "negative Bank of Hours" with excess contributions, you will not accumulate any positive hours in your Bank of Hours and, thus, will not have any extended eligibility until such time as all of the negative hours in the Bank of Hours have been eliminated, and you have begun to accumulate a positive Bank of Hours.

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

CONTINUATION OF COVERAGE

Your Bank of Hours 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 pursuant to the terms of the Collective Bargaining Agreement in effect. These contributions must be on the basis of hours worked per week. 150 hours will be deducted on the first of the month from the hours reported by your employer on your behalf (and from your Bank of Hours when you have a positive balance) 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 Bank of Hours and your Bank of Hours falls below 150 hours after you have established eligibility, these hours in your Bank of Hours 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 of Hours. You are only entitled to one Skip Month in a row. You may use up to two Skip Months in a 12 consecutive month period. These Skip Months cannot be consecutive.

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.

If you leave employment for any reason, you will run out your Bank of 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.

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 plus earn enough hours to offset the "negative Bank of Hours" balance that you had when terminated.

RETIREES FROM A PARTICIPATING "NEGATIVE BANK OF HOURS" BARGAINING UNIT

You will be eligible to receive retiree benefits from the Benefits Fund if:

BEFORE MEDICARE ELIGIBILITY

If a Participant, on or after turning 55 years of age, is eligible to continue under the Fund with Retiree Benefits until they are eligible for Medicare coverage or age 65 (whichever comes first), if they meet all of the following requirements:

1. The Participant is eligible for benefits on his or her retirement date, with either hours worked, banked hours, or COBRA self-payments
2. The Participant has been credited with at least 5,000 hours worked in the seven years immediately preceding your retirement. For this purpose, the Participant will be credited with 40 hours per week for each week he or she received Weekly Accident & Sickness benefits or Workers' Compensation benefits for which no contributions were made on their behalf. If the Participant did not have 5,000 hours during that period, he or she will not be eligible for coverage as a retiree under this Fund but will be eligible for COBRA coverage subject to the limitations for COBRA coverage under the Fund.
3. The Participant has been a participant of the Fund or participant of a Fund that has merged into this Fund for at least 10 consecutive years immediately before retirement, or has worked for a Participating Employer for at least 10 consecutive years immediately before retirement and participated in that Employer's health plan before the time it became a Participating Employer and have participated in the Fund from the time the employer became a Participating Employer.

4. The Participant makes the required monthly self-payment rate on time. The monthly self-payment rate is determined annually and may change during the pre-Medicare period.

MEDICARE ELIGIBLE

Once a Participant is covered under the Fund based upon the Before Medicare Eligibility provisions becomes eligible for Medicare, he or she must apply for and enroll in Medicare Parts A or B), and then their coverage will change to a **Medicare MedAdvantage Benefit**. If the retired Participant does not elect Medicare Parts A and B when they become eligible for Medicare, the Benefit Fund will not consider their Part A or Part B claims until proof of Medicare eligibility is provided to the Fund Office.

If you retire before working the required number of hours, the "negative Bank of Hours" bargaining unit 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 receipt of 5,000 hours, at the regular monthly retiree self-payment rate.

ELIGIBILITY PROVISIONS FOR NON-COLLECTIVELY BARGAINED EMPLOYEES

The Board of Trustees may enter into an agreement, known as a Participation Agreement, with a Contributing Employer to provide coverage under this Plan to its employees who do not work in employment covered by the Collective Bargaining Agreement and who are not members of another union and who have not "opted-out" of coverage. Contributions are paid under the terms of the Participation Agreement, and they are paid before the month of coverage.

ELIGIBILITY FOR NON-COLLECTIVELY BARGAINED EMPLOYEES

Non-collectively bargained employees will become covered on the first day of the month following the receipt by the Benefits Fund of the equivalent of two consecutive months of contributions required under the Participation Agreement.

Health coverage will be continued, every month, as long as the monthly contributions as required under the Participation Agreement are remitted timely.

Eligibility for benefits will terminate on the last day of the month in which any of the following occur:

- The Employer has paid contributions to maintain eligibility;
- The Participation Agreement terminates; or
- The Plan terminates or no longer allows coverage for non-collectively bargained employees.

Non-collectively bargained employees do not have any reinstatement provisions; they will be offered COBRA privileges when they leave employment under the COBRA rules and must reestablish eligibility pursuant to the initial eligibility rules. Only if you leave employment with the Employer or have another "qualifying event" will you be offered COBRA privileges.

BANK OF HOURS

Non-collectively bargained employees do not accrue a Bank of Hours. However, if a Collectively Bargaining Agreement employee has a Bank of Hours and becomes employed under a Participation Agreement as a Non-Collectively Bargained participant, he or she will retain the unused Bank of Hours previously accumulated.

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 (160 or 200 hours, as the case may be) 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 160 or 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.

ELIGIBILITY FOR RETIREE BENEFITS

ELIGIBILITY BEFORE MEDICARE

If you retire on or after turning 55 years of age, you are eligible to continue your coverage under the Plan 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, based on Employer contributions, your Bank of Hours, or COBRA self-payments.
2. You have been credited with at least 5,000 hours of contributions 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 retiree coverage under the Plan, 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 at least annually and may change at any time.
4. You have been a participant for at least ten consecutive years immediately before retirement in this Benefits Fund or in a health fund that has merged into this Fund and

ELIGIBILITY AFTER YOU BECOME ELIGIBLE FOR MEDICARE

To qualify for your Anthem Medicare Advantage Plan (PPO) you must meet the following conditions:

- You are a United States citizen or lawfully present in the US.
- You are entitled to Medicare part A and enrolled in Part B
- You pay your Medicare Part B premiums.

To qualify for your Medicare Part D plan through UHC/Sav-Rx you must be enrolled into Part D and or have creditable coverage for your previous prescription drug plan.

For any questions pertaining to your Medicare insurance plan (Medical or Drug) please contact Labor First at (203) 204-6223 or toll free (833) 550-1684.

DELAYING RETIREE COVERAGE

Upon retirement, a Participant who is otherwise eligible for retiree coverage but subsequently left the plan and maintained continuous credible coverage elsewhere, to reenter the plan for retiree coverage at the then-current retiree rates for their applicable class of coverage.

At the time of the delayed election of retiree coverage, both the retiree and spouse must show proof of continuous coverage for the entire period from the date they were first eligible for retiree benefits through the date of the delayed election.

COVERAGE FOR DISABLED PARTICIPANTS

Participants who become disabled before age 62 may be eligible to continue coverage in the Plan after their Bank of Hours has been used. 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 Pension Trust Fund affiliated with a Local Union participating in the Benefits 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

If you are called into "qualified military service," as that term is defined in Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), your coverage will terminate on the last day of the month you are called into such service, and your Bank of Hours will be frozen on that date. Your Eligible Dependents will continue to be covered for eighteen (18) months. 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").

