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Inland Empire Electrical Workers Welfare Trust Fund

Health and Welfare Plan and Summary Plan Description

July 1, 2015

NECA
NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS

INLAND EMPIRE ELECTRICAL WORKERS WELFARE TRUST FUND

HEALTH AND WELFARE PLAN
AND
SUMMARY PLAN DESCRIPTION

July 1, 2015

To All Eligible Participants

This booklet has been updated to reflect the Inland Empire Electrical Workers Health and Welfare Plan benefits and provisions as of July 1, 2015. We encourage you to become familiar with your benefits and the valuable protection they offer. This booklet will also help you understand what services are and are not covered and any special steps you need to take to get the highest level of coverage.

The Board of Trustees for the Inland Empire Electrical Workers Welfare Trust Fund are pleased to provide you with the benefits described in this booklet. The Trustees are responsible for the design and management of the health care benefits that are funded by monthly employer contributions to this Plan. Keep in mind, the Plan is self-insured which means the contributions that come into the Trust Fund go only to pay claims for our members and to pay for the cost of running the Plan – there is no insurance company providing health care coverage. How you use your benefits can help make our health care dollars stretch farther. Here are four things that you can do to help keep our health care costs reasonable:

- **Use the Preferred Provider Network**. You and the Plan save money when you use preferred (PPO) providers (doctors, hospitals, labs, etc.) in the **Aetna PPO** network. These providers have agreed to provide eligible participants with efficient, cost effective services and supplies at discounted rates.

- You can also save money on your prescription drugs by **using Sav-Rx network pharmacies** and the **mail-order pharmacy program**.

- Dental services received from a **Delta Dental** network dentist can save you and the Plan money. Also, these dentists will file the claim on your behalf.

- **Call the *Healthier at Home* Nurse Line** at (866) 886-0633 any time you or a family member is sick, hurt or in need of medical advice.

If you have questions about your coverage or eligibility, please contact the Trust Office.

Sincerely,

Board of Trustees

To keep your eligibility records accurate, notify the Trust Office in writing about any change in:

- Address
- Dependent status (birth, adoption, legal placement for adoption, legal guardianship, death, marriage, divorce, child custody)
- Designated beneficiary

Submit any changes to the Trust Office on a new Participant Data Form.

How to Reach Your Trust Office

Trust Office
Inland Empire Electrical Workers Welfare Trust Fund
1322 N. Post Street
Spokane, Washington 99201

Telephone: (509) 534-0600
Toll Free: (800) 872-8979
Fax: (509) 535-7883
Email: ewwellpower.com

Office Hours

8:00 a.m. to 5:00 p.m. Monday through Thursday
8:00 a.m. to 4:00 p.m. Friday

All times are Pacific Time
Messages may be left on voice mail after hours

This booklet is the summary plan description for the Inland Empire Electrical Workers Health and Welfare Plan medical, prescription drug, dental, vision, life, accidental death and dismemberment and weekly time loss benefits effective July 1, 2015. All benefits described here are subject to eligibility and maintained pursuant to collective bargaining agreements.

The Trust Office personnel are the only authoritative source of information about these plans and your eligibility status. No other organization or people are authorized to represent the Fund in relation to the terms and conditions of these plans.

The Trustees of the Plan can only provide benefits to the extent that the Fund has sufficient assets. The various parties to the collective bargaining agreements may or may not agree to continue contributions, and since current contributions are necessary to maintain the benefits, no employee or spouse should believe that they have a vested right in this Plan, or that the benefits of the Plan will necessarily be guaranteed indefinitely into the future. Unlike a pension plan, this Plan does not guarantee benefits for the rest of the employee's or their dependent's life.

The Trustees reserve the right to exercise discretionary authority to interpret the Plan, as well as the intent of certain provisions, whether specifically included within this Plan document or implied by reasonable standards within the health care industry, including claims processing procedures. The Trustees also reserve the right to modify the Plan, to request additional contributions to fund the Plan, and to establish COBRA contribution rates in accordance with limitations imposed by Federal legislation.

It is expected that this Plan will be continued indefinitely. However, the Trustees reserve the right to modify, change or terminate the Plan at any time.

Table of Contents

Summary of Benefits

The following provides a brief summary of your benefits. For a complete description of the benefits listed below, refer to the appropriate section in this booklet.

Medical Benefits	
Annual deductible: Regular Medical Plan Option B Medical Plan	 $300 per person; $900 family maximum $2,500 per person; $7,500 family maximum
Coinsurance	Plan pays 80% after the annual deductible is met
Annual coinsurance out-of-pocket maximum (after the deductible)	$2,500 per person Once you pay $2,500 in coinsurance, covered charges for the rest of the calendar year are paid at 100%
Prescription Benefits	
Sav-Rx Network Retail Pharmacy (maximum 30 day supply)	$ 5 copayment – generic drugs $25 copayment – brand name drugs
Sav-Rx Mail Order Pharmacy (maximum 90 day supply)	$10 copayment – generic drugs $50 copayment – brand name drugs
Non-network Retail Pharmacy (maximum 30 day supply)	See page 40
Dental Benefits	
Annual deductible	$25 per person; $75 family maximum
Annual maximum benefit	$2,500 per person
Part 1 – Routine oral exams Part 2 – Restorative dentistry and oral surgery	Plan pays 70% the 1st calendar year and benefit payments increase 10% each year, up to 100%, provided the dentist is visited once each calendar year. For each year that you or a covered dependent do not visit the dentist, the amount payable for that person will decrease by 10%, but will not be less than 70%.
Part 3 – Prosthetics	Plan pays 50% of reasonable and customary charges each calendar year
Orthodontia	Plan pays 50%, up to a lifetime maximum of $1,500, for dependent children up to age 26.

Vision Benefits	See pages 47 through 51
Supplemental Benefits Account Plan	Allows you to pay eligible health care expenses for you and your eligible family members with tax-free employer contributions
Employee Weekly Time Loss Benefits	$300/week – Weeks 1-4 $400/week – Weeks 5-26
Employee Life Insurance	$5,000
Employee Accidental Death and Dismemberment Insurance	$5,000

Note: All claims must be submitted within one year of the date services are rendered unless you are not legally capable. Claims submitted more than one year from the date of service will not be considered.

Website Available

The Inland Empire Electrical Workers Welfare Trust Fund has established a website to provide you with immediate access to your Plan information. The site, located at **www.ewwellpower.com**, includes the following Fund related general material:

- HIPPA Privacy Notice and Information

This site will also provide a link to your personal information, which may be viewed through a secure location. This information requires the entry of your user name and password, which you can set up by contacting the Trust Office. The following are included on your personal site:

- Personal Information – name, address, gender, birth date, marital status, etc.
- Health Eligibility – eligibility for the past five years
- Dependent Enrollment Information
- Claim Status - either pending or paid
- Supplemental Benefits Account – check on your balance
- Forms
- Summary Plan Description Booklet – including recent changes to your Plan
- Links to Plan Preferred Provider Networks
- Frequently Asked Questions

If you have any questions about the contents of the website or access to your personal information, please contact the Trust Office at (509) 534-0600 or (800) 872-8979.

Getting Started

It's important for all Plan participants to use these benefits wisely, which starts with understanding them. Carefully read and keep this booklet for future reference, so you understand how to make the Plan work best for you.

Meanwhile, here are some quick tips to help you get started:

Getting Started with Your Coverage

Coverage for you and your enrolled dependents will become effective when you and they meet the Plan's eligibility requirements (see the Eligibility section starting on page 10).

You will be asked to complete and submit a Participant Data Form to provide information about yourself and your dependents, to ensure they will be able to use their benefits. Remember to promptly file a revised Participant Data Form if you have a change that will affect your coverage or access to coverage – changes in address, marital status, number of dependents and information about other insurance are critical. Participant Data Forms can be obtained from the Fund's website (**www.ewwellpower.com**) as well as the Trust Office.

Use Preferred Provider Networks to Save Money

It's important to understand that you and the Plan save money when you use preferred (PPO) providers (doctors, hospitals, labs, etc.) in the **Aetna PPO** network, purchase your prescription drugs through the **Sav-Rx** pharmacy network, and use a **Delta Dental** provider for your dental services.

Your PPO network for medical services is provided through Aetna. To find information on PPO health care providers and facilities, go to the Aetna network website at **www.aetna.com/docfind/home.do** or call the Trust Office at (800) 872-8979.

You can also save money on your prescription drugs by using Sav-Rx network pharmacies and the mail-order pharmacy program. To find a network pharmacy, go to **www.savrx.com**.

Delta Dental network providers have agreed to discounted fees for their services, saving both you and the Plan money. To locate a network provider go to **www.DeltaDentalWA.com**.

For more information and important details about using these networks, see the Medical, Prescription Drug, and Dental benefit sections.

Use Your Card to Access Care

Eligible participants receive a plan identification card that you should carry with you and show to all of your health care providers — for medical, prescription drug and dental benefits. Your card contains important information these providers will need in order to submit claims accurately.

Quick Tip
Carry Your Card

Carry your ID card with you and show it to all health care providers. Your card has important information your doctor, dentist, pharmacist or provider needs in order to file your claim.

Eligibility

Eligibility for benefits is generally determined by contributions made to the Plan for the hours you work each month for participating employers.

When you work under a bargaining agreement requiring contributions to the Fund, ***two dollar bank accounts*** may be established on your behalf:

- One dollar bank account for medical/prescription drug, vision, weekly time loss, life insurance, and accidental death and dismemberment benefits, and
- A second account for dental benefits.

Contributions from your employer for the hours you work go into your dollar bank. For each month you are eligible for benefits, a dollar amount equal to 145 hours multiplied by the current contribution rate will be deducted from your dollar bank to "purchase" eligibility.

Please note, some participating employers have signed agreements that provide for the participation of their non-bargaining unit employees, and eligibility for these employees varies from the general eligibility rules described here. These variations, where they exist, are detailed throughout this section.

Initial Eligibility

Medical/Prescription Drug, Vision, Weekly Time Loss, Life Insurance, and Accidental Death and Dismemberment Benefits

Monthly contributions from your employer for the hours you work are added to your dollar bank. You become eligible for medical/prescription drug, vision, weekly time loss, life insurance, and accidental death and dismemberment benefits on the first day of the second month following the month in which you have accumulated 245 hours worth of contributions at the current contribution rate. For your initial month of eligibility, the deduction from your dollar bank is equal to 245 hours multiplied by the current contribution rate (145 hours to purchase a month of coverage and the additional 100 hours for initial administrative expenses). Any leftover dollars after this deduction stay in your dollar bank and can be used toward future coverage.

The month between the month hours are worked and the month you are eligible for coverage is called the "lag month." Benefits become effective in the month after the lag month. The lag month provides the Fund with the necessary time to receive and process employer contributions, add them to your dollar bank, and establish eligibility.

Dollars are deducted from your dollar bank as you use them for eligibility.

Dental Benefits

Generally, you become eligible for dental benefits when you are eligible for all other Fund benefits provided you have 245 hours in your dental dollar bank account and the required contributions are paid to the Fund. If you do not meet these requirements, then you become eligible for dental benefits on the first of the month following a month in which you meet these requirements.

The following are some examples of how this may work.

Example 1

January	February	March	April	May
Work 145 hours	Work 145 hours Your employer contributes for January hours 145 hours in your dollar bank	Work 145 hours Your employer contributes for February hours **"Lag month"** 290 hours in your dollar bank	Work 145 hours Your employer contributes for March hours 435 hours in dollar bank. 245 hours are deducted from your dollar bank and **coverage begins** 190 hours remain in your dollar bank	Work 145 hours Your employer contributes for April hours 335 hours in dollar bank. 145 hours are deducted from your dollar bank for continued coverage 190 hours remain in your dollar bank

Example 2

January	February	March	April
Work 100 hours	Work 145 hours Your employer contributes for January hours 100 hours in your dollar bank	Work 145 hours Your employer contributes for February hours **"Lag month"** 245 hours in your dollar bank	Work 145 hours Your employer contributes for March hours 390 hours in dollar bank. 245 hours are deducted from your dollar bank and **coverage begins** 145 hours remain in your dollar bank

If You Do Not Work 145 Hours in a Month

If you do not work 145 hours in a particular month, the employer contribution for the hours you did work will be credited to your dollar bank. Once you have accumulated 145 hours multiplied by the current hourly contribution rate in your dollar bank, you will be eligible for coverage in the month ***after*** the lag month.

If You Work More than 145 Hours in a Month

Extra dollars will accumulate and remain in your dollar bank, up to a maximum of 2,000 hours multiplied by the current hourly contribution rate.

Maximum Dollar Bank Balance

The maximum amount you may accumulate in each dollar bank is 2,000 hours multiplied by the current hourly contribution rate. If either dollar bank reaches this maximum, no additional dollars will be credited to your bank until your balance drops below the maximum again.

Non-Bargaining Unit Employees

If you are covered under this Plan as a non-bargaining unit employee of a participating employer that has signed a special agreement providing for your participation, you become eligible for Plan benefits on the first day of the second month following the month in which you have accumulated 245 hours worth of contributions at the current contribution rate. For your initial month of eligibility the deduction from your dollar bank is equal to 245 hours multiplied by the current contribution rate (145 hours to purchase a month of coverage and the additional 100 hours for initial administrative expense). Any leftover dollars after this deduction stay in your dollar bank and can be used toward future coverage.

Maintaining Your Eligibility

Every month after you have established initial eligibility, all contributions made for hours worked are added to your dollar bank. The required dollar amount (145 hours times the current hourly contribution rate) is deducted from your dollar bank for each month of continued eligibility.

Note: there is always a lag month between the month in which hours are worked and the month of eligibility based on those hours, as shown:

January	February	March	April	May
Work 145 hours	Lag month	January hours buy March eligibility		
	Work 145 hours	Lag month	February hours buy April eligibility	
		Work 145 hours	Lag month	March hours buy May eligibility

Non-Bargaining Unit Employees

If you are a non-bargaining unit employee covered under a special agreement, you maintain your eligibility after working the required number of hours each month, followed by a lag month. The required contribution must be paid by your participating employer.

Eligible Dependents

Eligible dependents will be covered as soon as you become eligible. Eligible dependents include your:

- Legally married spouse
- Children under age 26. An eligible child is one of the following:
  - A natural offspring of either you, the employee, or your spouse
  - A legally adopted child
  - A child placed with you for the purpose of legal adoption in accordance with state law. Placed for adoption means assumption and retention by the employee of a legal obligation for total or partial support of a child in anticipation of adoption of such child
  - Children covered under a qualified medical child support order (QMSCO)
  - A stepchild, foster child or a child for whom you are the court-appointed legal guardian.

Dependents that are in full-time military service are not eligible.

Continued Eligibility for a Disabled Child

Coverage may continue after age 26 for an unmarried dependent child who cannot support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following criteria are met:

- The child became disabled before reaching age 26
- The child is incapable of self-sustaining employment because of developmental disability or physical handicap and is chiefly dependent on you for support and maintenance
- You are covered under this Plan
- Within 31 days of the child reaching age 26, you furnish the Plan with information that substantiates the child’s developmental or physical disability.

When Eligibility Ends

Eligibility for you as an employee ends:

- On the last day of the month in which you have less than 145 hours times the current hourly contribution rate in your dollar bank account.
- On the date you enter the Armed Forces of any country.
- On the date the Plan is terminated.
- On the last day of the month in which you fail to make any required contribution.

