TABLE OF CONTENTS

GENERAL INFORMATION **Page**

Important Notice 1
Letter from the Board of Trustees 2
Important Information to Help You Identify this Plan 3
Provisions Applicable to the Retiree Health Plan 6
Statement of Your Rights under ERISA 9
Definitions 11

ELIGIBILITY RULES

Retired Employee Eligibility 16
Dependent Eligibility 17
Retiree Premiums 19
COBRA (Continuation of Coverage) 20

MEMBER BENEFITS – UNDER AGE 65

Schedule of Benefits for Retirees/Widows Under Age 65 23
Comprehensive Major Medical Expense Benefits 25
    Covered Charges 26
    Exclusions and Limitations 28
Prescription Drug Card Benefit 30
Coordination of Benefits 32
Benefit Credit Account 35
Claims Procedures 37
How to Obtain Benefits 39
How to File a Claim 40
Appeal Procedures 41
IF YOU HAVE QUESTIONS 45

MEDICARE TRANSITION ASSISTANCE 46

MEMBER BENEFITS –AGE 65 & OVER

Schedule of Benefits for Retirees/Widows Age 65 & Over 48
Health Reimbursement Arrangement (HRA) 49
IF YOU HAVE QUESTIONS 52

BURIAL BENEFIT 53

EMPLOYEE ASSISTANCE PROGRAM 54

PRIVACY PRACTICES 56

THIS PAGE INTENTIONALLY LEFT BLANK

YOU ARE REQUIRED TO NOTIFY THE FUND OFFICE WHENEVER:

1. You change your home address.
2. You get married or divorced (copy of marriage license required and a complete full copy of divorce decree required).
3. You have a new dependent (copy of marriage license, birth certificate or adoption record required).
4. You wish to change your beneficiary.
5. You are receiving Worker's Compensation Benefits.
6. You return to work from retirement status.
7. You enter the Armed Forces of the United States.

You have 15 days from the date of divorce to notify the Fund Office and provide a full copy of the divorce decree. If the Retiree Health Plan discovers that benefits have been improperly paid for a former spouse and the Fund Office was not properly notified, the Retiree Health Plan will take steps to recover such improper payments from the participant, which may include either litigation or a setoff against future benefits.

IMPORTANT NOTICE

In this booklet we have attempted to explain as clearly and briefly as possible the benefits that are available to you under the Plan. All the provisions of the Plan are contained in the Plan Document adopted by the Board of Trustees. Since the Plan Document is complete in detail, it will govern the final interpretation of any specific provision.

In the case of a conflict between the Plan and Trust Documents or the Collective Bargaining Agreement and this Summary Plan Description, the Plan and Trust Documents or Collective Bargaining Agreement shall control.

Participants and beneficiaries, benefits, eligibility rules, and contributions required from participants, if any, are subject to modification, amendment and/or termination by the Board of Trustees.

This Summary Plan Description is effective September 1, 2017.

IBEW LOCAL 613 AND CONTRIBUTING EMPLOYERS RETIREE HEALTH PLAN
3715 NORTHSIDE PARKWAY, SUITE 2-495, ATLANTA, GEORGIA 30327
TOLL-FREE: 800-922-1613

Dear Participant:

This Summary Plan Description is intended to outline to you in detail how your Retiree Health Plan works.

This Fund was established and is maintained through Collective Bargaining between your Union and Participating Employers. The benefits provided to you by this Fund are funded by employer contributions and retiree self-payments, supplemented by such earnings as may be realized from the Fund's investments. The Fund is a Welfare Benefit Fund.

The Trustees are dedicated to providing you with the best Health Benefits possible utilizing the funds available. We urge you to read this Summary Plan Description thoroughly to familiarize yourself with the eligibility rules, benefits available, and those circumstances which might result in disqualification, ineligibility, denial, loss, forfeiture, or suspension of any benefit which you or your beneficiary might otherwise expect the Fund to provide.