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 of "Continuation of Coverage". This Participant's Employer may continue to remit monthly contributions under 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 coverage and self-pay for benefits until he or she meets the "Continuation of Coverage" rules of the Plan. For employees of bargaining units with "negative Bank of Hours", 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 Bank of Hours. A participant who requests that his or her Bank of Hours be frozen must notify the Fund Office when he or she leaves work in Covered Employment and begins work in Non-Collectively Bargained employment at the Contributing Employer.

SPOUSE AND DEPENDENTS' COVERAGE AFTER AN EMPLOYEE'S DEATH

If you die while you are an active participant based on your employment, your covered spouse and your covered Dependents will be provided with full coverage under the Plan, at no cost, for a period of three (3) years. Eligible Dependents will first be eligible based on your Bank of Hours, if any, and then the three (3) year period commences. After that, your spouse will be eligible for benefits in the Plan for your spouse's lifetime on a self-pay basis. Your spouse must timely make monthly payments at the subsidized COBRA monthly premium to maintain coverage. If your spouse is age 60 and over with at least ten (10) years of

coverage under the Plan, coverage will be free. If the Spouse has less than ten (10) years in the Plan when age 60 is attained, they may pay until reaching combined ten (10) years in the Plan and coverage becomes free. If your spouse remarries, coverage in the Plan will terminate.

If you die while you are an eligible retiree, your spouse and your Dependents will be provided with full coverage under the Plan, at no cost, for a period of three (3) years. After that, your spouse will be eligible for benefits in the Plan for your spouse's lifetime on a self-pay basis. Your spouse must timely make monthly payments at the subsidized COBRA monthly premium to maintain coverage, unless they attained age 60 with ten (10) years of coverage under the Plan, then it would be free. If your spouse remarries, coverage in the Plan will terminate.

DEPENDENTS' COVERAGE AFTER A PARTICIPANT'S DEATH

Covered Dependent children who have parents who are either deceased or incarcerated and who were eligible for benefits in the Plan before their parent's 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.

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" for additional information about continuing coverage)

The Trustees may, in their sole discretion, from time to time, change, or discontinue all or any part of the benefits. 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. 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, from time to time change the premiums that shall be paid to maintain coverage under the Plan.

TERMINATION OF DEPENDENT COVERAGE

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

1. The date on which the employee in Covered Employment's coverage terminates (See "Spouse and Dependents' Coverage After a Participants' Death" above for additional information).
2. The date a Participant no longer satisfies the eligibility rules for Dependent coverage. However, an Eligible Dependent whose coverage is terminating may be eligible to elect COBRA continuation coverage.
3. 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 I.B.E.W. Local 104 Plan of Benefits may run out his or her Bank of Hours. Once the Bank of Hours is exhausted, the participant shall be deemed "Unavailable for Work in Covered Employment." The participant will be offered "Not Available for Work" COBRA continuation coverage. See "Forfeiting your Bank of Hours" 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 a "Qualifying Event" (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 Plan due to the termination of employment (for other than gross misconduct) or a reduction in work hours, the covered Participant may purchase continued coverage 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 non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29-month disability extension. Note that the monthly COBRA premium will be 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 Plan 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 a Participant while the Participant is on COBRA continuation coverage may make an election to go on COBRA continuation coverage (or the Participant may make an election to cover the child if the child is a minor), if the Participant enrolls the new child upon birth or adoption.

4. If the spouse or dependent child of any covered Participant is covered by the Plan 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 employee in Covered Employment

- Divorce of the employee and spouse
- A dependent child is no longer considered a dependent child as defined by the Plan; or
- A dependent child or spouse loses coverage because the employee becomes entitled to Medicare.

5. A covered employee'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.

NOTIFYING THE FUND OFFICE

A covered Participant must notify the Fund Office within 60 days after a divorce or a dependent child's loss of Fund eligibility. Your right to COBRA coverage depends on this notice. Also, 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 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 Zenith American Solutions
P.O. Box 5817
Wallingford, CT 06492-7617
Attention: COBRA Notification

Important: Be sure to provide the notice in such a manner to ensure that the Fund Office receives your notice within the time limits. If the covered Participant 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 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 Office 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.

HOW COBRA COVERAGE IS PROVIDED

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. However, employees may also elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

ELECTION PERIOD

You must elect COBRA continuation coverage within 60 days of the date you are notified of your right to elect COBRA continuation coverage or the date that your coverage ends, if later.

You must complete and return the election form provided to you by the Plan Administrator. Your coverage under the Plan will be continued under COBRA from the day that you would have lost coverage provided that:

a. The election form is completed and received by the Plan Administrator within 60 days of the date you were notified of your right to elect COBRA continuation coverage, 60 days from the end of coverage based on the Bank of Hours or 60 days from the date of your "qualifying event," whichever is later, and
b. The initial required premium is paid to the Plan within 45 days following the date of your COBRA election and is thereafter remitted to the Plan when due on the first of each month.

COBRA PREMIUM PAYMENT

COBRA is paid in monthly installments. The amount of the monthly COBRA premium will be provided to you 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 45 days from the date of the COBRA election and must cover the entire period of time going back to when your coverage terminated. For example, if you lose coverage as of March 1 and elect to take COBRA coverage on April 15, you have until May 31 to make your first premium payment, but it must cover the period going back to March 1—the date you had to begin to self-pay for COBRA coverage—which is three months.

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: Payments after the first COBRA payment must be made on or before the first day of each month. You will not be billed monthly. You will have a grace period to pay the required monthly premium until the end of the month or 30 days, whichever is longer. It is recommended that COBRA payments be received in the Fund Office the month before the coverage month: for example, January's COBRA payment should be mailed so that it is received by the Fund Office on December 20th. This will avoid any interruption of claim and/or prescription coverage.

Failure to pay the required monthly premium by the end of the grace period will result in the termination of your COBRA continuation coverage back to the beginning of the month. All claims submitted for services rendered in that month will be denied. Once terminated, your COBRA continuation coverage cannot be reinstated.

The type of coverage will generally be the same as the type of coverage the covered Participant 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 concerning whom a Qualifying Event has not occurred. Your COBRA coverage will include coverage of Accident and Sickness benefits, as described in this SPD. 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 in the Plan, the Participant should notify the Plan. 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 Office.

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.

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 becomes 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.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office as defined in this document at the address in the front of this SPD. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website.)

KEEP THE FUND OFFICE INFORMED OF ADDRESS CHANGES

To protect your family's rights, you should keep the Fund Office up to date on any changes to the addresses of your family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

TRADE ACT OF 2002 AND COBRA

The Trade Act of 2002 created a special second COBRA election period, of up to 60 days, for individuals whose employment was displaced by import competition or shifts of production to other countries. In addition, the Act provided that the Treasury Department could advance Health Care Tax Credit ("HCTC") directly to a group health plan for qualified workers. The Trade Act of 2002 was signed into law on August 6, 2002, and was effective as of November 4, 2002.

The Act provides for this second election period so that people who did not elect to take COBRA benefits during their initial election period could have another opportunity to elect extended benefits after becoming eligible for the HCTC (or state assistance for medical benefits).