Eligibility for your dependents ends:

- On the date the employee's coverage ends.
- On the date the dependent enters the Armed Forces of any country
- On the last day of the month that the dependent no longer meets the definition of an eligible dependent.

Eligibility for non-bargaining unit employees ends on the last day of the month following the month in which the employee works less than the required monthly hours.

Continuing Your Coverage Under COBRA

If you or your covered family members lose eligibility and coverage ends, generally you and they are eligible to continue on a self-pay basis under COBRA rules for a period of time. For details, see the COBRA section beginning on page 18.

Coverage may generally be continued under COBRA continuation coverage as described on page 18. As an alternative to COBRA, you may also qualify for the self-payment option - see page 17 for more information.

Reinstating Your Eligibility

If your coverage ends because your dollar bank has less than 145 hours worth of contributions at the current contribution rate, the balance in your dollar bank, if any, is carried for 12 months. If during the next 12 months you work and add dollars to your account, your eligibility will be reinstated on the first day of the second month after your dollar bank has the minimum required for a month of eligibility.

If your eligibility is not reinstated during the 12 month period following the date your coverage ends, the balance in your dollar bank is cancelled, and you are required to satisfy the initial eligibility rules to again be covered.

Termination of Coverage on Bargaining Unit Withdrawal

To protect the financial security of the Plan for the benefit of its remaining participants, the Board of Trustees shall have the authority to cancel any dollar bank accounts of participating employees included in bargaining units and non-bargaining units that cease participation in the Plan. The cancellation of such dollar bank accounts shall be effective on the first day of the second calendar month following the cessation of participation in the Plan.

Reciprocal Coverage

In order that you may protect yourself and your family against becoming ineligible while working outside the Inland Empire Electrical Workers Welfare Trust Fund area, the Trustees have entered into Electrical Industry Health and Welfare Reciprocal Agreements. In order to take advantage of these arrangements, you must take action prior to leaving this area. We recommend you obtain details from your local union office or the Trust Office before leaving for employment outside this area.

Eligibility When Disabled

If you, the employee, would otherwise become ineligible because of your own total disability (occupational or non-occupational), your eligibility for all the benefits you had immediately prior to your disability will continue while you are disabled up to a maximum of six months. No contributions or self-payments are required during the period of total disability extension. Total disability is established by qualifying for weekly timeloss benefits under Workers' Compensation or from the Fund. You must complete and submit a weekly timeloss claim form to the Trust Office for consideration.

This extension will only be granted if you become disabled during a month when you are eligible for Plan benefits and you are unable, due to injury or illness, to perform any work for wage or profit. Contact the Trust Office for assistance with filing a claim.

Family or Medical Leave of Absence

A federal law may apply to family and medical leaves when you work for an employer with 50 or more employees within a 75-mile radius.

To be eligible, you must have worked for your current employer for at least 12 months (not necessarily consecutively) and for at least 1,250 hours in the 12 consecutive months before your leave.

Medical, dental, and vision benefits will continue while you are on certain types of family or medical leave. You and your dependents may be entitled to coverage for up to 12 weeks during a 12-month period while you are on a family or medical leave due to:

- The birth of your child, or placement of a child with you for adoption or foster care
- A serious health condition of your child, spouse or parent, or
- Your own serious health condition.
- Any qualifying exigency arising out of an employee's spouse, child or parent who is a covered military member on covered active duty.

This leave may be extended to 26 weeks for an employee whose spouse, child or parent is a covered military member with a serious injury or illness.

You should contact your employer as soon as you think you are eligible for a family or medical leave; it is not the role of the Trustees or the Trust Office to make this determination. You are required to give 30 days notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer must make arrangements with the Fund to continue your coverage.

If you advise that you are not returning or if you do not return to work after your leave ends, coverage for all Plan benefits will end. You and your dependents will then be able to elect the Self-Pay option (see page 17) or COBRA continuation coverage (see page 18).

USERRA Rights Notice

Employees who satisfy conditions imposed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) may be entitled to have eligibility frozen for their period of military service. Under current law, Veterans will receive credit for purposes of eligibility for a period of up to five years of active duty service in the U.S. Armed Forces, National Guard, Coast Guard or public health service. Upon his or her return from military service, a Veteran is entitled to all benefit changes granted to active employees during the period of military service. Also, returning Veterans may not be subject to exclusions or waiting periods to re-establish participation in the Health and Welfare Plan after their military service, provided they were eligible at the time they left for such service.

In order to be eligible for the reemployment and benefit rights under USERRA, a Veteran's discharge from the military must be other than dishonorable, and he or she must have worked in covered employment before and after the period of military service. To be eligible for military service credit, a Veteran must have been eligible for coverage at the time prior to entering military service, and the Veteran must return to or apply for covered employment within the following time periods after the end of his or her military service:

Length of Military Service	Reemployment Deadline
Less than 31 days	1 day post-discharge
31 through 180 days	14 days post-discharge
More than 180 days	90 days post-discharge

If the employee was hospitalized or otherwise incapacitated by service-related illness or injury, those reemployment periods may be extended up to two years.

In the event that an employee voluntarily enlists or is called up for active duty military service, that employee should notify either his employer or the Trust Office of such military service, and the date such service will commence. If such military service is for less than 31 days, the Plan will continue coverage for the employee without expense to the employee. This includes preserving credit earned for non-eligible employees.

Should the employee have dependents, the dependents will be offered up to 24 months' coverage under COBRA after the absence begins or for the period of military service, whichever is shorter, with reinstatement upon return of the employee without any waiting period or new exclusions. If the dependents are eligible for CHAMPUS coverage through the military, then coverage through this Plan will be primary to the CHAMPUS coverage.

If you have any questions regarding USERRA protected rights, you should contact the Trust Office.

Self-Payment Option

If your eligibility for benefits ends because you have less than 145 hours available in your dollar bank account, you can continue Plan benefits by making self-payments for coverage. If you are eligible to continue coverage under COBRA and you choose the Self-Payment option instead, you waive your COBRA continuation coverage rights (see page 18).

Eligibility

To be eligible for the Self-Payment option under the Plan, you must meet **all** of the following requirements:

- You are available for work in the Inland Empire area
- You are registered with your local union for referral to participating employers
- You are not receiving Workers' Compensation benefits or weekly time loss benefits for a disability
- You are not retired and receiving an IBEW or NEBF pension or social security benefits

Employees between age 60 and 65 do not need to meet these requirements. Once an employee reaches age 65, you are no longer eligible for this benefit.

Medical Plan Options

When you self-pay for coverage, you can continue the regular medical/ prescription drug, dental, vision, life, accidental death and dismemberment and weekly time loss benefits you were previously eligible to receive (Option A) or you can choose an alternate benefits plan – Option B Medical Plan.

Option B Medical Plan offers the same coverage as the regular medical plan, including prescription drug benefits, except for the following differences:

- $2,500 per person annual deductible, $7,500 per family maximum
- No dental, vision, weekly time loss, life or AD&D insurance is provided.

Once you choose a self-payment medical plan (Option A or Option B) you may not change your option until your eligibility is reestablished by employer contributions.

Also, once you stop making self-payments, you cannot start again until your eligibility is reestablished by employer contributions.

How the Self-Payment Option Works

You must make the necessary self-payment to the Trust Office by the 15th of each month to maintain coverage. The rate for self-payment coverage is set by the Plan and may change from time to time. Contact the Trust Office for current rate information.

Any amount remaining in the employee's dollar bank may be used to pay the first month of self-pay coverage, up to the full amount of the self-payment.

You will be notified by the Trust Office when your dollar bank account has less than 145 hours available and you are eligible to self-pay for continued Plan coverage. **It is your responsibility to track the balance of your dollar bank account and to keep the Trust Office informed of any address changes.** Contact the Trust Office if you need assistance determining the amount of your dollar bank account.

You may, if you wish, make self-payment contributions while employed for additional month's coverage. This provision is intended as a convenience for you. Please contact the Trust Office for further details.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), if you, your legal spouse or eligible dependents do not qualify for coverage in any month, you may continue some or all of the health benefits lost by making COBRA self-payments to the Fund.

To obtain COBRA continuation coverage, an individual must have a qualifying event, make a timely election to continue coverage, and make timely self-payments. These terms are defined below.

COBRA Qualifying Events

To be eligible for continuation coverage, an individual's coverage must have ended because of the following qualifying events:

18-Month Qualifying Events:

An individual (employee or dependent) may elect COBRA continuation coverage for a maximum of 18 months if their coverage would otherwise end due to one of the following:

- The employee's termination of employment for any reason (this includes retirement and voluntarily quitting) other than gross misconduct; or
- The employee's reduction in hours of employment.

29-Month Qualifying Events:

If Social Security determines an individual is totally disabled prior to the 18-month qualifying event or within the first 60 days of COBRA continuation coverage, the disabled individual and all qualified beneficiaries may extend COBRA coverage for an additional 11 months, to a maximum of 29 months. In order to qualify for this extension, the individual or qualified beneficiary must provide the Trust Office with proof of the Social Security disability determination within 60 days of their receipt of the determination, but no later than the date that the initial 18-month COBRA continuation period ends.

36-Month Qualifying Events:

A dependent (lawful spouse or dependent child) may elect COBRA continuation coverage for a maximum of 36 months if their coverage would otherwise end due to one of the following:

- Death of the employee;
- The employee becomes entitled to Medicare;
- Divorce or legal separation between the employee and their spouse; or
- For a dependent child, ceasing to meet the plan's definition of an eligible dependent.

Second Qualifying Event:

An 18-month period of COBRA may be extended to 36 months for the affected dependent (lawful spouse or dependent child) if one of the 36-month qualifying events occurs during the first 18 months of COBRA continuation coverage. In no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the initial qualifying event.

COBRA Notification Responsibilities

For any initial or second qualifying event, the employee or dependent must notify the Trust Office:

- Within 60 days of a death, divorce, legal separation, or child losing dependent status prior to age 26;
- Upon becoming covered under any other group health plan, including Medicare, after electing COBRA continuation coverage;
- For a Social Security disability extension, within 60 days of Social Security determining an individual is disabled, but not later than the date the initial 18-month COBRA period ends; and
- Within 30 days of Social Security determining an individual is no longer disabled.

The employer has the responsibility to notify the Trust Office of the employee's termination of employment or reduction of hours.

Election of COBRA Coverage

Upon receiving notification that a qualifying event may have occurred, the Trust Office will notify you, your lawful spouse and each of your covered dependents of their right to elect continuation coverage. The individuals must then select continuation coverage by the later of:

- 60 days after the individual's coverage ends; or
- 60 days after the individual receives notification of the continuation rights from the Trust Office.

Failure to elect continuation coverage within this 60-day period will result in the loss of the right to elect COBRA continuation coverage.

Note: The law requires the COBRA election notices to be sent to the last known address on file at the Trust Office. If the election notice is sent to the wrong address due to your failure to notify the Trust Office about a change of address, the 60 day time limit may be exceeded, in which case COBRA continuation coverage would not be offered**. It is your responsibility to keep the Trust Office informed of any address changes.**

Newly Acquired Dependents During COBRA Coverage

If you acquire an eligible dependent while eligible for COBRA continuation coverage you may elect to enroll the dependent for continuation coverage in accordance with the Plan's normal enrollment rules. However, only child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA continuation coverage are qualified beneficiaries entitled to an extension of coverage as a result of a second qualifying event. Spouses and stepchildren acquired after a qualified event are not eligible for 36 months of coverage due to a second qualifying event.

Types of COBRA Coverage Available

If you choose continuation coverage, you are entitled to the same benefits you had in the month immediately before you lost coverage. The following benefit options are available under COBRA:

- Medical, Prescription Drug only.
- Medical, Prescription Drug, Dental, Vision.

Continuation coverage is not available for weekly time loss, life or accidental death and dismemberment benefits.

Once you have elected COBRA coverage you may not change your benefit option after the initial 60-day election period, until your eligibility is reestablished by employer contributions.

Continuous COBRA Coverage Required

Your coverage under COBRA must be continuous from the date Fund coverage would have ended if monthly self-payments were not made.

Monthly Self-Payments for COBRA Coverage Required

You and your covered dependents are responsible for the full cost of continuation coverage. The payments must be made to the Trust Office within 30 days of the premium due date.

The only exception is that the initial self-payment for the period preceding the election of COBRA continuation coverage may be made up to 45 days after the date of election. All payments must become current by 45 days after the date of election. Failure to make timely payments will result in the permanent loss of COBRA continuation coverage. Eligibility will not be granted until payment has been received.

Note: You may make your payments by check or money order, or by calling the Trust Office using your Visa or Master Card (subject to a convenience charge).

End of COBRA Coverage

COBRA continuation coverage will end on the earliest of the following dates:

- 18 months from the date continuation coverage began for individuals whose coverage ended because of a reduction of hours or termination of employment.
- 29 months from the date continuation coverage began if the individual was disabled as of the time their eligibility ended, or within 60 days thereafter, and they provide proof of the Social Security Administration's disability determination within both 60 days of their receipt of it and during the initial 18-month continuation period.
- 36 months from the date continuation coverage began for individuals whose coverage ended because of the death of the employee, divorce or legal separation from the employee, the dependent ceasing to meet the definition of an eligible dependent, or the employee's entitlement to Medicare. If an employee has an 18-month qualifying event after becoming entitled to Medicare, continuation coverage for dependents (lawful spouse or dependent child) will end on the later of 18 months from the date continuation coverage began because of a reduction of hours or termination of employment, or 36 months from the date the employee becomes entitled to Medicare.
- End of any month for which the required premium for your COBRA coverage is not paid within 30 days of the first of the month for which the payment applies. Checks returned for non-sufficient funds will be treated as failing to make a self-payment and if not reissued by the end of the coverage period, coverage will terminate.
- The date the individual becomes covered under any other group health plan (except to the extent the other group health plan limits benefits for preexisting conditions that affects the individual's coverage).

- The date the individual becomes entitled to Medicare.
- The date your employer no longer provides health care coverage for its employees.
- The date this Plan ends.

Health Insurance Marketplace Coverage

In addition to COBRA continuation coverage, there may be other coverage options for you and your family. The Health Insurance Marketplace offers many health plans to choose from. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. If you are eligible for COBRA but decline, you may still be eligible for coverage for a tax credit through the Marketplace.

Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

For More Information

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 Benefits 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 EBSA's website.) Also, please refer to the Statement of Rights Under ERISA on page 74 of this booklet.

Medical Benefits

The Fund provides comprehensive medical benefits to help you pay the cost of health care and to support your good health. You and the Plan share in many of the costs of services. To keep your medical benefits affordable, it's important to use health care services wisely, to avoid unnecessary expenses and to get the best outcome.

Using health care services wisely also means taking good care of yourself, so you stay as healthy as possible. The Fund offers several tools to help you make the most of your benefits and make wise and cost-effective health care decisions.

Health Tool	Highlights	Go to this page for details
Network of providers (PPO)	A preferred provider network of hospitals and physicians that can help you and the Plan save money	Page 24
Healthier at Home Nurse Line	A free and confidential Nurse Advice Line, provided through AIPM, that you can call anytime, 24/7 at (866) 886-0633. In an emergency, call 9-1-1, not the nurse line	Page 27
Preventive care benefits	Benefits that encourage and enable you to get good preventive care including a Tobacco Cessation Program offered through AIPM. Call (800) 345-2476, ext. 233 to enroll.	Pages 27 and 35
Pre-certification of hospital admissions and certain outpatient procedures	A recommended step that helps to ensure hospital stays and certain outpatient procedures (like surgery) are medically necessary — like a built-in second opinion	Page 25

These are just the highlights. Go to the page number shown in the chart for details.