Sincerely,

Your Board of Trustees

IMPORTANT INFORMATION TO HELP YOU IDENTIFY THIS PLAN

- **Name of Plan.** This Plan is known as the IBEW LOCAL 613 AND CONTRIBUTING EMPLOYERS RETIREE HEALTH PLAN.
- **Type of Plan.** This Fund is maintained for the purposes of providing medical benefits and compensation in the event of death.
- **Plan Identification Number.** The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 46-3415861.
- **Board of Trustees.**

a) Members. This Plan is maintained and administered by a Board of Trustees, which consists of an equal number of employer and Union representatives. This Board has the primary responsibility for decisions regarding eligibility rules, type of benefits, administrative policies, management of Plan assets, and interpretation of Plan provisions.

As of September 1, 2017, the Trustees of this Plan are:

Union Trustees	Employer Trustees
Kenny Mullins (Secretary) IBEW Local No. 613 501 Pulliam Street, SW Atlanta, GA 30312	Chris Foster (Chairman) Whitehead Electric Co. 5843 Jacaranda Drive SE Mableton, GA 30126-2937
Kevin Swanson IBEW Local No. 613 501 Pulliam Street, SW Atlanta, GA 30312	Chris Reichart Allison-Smith 1869 South Cobb Industrial Blvd. Smyrna, GA 30082
David Lawson IBEW Local No. 613 501 Pulliam Street, SW Atlanta, GA 30312	Champ Rittenhouse Eckardt Electric 3690 North Peachtree Road Atlanta, GA 30341
Robby Evans - Alternate IBEW Local No. 613 501 Pulliam Street, SW Atlanta, GA 30312	David Sokolow - Alternate Atlanta Electrical Contractors Association 4221 North Peachtree Road Atlanta, GA 30341

b) Address and Telephone Number. If you wish to contact the Board of Trustees, you may use the address and telephone numbers below:

3715 Northside Parkway, Suite 2-495
Atlanta, Georgia 30327
678-705-0200 or 800-922-1613

- **Administrative Operations.** The Board of Trustees is legally designated as the Plan Administrator. The Board has selected a professional employee benefit administration firm, National Employee Benefit Administrators, Inc. ("NEBA") to serve as the Administrative Manager of the Plan. The Administrative Manager serves as the "Fund Office" and maintains eligibility records, accounts for contributions, informs participants of Plan changes, and other routine administrative functions as directed by the Board of Trustees. You may contact the Administrative Manager at the following address and phone number:

  National Employee Benefits Administrators, Inc. (NEBA)
  3715 Northside Parkway, Suite 2-495
  Atlanta, Georgia 30327
  678-705-0200 or 800-922-1613

  Additionally, the following professionals have been retained by the Board of Trustees to assist in the operation of the Plan:

Claims Administrator/Provider Network/ Utilization Review Provider	**Medicare Private Exchange/Health Reimbursement Arrangement**
CIGNA Healthcare P.O. Box 5200 Scranton. PA 18505 800-244-6224	OneExchange 10975 S. Sterling View Dr. South Jordan, UT 84095 855-389-4390

Attorney	**Auditor**
Jeffrey D. Gordon Arnall Golden Gregory LLP 171 17th Street NW #2100 Atlanta, Georgia 30363 404-873-8542	Dennis G. Jenkins, CPA 1690 Stone Village Lane Suite 501 Kennesaw, Georgia 30152 770-424-5755

Consultant

BHA Consulting LLC
5400 Laurel Springs Parkway
Suite 1306
Suwanee, Georgia 30024
678-456-6200

- **Collective Bargaining Agreements.** This Plan is maintained pursuant to one or more Collective Bargaining Agreements. Copies of any or all of these Agreements shall be made available to you for your inspection at the Plan Office or at your Local Union Office during normal business hours. You

may obtain a copy of the Agreements for a reasonable charge by contacting the Board of Trustees at the address or phone number listed