The US Department of Labor (DOL) must certify that individuals are eligible. Employers may apply to the DOL for certification of a group of workers, or an individual worker may apply for individual certification. The DOL determines if the worker's job was lost for trade-related reasons.

HEALTH CARE TAX CREDIT

The Health Care Tax Credit ("HCTC") is a federal income tax credit of up to 65% of the premiums paid for qualified health insurance coverage, including COBRA coverage, by eligible "trade-displaced workers" who do not have other specified coverage. Workers are generally eligible for the HCTC if they are receiving trade assistance under the Trade Act of 1974 or getting a pension paid for by the Pension Benefit Guaranty Corporation (PBGC). "Qualified health coverage" means coverage of immediate family members for qualified coverage that excludes dental benefits.

The Trade Act of 2002 provides for the advance payment of HCTC directly to the qualified insurers for credit-qualified workers beginning on August 1, 2003. However, regardless of the payments from the Treasury Department, the worker would still have to pay at least 35% of the COBRA premium in keeping with the terms of the Plan.

SECOND ELECTION PERIOD

The second COBRA election period of up to 60 days begins the first day of the month in which a worker becomes eligible for federal trade adjustment assistance. However, the period may not extend beyond six months after the worker's original qualifying event.

An individual is eligible for this second election period if he (1) is receiving trade adjustment assistance (which requires government certification); (2) lost health coverage because he lost his job in a way that triggered his eligibility for trade adjustment assistance; and (3) failed to elect COBRA during the regular COBRA election period.

If the worker elects extended benefits during this second election period, coverage begins on the first day of the second election period. There is no retroactive coverage for the gap between the initial loss of coverage and the first day of the second election period. However, the second COBRA election period does not extend the original COBRA benefit period, which is still measured from the loss of coverage due to a qualifying event. Individuals seeking to elect COBRA coverage during this second election period must prove that they are certified to receive assistance.

Only a former worker may take advantage of the second election period, though he may do so on behalf of his eligible dependents. Dependents do not have an independent right to elect COBRA coverage in the second election period.

The Trade Act of 2002 does not create any new COBRA rights. Only workers who received COBRA notices after their qualifying event can elect COBRA during the second election period.

When the Fund Office receives the election form, the worker's coverage begins on the first day of the second election period. Please note that the workers' period of coverage runs from the date of his qualifying event, even though coverage is not retroactive to that date.

SECTION 2. MEDICAL BENEFITS – ABOUT AND HOW TO

Since August 1, 1976, the Fund has administered its own self-funded health plan. Your employer makes contributions to the Fund on your behalf under the Collective Bargaining Agreement to which is signatory with the I.B.E.W. Local No. 104, or through a Participation Agreement for non-Collectively Bargained workers. The Trustees use these contributions to fund the benefits provided to you and your family.

At times, you may be asked for certain information about a claim for benefits. For instance, 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. You and your eligible Spouse and Dependents will be required to submit information about any other insurance you may have that may cover health claims. 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.

INTERNET

You may also access your claim information at any time by visiting the Fund Office's website: www.zenith-american.com. The first time you visit the website, click on Member Access (on the right side of the site) and enter your "Login ID," which is your last name in ALL CAPITAL LETTERS; your "Password" is the last four digits of your 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, at (800) 832-6538 if you need assistance with your online 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)." The vast majority of the medical providers in your area participate in the Anthem network. When you choose an "In-Network" provider, 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.

SECTION 3. MEDICAL BENEFITS - SCHEDULE OF BENEFITS

WHAT DO "IN-NETWORK" AND "OUT-OF-NETWORK" MEAN?

The Fund has contracted with Anthem to use Anthem's "Network" of medical professionals. Anthem has an agreement with these professionals regarding the cost of the services they provide. As a result, you pay only a copayment when you see these professionals or use facilities that are in the Anthem network. Any medical professional who is part of the Anthem network is considered to be **In-Network**.

All other medical professionals are considered to be **Out-of-Network**. The Plan only covers a portion of the "reasonable and customary" charges, as determined by the Fund Office for services provided by **Out-of-Network** providers. You must pay any amount the Plan does not pay.

Whenever possible, you should visit an In-Network medical professional and use In-Network medical facilities. You can find these by going to the Anthem website.

PREVENTIVE CARE SERVICES (UNDER ACA) PROVIDED BY THE PLAN

Even though this Fund is Grandfathered under the rules of the Affordable Care Act (ACA), it follows the ACA's rules regarding preventive care. You will have **no copayment** for any In-Network services that are considered ***preventive care*** under the ACA. The list of those services is subject to change. For information about what services are considered to be "preventive care" under the ACA, please go to the following link: https://www.healthcare.gov/coverage/preventive-care-benefits/

SUMMARY OF COVERED BENEFITS

The following is a summary of covered benefits provided through the Plan. Use this chart for quick reference when you need these services. In the table below, you are 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 Plan pays and the amount billed by the Out-of-Network provider.

COVERED SERVICE	**IN-NETWORK:** YOU PAY	**OUT-OF-NETWORK:** AFTER YOU PAY THE OUT-OF-NETWORK DEDUCTIBLE, THE PLAN PAYS
ROUTINE SERVICES		
Routine Examinations (includes immunizations): age 2 and over One exam per calendar year[1]	No copayment (ACA *preventive care* benefit)	50% of "Reasonable and Customary" Amount
Routine Examinations (includes immunizations): age 2 and over **Additional exam in calendar year**Error! Bookmark not defined.	$30 Copayment	
Well women visits[2] One exam per calendar year	No copayment (ACA *preventive care* benefit)	50% of "Reasonable and Customary" Amount

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

[2] These visits focus on preventive care for women, which may include: services, like shots, that improve your health by preventing diseases and other health problems' screenings, which are medical tests to check for diseases early when they may be easier to treat; education and counseling to help you make informed health decisions

COVERED SERVICE	**IN-NETWORK:** YOU PAY	**OUT-OF-NETWORK:** AFTER YOU PAY THE OUT-OF-NETWORK DEDUCTIBLE, THE PLAN PAYS
Pap smears	No copayment (ACA *preventive care* benefit)	50% of "Reasonable and Customary" Amount
Mammogram One mammogram per calendar year	No copayment (ACA *preventive care* benefit)	50% of "Reasonable and Customary" Amount
Intrauterine Device ("IUD")	No copayment	50% of "Reasonable and Customary" Amount
Routine Well Baby Care (includes immunizations) up to 2 years of age	No copayment (ACA *preventive care* benefit)	50% of "Reasonable and Customary" Amount
Physical Examination for Federal Commercial Driver License (1 per year) (in lieu of a Routine Examination)	$30 Copayment	You pay: $30 Copayment
Colonoscopy	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Proctoscopy/Sigmoidoscopy	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Prostate-Specific Antigen	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Endoscopy	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Cardiac Rehab/Phases I, II, and III (with documented diagnosis during the preceding 12 months)	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Pulmonary Rehab (with documented diagnosis during the preceding 12 months)	Covered by "Inpatient ($200)" 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 ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Wound Care/Hyperbaric Chamber	$30 Copayment	50% of "Reasonable and Customary" Amount
Neuropsychology Testing (educational testing is not a covered expense)	$30 Copayment	50% of "Reasonable and Customary" Amount
Crisis Intervention	$30 Copayment	50% of "Reasonable and Customary" Amount