Medical Benefit Highlights

The chart below shows key features of the Plan's medical benefits. Please note, these are just the highlights – many details aren't included in this chart but are covered in depth in the rest of this booklet.

Annual deductible	$300 per person $900 family maximum
Annual coinsurance out-of-pocket maximum	$2,500 per person (plus deductible)
Office visits	Covered at 80%, after deductible
Outpatient lab and X-rays	Covered at 80%, after deductible
Preventive care ▪ *Routine physical exams*	Covered at 100%, no deductible (age 0-1 max 7 visits; age 1-2 max 3 visits; age 2 and older max 1 visit per calendar year)
▪ *Well child care and immunizations*	Covered at 100%, no deductible
▪ *Cancer screenings*	Covered at 100%, no deductible
Emergency room	Covered at 80%, after deductible
Hospital services	Covered at 80%, after deductible
Chiropractic services	Covered at 80%, after deductible Maximum 12 visits per calendar year
Occupational therapy, physical therapy and speech therapy	Covered at 80%, after deductible subject to approval by Aetna
Mental health care	Covered at 80%, after deductible
Chemical dependency	Covered at 80%, after deductible
Surgery	Covered at 80%, after deductible Certain surgical procedures will be covered at 50% after deductible, unless the surgery is performed on an outpatient basis. See page 35 for more information.

Option B Medical Plan offers the same coverage as the regular medical plan, including prescription drug benefits, except for the following differences:

- $2,500 per person annual deductible; $7,500 family maximum
- No dental, vision, weekly time loss, life or AD&D benefits are provided.

Note: If you choose the Option B medical plan, you may not switch back to the regular medical plan while you are making self-payments for coverage.

Use the PPO Network to Save Money

The Plan allows you to use any provider you wish, but there are advantages when you use a PPO network provider. That's because the PPO credentials and contracts with preferred providers to offer a network of primary care physicians, specialists, hospitals, labs and clinics. The PPO negotiates fees with these doctors and facilities and passes the savings on to you and the Plan.

When you choose from the PPO's network of qualified providers, they will handle your claim paperwork. In addition, your out-of-pocket expenses will be less than if you were treated by a non-network provider, since your benefits are based on discounted rates. You will be responsible for paying the deductible, and coinsurance.

If you decide to use a non-network provider, the Plan will pay a percentage of reasonable and customary charges after the deductible has been met. You will be responsible for paying any amount the provider charges which is over the reasonable and customary charge, as well as the deductible and coinsurance.

Your PPO network for medical services is provided through Aetna. To access information on availability and locations of PPO providers, including provider and facility lists, go to the Aetna website at **www.aetna.com/docfind/home.do**. or call the Trust Office at (800) 872-8979

How the Annual Deductible Works

A deductible is the amount you must pay toward certain covered benefits each calendar year before the Plan pays most benefits. The annual deductible for the regular medical plan is $300 per person, with a limit of $900 per family each calendar year. For the Option B medical plan, the annual deductible is $2,500 per person, with a limit of $7,500 per family each calendar year.

The deductible does not apply to preventive care, pre-admission testing, second opinion consultations or newborn well nursery care. For all other covered services, however, you must pay the deductible before the Plan pays benefits, unless otherwise noted.

Any eligible expenses you have during the last three months of the year that are credited to your annual deductible will also be credited to the following year's annual deductible.

How Coinsurance Works

For many services, the Plan pays a percentage of the cost and you pay the rest; this is called coinsurance. For example, most services are covered at 80% (the Plan's basic benefit percentage or coinsurance rate). You pay the remaining 20% as your coinsurance.

The Plan pays its percentage of PPO allowed charges if you use a PPO provider. The provider is not allowed to charge you any amount that exceeds the PPO allowed charge and benefits will be based on the PPO allowed charge.

If you decide to use a non-network provider, the Plan will pay a percentage of reasonable and customary charges after the deductible. In addition, you will be responsible for paying any amount over the reasonable and customary charge when you use non-network providers.

By using PPO network providers, you are protected against having to pay any amount the provider charges over reasonable and customary, because PPO network providers agree to charge only negotiated fees.

How the Annual Coinsurance Out-of-Pocket Maximum Works

Each year, after the annual deductible is met, there is a $2,500 per person out-of-pocket maximum for all subsequent charges for covered services. This is the maximum amount of coinsurance an individual will be required to pay in a single calendar year.

Once you reach the coinsurance out-of-pocket maximum, covered services are paid at 100% for the rest of that calendar year, except for those services that are limited benefits. (See the definition of limited benefits in the Definitions section, beginning on page 58). The out-of-pocket maximum helps prevent you from having a catastrophic bill in any single year – it's an important financial protection for you.

Please note, the deductible, non-covered charges and charges above benefit limits or above reasonable and customary charges do not count toward the coinsurance out-of-pocket maximum.

Note: If a covered person or dependent receives $250,000 of benefit payments, all remaining covered charges in that person's lifetime are paid at 100%, with no further deductible required.

Preventive Care Benefits

Because good preventive care is important to maintaining good health and controlling long-term costs, the Plan covers preventive care for you and your covered dependents, including annual adult physicals, well-child care, immunizations and important screening tests. Many of these services are covered at 100% with no deductible, to make it easy for you and your family to get the preventive care you need!

For specific benefit details, refer to *Preventive Care Benefits* on page 35.

Pre-certification Recommended

All benefits payable under this Plan must be medically necessary. If you are thinking about having surgery or getting a test or treatment that will involve a major expense, you should ensure the procedure is medically necessary first, to avoid having your claim denied. The Plan has a built-in way for you to do this: **pre-certification**.

If you use an Aetna PPO provider, your provider is responsible for obtaining the necessary pre-certification for you. If your provider fails to pre-certify required services, and the services are later determined not medically necessary, the provider will not be reimbursed and they cannot bill you for the services.

If you use a non-PPO provider, your provider may pre-certify for certain services on your behalf. If you or your provider fail to pre-certify those services, Aetna will review the medical necessity of those services when the claim is filed. If the service is not medically necessary and is not approved, no benefit will be paid, and the provider may bill you for the services provided. If the services are medically necessary, benefits will be paid according to the Plan.

The Plan recommends that you **pre-certify** all inpatient hospital, skilled nursing facility and approved treatment facility stays as well as certain other services *before* receiving treatment, or as soon as possible after an emergency inpatient admission. When you're about to have a major treatment or inpatient stay, getting the service pre-certified ensures that the treatment is medically necessary – it's like a built-in second opinion, and there's no cost to you.

Pre-certification is strongly recommended for the following services:

- Inpatient stay at a hospital or approved treatment facility
- Inpatient and outpatient surgical procedures
- Durable medical equipment
- Nursing and rehabilitation facility services
- Home health care services
- Hospice care
- Dialysis visits
- Applied Behavioral Analysis (ABA)
- Proton Beam Radiotherapy
- Injectable drugs dispensed in a doctor's office
- Prosthetics
- Hyperbaric oxygen therapy
- Spinal procedures and implants
- Genetic testing
- Sleep studies

Your provider should call Aetna at (888) 632-3862 before you are admitted to the hospital, skilled nursing facility or approved treatment facility or receive any of the services listed above. If you are admitted to the hospital or facility on an emergency basis, your provider should call Aetna as soon as possible after your admission. You will also find the telephone number for Aetna listed on your ID card.

Once you call, a medical professional will review your information to certify that the requested services are medically necessary. In the unlikely event Aetna determines that the requested services are not medically necessary, Aetna will notify you and talk to your doctor to explore an alternative treatment plan. Remember, the Plan will not cover services that are not medically necessary.

Pre-certification only determines medical necessity; however, it doesn't guarantee coverage. Coverage is always subject to Plan eligibility requirements and limits. To verify coverage, contact the Trust Office.

Pre-certification is strongly recommended by the Plan. If you do not pre-certify a service and it is found to be not medically necessary, the Plan will pay no benefit; you will have to pay the entire cost, because only medically necessary services are covered.

Second Surgical Opinion

A second opinion is occasionally recommended to determine if the proposed procedure is medically necessary. Second opinions are covered at 100%, not subject to the deductible, and recommended for the following surgeries:

- Adenoidectomy and/or Tonsillectomy
- Breast surgery
- Disc and/or spinal surgery
- Eye or eyelid surgery
- Foot surgery
- Gallbladder and bile duct surgery
- Gastric and/or intestinal surgery
- Heart and/or cardiovascular surgery
- Hemorrhoid surgery
- Hernia surgery
- Jaw surgery
- Joint surgery
- Kidney and/or urinary tract surgery

- Nasal surgery
- Prostate surgery
- Reproductive organ surgery
- Thyroid surgery
- Varicose vein surgery

Resources for Your Health

The Fund offers several benefits designed to provide information and other resources for your health.

Healthier at Home Nurse Line: 24/7 Telephone Access to Registered Nurses

Your medical benefits include toll-free telephone access to a registered nurse. The Healthier at Home Nurse Line allows you to contact experienced registered nurses for questions regarding your symptoms, medications, or other health information. The Nurse Line is provided through the American Institute for Preventive Medicine (AIPM).

Also available is an audio library of health information topics that you can listen to at your convenience.

You may reach the Nurse Line by telephone any time at (866) 886-0633 (toll-free). The Nurse Line is voluntary and confidential, and there is no cost to you for this service — it's part of your Plan benefits!

Case Management

The Plan has contracted with Aetna to provide case management services in certain health care treatment situations.

The Case Management program provides professional intervention to help participants who have catastrophic or significant ongoing health conditions. Case managers (usually registered nurses) will evaluate patients for inclusion in the Case Management program based on diagnosis, hospital stays, or at the request of the Plan or participant. The case manager will work with the patient, doctors and family members to coordinate care.

The purpose of the program is to help the patient navigate the complex health care system and ensure that proper and cost-effective care is being received. The Case Management program is voluntary and strictly confidential.

Smokeless Tobacco Cessation Program

The Smokeless Tobacco Cessation program is available to you and your eligible spouse and children at no cost. Call AIPM at (800) 345-2476, extension 233 to enroll. You'll get five phone consultations with a health coach, nicotine gum or patches delivered to your home and a comprehensive kit of information to help you survive your days without nicotine.

Prescription medications to help you quit, such as Zyban and Chantix, are covered under the Fund's prescription drug benefit through Sav-Rx.

What the Medical Benefits Cover

This section lists covered services in alphabetical order and specifies the benefit levels and exactly what is covered by the Plan. Please note, to be covered by this Plan, services must be **medically necessary** as determined by the Plan. *Please see page 60 for a definition of "medically necessary."*

Ambulance Services
Benefits are provided for necessary licensed ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. This benefit only covers the person that requires transportation.

Ambulatory Surgical Center Services
Services and supplies provided by an ambulatory surgical center or hospital.

Cancer Screenings
Cancer screenings are covered at 100%, not subject to the annual deductible, for the following procedures and limitations:

- Breast Cancer
  - A screening mammogram is covered once each calendar year.
- Colon and Rectal Cancer
  - For individuals age 50 and over fecal occult blood test (FOBT) once each calendar year plus coverage for one of the following testing schedules:
    - Flexible sigmoidoscopy – once every five calendar years.
    - Fecal occult blood test plus flexible sigmoidoscopy- once every five calendar years.
    - Double-contrast barium enema – once every five calendar years.
    - Colonoscopy once every ten calendar years.
  - For eligible individuals under age 50 – the above screenings provided when there is a family history of colon or rectal cancer.
- Cervical Cancer
  - For women – one Pap test each calendar year.
- Endometrial (Uterine) Cancer
  - For women age 35 and older and at high risk for hereditary nonpolyposis colon cancer (HNPCC) – screening with endometrial biopsy once each calendar year.
- Prostate Cancer
  - Prostate-specific antigen (PSA) blood test and digital rectal exam (DRE) is provided:
    - For men age 50 and older – once each calendar year.
    - For men at high risk (African-American and men with family history at age 45) – once each calendar year beginning at age 45
    - For men at higher risk (multiple relatives affected at an early age) – once each calendar year beginning at age 40.

Any professional office charge made in conjunction with these tests may be covered under the routine physical exam benefits, as outlined beginning on page *35*.

Chemical Dependency Treatment (alcohol and drug rehabilitation)
Benefits provided for inpatient and outpatient chemical dependency treatment and supporting services. Covered services must be furnished by a state-approved treatment program. Inpatient services should be pre-certified to ensure it is medically necessary. *See page 25 for instructions on how to pre-certify*.

Chiropractic Care
Chiropractic care is covered up to a maximum of 12 visits per calendar year, for services to treat the spine or supportive structure which are of a maintenance or supportive nature. Additional visits must be determined to be medically necessary to relieve pain or treat a covered illness, injury or condition. Services must be provided by a licensed provider acting within the scope of their license.

Contraceptive (Birth Control) Services
Contraceptive services are covered as follows:

- Office visits and consultations related to contraception
- Professional services related to reversible prescription implants and injectable contraceptives.
- Oral contraceptives dispensed by a licensed pharmacy and all other contraceptive devices approved by the FDA are covered under the Prescription Drug benefit (see page 40).

Dental Services
Routine dental care is generally provided under your dental benefit (if eligible), not under this medical benefit (see Dental section beginning on page 43). However, dental treatment that is necessary as a result of an injury, or directly related to radiation of the mouth or neck is covered on the same basis as any other condition when they are:

- Necessary as a result of an injury or treatment (radiation of mouth or neck) related to cancer of the mouth or neck
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing, even if due to foreign object in food
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of injury (this requirement does not apply to treatment related to a medical diagnosis). "Functionally sound" means that the affected teeth do not have:
  - Extensive restoration, veneers, crowns or splint
  - Periodontal disease or other condition that, in our judgement, would cause the tooth to be in a weakened state prior to the injury

When dental services are related to an injury, or radiation of mouth or neck, benefits are provided for the repair of the natural tooth structure when such repair is performed within 24 months of the injury or beginning of treatment. If necessary services cannot be completed within 24 months of an injury or beginning of treatment related to radiation of mouth or neck, coverage may be extended if your dental care meets the Plan's extension criteria. The Plan must receive extension requests with 12 months of the injury or beginning of treatment date.

Services and supplies furnished by an ambulatory surgical center are covered under this benefit when all other criteria are met.

General anesthesia and related facility services for dental procedures are covered when medically necessary for one of two reasons:

- The person is under the age of seven or is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office
- The person has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a hospital or ambulatory surgical center.

Diagnostic Services (Labs and X-Rays)
Covered diagnostic services include:

- Diagnostic imaging and scans. MRI and CT scans should be pre-certified to determine medical necessity. *See page 25 for instructions on how to pre-certify.*
- Laboratory services
- Pathology tests

Diagnostic surgeries, including biopsies, and scope insertion procedures, such as endoscopy, are covered under the Surgical Services benefit.

Emergency Room Services
Covered emergency room services include related services and supplies, such as surgical dressings and drugs, furnished by and used while in the hospital.

Home Health Care
Home health care should be pre-certified to ensure it is medically necessary. *See page 25 for instructions on how to pre-certify*.