- **Participating Employers and Union.** You are entitled to receive from the Plan Administrator, upon request, information as to whether a particular employer is a Participating Employer in the Plan and, if so, the employer's address. International Brotherhood of Electrical Workers, Local 613 is the Union affiliated with the Plan.
- **Source of Contributions.** The primary sources for the benefits provided under this Plan are employer contributions and retiree contributions. The Collective Bargaining Agreement determines the amount of employer contribution. The Board of Trustees determines the monthly self-pay contribution to be paid by the retiree. A portion of the Plan's assets is invested, which also produces additional Fund income.
- **Trust Fund.** All contributions and investment earnings are accumulated in a Trust Fund. All benefits are paid directly from the Trust Fund.
- **Identification of Insurance Company.** All benefits are self insured and paid directly by the Fund.
- **Accounting, Plan and Reporting Year.** Each 12-month period ending on December 31st constitutes a fiscal year for accounting purposes of all reports to the Department of Labor, to the Internal Revenue Service, and, where required, to any agency of those states in which contributing employers are located. The same 12-month period comprises a Plan Year within the meaning of ERISA.
- **Procedure for Obtaining Additional Plan Documents.** If you wish to inspect or receive copies of additional documents relating to this Plan, contact the Fund Office. You will be charged a reasonable fee to cover the cost of any materials you wish to receive.
- **Eligibility for Benefits.** Please see the Eligibility Rules section of this booklet.
- **Effective Date.** The effective date of this Summary Plan Description is September 1, 2017.
- **Agent for Service of Legal Process**. When legal disputes involving the Plan arises, any legal documents should be served upon:

Jeffrey D. Gordon
Arnall Golden Gregory LLP
171 17th Street NW #2100
Atlanta, Georgia 30363
404-873-8542

Service of Legal process may also be made upon any Trustee or the Plan Administrator (Board of Trustees). The address of the Plan office and the addresses of the Trustees are provided under the fourth bullet, "Board of Trustees."

- **Continuation of Plan.** The Board of Trustees currently intends to continue the Retiree Health Plan described herein, but reserves the right, in its discretion, to amend, reduce or terminate the plan at any time for retirees, former participants and all dependants.
- **Accumulation of Assets and Funding of Benefits.** All contributions from Participating Employers are made in accordance with collective bargaining agreements between the Union and the employer.

The amounts of these contributions are set forth in the agreements. All benefits provided to participants in the Plan, their spouses, and their beneficiaries are funded from employer and, in some instances, employee contributions and earnings on investments.

- **Facility of Payment**. If the Trustees determine that a person entitled to benefits under the Plan is unable to care for his affairs because of illness, accident or other incapacity, any payment due may be paid to his legal guardian or other representative. Any such payment shall be made for the account of such incapacitated person, and shall to the extent thereof be a complete discharge of the obligations under this Plan to such person.
- **Erroneous Payment**. If the Trustees determine that a claim has been erroneously paid as a result of a clerical error or on the basis of fraudulent or misleading statements made by the claimant, service provider, or any other entity, then the Trustees shall reserve the right to take necessary action to recover such payment.

PROVISIONS APPLICABLE TO THE RETIREE HEALTH PLAN

NOTICE OF YOUR RIGHT TO DOCUMENTATION OF HEALTH COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll in health coverage. Under the law, a pre-existing condition generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18 month) exclusion period is reduced by your prior health coverage. Upon termination from this Plan you and all dependents covered under your health coverage will receive a "Certificate of Creditable Coverage" that will show evidence of your prior health coverage through this Plan. When enrolling for new health coverage, check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

ENROLLMENT PROCEDURES

Enrollment cards must be completed on all participants, otherwise claims may be held pending receipt of the card. Future claims on new dependents added since completion of the card must be accompanied by supporting documents (i.e. marriage license, birth certificate, court papers, etc.). The Fund may, at its discretion, request new copies of supporting documents or other information to verify continued dependent status.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under Federal law, group health plans and health insurance issuers offering group health coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (for example, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable than the earlier

portion of the stay. In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans and insurance issuers offering group health coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall at a minimum provide for: (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and Coinsurance.