COVERED SERVICE	IN-NETWORK: YOU PAY	OUT-OF-NETWORK: AFTER YOU PAY THE OUT-OF-NETWORK DEDUCTIBLE, THE PLAN PAYS
HOSPITAL EXPENSES		
Inpatient (Room & Board and all related charges, including physician, x-ray, lab, etc.)[1]	$200 Copayment per day to a maximum of 3 days per stay (maximum $600[2]). This Copayment covers all services (for example, surgeon, anesthesia, and so on) at the 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 the facility.	50% of "Reasonable and Customary" Amount
Urgent Care Centers/Walk-In Clinics	$50 Copayment	50% of "Reasonable and Customary" Amount
Observation Stays Over 24 hours	$200 Copayment per day to a maximum of 3 days per stay	50% of "Reasonable and Customary" Amount
Emergency Room	$150 Copayment. Emergency Copayment is waived if Participant is admitted into the hospital	$150 Copayment. Emergency Copayment is waived if Participant is admitted into the hospital
Pre-admission testing	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
PHYSICIANS' EXPENSES		
Office Visits (includes Allergy Treatment)	$30 Copayment	50% of "Reasonable and Customary" Amount
Telehealth Option through *LiveHealth Online*	No Copay	N/A (only available through *LiveHealth Online*)
Allergy Treatments where there is no Office Visit	$5 Copayment	50% of "Reasonable and Customary" Amount

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

[2] The maximum amount that you will spend for your family in one calendar year is $1,200 (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 OUT-OF-NETWORK DEDUCTIBLE, THE PLAN PAYS
Surgery (outpatient services include related charges, such as an assistant surgeon, x-ray, lab, etc.)	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Anesthesia	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount[1]
Oral Surgery- Boney Impacted Wisdom Teeth	$30 Copayment	50% of "Reasonable and Customary" Amount
Maternity/Obstetrical Care – Inpatient (participant, eligible spouse or dependent daughter)	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Breast Pumps	100% no Copayment	50% of "Reasonable and Customary" Amount
Heart Catheterization	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Fertility: Coverage for *in vitro* fertilization, embryo transfer, and artificial insemination. (Office Visit = $30 Copayment). Lifetime Maximum of $20,000 per person.	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Elective Abortion - Outpatient	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Voluntary Sterilization (includes physician and hospital expense) Vasectomy Tubal Ligation	Covered by "Inpatient ($200)" or "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Radiation Therapy	No copayment	50% of "Reasonable and Customary" Amount
Chemotherapy	No copayment	50% of "Reasonable and Customary" Amount
Injections to treat a disease or illness (B12 shots, cortisone, etc.)	$30 Copayment	You pay: $30 Copayment
PRP & Stem Cell Injections -to treat osteoarthritis	$30 Copayment	You pay: $30 Copayment

[1] Note: if treatment is provided by an In Network physician at In Network facility, anesthesia will be considered "In Network"

COVERED SERVICE	IN-NETWORK: YOU PAY	OUT-OF-NETWORK: AFTER YOU PAY THE OUT-OF-NETWORK DEDUCTIBLE, THE PLAN PAYS
Vaccination to prevent disease (regardless of where vaccination is administered) (Flu shots, shots to prevent disease, shingles, pneumonia, etc.)	$30 Copayment	You pay: $30 Copayment
"Typing" recipient (and donor search costs) for immediate family members related to bone marrow transplants.	$30 Copayment	50% of "Reasonable and Customary" Amount
Medically Necessary and Approved Transplants	Covered by one "Inpatient ($200)" or one "Outpatient ($100)" Copayment	50% of "Reasonable and Customary" Amount
Therapies • Chiropractic Care • Physical Therapy • Occupational Therapy • Speech Therapy[1] • Massage Therapy[2,3] For each of these five types of therapy, there is a limit of 30 visits per therapy per calendar year. An additional 15 visits are allowed if related to surgery[4].	10 Copayment $30 Copayment for Office Visits	50% of "Reasonable and Customary" Amount
Second and Third Surgical Opinion	$30 Copayment	50% of "Reasonable and Customary" Amount
Diagnostic X-Ray/Laboratory Tests	No copayment	50% of "Reasonable and Customary" Amount
Major Imaging (MRI, CAT Scan, PET Scan, Bone Density, etc.)	$30 Copayment	50% of "Reasonable and Customary" Amount
Ambulance Services	$30 Copayment only if charges are incurred because of injury or life-threatening illness. The Plan will not pay any ambulance charges for services incurred strictly for the convenience of the patient.	

[1] Effective January 1, 2022, the Speech Therapy benefit for Medicare-eligible retirees allows Medicare-eligible retirees a maximum 30 visits per plan year. This coverage is now provided by the Fund's Medicare Advantage provider.

[2] Massage therapy is treated as any other therapy, up to the combined thirty (30) visits per calendar year with a $10 copayment. The Plan'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.

[3] For Medicare-eligible retirees, the massage benefit is the same benefit as active participants receive (there is a limit of 30 visits per therapy per calendar year, with an additional 15 visits allowed if related to surgery).

[4] For example, a participant can receive 30 Chiropractic and 30 Physical Therapy visits in a calendar year. Before July 1, 2020, this was an overall limit (all therapies combined were limited to 30 visits per year).

COVERED SERVICE	IN-NETWORK: YOU PAY	OUT-OF-NETWORK: AFTER YOU PAY THE OUT-OF-NETWORK 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	$30 Copayment	50% of "Reasonable and Customary" Amount
HOSPICE CARE		
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")		
For charges in excess of $1,500, benefits can only be paid if Health Care Strategies determines that the treatment is a medical necessity[1]	$30 Copayment	50% of "Reasonable and Customary" Amount
MENTAL AND NERVOUS BENEFIT (AT A FACILITY WITH PROPER ACCREDITATION AS DETERMINED BY LOWER HUDSON VALLEY EMPLOYEE ASSISTANCE PROGRAM)		
Inpatient (Room & Board and all related charges, including physician charges, x-ray, lab, etc.)	$200 Copayment	50% of "Reasonable and Customary" Amount
Partial Hospitalization (2 for 1)	$200 Copayment	50% of "Reasonable and Customary" Amount
Outpatient Treatment (includes intensive treatment)	$30 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.)	$200 Copayment	50% of "Reasonable and Customary" Amount

[1] Medically necessary expenses for the treatment of temporomandibular joint ("TMJ") disorders in excess of $1,000 are covered once medical necessity is determined by utilization review entity. 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 OUT-OF-NETWORK DEDUCTIBLE, THE PLAN PAYS
Partial Hospitalization (2 for 1)	$200 Copayment	50% of "Reasonable and Customary" Amount
Outpatient Treatment (includes intensive treatment)	$30 Copayment	50% of "Reasonable and Customary" Amount
Other Services		
Durable Medical Equipment[1]	$30 Copayment	50% of "Reasonable and Customary" Amount
Dialysis Benefits	No Copayment	50% of "Reasonable and Customary" Amount
Hearing Care Benefits	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 in SECTION 6	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	$30 Copayment	50% of "Reasonable and Customary" Amount
Orthotics	$30 Copayment	50% of "Reasonable and Customary" Amount
Acupuncture	$30 Copayment	50% of "Reasonable and Customary" Amount
Nutritional/Educational Services (Maximum 10 visits per calendar year[2])	$30 Copayment	50% of "Reasonable and Customary" Amount
Feeding Specialist[3]. The Fund provides up to 30 Feeding Specialist visits per calendar year for any patient who meets the guidelines noted below.	$30 Copayment	50% of "Reasonable and Customary" Amount

[1] 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

[2] Additional educational sessions, in excess of the Plan'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.