Services of an approved Home Health Care Agency in the patient's home are covered for medically necessary treatment of an illness or injury up to 130 visits per calendar year, if all of the following conditions are met:

- The patient's condition must be serious enough to require confinement in a hospital or skilled nursing facility in the absence of Home Health Care services
- The patient's physician must establish or approve and periodically review a written treatment plan that specifically describes the home care services and supplies to be provided.

An approved Home Health Agency is one that is a private or public agency that administers and provides home health care and is certified by the proper authority of the state in which it operates.

Services covered under this benefit include the following:

- Physician services

- Nursing services by a registered nurse (RN) or licensed practical nurse (LPN)
- Physical therapy services by a licensed physical therapist
- Speech therapy services by a licensed speech therapist
- Occupational therapy services by a licensed occupational therapist
- Medical social services by a person with a master's degree in social work
- Home health aide services by an aide who is under the supervision of a Home Health Agency, limited to part-time or intermittent medical or therapeutic care
- Respiratory therapy services of a licensed inhalation therapist
- Laboratory services, medical supplies, drugs and prescription medications dispensed by a Home Health Agency that would have been provided on an inpatient basis
- Rental of durable medical equipment.

The following services and materials are not covered:

- Services provided under the hospice benefit
- Services of volunteers, household members, family or friends
- Transportation (except Ambulance Services as described on page 28)
- Supportive environmental materials, including but not limited to ramps, handrails or air conditioners
- Custodial or maintenance care
- Nutritional guidance
- Services or supplies not included in the written treatment plan, not specifically set forth as covered benefits or limited or excluded under the limitation and exclusions of this Plan.

Any expense for home health care that qualifies both under this benefit and under any other benefits of the Plan (for example, hospice care) will be covered only under the benefit the Fund determines to be most appropriate.

Hospice Care

Hospice care should be pre-certified to ensure it is medically necessary. *See page 25 for instructions on how to pre-certify*.

If the patient is terminally ill, hospice care services will be covered for a maximum of six months. Services must be provided by a hospice, hospice care team, hospital, home health care agency, extended care facility or skilled nursing facility for the terminally ill patient and family members, subject to the conditions and limitations specified here.

To be covered, hospice care services must be provided under the terms of a hospice care program and billed by the hospice that manages the program.

Covered hospice care services include:

- Inpatient and outpatient care, home care, nursing care, counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the terminally ill patient
- Drugs, medicines, and other supplies prescribed for the terminally ill patient by any physician who is a part of the hospice care team
- Instructions for care of the patient, counseling, and other supportive services for the family of the terminally ill patient
- Short-term respite care for primary caregivers up to five days per three-months of hospice care in the most appropriate setting
- Ambulance service certified by a physician as medically necessary or for emergencies.

The following services and materials are not covered:

- Transportation (except Ambulance Services as described on page 28)
- Custodial or maintenance care, other than general nursing care
- Services or supplies not approved by the patient's physician, or limited or excluded under the limitations and exclusions of this Plan
- Services or supplies in excess of the maximum benefit for hospice care services.

Any expense for hospice care that qualifies both under this benefit and under any other benefits of the Plan (for example, home health care) will be covered only under the benefit the Fund determines to be most appropriate.

Hospital Inpatient Care
Hospital inpatient care should be pre-certified to ensure it is medically necessary. *See page 25 for instructions on how to pre-certify*.

Benefits are provided for:

- Room and board expenses up to the most frequent semiprivate room rate charged by the hospital. Confinement in an intensive care or coronary care unit is limited to the hospital's average charge for such unit.
- Other required services and supplies furnished by the hospital for drugs, x-rays, lab tests, operating room, surgical supplies, hospital anesthesia services and other non-physician services and supplies used during a hospital stay.

This benefit does not cover:

- Weekend hospital admission charges for room and board on the first Friday and Saturday of a hospital stay, unless the patient is admitted for emergency treatment services, a surgical operation is scheduled for the day of or the day after admission, or medical treatment requiring hospital confinement is scheduled for the day of or the day after admission.

- Any days of inpatient care that exceed the length of stay that is, in the judgment of the Plan, medically necessary to treat your condition.

Hospital Outpatient Care
Benefits for outpatient surgery and other outpatient services are provided. This benefit covers operating rooms, procedure rooms, and recovery rooms. Also covered are services and supplies, such as surgical dressing and drugs, furnished by and used while at the facility.

Immunizations
See *Preventive Care Benefits* on page 35.

Labs and X-Rays
See *Diagnostic Services* on page 30.

Mammography
Diagnostic mammograms are covered the same as any other diagnostic service. Annual screening mammograms are covered under the cancer screening benefit (see page 28).

Mastectomy and Breast Reconstruction Services
Office visits related to mastectomy and breast reconstruction services are covered the same as any other office visit. Other inpatient and outpatient facility, professional and surgical services are covered the same as any other surgery. Benefits are provided only for mastectomy necessary due to disease, illness or injury. For any person electing breast reconstruction in connection with a mastectomy, this benefit will cover:

- Reconstruction of the breast on which the mastectomy has been performed

- Surgery and reconstruction of the other breast to produce a symmetrical appearance

- Prostheses (not subject to the benefit maximum stated in the Medical Equipment and Supplies benefit)

- Physical complication of all stages of mastectomy, including lymphedemas.

Services are to be provided in a manner determined in consultation with the attending physician and the patient.

Reconstructive services should be pre-certified to ensure it is medically necessary. *See page 25 for instructions on how to pre-certify.*

Maternity (Employees and Spouses only)
Maternity related expenses, including pregnancy, childbirth, miscarriage, or abortion, are covered like any other medical condition. In accordance with federal law, the Plan does not restrict lengths of hospital stays for a mother or newborn to less than 48 hours following normal vaginal delivery or 96 hours following cesarean delivery. In consultation with your physician, you may choose not to stay the full 48/96 hours. The length of inpatient care may, however, be extended upon application of the mother's or newborn's

attending physician to the Plan, provided that the Plan determines that the extended stay is medically necessary.

Medical Supplies
Including surgical dressings, casts, splints, braces, crutches, artificial limbs, artificial eyes, blood, plasma, oxygen, or for rental or purchase of medically necessary durable medical equipment.

Durable medical equipment is equipment able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally used in the absence of illness or injury. The durable medical equipment must be prescribed by a physician for therapeutic use and include the length of time needed, the cost of rental and cost of purchase prior to any benefits being paid. Examples include: crutches, wheelchairs, hospital beds, and equipment for the administration of oxygen.

Mental Health Care
Inpatient and outpatient mental health services are covered as any other condition. Inpatient care should be pre-certified to ensure it is medically necessary. *See page 25 for instructions on how to pre-certify.*

Covered mental health services include inpatient care, partial hospitalization and outpatient care to manage or lessen the effects of a psychiatric condition.

Naturopathic Care
Naturopathic care is covered only when services are necessary to relieve pain or treat a covered illness, injury or condition and services are provided by a licensed provider acting within the scope of their license.

Neurodevelopmental Therapy
Benefits are provided for the treatment of neurodevelopmental disabilities, including applied behavioral analysis (ABA) therapy, to restore and improve function or to maintain function where significant physical deterioration would occur without the therapy. The Plan will pay for covered charges for ABA therapy treatment for covered persons diagnosed with autism spectrum disorder (ASD). To be covered, the person must be referred for ABA therapy treatment by a physician, and all ABA services must be medically necessary. Services should be precertified to ensure they are medically necessary. *See page 25 for instructions on how to pre-certify.*

Newborn Well Nursery Care (Employees and Spouses only)
Newborn children are covered automatically at 100%, with no deductible, for up to 4 days from birth when the mother is hospitalized.

See the Preventive Care Benefits for well child care.

Occupational Therapy
Occupational therapy should be pre-certified to ensure it is medically necessary. *See page 25 for instructions on how to pre-certify.*

Office Visits
See Physician Visits and Services.

Outpatient Surgery
See *Surgery.*

Physical Therapy
Physical therapy should be pre-certified to ensure it is medically necessary. *See page 25 for instructions on how to pre-certify.*

Physician Visits and Services
Benefits are provided for the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis.

Prescription Drugs
See the Prescription Drug section beginning on page 40.

Preventive Care Benefits
Good preventive care and wellness benefits can improve your health and help control long-term costs, but only if you use them. The following preventive care and wellness benefits are covered under the Plan for you and your covered dependents:

- **Physical exams:** Routine physicals and wellness exams (employees and dependents) are covered at 100% with no deductible, including laboratory and x-ray services, up to the following limits:

Age 1 – 2	3 visits
Age 2 and older	1 visit per calendar year

- **Routine Immunizations:** Covered at 100% with no deductible. Routine immunizations are those recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers of Disease Control (CDC) annual immunization schedules for children and adults found at **www.cdc.gov/vacinnes.**

- **Well baby care:** Covered at 100% with no deductible for up to seven physician visits during the first 12 months of the child's life.

- **Cancer screenings:** See page 28 for a complete description.

Skilled Nursing Facility Services
Skilled nursing facility services should be pre-certified to ensure they are medically necessary. *See page 25 for information on how to pre-certify.*

Room, board, services and supplies are covered while confined in a state licensed skilled nursing facility. This benefit is only provided if your physician certifies that 24-hour nursing care is essential for recovery and is in-lieu of hospitalization. Also, the skilled nursing facility confinement must be preceded by at least 3 consecutive days of hospital confinement which qualified for benefits under the Plan and commenced within 14 days after termination of such hospital confinement or within 14 days after termination of a skilled nursing facility confinement which qualified for benefits under the Plan.

Speech Therapy
Speech Therapy should be pre-certified to assure it is medically necessary. *See page 25 for instructions on how to pre-certify.*

Surgery
This benefit covers medically necessary surgical services performed on an inpatient or outpatient basis in such locations as a hospital, ambulatory surgical facility or surgical suite. The Plan recommends that the

surgical procedures listed below be performed on an outpatient basis (admitted for less than 15 hours) or at a location other than a hospital. If these procedures are performed on an inpatient hospital basis, (admitted for 15 hours or more) covered surgical charges will be paid at 50%, after the deductible is met, unless special risk factors existed or inpatient hospital care was medically necessary.

Endoscopy

Upper GI endoscopies
Bronchoscopies
Small bowel biopsies
Procoto/proctosigmoid
Colonoscopy
Hermorrhoidectomies, simple

General Surgery/Digestive System

Teeth extraction
Liver biopsy (needle)
Repair inguinal hernia, under age five

General Surgery/Integumentary System

Excision of lesion or skin biopsies
Excision of nail and nail matrix
Wound repair and skin abrasion
Breast biopsies, any technique
Artery or vein ligation, simple

Gynecology/Female Genital System

Excision of Bartholin's cyst
Colposcopies and biopsies
Dilation and curettage, diagnostic and/or therapeutic
Laparoscopy, therapeutic or sterilization

Neurosurgery/Nervous System

Excision, benign tumor; subcutaneous
Carpal tunnel

Orthopedics/Musculoskeletal System

Reconstruction of nail bed, simple or complicated
Tentomies or arthotomies
Tentomy, flexor, single, finger open, each
Arthroscopies, knee
Hammertoes and bunions
Fractures, simple

Otolaryngology/Auditory System

Treatment of closed or open nasal fracture
Myringotomies or typanostomies

Urology/Urinary System

Urethrocystography or cystourethroscopies
Meatotomies
Urethral dilations
Circumcisions
Vasectomy
Varicocele repair

Cosmetic surgery is covered only when medically necessary to repair an accidental injury and is performed, or treatment or service is furnished within 12 months of the date of the accident.

Surgery for sexual transformation, sexual dysfunction or inadequacy, to treat infertility or to reverse sterilization is not covered. Surgical treatment of obesity also is not covered.

Pre-admission testing for medically necessary surgical service performed on an outpatient basis will be covered at 100%, not subject to the annual deductible.

Transplants (Organ and Bone Marrow Transplants)
Organ and bone marrow transplants that are medically necessary and determined to be appropriate treatment using prevailing standards of medical practice. Proposed transplants will not be covered if considered experimental or investigational for the participant's condition.

Covered expenses include:

- Donor typing, testing and search fees
- Donor organ evaluation, removal, storage and transportation of the surgical/harvesting team and/or the donor organ or bone marrow.
- Donor benefits for the procurement of the donor organ or bone marrow are covered up to $40,000 per transplant.

Well Baby Care
See *Preventive Care Benefits* on page 35.

Benefits After Termination of Coverage

Medical benefits are continued to a totally disabled individual if covered charges are incurred during the twelve-month period immediately following termination of coverage. In no event will continuation of benefits be provided for a period of months longer than the coverage was in effect, not to exceed twelve months.

For the individual to qualify, the total disability must be continuous from the date of termination to the date of treatment or service and the covered charges must be incurred as a result of injury or sickness existing on the date of termination.

Medical Benefit Exclusions

This section of your booklet lists specific things the Plan **does not** cover. Benefits may also be affected by your eligibility. In addition, some benefits have their own specific limitations which are generally stated in the section called What the Medical Benefits Cover.

In addition to the specific limitations stated elsewhere in this booklet, the Plan **will not provide benefits** for the following:

- Acupuncture
- Bariatric surgery
- Benefits that exceed the reasonable and customary charge
- Biofeedback services

- Birth control drugs and devices, except as listed on page 29 under the Contraceptive (Birth Control) Services benefit, and as provided under the Prescription Drug benefit beginning on page 40.

- Birth control products obtainable over the counter such as condoms, spermicide gels, foams contraceptive sponges

- Cosmetic services, surgery and supplies unless to:

  – Repair a defect that is the direct result of an accidental injury treated within 12 months of the date of the accident, or

  – Reconstructive breast surgery in connection with a mastectomy as specified under *the Mastectomy and Breast Reconstruction Services* benefit.