SUBROGATION

The Trustees have adopted a subrogation policy to avoid the duplicate payment of medical bills. The purpose of this policy is to reduce the cost to the Fund by making certain third parties who cause injury to Fund participants bear their share of responsibility. In this instance, subrogation means the assignment of legal rights to recover an amount from a third party where that third party has been held or may be responsible for medical bills which were paid by the Fund. In the event of such a claim, the Fund will still pay benefits due the individual, but only after receiving an assignment of subrogation rights from the employee. The Fund will then be able to recover any amount paid for which a third party is liable. The following describes the Fund's subrogation provisions:

(a) In the event that a Covered Individual receives any benefits (the "Benefits") under this Plan arising out of any loss, injury, or illness (the "Injury") for which the Covered Individual has asserted or may assert any claim or right to recovery against a third party or parties or his or her or their insurer(s), except against any insurer on any policy of insurance issued to and in the name of such Covered Individual, then any payment or payments by the Fund for such Benefits shall be made on the condition and with the agreement and understanding that the Fund shall receive restitution from the Covered Individual to the extent of, but not exceeding, the amount or amounts received by the Covered Individual (the "Recovery") from such third party or parties or his or her or their insurer(s) (the "Responsible Party"), whether by way of settlement or in satisfaction of any judgment(s) or otherwise.

(b) The Covered Individual shall provide restitution to the Fund, starting with the first dollar that the Covered Individual receives from the Responsible Party, no matter whether the Recovery is designated as actual or punitive damages, costs or expenses, medical expenses, pain and suffering, lost wages, workers' compensation, disability payments, loss of consortium, loss of work payments, emotional distress, or otherwise, and the Covered Individual shall continue to make restitution to the Fund until the Fund has received full restitution for all Benefits related to the Injury; provided, however, that a Covered Individual shall not be required to make restitution in excess of his or her Recovery.

(c) The Fund has the right to first recovery and the "make whole" doctrine is not applicable to the Fund's subrogation and reimbursement rights. The Fund has the right of first reimbursement for all Benefits paid related to the Injury, such first reimbursement to be paid out of any Recovery the Covered Individual is able to obtain, even if the Covered Individual has not been fully compensated for

the Injury. Any Recovery held by the Covered Individual or third party on behalf of the Covered Individual shall be deemed to be held in trust on behalf of the Fund.

(d) If it becomes necessary for the Covered Individual to retain an attorney in order to obtain a Recovery or to recover Benefits paid by the Fund relating to the Injury, the amount to be restored to the Fund may, at the sole discretion of the Fund, be reduced by the Fund's *pro rata* share of those attorneys' fees and expenses. The pro rata shares shall be calculated by multiplying the total attorneys' fees and expenses actually incurred by the Covered Individual by the Fund's gross reimbursement (before considering any party's attorneys' fees or expenses) divided by the total gross Recovery (before considering any party's attorneys' fees or expenses). The Fund, however, is not required to reduce the amount reimbursed to the Fund for any attorneys' fees and expenses. The Fund does not recognize the "Common-Fund Doctrine," the "Fund Doctrine," the "Attorneys' Fund Doctrine," or any other legal theory compelling the Fund to reduce the amount it is owed hereunder in order to pay any portion of a Covered Individual's attorney's fees and costs.

(e) If the Trustees retain an attorney to enforce the subrogation and restitution rights under this Section, then the Covered Individual shall be liable for, in addition to all amounts outlined in the previous paragraphs, expenses involved, including the Fund's reasonable attorneys' fees and expenses. As a means of enforcing its subrogation and restitution rights under this Section, the Fund may, in addition to any other means allowed by law or equity, set off future Benefits to the Covered Individual or lessen the reduction allowed by the Fund for the Covered Individual's attorneys' fees and expenses incurred in obtaining the Recovery. However, this Section shall not limit the Fund's right to recover its attorneys' fees and expenses and shall be cumulative with all other rights the Fund may have to recover its attorneys' fees and expenses.