[3] 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 OUT-OF-NETWORK 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 (available by prescription only)	$25 Copayment	$25 Copayment
Naturopath/Homeopathic/Osteopathic services (does not include supplies)	$30 Copayment	50% of "Reasonable and Customary" Amount
Smoking Cessation Program	$30 Copayment	$30 Copayment
Certain Dental Services are considered under medical if necessitated by bone loss due to cancer treatment	$30 Copayment	You pay: $30 Copayment

PRECERTIFICATION

The Fund requires Active and Non-Medicare Retired Participants to "Pre-certify" all inpatient stays and many outpatient services. The program is designed to help you evaluate the care you need.

PRECERTIFICATION REVIEW

The precertification review process 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 Plan?
- Are the proposed health care providers considered In-Network providers?

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 THE PRECERTIFICATION REVIEW WORKS

- Precertification is required for a hospital admission. If your Physician recommends a Hospital admission or certain services that require certification by HealthLink, remind him or her that you will need to obtain this precertification.
- Examples of Services Requiring Pre-Certification
    - Inpatient Services
    - Surgical Procedures
    - Ancillary Services
    - Durable Medical Equipment
    - Diagnostic Imaging

- Specialty Infusion Drugs
- NOTE: the list of services are subject to change periodically; contact HealthLink (at the number below)

- You or your Physician should call the precertification phone number – (877) 284-0102 – before a scheduled treatment. You must call at least one business day before your Hospital admission or treatment; 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 the 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 the Precertification 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 Plan also provides 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.

TELEHEALTH OPTION

You and your dependents will be able to contact a qualified primary care provider, psychologist, or therapist online using Anthem Blue Cross Blue Shield's LiveHealth Online. You'll be able to use your smartphone, tablet, or computer (if it has a webcam) to receive a "virtual checkup" without leaving your home.

There is no cost to you (no copayment), so this should be a more convenient and effective way for you and your dependents to receive medical attention for minor medical services. Of course, this service should only be used for services such as allergies, cold, flu, bronchitis, pink eye, rash, and the like. You can also get help for issues like stress, anxiety, depression, and family/relationship concerns. LiveHealth Online doctors can even write prescriptions.

Just download the app or register online by entering your name, email address, and a personal password of your choice. Then select "Anthem Blue Cross/Blue Shield" as the provider and enter the EWQ number shown on your new ID card.

Remember that LiveHealth Online is not for emergencies. If you're experiencing an emergency, call your doctor or 911 immediately.

You'll need high-speed Internet access, a webcam built-in, and audio (microphone/speaker). To learn what computer hardware and software you need, go to LiveHealthOnline, select "Frequently Asked Questions" under the "How it Works" tab.

For a smartphone app, search for "LiveHealthOnline" in the app store for your smartphone.

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 [(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 during a Hospital stay will be made on the same basis as any other illness.

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.

OUTPATIENT BENEFIT

You will be responsible for a $30 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, as well as any balance of the billed amount. Please see the schedule of benefits.

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 (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.

OUTPATIENT BENEFITS

You will be responsible for a $30 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. as well as any balance of the billed amount. Please see the schedule of benefits.

[RESERVED FOR FUTURE USE]

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 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 as "In-Network," and the Plan 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

The plan has no 'deductible' for In-Network medical services.

In addition, there is no coinsurance for any In-Network services. However, In-Network co-payments may apply, as listed above.

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 (payments in 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 generally pay 50% of all "Reasonable and Customary" charges after you have paid the deductible shown above.

ANNUAL MAXIMUM / LIFETIME MAXIMUM

The Plan has no annual maximum and no lifetime maximum on the level of benefits it pays for you and each of your covered Dependents. That is, all expenses that you and/or your covered Dependents incur will be paid by the Plan (subject to any coinsurance and subject to the rules of the Plan).

OUT-OF-POCKET MAXIMUM: OUT-OF-NETWORK AND IN-NETWORK

The Plan limits the amount that you will pay "out of pocket" for In-Network coverage during a Plan Year. The Plan has no limit to Out-of-Network "out of pocket" payments. Copayments apply to the In-Network "Out-of-Pocket Maximum" and Copayments, deductibles, and co-insurance applies to the Out-of-Network "Out-of-Pocket Maximum".

The current limits, which can change annually, are:

	In-Network		Out-of-Network
	Medical	Prescription	
Individual	$ 5,400	$1,200	N/A
Family	$10,800	$2,400	N/A

SECTION 4. 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 Available.

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[1]	Mail Order Pharmacy[2]
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 Plan will not cover a prescription filled at either Walmart or Sam's Club.

WALK-IN (90-DAY AT RETAIL) PRESCRIPTION BENEFIT

The Fund allows you to receive a 90 day supply of prescriptions at a retail pharmacy. Your copayment is the same as the "Mail Order Pharmacy" amount shown on this page.

[1] Maximum 30 day supply
[2] 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

The Plan covers baby formula that requires a prescription. The Plan 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. This prescription *is not* Part of the Prescription Drug Program. It will be paid directly from the Fund. Baby formula that is available over-the-counter *is not* covered under this Plan. Periodic updates will be requested from the Fund Office.

SECTION 5. HEARING CARE BENEFIT

The Plan 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

OTHER HEARING CARE BENEFIT PROVIDERS

The Plan covers 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 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 Plan's maximum reimbursement.

BENEFITS

You will be reimbursed 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.
- Cochlear Implant Processors are considered and paid as an In-Network benefit.

SECTION 6. VISION CARE PLAN

Effective May 1, 2014, the Fund uses the "Blue View Vision" program through Anthem. The Plan's vision expense benefit has an "In-Network" and "Out-of-Network" component, much like the medical benefits.

- If you receive benefits from "In-Network" providers, you may have a lower out of pocket cost.
- If you use an "Out-of-Network" provider, the Blue View Vision program will reimburse you at the benefit level as described in this SPD.
- But, by using an Anthem "In-Network" provider, you should save on vision services, glasses, and contact lenses.

Here's a brief summary of the Plan's vision benefit. Each year, you receive an "allowance" for either eyeglasses or contact lenses, but not both. An "allowance" is the amount that the Plan will pay toward the item.