- Custodial care, except when provided for hospice care *(see the Hospice Care benefits)*

- Dental services or supplies, except for dental services due to an accidental injury *(see Dental benefit starting on page 43 for regular dental benefit information)*

- Dietician services, except through a hospital for diabetes education

- Experimental or investigational treatment or services

- Family members or volunteers' services, including:

  – Services or supplies you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage, or adoption. Examples of such providers are your spouse, parent or child

  – Services or supplies provided by volunteers, except as specified in the Home Health and Hospice Care benefits

- Foot care including hygienic care, impression casting for prosthetics or appliances, fallen arches, flat or pronated feet, care of corns, bunions, calluses, toenails and other symptomatic foot problems. This includes foot-support supplies, correctional shoes, and orthotics

- Gender transformations: treatment or surgery to change gender, including any direct or indirect complications and after effects thereof

- Hearing aids

- Infertility restoration or the promotion of conception, including but not limited to the reversal of a tubal ligation or vasectomy, tubal plasty, fertility drugs, artificial insemination, in-vitro fertilization and embryo transplantation

- Long term care

- Marriage or family counseling services

- Massage therapy

- Naturopathic benefits other than those specified under the Naturopathic Care benefit (see page 34)
- Non-emergency care when traveling outside the United States
- Nursing services except as specifically listed
- Nutritional therapy
- Physician exam over the telephone, via the internet or where not physically seen by the provider
- Pregnancy and childbirth, complications of childbirth or abortion, for dependent children
- Private duty nursing
- Routine vision exams (*see the vision exam benefit on page 47*)
- Skilled nursing facility coverage except as specified under the Skilled Nursing Facility benefit, including custodial care, care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of chemical dependency
- Smoking or nicotine cessation services and supplies other than through the *Smokeless Tobacco Cessation Program (see page 27) or under the Prescription Drug benefit (see page 40)*
- Surgery, treatment, services, hospitalization or other confinement that are not medically necessary
- Taxes incurred when purchasing covered supplies
- Temporomandibular joint syndrome (TMJ), orthognatic surgery or myofascial pain syndrome
- Treatment, service or hospitalization not prescribed by a physician
- Treatment of obesity or morbid obesity
- Treatment or services for which coverage is available from other sources, including Workers' Compensation or for an injury due to any employment for wage or profit
- Treatment or services furnished by any federal, state or provincial government agency except as required under Medicaid provisions or Federal law
- Treatment or services resulting from war or an act of war
- Treatment of services arising from commission of a felony by an employee or dependent over age 19
- Vision therapy/orthoptics
- Vitamins and dietary supplements prescribed or over-the-counter *(Many prescription drugs are covered under the separate Prescription Drug benefit, refer to the section beginning on page 40)*
- Weight loss programs

Prescription Drug Benefits

You and your covered family members who are eligible for medical benefits are eligible for prescription drug benefits, too. The Fund has partnered with **Sav-Rx Prescription Services** to serve as the Prescription Benefit Manager. Your prescription drug benefits have two parts that work together to help save money for you and the Fund:

- **A retail pharmacy network**. These pharmacies have agreed to dispense prescription drugs at discounts below their normal retail prices.
- **A mail order pharmacy**. Mail order service is easy to use and you can get a larger supply of medication – up to a 90-day supply.

Retail Pharmacy

The retail pharmacy program is designed for short term or single use medications.

Sav-Rx has contracted with pharmacies nationwide that have agreed to fill prescriptions at negotiated price levels that should save money for both you and the Fund. However, you may use any pharmacy except Walmart and Sam's Club; the choice is yours each time you fill a prescription.

The Sav-Rx retail pharmacy network works as follows:

1. Take your prescription to a network pharmacy and present it and your Sav-Rx ID card to the pharmacist.
2. The pharmacy will have access to the Fund's on-line eligibility and your Plan's provisions and will confirm your eligibility. Once your eligibility for benefits is confirmed, the pharmacy will ask you to pay according to the following schedule for each prescription:
   - Generic Drugs - $5 copayment, for up to a 30 day supply
   - Brand-Name Drugs (generic not available) - $25 copayment, for up to a 30 day supply
   - Brand-Name Drugs (generic available) - $5 copayment plus the difference in cost between the brand name drug and the generic drug, for up to a 30 day supply
3. The pharmacist will then fill your prescription and bill the Plan directly for the remaining costs. You will not have to fill out any claims forms.

A list of Sav-Rx participating pharmacies can be obtained by going to the Sav-Rx website **www.savrx.com**, select "Locations" and enter the Group Number "IBEW" and zip code, or by contacting the Trust Office.

If you choose a pharmacy that is not in the Sav-Rx network, or you do not present your Sav-Rx ID card to the pharmacist, you will need to pay the full amount billed by the pharmacy for the prescription and then send the receipt and claim form to Sav-Rx for processing. These claims will be reimbursed at the network pharmacy's negotiated rate, less the appropriate copayment. The difference between the billed rate for the prescription and the Sav-Rx negotiated rate is an out-of-pocket cost to you. Reimbursement claim forms are available from Sav-Rx (**www.savrx.com**) or from the Trust Office.

Mail Order Pharmacy

The mail order program is designed for long term maintenance medications needed for ongoing or chronic conditions.

Using the mail order pharmacy will lower your out-of-pocket costs, and medications will be delivered directly to your home, or other address that you choose.

For prescriptions ordered through the mail order pharmacy, the following copayments apply for each prescription:

- Generic Drugs – $10 copayment, for up to a 90 day supply
- Brand-Name Drugs (generic not available) - $50 copayment, for up to a 90 day supply
- Brand-Name Drugs (generic available) - $10 copayment plus the difference in cost between the brand name and generic drug, for up to a 90 day supply

Ordering or Refilling Your Prescription

- Ask your doctor to write a prescription for up to a 90-day supply of each medication (plus refills for up to a year, if appropriate)
- Your physician may phone your prescription to Sav-Rx at (866) 233-4239 or fax your prescription to Sav-Rx
- You may fill out the Prescription Order Form. Orders forms are available on **www.savrx.com** or from the Trust Office.
- Send the order form, your prescription and payment for the required copayment to:

  Sav-Rx Prescription Services
  224 North Park Avenue
  Fremont, NE 68025

Your medication will be delivered, postage paid to your home, generally within two weeks. If you are currently taking a medication, or if you send a prescription for a new medication, be sure to have at least a two week supply on hand to cover the period before your mail order prescription arrives. After your first prescription, you can order refills online at **www.savrx.com** or over the phone at (866) 233-4239.

What the Prescription Drug Benefits Cover

Benefits will be paid for any brand-name or generic drugs requiring a prescription from a physician and not specifically excluded under the Plan.

Exclusions

The following are not covered:

- Prescriptions obtained at either Walmart or Sam's Club
- Replacement of lost or stolen prescription medications

- Drugs dispensed in a hospital, skilled nursing facility or approved treatment facility
- Fluorides or any medication containing fluorides
- Drugs required to treat work-related injuries or illness
- Drugs prescribed for cosmetic purposes only, including Catapres, when prescribed for the sole purpose of promoting or stimulating hair growth
- Over the counter vitamins and supplements
- Any prescription drugs prescribed for a medical condition that is excluded under the Medical Benefits
- Prescription drugs for the treatment of infertility
- Medical devices or appliances

Dental Benefits

The dental plan helps you and your covered family members pay the cost of needed dental health care. Although you may see any licensed dental provider, if you use a Delta Dental network dentist, you gain access to lower fees and your treatment cost should be lower.

Dental Benefit Highlights

The chart below shows the highlights of key dental plan benefits, at a glance. Many details are not included in this chart. All services are subject to Plan limitations and exclusions.

Feature	Coverage
Annual deductible (per calendar year)	$25 per person; $75 family maximum
Annual maximum benefit (per calendar year)	$2,500 per person; does not apply to pediatric oral care for dependents up to age 19.
Part 1 – Routine oral exams **Part 2 – Restorative dentistry and oral surgery**	The Plan pays 70% the 1st calendar year and benefit payments increase 10% each year, up to 100%, provided the dentist is visited once each calendar year. For each year that you or a covered dependent do not visit the dentist, the amount payable for that person will decrease by 10%, but will not be less than 70%.
Part 3 – Prosthetics	The Plan pays 50%
Orthodontia	The Plan pays 50%, up to a lifetime maximum of $1,500, for dependent children up to age 26.

Use a Delta Dental Network Provider to Save Money

The Plan allows you to use any dental provider you wish, but there are advantages when you use a Delta Dental network provider. That's because Delta Dental credentials and negotiates fees with these providers and passes the savings on to you and the Plan. Delta Dental has two networks to choose from:

- **Delta Dental PPO** network – Typically has the most discounted fees from the provider's regular charges.
- **Delta Dental Premier** network – These providers also provide discounted fees, but not as great as those in the PPO network.

Both the Delta Dental PPO and Delta Dental Premier providers will submit claims for you and receive payment directly from Delta Dental. Their payment will be based upon their pre-approved fees with Delta Dental and they cannot charge more than these fees.

If you choose a non-network dentist, you will be responsible for having the dentist complete and sign claim forms. It will also be up to you to ensure that the claims are sent to Delta Dental. Claim payments will be based on actual charges or the maximum allowable fees for non-network dentists, whichever is less. Any difference between the dentist's actual charges and the Plan's maximum allowable fees for non-

network dentists is your responsibility and can be balanced billed to you. This is in addition to any coinsurance responsibility you may have.

You can find a Delta Dental network dentist in your area by visiting their website at **www.deltadentalwa.com**. The Find a Dentist tool is under the Patient's tab on the home screen. Enter your provider's last name, city and state. When the general results appear, look for the Delta Dental PPO and/or the Delta Dental Premier network under the provider's name.

Contacting Delta Dental

Once you are enrolled in the dental plan, you will have access to numerous online tools that will help you manage your oral health. Visit **www.DeltaDentalWA.com.** When you use a secured application on this web site, such as the "MySmile® personal benefits center" – which is your personalized portal to your dental benefits, eligibility and claims information – you will be required to register with security software. This means you will be prompted through a one-time registration process to set up your user name and password, which will then be used on all subsequent visits.

For more information on your dental benefits, you may contact the Delta Dental customer service team at (206) 522-2300 or (800) 544-1907, or visit their website at **www.DeltaDentalWA.com.**

How the Dental Benefits Work

Covered dental charges are those charges made for services, supplies and treatment listed below, when performed by a legally qualified dentist or a legally qualified denturist operating within the scope of their license.

If alternate procedures, services or courses of treatment may be performed to properly correct a dental condition, the maximum dental covered charges which will be considered for payment will be for the least expensive procedure which will, as determined by the Fund, produce a professionally satisfactory result.

The annual maximum benefit of $2,500 per person is the maximum dollar the Plan will pay for the cost of dental care within a calendar year. Orthodontia benefits have a separate lifetime maximum and do not count towards the $2,500 annual maximum.

If covered dental charges for initial placement of full dentures are above the annual maximum benefit, the maximum may be increased up to an amount equal to the next year's annual maximum benefit. For example, if covered charges for full dentures are $3,500, then the dental maximum will increase to $3,500 for the year ($2,500 annual maximum plus $1,000 additional covered charges). Next year, the annual maximum will be reduced to $1,500 ($2,500 annual maximum minus $1,000 paid in the previous year).

Part 1 – Routine Oral Examinations

- Oral examinations, including cleaning of teeth are covered up to two examinations in any one calendar year
- Topical application of fluoride
- Routine dental x-rays. Full mouth x-rays are covered once every two years. Bitewing x-rays are covered once a year for covered individuals age 25 or older.

Part 2 – Restorative Dentistry and Oral Surgery

- Extractions
- Oral surgery
- Fillings
- Treatment of periodontal and other diseases of the gums and tissues of the mouth
- Endodontic treatment, including root canal therapy.
- Repair of dentures and bridges

Part 3 – Prosthetics

The Plan will pay 50% for the services listed below:

- Inlays, crowns and bridgework
- Initial installation of full or partial removable dentures or fixed bridgework to replace one or more natural teeth
- Replacement of full or partial dentures.

Orthodontia

The Plan will pay 50%, up to a lifetime maximum of $1,500, for dependent children up to age 26 for the covered services listed below:

- Diagnosis, including models and photographs
- Initial treatment, including necessary appliances and continuing services during the treatment period.

Orthodontia benefits are paid only for services incurred while your dependent is eligible for benefits.

Predetermination of Benefits

If your dental treatment will be $500 or more, you can ask your dentist to request a predetermination review. This will help you find out in advance what procedures are covered, how much the Plan will pay and how much you will have to pay for your share of the costs.

To get a predetermination review, ask your dentist to complete and submit a claim form with a description of the treatment plan to Delta Dental. A predetermination of benefits will be sent to both you and your dentist. Keep in mind, the predetermination is just an estimate – benefits paid by the Plan will depend on the actual services you receive.

Exclusions

The Dental Benefit does not cover:

- Treatment or services prescribed by other than a dentist and performed by a dentist or a dental hygienist, or is primarily for cosmetic purposes (including personalization or characterization of dentures and facing on crowns or pontics posterior to the second bicuspid)
- Orthodontia services for children older than 25
- Expenses resulting from occupational injuries or diseases, including any injury or dental disease for which the person on whom the claim is presented has received, or is entitled to receive, compensation for that particular condition under any Worker's Compensation or occupational disease law
- Replacement of full dentures until five years after the date of the initial replacement or the date of the most recent replacement, whichever is later
- Replacement of lost or stolen prosthetics or dentures
- Treatment due to war or an act of war
- Charges for drugs or medications. (*See Prescription Drug benefits on page 40*)
- Treatment of temporomandibular joint dysfunction (TMJ), orthognatic surgery or myofacial pain syndrome
- Treatment or services furnished by any federal, state or provincial government agency except as required under Medicaid provisions.

Vision Benefits

Your Plan coverage also includes certain vision care benefits. Effective January 1, 2016, the current self-funded vision benefits (see below) will be replaced by vision care benefits administered by VSP Vision Care (see page 49).

Self-Funded Vision Benefits – Effective Through December 31, 2015

The following summarizes the vision benefits currently in place through December 31, 2015. Thereafter, effective January 1, 2016, they will be replaced by the VSP Vision Care program as described beginning on page 49.

Vision Benefit Highlights

The chart below shows the highlights of key self-funded vision plan benefits, at a glance. It does not include details – please read this entire section to understand important features, limits and exclusions.

Feature	What the Plan Covers
Eye examination	Plan pays 80%, up to a maximum payment of $148 once per calendar year
Lenses (pair)*	
▪ Single vision lenses	Plan pays 80%, up to a maximum payment of $108
▪ Bifocal lenses	Plan pays 80% up to a maximum payment of $160
▪ Tri-focal lenses, progressive lenses, lenticular lenses	Plan pays 80%, up to a maximum payment of $215.20
▪ Contact lenses	Plan pays 80%, up to a maximum payment of $108, in lieu of regular lenses A pair of lenses is covered once every calendar year. Polycarbonate material is added into each lens maximum payment If contact lenses are prescribed after cataract surgery or if visual acuity is correctable to 20/70 or better only with contact lenses, then contact lenses are covered at 80% of reasonable and customary charge.
Frames*	Plan pays up to $100 toward the cost of frames, once every two calendar years.

* For employees only, a pair of safety glasses will be provided as a second pair of glasses, in addition to prescription glasses, subject to the same limitations and maximums listed above.

Note: For dependent children under age 19, the maximum Plan benefit payment for lenses does not apply, but the maximum of two lenses per calendar year does apply.

What the Vision Benefit Covers

This benefit provides for one complete visual analysis (routine vision exam) per person each calendar year. Covered services include:

- Examination of disease or pathological abnormalities of eyes and lids

- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and professional consultation.

For vision exams and testing related to medical conditions of the eye, please see the Physician Visits and Services under the medical benefit on page 35.

Exclusions

The self-funded vision benefit does not cover:

- Services or supplies that are not named above as covered, or that are covered under other provisions of this Plan
- Sunglasses, non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Replacement of lenses or frames that have been lost, stolen or broken
- Medical or surgical treatment of the eyes (may be covered under medical benefits)
- Orthoptics or vision training
- Charges for duplicate eyeglasses, lenses or frames
- Charges for any eye exam required by an employer as a condition of employment that an employer is required to provide through a labor agreement
- Contact lens, except as described in Vision Benefit Highlights
- Treatment or services not recommended or performed by a physician or legally licensed optometrist
- Services for which there is no charge
- Treatment or services due to an illness for which coverage is available from other sources, including Workers' Compensation or for an injury due to employment for wage or profit
- Treatment or service furnished by any federal, state or provincial government agency as required under Medicaid provisions or federal law
- Scratch resistance and anti-reflection materials
- Tints
- Transition/photo chromatic lenses
- Contact lenses fitting fee

VSP Vision Care – Effective January 1, 2016

Effective January 1, 2016, the Trust will enter into an agreement with VSP Vision Care to provide vision benefits to you and your eligible dependents. Under this agreement, you can use any provider you wish. However, if you use a VSP provider, you may receive higher benefits – and they automatically file claims for you.