(f) As security for all amounts due to the Fund under this Section, the Fund shall be subrogated to all of the claims, demands, actions, and rights of recovery of the Covered Individual against the Responsible Party or his or her or their insurer(s) to the extent of any and all Benefits paid under this Plan. The Covered Individual shall execute and deliver any instruments and documents requested by the Trustees and shall do whatever else the Trustees shall deem necessary to protect the Fund's rights. The Covered Individual shall take no action to prejudice the Fund's rights to such restitution and subrogation. The Trustees may withhold any Benefits to which the Covered Individual is entitled under this Plan until the Covered Individual executes and delivers any such instruments and documents as may be requested by the Trustees.

(g) Prior to the payment of Benefits under this Plan to a Covered Individual or assignee of a Covered Individual for injuries, expenses, or losses for which a third party is or may be liable in whole or part, the Covered Individual or assignee or both may be required to execute a written subrogation and restitution agreement in form and substance satisfactory to this Plan.

OTHER PROVISIONS

- **Not in Lieu of Worker's Compensation**
  This Plan is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.
- **Authority of Trustees to Interpret and Construe Plan**
  The Trustees shall have the right to make any and all determinations pursuant to the Plan. This includes, but is not limited to, the discretionary authority to determine eligibility for benefits, to determine the amount of benefits payable, to determine the meaning and applicability of Plan

provisions, to construe Plan terms, and to promulgate rules for processing and reviewing claims. Any and all determinations of the Trustees shall be conclusive and binding upon all parties having dealings with the Plan. It is the intent of the Trustees to maintain sole and complete authority to construe the Plan terms, including the definition of all Plan terms and the summary of all terms in this Summary Plan Description. In the event you are dissatisfied with a decision of the Board of Trustees, you may appeal the decision as outlined in the Claim Appeal Section of this Summary Plan Description. You must use the appeal procedure before filing a lawsuit against the Fund. The decisions of the Board of Trustees are entitled to judicial deference.

- **No Vested Benefits**
  There are no vested benefits under this Plan.
- **Authority of Trustees to Modify Benefits or Terminate Plan**
  It is the intention of the Trustees to continue operation of the Plan. The Trustees reserve the right to modify or terminate the Plan at any time. This includes the right to modify the level of benefits, to change the amounts to be contributed toward the cost of providing benefits by the sponsors or by the participants, or to change the class or classes. The Plan may be modified or terminated by vote of the Board of Trustees. In the event of any modification of the Plan, the Board of Trustees will communicate such modification to the Plan participants. Amendment or termination of the Plan may terminate your right to receive benefits, may limit your benefits, and may increase the amount which you must contribute toward the cost of providing benefits, or may reduce the benefits to which you were previously entitled.
- **Use of Assets upon Termination of Plan**
  If the Plan is terminated, the assets will be used for sole and exclusive benefit of the participants.

STATEMENT OF YOUR RIGHTS UNDER ERISA

As a participant in the IBEW Local 613 and Contributing Employers Retiree Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time.

ERISA provides that all Plan participants shall be entitled to the following:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such

coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA. If your claim for a (pension, welfare) benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal Court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay theses costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

DEFINITIONS

The following definitions apply to terms used in this booklet.

ACCIDENT and/or "Accidental Bodily Injury." When used in connection with Medical Expense Benefits is defined as a traumatic injury caused solely by mischance, without intent or volition, resulting indirectly and independently of all other causes and incurred while covered under this Plan.

ALLOWABLE EXPENSE. Any necessary, reasonable and customary item of expense which is covered, wholly or partially, under at least one of the Plans covering the person for whom the claim is made. Allowable expenses include expenses which would have been paid by another plan if all conditions of that plan had been satisfied.