Blue View Vision Plan Benefits	In-Network Provider	Out-of-Network Provider
Routine eye exam once every calendar year	You pay nothing	You will receive an allowance of $60 that will go toward the cost of the exam
Eyeglass frames Participants and their covered dependents: Once every calendar year, you can select an eyeglass frame and receive an allowance toward the purchase price through Blue View. Blue View: 866 723-0515 (members), 800 521-3605 (providers)	You will receive an allowance of up to $100. After that, you will receive a 20% discount off the remaining cost of the frames	You will receive an allowance of up to $100 toward the cost of the frames.
Eyeglass lenses *(Standard)* Once every calendar year, you can receive any one of the following lens options (note that you can choose only one of the following):		
• Standard plastic single vision lenses (1 pair)	You pay nothing	You will receive a $65 allowance
• Standard plastic bifocal lenses (1 pair)	You pay nothing	You will receive a $125 allowance
• Standard plastic trifocal lenses (1 pair)	You pay nothing	You will receive a $145 allowance
Eyeglass lens enhancements When you visit a Blue View Vision provider to get your eyewear, you can choose to add any of the following lens enhancements at no extra cost.		
• Transition© Lenses (for a child under age 19)	You pay nothing	No allowance
• Standard Polycarbonate (for a child under age 19)		
• Factory Scratch Coating		
Contact lenses once every calendar year		

Blue View Vision Plan Benefits	In-Network Provider	Out-of-Network Provider
Instead of eyeglasses, you can receive an "allowance" toward the cost of contact lenses. You can choose one of the following alternatives:		
• Elective conventional lenses	You will receive an allowance of up to $200 toward the cost of the contact lenses. After that, you will receive a 20% discount off the remaining cost of the contact lenses.	You will receive an allowance of up to $200 toward the cost of the contact lenses.
• Elective Disposable Lenses	You will receive an allowance of up to $200 toward the cost of the contact lenses.	
• Non-elective contact lenses	You pay nothing	

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;
- Ophthalmoscopic examination;
- Summary and findings;
- Recommendations

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

The Plan covers eye refractions for Retirees who are diagnosed with diabetes, regardless of whether Medicare approves and pays for these services up to a maximum $60 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 a 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 Plan's dental plan 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 Fund.

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

DENTAL NETWORK

The Plan now uses the Anthem Dental Network to take advantage of discounts from Anthem network dentists, much like the medical network discussed in this SPD. The fees that you are charged by participating dentists will, generally, be lower than those charged by dentists outside the network.

For example, 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 $2,000 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.

DENTAL BENEFIT

Calendar Year Maximum $2,000

- Note: there is no Dental Calendar Year Maximum for children under the age of 19

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 as determined by the Fund 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 Plan will cover 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 the Fund's utilization review provider. In addition, the Plan will cover 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 the 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

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 orthodontic services in full, you will be reimbursed in one payment (up to the Fund's Lifetime Maximum Benefit).

INELIGIBLE DENTAL EXPENSES

The Plan 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 an 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 the 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 or services that are necessitated by bone loss due to cancer treatment, to sound natural teeth are covered by the Medical benefits of the Plan.

DENTAL BENEFITS FOR CHILDREN, UNDER THE AFFORDABLE CARE ACT

The Affordable Care Act requires non-grandfathered plans to offer coverage of pediatric dental benefits with no copayment. . The Plan offers these benefits with no Copayment (if offered by an In-Network provider). Therefore, you will have **no copayment** for any In-Network services that are considered *preventive care* under the ACA using the Anthem Dental Network. Any child age 18 or under can receive preventive services every 5 months.

SECTION 8. WEEKLY ACCIDENT AND SICKNESS BENEFITS (LOSS OF TIME)

If an employee in Covered Employment is unable to work because of a non-work-related illness or injury, he or she may be eligible to receive a Weekly Accident and Sickness benefit. To be eligible for this benefit, an Employee 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 Plan, 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 for up to six months. In other words, you will maintain eligibility for up to a maximum of six months. 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 employee in Covered Employment or on COBRA, 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 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 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 working outside who is diagnosed with "diabetes with neurological manifestations[1]," this Weekly Accident and Sickness benefit is extended for a period of 30 to 90 days, based upon fall/and/or winter temperatures, effective January 1, 2007.

This benefit is payable to former employees in Covered Employment 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 Participant must agree, in writing, to reimburse the Fund for such extended disability benefits if Social Security 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

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

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 Bank of Hours 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 $800, 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 Fund pays the "Employer" portion of any FICA taxes.

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 the 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, Social Security, or Workers' Compensation, you are not eligible to receive Weekly Accident & Sickness benefits from this Plan.
2. If you are receiving benefits via a no-fault provision of an automobile insurance policy, you will be eligible for Weekly Accident & Sickness benefits only if the monthly benefit you are receiving under the no-fault provision is less than the Weekly Accident & Sickness benefit payable from this Plan. Under those circumstances, this Plan will pay you the difference between the Weekly Accident & Sickness benefit and the amount you are receiving through no-fault.
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 if 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 a weekly disability benefit from an outside fund, your employer, or your Local Union, this Plan will pay you the full weekly benefit, up to the Plan'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

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 benefits, 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,
- You are available for work pursuant to the rules of the Local 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 Workers' Compensation benefits for up to six months. In other words, you will maintain eligibility for up to a maximum of six months. 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 9. 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 and Eligible Dependents with life insurance coverage. 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, under age 70 ..... $50,000

Active employee age 70 and older[1] $25,000

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 65-69 ..... $10,000

Retired employee, age 70 and older $5,000

Dependent spouse of a retired employee $2,000

DEFECTIVE DESIGNATION OF BENEFICIARY

If, for any reason, in the sole discretion of the Trustees, a Participant's designation of a beneficiary is defective, then the death benefits shall be paid in the order listed below. This is known as the *per stirpes* provision of the Fund.

(a) To the Participant's spouse;
(b) To the Participant's surviving children, equally;
(c) To the Participant's surviving parents, equally;
(d) To the Participant's surviving sisters or brothers, equally;
(e) To the estate of the Participant; or
(f) if no executor or administrator is appointed and qualified within 180 days following receipt by the Trustees of notice of the death of the Participant, such death benefits may be paid as the Trustees in their discretion may determine, to or among any person or persons found by the Trustees to be equitably entitled thereto, for instance, by reason of having paid or incurred expenses on account of the funeral or the last illness of the Participant.

[1] On January 1 of the plan year.

SECTION 10. ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT BENEFIT

The Plan 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 employees in Covered Employment 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:

1. You suffer an accidental bodily injury while your insurance is in force; and
2. A loss results directly from such injury, independent of all other causes; and
3. 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[1] 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 SPD. 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.