Covered Vision Expenses

The following table summarizes your vision care benefits through VSP effective January 1, 2016:

Covered Expense	If you see a VSP provider the Plan reimburses...	If you see a non-VSP provider the Plan reimburses...
Exams (once/12 months from last date of service)	100%	up to $92
Lenses (once/12 months from last day of service)*		
▪ Single vision	100%	up to $38
▪ Bifocal – lined	100%	up to $60
▪ Trifocal – lined	100%	up to $78
▪ Lenticular	100%	up to $109
▪ Polycarbonate lenses for children	100%	N/A
Frames (once/24 months from last date of service)	up to $150 (20% discount on frame overage) ($80 at Costco)	up to $89
Contacts (once/12 months in place of eyeglass lenses and frames)		
▪ Elective	100%, up to $130 for contacts	up to $115
Contact Lens Exam (fitting and evaluation)	You pay up to $60 copay	N/A
▪ Necessary**	100%	up to $210

* You are responsible for additional non-covered lens options, such as progressive lenses and coatings. In network you will receive an average 20-25% discount on lens options.

** Covered (with prior VSP approval) following cataract surgery, to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, for certain conditions of anisometropia and for keratoconus.

In addition, VSP providers agree to:

- *Glasses and Sunglasses*
  20% off additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last well vision exam.
- *Retinal Screening*
  Guaranteed pricing on retinal screening as an enhancement to your well vision exam.
- *Laser Vision Correction*
  Average 15% off the regular price, or 5% off the promotion price; discounts only available from contracted facilities.

Prescription ProTec Safety Eyewear-Employee Only

VSP Provider Coverage

A pair of prescription safety gasses are available through VSP's ProTec Eyewear Plan as a second pair of glasses, in addition to the standard prescription glasses. Materials and services are subject to the same frequency as listed above; every 12 months for lenses and every 24 months for a Safety/ProTec frame. The exam is fully covered under your standard benefit as stated above.

Prescription polycarbonate lenses, plastic or glass, are covered through VSP's ProTec Plan. These lenses are certified according to ANSI (American National Standards Institute) requirements.

Frame and detachable side shields (for applicable frames) are fully covered when you choose a safety frame from a VSP provider's ProTec frame collection. These frames are certified according to ANSI requirements. To view a list of the ProTec Eyewear frames, you can log into vsp.com, choose your ProTec benefit and click on the link under "frame" benefit.

Note: Some providers carry a ProTec Eyewear frame kit in the event you would like to try on the frame. To confirm which VSP providers carry the frame kit, contact their office directly or call VSP's Customer Service (800) 877-7195.

Non-VSP Provider Coverage

Coverage is also available for out-of-network safety glasses. Below is the reimbursement schedule of allowances:

- Single Vision Lenses $35
- Lined Bifocal Lenses $45
- Lined Trifocal Lenses $60
- Frame $25

Low Vision Coverage

Low vision benefits are available (with prior VSP approval) for severe visual problems that are not correctable with regular lenses. Please discuss your options with your provider. Coverage includes:

- Supplemental care – 75% (25% copay)
- Supplemental testing – 100%
- Benefit maximum – $1,000 per two years for services related to low vision

Low vision care from a non-VSP provider is subject to the same limits and copays as described above for a VSP provider. You pay the non-VSP provider's full fee, then are reimbursed up to what would have been paid to a VSP provider.

Obtaining Vision Care

To receive eye care services or eyewear from a VSP provider:

- Contact VSP by calling (800) 877-7195 or visiting **www.vsp.com** to determine if your provider is in the VSP network or to locate a VSP provider close to your home or work.
- When making an appointment, identify yourself as a VSP member, provide the VSP provider with the employee's Social Security number and first and last name; before your visit they will verify your eligibility and available benefits.

- The patient will be responsible for the cost of any cosmetic options, as well as any frame or contact lens overage.

There's no need to file a claim – the VSP provider does it for you.

To receive service from a non-VSP provider:

- Make an appointment with any provider
- Pay the bill in full
- File a claim for reimbursement as outlined on page 67; the Plan reimburses you up to the covered amount

All claims must be filed within one year of the date vision services are completed. Reimbursement is made directly to you and can be assignable to the provider if they are willing.

VSP Vision Care Limitations and Exclusions

Because this Plan is designed to cover your visual needs rather than cosmetic eyewear, there is an extra charge for:

- Blended lenses
- Coated or laminated lenses
- Contact lenses (except as noted above)
- Cosmetic lenses and optional processes
- Frames that cost more than the Plan allowance
- Oversize lenses (61 mm or larger)
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses

The Plan does not cover:

1. Claims received after the 12-month filing limit.
2. Experimental procedures or lenses.
3. Eye exam or corrective eyewear required by an employer as a condition of employment.
4. Medical or surgical treatment of the eyes.
5. Orthoptics or vision training or any associated supplemental testing.
6. Plano lenses.
7. Replacement of lost or broken lenses or frames furnished under these vision benefits (except at the normal intervals).
8. Two pair of glasses in place of bifocals.

Supplemental Benefits Account (SBA)

The Supplemental Benefits Account (SBA) allows you to be reimbursed for eligible health care expenses for you and your eligible family members with tax-free employer contributions.

This Plan is designed to be used after you retire, to cover eligible expenses you incur during retirement. The account can be used for the cost of retiree health care coverage and/or cover out-of-pocket health care expenses which are not covered by health insurance. While the SBA is intended to be used during retirement, it is possible to access the funds at any time for eligible health care expenses.

Eligibility

You are eligible for this benefit if you meet the following requirements:

1. You are covered by a collective bargaining agreement requiring a SBA contribution be paid to the Fund
2. You are enrolled in the Inland Empire Electrical Workers Health and Welfare Plan

Contributions

Initially, an individual Supplemental Benefit Account will be established on your behalf when you are enrolled and eligible to participate in the Inland Empire Electrical Workers Health and Welfare Plan (or prove enrollment in another qualified group health plan which meets the minimum value requirements of the Affordable Care Act).

Once your account has been established, contributions received will be credited to your account each month as long as you are actually eligible for coverage under the Inland Empire Electrical Workers Health and Welfare Plan (or prove eligibility in another qualified group health which meets the minimum value requirement of the Affordable Care Act). Contributions received during any month in which you are not eligible for coverage will be pended and credited during the next month in which you are eligible.

The amount in your account can increase or decrease depending on the returns from the investments of the Fund. Any reimbursements that you request will decrease the overall account balance by the amount of your reimbursement. There is a $1.50 monthly administrative fee for each account, regardless of account size. You will receive an individual statement showing monthly contributions, investment earnings, administrative fees and distributions every six months, generally in January and July.

Eligible Expenses

The IRS determines what health care expense may or may not be eligible for reimbursement. Generally, these are health care expenses that qualify as a deduction on your federal tax return. Expenses that are reimbursed by any other benefit plan (such as your spouse's medical or dental plan or your spouse's flexible spending account) are not eligible.

Examples of eligible health care expenses include:

- Out-of-pocket health care expense such as annual deductibles, coinsurance, copayments and amounts above reasonable and customary charges for you and your eligible dependents

- Smoking cessation programs and related prescription drugs
- Orthodontia
- Premiums for self-payment to continue Plan benefits, Medicare supplement policies and long-term care, subject to additional limitations.

Examples of health care expenses that are not eligible include:

- Cosmetic surgery or treatment, unless medically necessary due to injury, disease or birth defect
- Expenses paid by any other health care plan or that you claim as a deduction on your income tax return
- Health club dues
- Weight-loss programs or products unless prescribed by a physician for treatment of a specific medical condition such as high blood pressure.

For a complete list of eligible and ineligible expenses, go to **www.irs.gov/publications** and select Publication 502 Medical and Dental Expenses.

Getting Reimbursed

When you have an eligible expense, first pay the bill out of your own pocket, then submit a reimbursement request form to the Trust Office. Reimbursement request forms can be obtained from the Fund's website (**www.ewwellpower.com**), as well as the Trust Office.

Along with each claim, you must provide acceptable documentation of your expense from your provider to the following address:

Inland Empire Electrical Workers
Supplemental Benefits Account Plan
PO Box 5433
Spokane, WA 99205

Acceptable documentation may include an itemized receipt or Explanation of Benefits (EOB) from an insurance company.

When Participation Ends

If you are no longer eligible to receive SBA contributions, you may continue to request reimbursement for eligible expenses until your account is depleted. In the event of your death, your surviving spouse or eligible dependents may continue to request reimbursement for eligible expenses until your account is depleted. If you are not survived by a spouse or eligible dependent, any remaining account balance will be forfeited to the Plan once all of your remaining qualified medical expenses have been reimbursed to your estate.

Weekly Time Loss Benefits

These benefits are available to eligible employees only, not dependent family members.

Weekly time loss benefits help replace lost income if you are ill or injured and can't work for a time. For disabilities beginning when you are covered by the Plan, the following weekly benefit is payable:

- Weeks 1 – 4: $300/week
- Weeks 5 – 26: $400/week

Benefits are payable on the first day of disability due to an accident and on the eighth day for a disability due to illness. However, if you are hospitalized or have outpatient surgery due to an illness, you will receive benefits as of the first day of disability.

Payments may continue as long as you remain disabled, up to a maximum of 26 weeks for each period of disability.

Two or more periods of disability due to the same cause will be considered one period of disability unless they are separated by a return or release to full-time work for a continuous period of at least two weeks. Periods of disability due to different causes will be considered one period of disability unless they are separated by a return or release to full-time work.

You are considered disabled, under the terms of this Plan, if all of the following are true:

- You must be totally and continuously disabled due to an accident or illness, and
- You are unable to perform the duties of your own occupation, and are not engaged in any other occupation for wage or profit, and
- You are under the professional care of a licensed physician.

Disability claim forms can be obtained from the Fund's website (**www.ewwellpower.com**) as well as from the Trust Office.

Exclusions

Benefits will not be paid:

- For a disability covered under any Workers' Compensation or occupational disease law, or arising out of any employment for wage or profit
- If you are receiving pay or other compensation from any other work or service
- If you are not under the professional care of a physician.

Social Security Tax (FICA)

Weekly time loss benefits paid by the Plan are subject to Social Security (FICA) taxes, which are paid by you and your employer. The Plan is required by federal law to withhold your share of the tax from each weekly benefit payment made. The Trust Office is responsible for sending your year-end tax information.

Life and Accidental Death and Dismemberment Insurance

Eligible employees, but not dependents, receive group life insurance and accidental death and dismemberment (AD&D) insurance coverage. These benefits are underwritten by Lincoln Financial Insurance Company and administered by the Trust Office.

Life and AD&D Insurance Highlights

Life Insurance	AD&D Insurance
$5,000	$5,000

Your life insurance pays a benefit to your beneficiary if you die from any cause while covered under this Plan. You may elect payment of your life insurance to your beneficiary in monthly installments in lieu of a lump sum payment. To arrange for such optional payment, contact the Trust Office.

Your AD&D benefit is paid for any of the following covered losses due to an accident, on or off the job, while covered under this Plan:

- Loss of life: $5,000 paid to your beneficiary. The AD&D benefit is $10,000 if death is due to an auto accident and you were wearing a seatbelt.
- Loss of both hands, both feet, sight of both eyes, or any combination: $5,000 paid to you.
- Loss of one hand, one foot, or sight of one eye: $2,500 paid to you.

Loss of a hand or foot must be by complete severance at or above the wrist or ankle. Loss of sight means the irrevocable loss of sight. No more than 100% of your AD&D insurance will be paid for all losses due to the same accident.

Accidental injury means an injury caused by external, violent and accidental means. The loss must result from an injury directly and independently of all other causes and occur within 365 days after the injury.

Your Beneficiary

To name your beneficiary, contact the Trust Office for a Participant Data Form. You can change your beneficiary at any time.

If you do not name a beneficiary, or if your beneficiary dies before you, life and AD&D insurance benefits will be paid in the following order:

- Your spouse
- Your child or children equally
- Your parents
- Your estate.

Your beneficiary designation should be kept up to date to assure that benefits will be paid in accordance with your wishes. No beneficiary change is effective until the Trust Office receives a newly signed Participant Data Form. Participant Data Forms are available on the Fund's website (**www.ewwellpower.com**) as well as from the Trust Office.

Life Insurance During Total Disability

If you become totally disabled prior to age 60 while you are covered under this Plan, your life insurance, but not AD&D insurance, will remain in force as long as you remain totally disabled. You must provide initial proof of total disability within one year after the day your disability begins and must be approved by Lincoln Financial Insurance Company. Proof of the continuance of the disability, as required by the group policy, must be submitted to Lincoln Financial Insurance Company. During the period you are totally disabled, life insurance premiums are waived.

No benefit will be provided if initial written proof of total disability is not furnished to Lincoln Financial Insurance Company within 12 months of the date the disability begins.

Converting to an Individual Policy if You Lose Coverage

If your life insurance ends, you have a 31-day period during which you may convert to an individual life insurance policy, without medical examination. The largest amount that can be converted is the amount of life insurance that ended or $2,000.

During this 31-day period, your group life insurance remains in effect. You may select any type of individual policy then customarily being issued by the company except term insurance or a policy containing disability or other supplemental benefits. The individual policy will become effective on the day following the end of the 31-day period, providing application is made and you pay the premium within the 31-day period.

If you die during the 31 days that applying for an individual policy is available, your beneficiary will be paid the amount of insurance you were entitled to convert, whether or not you applied for an individual policy.

Contact the Trust Office for assistance if you are interested in converting to an individual policy.

Exclusions

AD&D benefits will not be paid for any loss caused by:

- Disease, bodily or mental infirmity, or medical or surgical treatment
- Suicide or other intentionally self-inflicted injury
- Committing or attempting to commit a felony, or participation in a riot
- Military service
- War or act of war, declared or undeclared
- Voluntary use or consumption of any poison, gas or drug, except when prescribed by a physician

- Travel in any aircraft, including balloons and gliders, except as a fare-paying passenger or on a regularly scheduled flight
- The covered person driving an auto with a blood alcohol concentration of 0.10 or more per 100 milliliters of blood.
- Medical or surgical treatment for any of the above.

Definitions

Ambulatory Surgical Center — An appropriately licensed provider with an organized staff of physicians that meets all of the following criteria:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; and
- Provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; and
- Does not provide inpatient accommodations; and
- Is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

Approved Treatment Facility — Facility that provides treatment for mental health or chronic alcoholism and/or substance abuse and that is operating under the directions and control of the appropriate licensing or regulatory agency of the jurisdiction in which the facility is located.

Chemical Dependency — An illness characterized by physiological and/or psychological dependency on a controlled substance and/or alcoholic beverages.

Cosmetic Surgery — Surgery performed to alter the texture or configuration of the skin, or the configuration or relationship with contiguous structures of any feature of the human body, which is performed primarily for psychological purpose or which does not correct or materially improve a bodily function.

Custodial Care — Any portion of a service, procedure or supply that, in the judgment of the Plan, is provided primarily:

- For ongoing maintenance of the individual's health and not for its therapeutic value in the treatment of an illness or injury

- To assist the individual in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

Dental Hygienist — A dental professional who works under the supervision of a dentist and is legally licensed to practice dental hygiene in the area where the services are provided.