AMBULANCE and/or "Ambulance Service." A licensed company with a recognized vehicle for the transportation of the sick or injured to a Hospital. Eligible Charges include only professional ambulance service for local transport to and from the place the disability was contracted to a Hospital equipped to furnish special treatment necessary for the disability. "Local" is defined as the immediate geographic area in which the disability occurred.

CALENDAR YEAR DEDUCTIBLE. The amount of Covered Charges that must be paid by a Covered Individual each calendar year before Plan benefits will be applied to any remaining Covered Charges for the rest of that year. The deductible amount is described in the Schedule of Benefits in this booklet.

CHARGE. A "Charge" shall be deemed to be incurred on the date on which the particular service, treatment or supply giving rise to such charge is rendered or obtained. In the absence of due proof to the contrary, when a single charge is made for a series of services, treatments or supplies, each item shall be deemed to bear a pro rata share of the charge.

COINSURANCE. The percentage of remaining Covered Charges payable by the Plan, after application of all deductibles and Co-Pay amounts.

COLLECTIVE BARGAINING AGREEMENT. Any negotiated labor contract between an employer and the Union which requires the Participating Employer to contribute to this Fund, and any amendment, modification or renewal thereof.

CO-PAY. A set dollar amount payable by the Covered Individual to a PPO Provider at the time a treatment or service is rendered. The Co-Pay does not apply toward any deductible or out-of-pocket maximum. For prescription drugs, the Co-Pay is the amount of the cost of the prescription which is payable by the Covered Individual to the pharmacy at the time the prescription is purchased.

COSMETIC SURGERY. Surgery or services rendered for the alteration of tissue for the improvement of a person's appearance rather than improvement or restoration of bodily function.

COVERED CHARGE. For Medically Necessary expenses, as defined in the booklet, which are furnished upon the recommendation and approval of the attending Physician:

a) The fee established by the contract between an In-Network provider and the Network; or

b) For a Non-Network provider, the lesser of the provider's normal charge for a similar service or supply or the Plan-selected percentage of the prevailing fee or fees most frequently charged by the providers of like care, services, and/or supplies with similar training and experience for the provision of comparable care and/or supplies and/or the performance of comparable services, or the provision

of care and the performance of services of comparable gravity, severity, and magnitude, in the locality where the care and/or supplies were provided and/or the services were performed. The database used to determine the prevailing fee or fees shall be chosen by the Claims Administrator.

COVERED INDIVIDUAL. An Eligible Retiree and his or her Eligible Dependents.

CUSTODIAL CARE. Care which is designed primarily for the maintenance or assistance of daily living and which does not require the continuous attention of trained medical or paramedical personnel. Such care may involve preparation of special diets, supervision over medication that can be self-administered and assistance getting in and out of bed, walking, dressing, and eating.

DISABLED RETIREE. A Retiree who satisfies the eligibility requirements of a disabled retiree outlined in this booklet.

DURABLE MEDICAL EQUIPMENT. Equipment for the treatment of a medical condition which is (i) necessary for the medical treatment of a disease or injury, as certified in writing by the attending Physician; (ii) serves a therapeutic purpose with respect to the condition being treated in accordance with accepted medical practice; (iii) is truly durable in nature and made to withstand repeated use, such as a wheelchair; and (iv) does not have a value to the patient or members of the patient's family in the absence of the condition for which the equipment is prescribed.

ELIGIBLE DEPENDENT. The following are considered as "Eligible Dependents" for purposes of this Plan:

a) The legal spouse of an Eligible Retiree.
b) If you are an Eligible Disabled Retiree or Surviving Spouse and are under age 65, your natural or legally adopted children and children placed with you for adoption, whom:
   i) Are less than 26 years of age.
   ii) Are 26 years of age or over and are mentally or physically disabled and incapable of self-sustaining employment, provided that such disability occurred prior to the age at which they otherwise would have ceased to be an Eligible Dependent under this Plan.
c) If you are an Eligible Disabled Retiree or Surviving Spouse and are under age 65, children for whom you are mandated to provide benefit coverage for through a Qualified Medical Child Support Order (QMCSO), whom:
   i) Are less than 26 years of age.
   ii) Are 26 years of age or over and are mentally or physically disabled and incapable of self-sustaining employment, provided that such disability occurred prior to the age at which they otherwise would have ceased to be an Eligible Dependent under this Plan.