[1] "pyrogenic": producing pus

SECTION 11. EXCLUSIONS AND LIMITATIONS

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

1. Expenses for Experimental drugs or substances, or for devices, services, or treatments that are Experimental or Investigational, except as may be required under the Patient Protection and Affordable Care Act;
2. Services that are not medically necessary to diagnose or treat an illness, injury, symptom, or complaint, as determined by the Benefit Fund;
3. Claims submitted more than one year from the date of service;
4. Over-the-counter medical supplies including non-prescription drugs or medications;
5. Nutritional supplements, vitamins, and weight loss/gain diet programs, or medications;
6. Over-the-counter baby formula (prescription baby formula *is* a covered expense under the medical benefit);
7. Muscle enhancement drugs;
8. Physician telephone calls in lieu of an office visit, except through LiveHealth Online;
9. Exercise, aerobic, meditation programs and gym memberships;
10. Routine foot care by a podiatrist such as trimming of corns and calluses, except for participants diagnosed with diabetes;
11. Reversals of vasectomies or tubal ligations;
12. Services related to the procurement or storage of donor sperm, sperm banks, embryo storage, embryo freezing, and charges related to surrogate mothers;
13. An injury, illness, or disease suffered while in the military service or resulting from such military service;
14. Any treatment or charge incurred while the covered person is incarcerated in a county, state, or federal prison;
15. Psychiatric services for a condition that is not a mental disorder;
16. 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);
17. Any breast reduction or implant surgery for teenage male participants unless such breast reduction surgery is deemed medically necessary by the Benefits Fund;
18. Cosmetic surgery or plastic surgery, removal of tattoos, face lifting, rhinoplasty, and similar cosmetic procedures unless:
    (a) 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
    (b) Treatment or surgery for a congenital disease or anomaly that has resulted in a functional defect

19. 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;
20. Charges for which the Participant is entitled to benefits under any other group medical plan which is primary;
21. 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 (see Section on "Subrogation Rules" for additional information) within one year of the date that such compliance is requested;
22. Charges incurred because of a court order; such as drunken driving programs, substance abuse programs, spousal/child abuse counseling programs;
23. Any charge exceeding the Reasonable & Customary value of such services and supplies as determined by the Benefits Fund;
24. Blood testing for marriage or paternity tests;
25. Personal comfort items including, but not limited to, telephone, radio, television, air conditioners, saunas, non-prescription items, or personal care services;
26. Special home construction to accommodate a person with a disability;
27. The expense of travel, whether or not prescribed by a physician;
28. Hypnosis and Biofeedback;
29. Core evaluations, intelligence testing, services for Chapter 766 eligibility/early intervention services;
30. Custodial care, including room and board charges in a nursing home, rest home, hospice, old age home, or in a school-like setting;
31. Custodial care, education or training, and/or room and board charges in a facility primarily for the physically or mentally challenged;
32. Charges that the Participant is not required to pay;
33. Charges incurred before the effective date of coverage under the Plan or after coverage is terminated;
34. Any expenses or charges incurred in connection with gender dysphoria;
35. Any expenses or charges incurred in connection with sexual dysfunction (except for certain prescriptions covered by the prescription drug benefit);
36. 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;
37. 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' Compensation 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 in this Summary Plan Description for benefits within one year of the date that such compliance is requested;
38. Any treatment, surgery, medicines, supplies, or drugs not approved by the American Medical Association and/or the Federal Drug Administration;

39. Child birthing classes;
40. Services provided by an immediate family member;
41. Any medical charges incurred because of committing or attempting to commit a felony or felonious act;
42. Wigs or hair prostheses, unless prescribed due to loss of hair resulting from chemotherapy, radiation therapy, burns, lupus, alopecia totalis, or fungus;
43. Corrective shoes, back supports, pillows, and mattresses;
44. Procurement and storage of blood and DNA; and
45. Services not covered by the Benefit Fund's stop-loss carrier.

SECTION 12. PLAN AMENDMENT AND INTERPRETATION

The Trustees reserve the right to change from time to time or to discontinue all or any part of the Plan, including but not limited to the right to change eligibility requirements or benefits for Participants (including Dependents and 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 this SPD (including ambiguous or disputed terms) and any other instruments, forms, policies, or other matters of the Trust or relating to such Trust. Such decision, construction, or interpretation by the Trustees shall be binding upon each Participant and beneficiary.

SECTION 13. COORDINATION OF BENEFITS

In many two-parent families today, both spouses 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 these Coordination of Benefits ("COB") provisions to determine which plan of benefits pays first. The plan that pays first is called the Primary Payer. The plan that pays next is called the Secondary Payer. Under the COB provisions, 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 Expense (the "Allowable Expense" is the covered amount under the Primary Payer or, if lower, under the Secondary Payer, before application of Copayments or Coinsurance). For example,

- Your spouse who is covered by another plan, which is primary, incurs a $1,000 charge.
- Your spouses' plan allows $800 but applies an 80% Coinsurance (or your spouse's plan pays $640.00).
- When the claim is received by the Benefits Fund, it is determined that the Anthem Allowable Charge would have been $850 (with no Coinsurance or Copayment) – more than the amount paid by Primary Payer's Allowable of $800; therefore, the Allowable Expense is $800. The Benefit Fund will provide a benefit as the Secondary Payer up to the Allowable Expense.
- The Benefit Fund will pay the difference between the Primary Payer's Allowable Amount of $800 and the amount the Primary Payer actually paid, 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. These COB rules are designed to conserve health care costs and ensure that providers are not overpaid. If used correctly, the COB rules 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 parents' plans 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 plan of the parent with custody of the child;

c. Third, the plan of the step-parent married to the parent with custody of the child; or

d. Fourth, the plan of the parent not having custody of the child;

5. The plan 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

1. You or any of your Dependents are eligible for Medicare and

2. You remain eligible for benefits from the Plan 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 another document;

Then

1. The Fund will continue to pay for your benefits and your Dependents' benefits as the Primary Payer (pursuant to the other Coordination of Benefits 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 Payer.

IF YOU ARE RETIRED

Medicare is the Primary Payer 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 MedAdvantage 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 Fund's Medicare Crossover number, which is CB00180. Please see the "Medicare Crossover" Section following this Section.

MEDICARE CROSSOVER

If you are retired and on Medicare, you must provide the Fund Office with your Medicare Beneficiary Identifier Number (MBI number). The easiest way to inform the Fund Office is to send in a copy of your Medicare Card. The MBI Number is on the front of the card and consists of nine numbers immediately followed by a letter. All nine 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 MedAdvantage Program.

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 Plan are "Secondary" (pays second). The benefits provided under the Retiree Medicare MedAdvantage 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 Plan will pay these expenses at 100%, including Medicare deductibles, subject to the limitations and exclusions of this Plan.

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.

NOTE: Ambulance Services Exception - if you are a Medicare Participant and require ambulance service that Medicare does not cover, the Fund will pay the benefits as it does for all non-Medicare Participants for injury or life-threatening illness (the Fund will not pay for services incurred strictly for the convenience of the patient).

The Fund requires Retired or Inactive Participants to purchase both Medicare Part A and Part B when they become eligible. If a Participant is eligible to purchase Medicare and does not, the Plan will not provide Medical Coverage for either Medicare Part A or Medicare Part B services until the retiree shows proof of Medicare coverage.