Dentist — A duly licensed dentist, physician or denturist operating within the lawful scope of their license at the time and place covered services are performed.

Dependent — See the Dependent Eligibility section beginning on page 13.

Employee — An employee for whom contributions are made to the Fund by a contributing employer, as specified in the applicable collective bargaining agreement or special agreement.

Experimental or Investigational Services — Experimental, unproven or investigational services include treatments, procedures, equipment, drugs, drug usage, medical devices or supplies that meet one or more of the following criteria as determined by the Plan:

- A drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and has not been granted such approval on the date the service is provided

- The service is subject to oversight of an Institutional Review Board

- There is a lack of reliable evidence demonstrating that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition

- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy

- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

- The service is deemed experimental or investigational by the American Medical Association, the Food and Drug Administration or the Health Care Financing Administration of the Department of Health and Human Services, unless otherwise required by applicable law.

Reliable evidence includes but is not limited to reports and articles published in authoritative peer reviewed medical and scientific literature.

Fund — The Inland Empire Electrical Workers Welfare Trust Fund.

Hospice — A facility, agency or service that is licensed, accredited or approved by the proper regulatory authority to establish and manage hospice care programs; and arranges, coordinates and/or provides hospice care services for dying individuals and their families; and maintains records of hospice care services provided and bills for such services on a consolidated basis.

Hospice Care Program — A program managed by a hospice and established jointly by a hospice, a hospice care team and an attending physician to meet the special physical, psychological and spiritual needs of dying individuals and their families.

Hospital — A facility legally operating as a hospital in the state in which it operates that meets all of the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians

- It continuously provides 24-hour nursing services by or under the supervision of registered nurses

- A “hospital” will never be an institution that is run mainly:

  – As a rest, nursing or convalescent home; residential treatment center; or health resort

  – To provide hospice care for terminally ill patients

  – For the care of the elderly

Limited Benefits – Any benefit payment that is limited to less than 80% coinsurance and/or has a maximum benefit amount or limited number of days.

Medical Emergency — Sudden severe physical symptoms that could not have been reasonably anticipated and require immediate medical treatment.

Medically Necessary — A treatment, hospitalization, service or supply prescribed by a physician that is, in the judgment of the Plan, necessary and appropriate for the medical condition, and not experimental, investigational or in conflict with accepted medical standards.

Mental Illness — Any condition listed in the Diagnostic and Statistical Manual (DSM) IV published by the American Psychiatric Association.

Non-network Provider — A provider who has not contracted with the Fund's PPO network.

Participant — An employee or dependent who is eligible and enrolled in the Plan.

PPO Network Provider — A physician, hospital or other provider who is part of a PPO network that has been contracted by the Fund.

Physician — A legally licensed:

- Medical Doctor (M.D.) and Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following provider types will be covered under the Plan, but only when the provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this Plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:

- Audiologist
- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Naturopath (N.D.)
- Nurse Practitioner
- Physician Assistant
- Podiatrist or Chiropodist (D.P.M.)
- Physical therapist, Occupational therapist and Speech therapist
- Psychologist (Ph.D.)
- Nurse (R.N.) or Nurse Midwife licensed in the state in which the service is provided
- Social Worker licensed in the state in which the service is provided

Physician Visit — A personal interview between you or your dependent and a physician and does not include telephone calls or interviews in which a physician does not see you or your dependent.

Plan — The Inland Empire Electrical Workers Health and Welfare Plan; the benefit terms and limitations as set forth in this summary plan description and administered by the Trust Office and the Plan fiduciaries.

Plan Year – January 1 through the following December 31.

Pre-Admission Testing Charges — Covered charges by a hospital or other health care provider for tests that are performed on an outpatient basis within seven days prior to a planned admission to a hospital for surgery or other inpatient treatment; and according to a formal pre-admission testing arrangement with the hospital where the surgery or other inpatient treatment will occur.

Reasonable and Customary Charges — Charges that do not exceed the fee usually charged by the individual or institution and are similar to charges by other providers with similar training and experience in the same geographic area for comparable services and supplies as determined by the Plan or, are reasonable based on the nature and extent of treatment of the particular case.

Second Opinion Consultation Charges — Covered charges for consultation with a physician to obtain a second (and third, if necessary) opinion prior to the performance of surgery for which a second opinion is recommended; and necessary diagnostic X-ray and laboratory examinations performed in connection with such consultation.

Skilled Nursing Facility or Extended Care Facility — An institution, or a distinct part thereof, which is licensed pursuant to state or local law and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from injury or sickness; and has organized facilities for medical treatment and provides twenty four hour nursing service under the full-time supervision of a physician or graduate registered nurse; and maintains daily clinical records on each patient and has available the services of a physician under an established agreement; and provides appropriate methods of dispensing and administering drugs and medicines; and has transfer arrangements with one or more hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one physician excluding any institution which is, other than incidentally, a rest home, or a home for the aged.

Total Disability — The inability, due to injury or sickness, of a person to engage in any work for gain or profit, or of a dependent, to carry on the regular and customary activities of an individual in good health of the same age and sex.

Trust Office — The contract Trust Administrator:

A.W. Rehn & Associates, Inc.
P.O. Box 5433
Spokane, WA 99205
(509) 534-0600
(800) 872-8979

Coordination With Other Plans

This Plan will coordinate medical, vision, and/or dental benefit payments with any other group or individual plan you or a member of your family may have, including motor vehicle policies. This means that when you are covered by this Plan and another plan, your providers are not paid more than the total cost of the services provided. Coordination of benefits lowers the cost of health care for everyone because no one receives double payment for any medical service provided.

If you or your dependents have coverage in addition to this Plan, please submit the claim to us and all other insurers at the same time. This helps us coordinate benefits and pay your bills more quickly.

This Plan uses traditional coordination of benefit rules: when this Plan is the primary plan, it pays its normal benefits first, and then the secondary plan may or may not pay any additional amounts under its own coordination of benefits rules. When another plan is the primary plan and this Plan is the secondary plan, this Plan will coordinate benefits to 100% of covered charges. For example, if the primary plan pays 80% of the cost, this Plan will pay the other 20%.

Order of Benefit Determination

How your benefits will be coordinated is determined in part by which plan is determined to pay first (the "primary plan") and which plan pays second ("the secondary plan").

The benefits of a plan that does not have a coordination of benefits provision described in this section will always be determined before the benefits payable from a plan that does have such a provision. In all other instances, the order of determination will be as follows:

- **Nondependent/Dependent** — The benefits of a plan that covers the individual for whom benefits are claimed as an employee (that is, other than as a dependent) are determined before the benefits of a plan that covers the individual as a dependent.

- **Dependent Child — Parents Not Separated or Divorced** — When this Plan and another plan cover the same child as a dependent of different persons called "parents," the benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time. However, if another plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- **Dependent Child — Separated or Divorced Parents** — If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

  – First, the plan of the parent with custody of the child

  – Then, the plan of the spouse of the parent with custody of the child and

  – Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Active/Inactive Employee** — The benefits of a plan that covers an individual as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before the benefits of a plan that covers that individual as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

- **Longer/Shorter Length of Coverage** — If none of the above rules determine the order of benefits, the benefits of the plan that covered an employee longer are determined before those of the plan that covered that individual for the shorter time.

How Medicare Affects Coverage

If you or your spouse are age 65 or older and are eligible for Medicare, this Plan will remain as the primary coverage for coordination of benefits purposes. Therefore, benefits for you or your spouse will remain the same as before.

Exception to the Above

This Plan will be primary unless you elect in writing to drop this Plan and to take Medicare as your primary hospital and medical coverage. If you elect Medicare as primary coverage, this Plan is precluded by government regulations from providing secondary hospital and medical coverage to supplement Medicare. If your spouse becomes eligible for Medicare before you, the decision to elect either this Plan or Medicare as primary hospital and medical coverage must be made at that time, but your coverage under this Plan will be unaffected by that decision until you become eligible for Medicare.

Whether or not you elect this Plan as primary, it is very important that you sign up for Medicare on or before your eligibility date to avoid late enrollment fees and to be sure your coverage is in force when your eligibility under this Plan ends.

Facility of Payment

The Trust may reimburse any other plan if benefits were paid by that other plan, but should have been paid under this Plan in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under this Plan and, to the extent of those amounts, will discharge the Fund from liability.

Right of Recovery

If it is determined that benefits paid under this Plan should have been paid by any other plan, the Fund will have the right to recover those payments from the individual to or for whom the benefits were paid, and/or the other companies or organizations liable for the benefit payments.

Subrogation

If you or your eligible dependents are entitled to receive benefits from the Plan for injuries caused by a third party or as a result of any accident (for example, an auto accident), or if you or your eligible dependents receive an overpayment of benefits from the Plan, the Plan has the right in equity, and a right in contract, to obtain full restitution of the benefits paid by the Plan from:

- Any full or partial payment that your insurance carrier makes (or is obligated or liable to make) to you or your eligible dependents; and
- You or your eligible dependents, if any full or partial payments are made to you or your eligible dependents by any party, including an insurance carrier, in connection with, but not limited to, your, your dependent's or a third party's:
  - Automobile liability coverage
  - Uninsured motorist coverage
  - Underinsured motorist coverage
  - Homeowner's coverage
  - Other insurance coverage.

This means that, with respect to benefits the Plan pays in connection with an injury or accident, the Plan has the right to full restitution from any payment received by you or your eligible dependents from any third party, whether or not the payment separately allocates an amount to the restitution of the expenses or types of expenses covered by the Plan or the benefits provided under the Plan. Any payment received by you, or your representative, from a third party is subject to a constructive trust. Any third party payment received by you must be used first to provide restitution to the Plan to the full extent of the benefits paid by or payable under the Plan. The balance of any third party payment must first be applied to reduce the amount of benefits that are paid by the Plan for benefits after the payment and second be retained by you or your eligible dependents. The Plan does not recognize the Make-Whole Doctrine.

You and your eligible dependents are responsible for all expenses incurred to obtain payment from third parties, including attorneys' fees, which amounts will not reduce the amount due to the Plan as restitution. The Plan expressly rejects the Common Fund Doctrine with respect to payment of attorneys' fees.

The Plan is entitled to obtain restitution of any amounts owed to it either from third party funds received by you or your eligible dependents, regardless of whether you or your eligible dependents have been fully indemnified for losses sustained at the hands of the third party. The Plan may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable and/or contractual right to obtain full restitution.

By participating in the Plan, you and your eligible dependents acknowledge and agree to the terms of the Plan's equitable (or other) rights to full restitution. You and your eligible dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan administrator, including the signing of any documents or agreements necessary for the Plan to obtain full restitution.

You and your eligible dependents are also required to:

- Notify the Trust Office as soon as possible and in writing that the Plan may have an equitable (or other) right to obtain restitution of any and all benefits paid by the Plan
- Inform the Trust Office in advance of any settlement proposals advanced or agreed to by a third party or a third party's insurer
- Provide the Trust Office all information requested by the Trust Office regarding an action against a third party, including an insurance carrier
- Fully cooperate with the Trust Office in all respects in the Plan's enforcement of its equitable (or other) rights to restitution
- Not settle, without the prior written consent of the Trust Office, any claim that you or your eligible dependents may have against a third party, including an insurance carrier
- Take all other action as may be necessary to protect the interests of the Plan.

In the event you or your eligible dependents do not comply with the requirements of this section, the Plan may deny benefits to you or your eligible dependents or take such other action as the Trustees deem appropriate. The Plan has the right to reduce future payments due to you or your eligible dependents by the amount of benefits paid by the Plan. This right of offset shall not limit the equitable and/or contractual rights of the Plan to recover such moneys in any other manner.

If You Have Questions

If you have questions about how your benefits under this Plan are paid when another plan is involved, please contact the Trust Office.

Claims and Appeals Procedures

Filing a Claim

To perfect a claim for benefits under this Plan it is necessary to complete and submit a claim form within **one year** of the date charges were incurred. Claim forms are available from any participating local union office, from the Trust Office, and online at **www.ewwellpower.com**.

The Board of Trustees has established the following requirements for filing claims.

Medical Claims

In most situations, providers will submit bills directly to Aetna. If the provider does not bill directly, participants should request an itemized statement of the services and charges including a diagnosis and submit it to:

Inland Empire Electrical Workers Health and Welfare Plan
c/o A.W. Rehn and Associates, Inc.
P.O. Box 5433
Spokane, WA 99205

Dental Claims

When you see a Delta Dental participating provider, there is no need to file a claim; your dentist will do it for you.

When you choose a non-participating provider, submit a claim form directly to:

Delta Dental of Washington
P.O. Box 75983
Seattle, WA 98175-0983

Prescription Drug Claims

For prescriptions obtained at a Sav-Rx network pharmacy, there is no claim to file; you just pay the required copayment when you pick up your prescription.

For prescriptions obtained at a non Sav-Rx network pharmacy, submit a claim form directly to:

Sav-Rx
224 North Park Ave.
Fremont, NE 68025

Vision Claims

Self-Funded Vision Benefits
(for claims incurred on or before December 31, 2015)

In most situations, providers will submit bills directly to Aetna. If the provider does not bill directly, participants should request an itemized statement of the services and charges and submit it to:

Inland Empire Electrical Workers Health and Welfare Plan
c/o A.W. Rehn and Associates, Inc.
P.O. Box 5433
Spokane, WA 99205

VSP Vision Care Benefits
(for claims incurred or after January 1, 2016)

When you see a VSP provider, there is no need to file a claim; the VSP provider will do it for you.

If you chose an out-of-network provider:

1. Pay the bill in full.
2. File a claim for reimbursement. Write the employee's name, date of birth, Social Security number as well as the patient's name, date of birth and relationship to the employee and Inland Empire Electrical Workers Welfare Trust Fund on the bill, or submit an out-of-network claim form with the bill to:

   VSP
   Out of Network Provider Claims
   P.O. Box 997105
   Sacramento, CA 95899-7105
   (800) 877-7195

3. Reimbursement is made directly to you and can only be assignable to the provider if they are willing.

Weekly Time Loss Claims

You must submit a weekly time loss claim form that has been completed and signed by you and your physician to:

Inland Empire Electrical Workers Health & Welfare Plan
c/o A.W. Rehn and Associates, Inc.
P.O. Box 5433
Spokane, WA 99205

Life and Accidental Death & Dismemberment Insurance

In the event of an employee's death, a certified copy of the employee's death certificate should be mailed to the Trust Office.

The Trust Office will send all of the information to Lincoln Financial Insurance Company for processing.

The Trust Office may require additional information on any claim to process claims or to ensure compliance with Plan requirements. This may include inquiries related to eligibility, the nature of services or supplies provided, coordination of benefits, other insurance, third party reimbursement requirements or other Plan provisions. Failure to provide this required information in the timely filling period (one year from the date of service) will result in the denial of a participant's claim for benefits.

Procedures for Processing Claims

Urgent Claims — For Claims Requiring Pre-authorization

For benefit claims applications for urgent care, a claimant will be notified of the benefit determination in writing as soon as possible, but no later than 72 hours from receipt of the initial claim.

The Plan will notify the claimant of the need for additional information within 24 hours of receipt of the claim, and the claimant will be allowed at least 48 hours to respond. The deadline for initial determination is then suspended for 48 hours or until information is received.