See Eligibility Rules for more information on Qualified Medical Child Support Orders.

ELIGIBLE EMPLOYEE. An Employee or Inside Employee who is eligible for benefits under the Family Health Plan by having satisfied the eligibility requirements of the Family Health Plan.

ELIGIBLE RETIREE. A former Employee or former Inside Employee who is eligible for benefits under the Plan by having met the eligibility requirements outlined in the booklet.

ELIGIBLE SURVIVING SPOUSE. A Surviving Spouse who is eligible for benefits under the Plan by having met the eligibility requirements outlined in the booklet.

EMPLOYEE. An employee who is working in a job classification for which Participating Employers are required, under the terms of the current Collective Bargaining Agreements, to make certain contributions to the Fund.

EXCLUSIONS AND LIMITATIONS. Certain charges, services or supplies which are limited or excluded from payment under this Plan.

EXPERIMENTAL OR INVESTIGATIVE. Any treatment, procedure, facility, equipment, drugs, drug usage, or supply that is not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice.

FAMILY HEALTH PLAN. IBEW Local 613 and Contributing Employers Family Health Plan.

FUND. IBEW Local 613 and Contributing Employers Retiree Health Fund.

HOSPITAL. A legally constituted and operated institution which:

a) Is primarily engaged in providing, for compensation from its patient and on an In-Patient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured or sick persons by or under the supervision of a staff of Physicians.
b) Continuously provides 24-hour-a-day nursing services by registered graduate nurses.
c) Has a laboratory, x-ray equipment and operating rooms where major surgical operations may be performed.

In no event, however, shall the term "Hospital" include any institution or part thereof which is used, other than incidentally, as a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, a hotel or the like.

IN-NETWORK. A healthcare provider or facility that is participating in the Provider Network.

INSIDE EMPLOYEE. An individual who is employed by a Participating Employer and upon whose behalf contributions to the Family Health Plan are made under a Participation Agreement. Also referred to as Non-Bargaining Employee.

LIFE THREATENING EMERGENCY. For purposes of this Plan, "Life Threatening Emergency" means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in serious and immediate impairment of the individual's body functions or the ability to regain maximum function, or in death.

MEDICALLY NECESSARY. A service or supply that meets all of the following conditions:

a) Is consistent with the symptom or diagnosis and treatment of the patient's illness or injury;
b) Is appropriate with regard to standards of good medical practice and recognized by an established medical society in the United States;
c) Is not considered Experimental by an established medical society in the United States;
d) Is not solely for the patient's convenience or that of his Physician of the facility at which the patient receives treatment; and
e) Is specifically allowed by the licensing statutes that apply to the provider who renders the service.

MEDICARE. The program established by Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is constituted on the effective date of the Policy and may subsequently be amended.

MENTAL AND NERVOUS DISORDER. A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

NON-OCCUPATIONAL ILLNESS OR INJURY. An illness or injury that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from such work for pay or profit. However, if proof is furnished to the Trustees that an individual covered under a Workers' Compensation law (or other law of similar purpose), is not covered for a particular illness under that law, that illness will be considered "Non-Occupational" regardless of its cause.

In the event an Employee claims that an illness or injury is work related and the employer disputes this contention, the Trustees agree to be bound by the final decision of any court or commission which determines the issue. In the event a legal determination is not sought in such case, the Trustees may decide whether the illness or injury is occupational or Non-Occupational. In the event payments are made under this Plan for a condition later determined to be occupational and compensable under any Workers' Compensation or similar law, the Employee receiving the payments is obligated to pay back to the Trustees the amount of benefits received from any settlement or judgment obtained.