SECTION 14. REIMBURSEMENT, 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 preempts 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 before coverage under the Plan. 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 other person or an insurance carrier, however described or allocated. The Fund shall be reimbursed from such 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 applies 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 assignments.

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 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, your attorney (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 your attorney 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 Plan. The Participant is required to notify the Fund Office of any claim made by the Participant or an 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 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 to the extent of such expenses. The Trustees may intervene in or be subrogated to any related claim or cause of action 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 family'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% 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 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. **In other words, after you receive any payment in damages related to your accident, the Plan will not cover any claims related to that accident.**

WORKERS' COMPENSATION

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 and Weekly Accident and Sickness benefits provided a copy of the "Notice to Contest Liability" is submitted to the Fund Office and 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 in this Section.

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.

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.

NO-FAULT

The following applies to Participants 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 15. GENERAL INFORMATION

CARRYOVER 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 at 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 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 providers, you may be required to pay for them yourself. When you make a 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 SPD, the Fund may recover the excess. The Trustees may recover from you, your spouse, or Eligible Dependent any overpayments or payments made in error. 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, have a death in the family or if 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.

IMPORTANT: each year, you will be required to complete the DEPENDENT INFORMATION REQUEST FORM. Federal regulations require that the Fund updates this additional information regarding any other insurance coverage for you or your covered dependents.

SECTION 16. 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 SPD 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 SPD. General inquiries about the Plan'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, Life Insurance, 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 provided when 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 the condition related to the 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-10 (the diagnosis code found in the *International Classification of Diseases*, 10th 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, the 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 ("EOB") statement 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. You don't need 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 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 12 months after you received treatment or, in the case of Disability benefits, more than six 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 12 months after the date that it was requested. No claim will be paid if the Fund receives this information more than 12 months after it is requested.

Claims for a Life Insurance benefit are not subject to the 12 month claim filing period. The beneficiary of a Live Insurance 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 Life Insurance 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 included in SECTION 26 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 17. ADVERSE BENEFIT DETERMINATIONS

If you believe benefits provided for under the Plan 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 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 SPD (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, an 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 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 (the claimant) will have 180 days following receipt of notification of the denial of 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 before 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 before 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," of this SPD.

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 the deadline for initial claim decision by 15 days	N/A, but may extend the deadline for initial claim decision twice, for periods of up to 30-days each	N/A, but may extend the 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 the 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 the 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 the 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
Claimant Deadline to Appeal Decision	180 days after receiving claim denial	180 days after receiving claim denial	60 days after receiving claim denial

TIME LIMITS FOR CLAIMS			
	Health Claims	Disability Claims	All Other Claims
Trustees Action on Appeal on Post Service Claims	No later than the date of the meeting of the Board of Trustees next following Fund Office's receipt of the appeal request. If the appeal request is received within 30-days of the next meeting, a determination will be made by the date of the second meeting next following receipt of the appeal request. If an extension of time is needed, then a decision will be made by the date of the third meeting following receipt of the 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
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

EXTERNAL REVIEW PROCESS

If your appeal was denied on the basis of a medical judgment, such as a determination that the treatment or service was not Medically Necessary, or was Investigational or Experimental, or a rescission of coverage, you have the right to an external review by a third party.

Note: Determinations that a claimant does not meet the eligibility requirements for the Plan are not subject to external review.

Your request for an external review must be made within four (4) months of the date you receive the Trustees' decision regarding your appeal.

Once you request an external review, the Fund will notify you within six (6) days as to whether your request is complete and whether it is eligible for external review. If your request is incomplete, you will be given until the end of the four (4) month filing period or, if this period has been reached, an additional two (2) days to complete your request.

Once your request for external review is approved, it will be referred to one of the Independent Review Organizations contracted by the Fund.

Within 45 days of referral, the Independent Review Organization will provide a decision to you and the Fund.

EXPEDITED EXTERNAL REVIEW

For certain claims where the timeframe for completion of a standard expedited internal review or a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, an expedited external review may be requested.

If the Fund determines that your request is eligible for expedited external review, it will be referred to an Independent Review Organization who will provide a decision within 72 hours to you and the Fund.

SECTION 18. 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 No. 104 of International Brotherhood of Electrical Workers, AFL-CIO, and the 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 PLAN

The Plan provides medical benefits, prescription drug benefits, dental benefits, vision benefits, hearing benefits, short-term disability benefits, and life 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 Plan may maintain eligibility for a limited period of time on a self-pay basis.

ELIGIBILITY

The Plan'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 SPD. Also, please note any restrictions or requirements in relation to particular benefits are set forth in the Sections of this SPD that describe those benefits.

DESCRIPTION OF BENEFITS

The benefits provided by this Plan are set forth in this SPD. 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 S PD. 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 PLAN/TRUSTEES RIGHT TO CHANGE OR DISCONTINUE THE PLAN

The provisions of this Plan 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 19. 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[1]. ERISA provides that all Plan 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 worksites 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 SPD 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 Plan due to a qualifying event. You, your spouse, or your Dependents may have to pay for such coverage. Review this SPD 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. This Plan does not exclude coverage for pre-existing conditions.

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, including the Trustees. 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.

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.

[1] The Employee Retirement Income Security Act of 1974

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 20. 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 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 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.

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 people 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 a 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 the 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 processes (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 the 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 the 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 the 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 on-site), 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 21. 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 (based on an actuarial analysis of this Fund's prescription drug program), 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 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 SECTION 4 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 your 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 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 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 22. OTHER LEGAL REQUIREMENTS

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 an 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 Plan 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 other 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 act-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 20 business days after the date of the NMSN, the Company shall provide the Fund Office with the notice. Within 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 23. 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 Plan 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 in SECTION 3 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 more 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 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. 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 Plan. 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 is covered until age 26.

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 the accident is related to the actions or inactions of a third party, 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 4 for additional information.

SECTION 24. 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 Participants. Therefore, Participants 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 you help the Fund to receive a credit for that item, the Fund will pay you 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 25. 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 regularly taking. 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 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 in 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 Plan. 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 26. 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, that 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"

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 Fund for participation in this Plan and any other employer 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 for participation in this Plan.

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 agreement with the Trustees providing for contributions to the Benefits Fund for participation in this Plan or work performed for a Participating Union for which it has agreed to contribute to the Benefits Fund for participation in this Plan.

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, 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). Note that this is just an example of a deductible; the Plan's current deductible is noted in SECTION 3.

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").

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. 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 treatment's 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.

FUND OR BENEFITS 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 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 that 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.

INDEPENDENT REVIEW ORGANIZATION (IRO)

AN ENTITY THAT CONDUCTS INDEPENDENT EXTERNAL REVIEWS OF ADVERSE BENEFIT DETERMINATIONS AND FINAL INTERNAL ADVERSE BENEFIT DETERMINATIONS.

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) that 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 PLAN OF BENEFITS

The I.B.E.W. Local 104 Plan of Benefits 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

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.