Pre-Service (Pre-Authorization) Claims

For benefit applications for pre-service, or pre-authorization of claims, a claimant will be notified of the benefit determination in writing within 15 days of receipt of initial claim.

The Plan Administrator may extend the determination deadline by up to 15 days, in the event the administrative agent determines the extension is necessary due to matters beyond control of the Plan, and will notify the claimant of the extension prior to expiration of the initial determination period. If the extension is necessary because the claimant failed to provide necessary information, the notice of extension will specify the information needed. The claimant will be allowed 45 days to respond. The Plan will issue a determination within 15 days of receiving the needed information.

Post-Service Claims

For post-service benefit claims applications, a claimant will be notified in writing of the benefit determination within 30 days after receipt of the application. An extension of up to 30 days is permitted in the event the administrative agent determines that such an extension is necessary for reasons beyond the control of the Plan, and provided the administrative agent files an extension notice with the claimant. If an extension is needed to obtain further information from the claimant, the claimant will be allowed at least 45 days to provide the requested information. The benefit determination will then be made within 15 days from the last date of the extension period.

Appealing a Claim

In the event a claim for benefits is denied, the Board of Trustees has adopted the following procedures to redress benefit claim denials:

Notification of Benefit Denial

If a claim is denied or partly denied, you will be notified in writing and given an opportunity for review. The written denial will give:

- The specific reasons for denial
- Specific reference to pertinent Plan provisions on which the denial is based

- A description of any additional material or information necessary for the claimant to perfect the claim and explanation of why such material or information is necessary

- If the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request

- An explanation of the Plan's claim review procedure, including a statement of the claimant's right to bring a civil action under ERISA § 502(a).

Appeal to the Board of Trustees

Notice of Appeal — Any employee, retired employee or beneficiary (hereafter claimant) who applies for benefits under this Plan and is ruled ineligible by the Trustees (or by the Trust Administration Office acting for the Trustees) or who believes he did not receive the full amount of benefits to which he is entitled or who is otherwise adversely affected by any action of the Trustees or the Trust Administration Office, shall have the right to appeal the matter to the Board of Trustees, provided that he files a written notice of appeal within 180 days after receipt of the adverse decision, and provided further that the Trustees or their representatives shall not consider applications for appeal which are submitted without an authorization to release health care information relevant to the denied claim.

The appeal shall be conducted by the Board of Trustees, or by the Appeals Committee of the Board of Trustees which has been delegated the authority for making a final decision in connection with the appeal.

Scheduling of Appeal — The Trustees shall review a properly filed appeal at the next regularly scheduled quarterly meeting of the Appeals Committee, unless the request for review is received by the Trustees within thirty (30) days preceding the date of such meeting. In such case, the appeal will be reviewed no later than the date of the second quarterly meeting following the Trustees' receipt of the notice of appeal, unless there are special circumstances requiring a further extension of time, in which case a benefit determination shall be rendered not later than the third quarterly meeting of the Appeals Committee following the Trustees' receipt of the notice of appeal. If such an extension of time for review is required because of special circumstances, such as a request for hearing on the appeal, then prior to the commencement of the extension, the Plan shall notify the claimant in writing of the extension, describe the special circumstances and the date as of which the benefit determination will be made.

Appeal Procedures — The claimant is generally entitled to present his position and any evidence in support thereof, at an appeal hearing. The claimant may be represented by an attorney or by any other representative of his choosing at his own expense.

The claimant will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to his or her claim for benefits.

The claimant must introduce sufficient credible evidence on appeal to establish, prima facie, entitlement to the relief from the decision or other action from which the appeal is taken. The claimant will have the burden of proving his right to relief from the decision or action appealed, by a preponderance of evidence. The Trustees will review all comments, documents, records and other information submitted by the claimant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Trustees will not afford deference to the initial adverse benefit determination.

When deciding an appeal of a claim that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be identified to the claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Decision After Appeal Hearing — The Trustees will issue a written decision on review of a claim as soon as possible, but not later than 5 days following the conclusion of the Appeals Committee meeting. Where necessary, the Trustees may issue a more detailed explanation of the reasons for an adverse decision within 30 days of the conclusion of the Appeals Committee meeting. In the case of an adverse benefit determination, the written denial will indicate:

- The specific reasons for the adverse benefit determination and a specific reference to pertinent Plan provisions on which the denial is based.

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits.

- A statement of claimant's right to bring a civil action under ERISA § 502(a).

Review of Trustees' Decision — The Plan does not provide for any voluntary alternative dispute resolution procedures. If a claimant remains dissatisfied with the Plan's determination after exhausting the claim appeal procedures, the claimant may bring a civil action under ERISA § 502(a). The question on review of the Trustees' determination will be whether, in the particular instance, the Trustees: (1) were in error upon an issue of law; (2) acted arbitrarily or capriciously in the exercise of their discretion; or (3) whether their findings of fact were supported by substantial evidence.

Sole and Exclusive Procedures — The Plan's appeal procedures are the sole and exclusive procedures available to a claimant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees. The appeal procedures must be exhausted prior to filing a legal action.

Special Disclosure Information

This section includes important administrative, procedural and legally-required information about your Plan.

Name of Plan

The official name of the Plan described in this booklet is the Inland Empire Electrical Workers Health and Welfare Plan.

Names and Addresses of Plan Sponsor

This Plan is sponsored and administered by a joint labor — management Board of Trustees.

Board of Trustees
Inland Empire Electrical Workers Welfare Trust Fund
1322 N. Post
Spokane, WA 99201
(509) 534-0600
(800) 872-8979

Employer Identification Number

The employer identification number assigned to the Trust Fund by the Internal Revenue Service is EIN 91 – 6062784.

Plan Number

The Plan number is 501.

Type of Plan

This Plan is a welfare benefit plan that provides medical, vision, dental, prescription drug, life, accidental death and dismemberment and disability benefits.

Type of Administration

This Plan is administered by the Board of Trustees with the assistance of A. W. Rehn & Associates, Inc., a contract administrative organization.

Name and Address of Plan Administrator

Board of Trustees
A.W. Rehn & Associates, Inc.
1322 N. Post
Spokane, WA 99201

Name and Address of Agent for Service of Legal Process

A.W. Rehn & Associates, Inc.
1322 N. Post
Spokane, WA 99201

The agent for service of legal process is A. W. Rehn & Associates, Inc., whose address appears above. In addition, each member of the Board of Trustees is designated as an agent for purposes of accepting service of legal process on behalf of these Plans. The names and addresses of the Trustees follow.

Board of Trustees	
Andy Dahlman Aztech Electric 5204 East Broadway Spokane, WA 99221 (509) 536-6200	Ken Brown I.B.E.W. Local 73 1616 North Washington Spokane, WA 99205 (509) 326-2182
David Chally Inland Empire Chapter N.E.C.A. 1715 North Atlantic Spokane, WA 99205 (509) 328-9670	Gordon Vally I.B.E.W. Local 73 1616 North Washington Spokane, WA 99205 (509) 326-2182
Dave Peterson Peterson Electric 5622 N. Myrtle Street Spokane, WA 99217 (509) 489-1950	Pete Marsh I.B.E.W. Local 112 2637 West Albany Kennewick, WA 99336 (509) 735-0512
Mitch Murphy Sierra Electric 3508 Stearman Ave. Pasco, WA 99301 (509) 542-8682	Tim Murray I.B.E.W. Local 112 4505 Desert Plateau Dr. Pasco, WA 99301 (509) 735-0512

Description of Collective Bargaining Agreements

This Plan is maintained pursuant to more than one collective bargaining agreement. These agreements generally provide that the employers who are parties thereto will make monthly contributions to the Inland Empire Electrical Workers Welfare Trust Fund for the purpose of enabling the employees working under such agreements to participate in the Inland Empire Electrical Workers Health and Welfare Plan. The contribution rates required by such agreements are established from time to time.

A copy of such agreements may be obtained by participants and beneficiaries upon written request to the Trustees. Such agreements are also available for examination by participants and beneficiaries at the Trust Office, or local union offices upon 10 days written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreements.

Participation, Eligibility and Benefits

Employees are entitled to participate in this Plan if they work under one of the collective bargaining agreements described above and if their employer makes contributions to the Trust Fund on their behalf.

The eligibility rules that determine which employees and beneficiaries are entitled to benefits are set forth in the Eligibility section of this booklet, beginning on page 10.

Circumstances that May Result in Ineligibility or Denial of Benefits

An employee or beneficiary who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- The employee's failure to work the required hours to maintain eligibility or failure to make an authorized self-payment or COBRA payment
- The employee becomes ineligible
- The employee's employer fails to make contributions on the employee's behalf
- The beneficiaries are no longer dependents, or
- They have attained disqualifying age.

An employee or beneficiary who is eligible may be denied benefits for one or more of the following reasons:

- Failure of the employee or beneficiary to file a claim for benefits within 365 days of the date the service was provided
- Failure of the employee to file a complete and truthful benefit application
- Where the employee or beneficiary has other group coverage or individual coverage, benefits under this Plan may be reduced or denied according to the "Coordination of Benefits" rules in this booklet.

Source of Contributions

This Plan is funded through employer contributions, the amounts of which are specified in the underlying collective bargaining agreements. Also, employee self-payments under COBRA are permitted.

Entities Used for Accumulation of Assets and Payment of Benefits

Employer contributions, employee self-payments under COBRA and the self-payment option are received and held in trust by the Board of Trustees. The Board of Trustees pays premiums to Lincoln Financial Insurance Company and HCC Life Insurance Company and pays the other benefits directly from the Fund assets. Funds remaining are used to pay the administrative expenses of operating the Plan and the balance is invested by the Board of Trustees and held as Fund reserves.

Plan Year

The Plan is on a fiscal year ending June 30, for financial reporting. Benefits are based on the calendar year, January 1 through December 31.

Statement of Rights Under ERISA

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

- Examine, without charge, at the Trust Office and at all local union offices upon 10 days written request, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon 10 days written request to the Board of Trustees. The Board of Trustees may impose a reasonable charge for the copies. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

- Receive a summary of the Plan's annual financial report. The Board of Trustees is required by law to furnish each participant with a copy of this summary annual report.

- File suit in a federal court if any materials requested are not received within 30 days of a participant's request, unless the materials were not sent because of matters beyond the control of the administrator. The court may require the Board of Trustees to pay up to $110 for each day's delay until the materials are received.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the employee benefits plan. These persons are referred to as “fiduciaries” of the Plan. Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of their Plan duties.

In the event Plan fiduciaries misuse the assets of the Plan, you may request assistance from the U.S. Department of Labor or sue in federal court, which may award you costs of suit, including your attorney fees if you are successful. If you are not successful, the court may award you with the Fund attorney fees.

If you have any questions about this statement or about your rights under ERISA, 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 NW, Washington, D. C. 20210.

All questions with respect to Plan participation, eligibility for benefits or the nature and amount of benefits, or with respect to any matter of Plan administration, should be referred to the office of:

Inland Empire Electrical Workers Welfare Trust Fund
PO Box 5433
Spokane, WA 99205
(509) 534-0600
(800) 872-8979

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Pursuant to regulations issued by the federal government, the Fund is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As required by law, the Fund has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

Protected Health Information

Protected health information generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

Use and Disclosure of Health Information

Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the "minimum necessary," as defined under the Privacy Rules.

To Make or Obtain Payment. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may use your health information to pay claims, or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment. The Fund may disclose information to facilitate treatment which involves the provision, coordination or management of health care or related services. For example, the Plan may disclose the name of your treating physician to another treating physician for the purpose of obtaining x-rays.

To Conduct Health Care Operations. The Fund may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants. Health care operations include such activities as: contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Fund (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities).

In Connection With Judicial and Administrative Proceedings. If required or permitted by law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Fund will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required For Law Enforcement Purposes. The Fund will disclose your health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Conduct Health Oversight Activities. The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In the Event of a Serious Threat to Health or Safety. The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require the Fund to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

To Your Personal Representative. The Fund may disclose your health information to an individual who is considered to be your personal representative under applicable law.

To Individuals Involved in Your Care or Payment for Your Care. The Fund may disclose your health information to immediate family members, or to other individuals who are directly involved in your care or payment for your care.

To Business Associates. The Fund may disclose your health information to its Business Associates, which are entities or individuals not employed by the Fund, but which perform functions for the Fund involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Fund's Business Associates are required to safeguard the confidentiality of your health information.

For Workers' Compensation. The Fund may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

For Disclosure to the Plan Trustees. The Fund may disclose your health information to the Board of Trustees (which is the plan sponsor) and to necessary advisors for plan administration functions, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the plan. The Fund may also disclose information to the Trustees regarding whether you are participating or enrolled in the plan.

Authorization to Use or Disclose Health Information

Other than as stated above, the Fund will not disclose your health information without your written authorization. Authorization forms are available from the Privacy Contact Person, listed below. If you have authorized the Fund to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Contact Person, listed below.

Special rules apply to disclosure of psychotherapy notes. Your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your observations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

Your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Fund.

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information that the Fund maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request unless the disclosure is to another health plan for the purposes of carrying out payment or health care operations and your health care provider has been paid out of pocket in full. If you wish to request restrictions, please make the request in writing to the Fund's Privacy Contact Person listed below.

Right to Confidential Communications. You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Fund's Privacy Contact Person, listed below. The Fund will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information in paper or electronic format, if available. You also have the right to have the Fund transmit a copy of your health information to an entity or person of your choice. These rights, however, do not extend to psychotherapy notes or information compiled in anticipation of civil, criminal or administrative proceedings. The Fund may deny your request in certain situations subject to your right to request review of the denial. A request to inspect, copy or transmit records containing your health information must be made in writing to the Privacy Contact Person, listed below. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic format shall not be greater than the Fund's labor costs in responding to the request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing to the Fund's Privacy Contact Person, listed below. The Fund may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting be amended is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

If the Fund denies a request for amendment, you may write a statement of disagreement. The Fund may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the Fund's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Fund. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003 when the Privacy Rules became effective. Accounting requests may not be made for periods of time going back more than six (6) years. An accounting will not include disclosure made to carry out treatment, payment, and health care operations; disclosures that were made to you; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules;

disclosures made pursuant to an authorization; or in other limited situations. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications. If the Fund participates in fundraising, you have the right to opt-out of all fundraising communications.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person, listed below. You will also be able to obtain a copy of the current version of the Fund's Notice at its web site, **www.ewwellpower.com**.

Privacy Contact Person. To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Fund has also designated a Privacy Official, listed below.

Privacy Contact Person

Administrative Agent
Rehn and Associates
P.O. Box 5433
1322 N. Post
Spokane, WA 99205
(509)534-0600
rehn@rehnonline.com

Privacy Official

Administrative Agent
Rehn and Associates
P.O. Box 5433
1322 N. Post
Spokane, WA 99205
(509)534-0600
rehn@rehnonline.com

Duties of the Fund

The Fund is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify you following a breach of unsecured protected health information. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to the Privacy Contact Person identified above. The Fund encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

The Fund is prohibited by law from using or disclosing genetic health information for underwriting purposes.

Effective Date

This Notice is effective April 14**,** 2003, and updated September 12, 2013.

Trust Administrative Office
Inland Empire Electrical Workers
Welfare Trust Fund
Post Office Box 5433, Spokane WA 99205
1322 North Post, Spokane WA 99201

509.534.0600
800.872.8979
ieew@rehnonline.com
www.ewwellpower.com