NON-PARTICIPATING PROVIDER or NON-NETWORK. A Hospital, Physician, pharmacy or other service provider who has not entered into a contractual agreement with the Plan for the purpose of furnishing health care services.

NURSE. A Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Vocation Nurse (LVN), or a Nurse's Aide if the Aide is supported at least three times per week by a Registered Nurse.

PARTICIPATING EMPLOYER. Any corporation, partnership, proprietorship or other business entity that is obligated to make contributions to the Fund in accordance with the provisions of a written Collective Bargaining Agreement in force with the Union.

a) The Union on behalf of its salaried employees or retired salaried employees, if any.
b) The Atlanta Electrical Joint Apprenticeship and Training Committee with respect to its full-time employees, if any.
c) The Atlanta Chapter of the National Electrical Contractors Association with respect to its full-time employees, if any.

PARTICIPATING PROVIDER or IN-NETWORK. A Hospital, Physician, pharmacy or other service provider participating in the Provider Network that has entered into a contractual agreement with the Plan for the purpose of furnishing health care services.

PHYSICIAN. A Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.), a Doctor of Chiropractic (D.C.), a Doctor of Dental Surgery (D.D.S.), Doctor of Medical Dentistry (D.M.D.), or licensed psychologist (Ph.D.) practicing within the scope of his license and who is licensed to practice as such in the State in which treatment is rendered.

PLAN. IBEW Local 613 and Contributing Employers Retiree Health Plan.

PROVIDER NETWORK. A network of providers including Hospitals, Physicians and other health service providers who have agreed to pre-negotiated charges through a contractual agreement between the Board of Trustees and the Provider Network. This Fund currently uses the CIGNA Open Access Plus Network for medical claims.

PREGNANCY. Pregnancy, miscarriage, abortion, childbirth, or complication from pregnancy, miscarriage, abortion or childbirth. For purposes of this Plan, pregnancy will be considered as a Non-Occupational illness and will be covered for Eligible Retirees and their Eligible Dependent spouses only.

RETIREE. A former Employee or former Inside Employee who has retired from employment with his or her employer, who is eligible for retirement benefits under Social Security or a qualified retirement plan associated with the electrical contracting industry, and who was an Eligible Employee at the time of such retirement.

ROOM AND BOARD. All charges for room and board, general duty nursing, and other charges which are made by the Hospital as a condition of occupancy of the class of accommodations occupied. "Room and Board" does not include charges for professional services of Physicians, or charges for intensive nursing care.

SEMI-PRIVATE. The standard charge by the Hospital for semi-private Room and Board accommodations, or the average of such charges where the Hospital has more than one established level of charges;

SURVIVING SPOUSE. The surviving spouse of an Eligible Retiree or Eligible Employee.

TRUSTEES, BOARD OF TRUSTEES OR BOARD. The persons designated to serve as Trustees of the Fund in accordance with the provisions of the Agreement and Declaration of Trust of the IBEW Local 613 and Contributing Employers Retiree Health Plan.

UNION. Local Union 613 of the International Brotherhood of Electrical Workers.

ELIGIBILITY RULES

FOR RETIRED EMPLOYEES AND DEPENDENTS

To participate in the Retiree Plan, you must complete and return an election form choosing retiree coverage at the time of your retirement. Eligibility for participation in the Retiree Health Plan is subject to the requirements outlined in this section.

RETIRED EMPLOYEE ELIGIBILITY

NORMAL AND EARLY RETIREES

1. You must be eligible under the Family Health Plan at the time of your retirement under the IBEW Local 613 Defined Contribution Pension Plan (or your retirement under the previous Defined Benefit plan: the IBEW Local 613 and Contributing Employers Pension Plan). Eligibility must be as an active Eligible Employee or through Self-Pay and cannot be through COBRA coverage.
2. You must have been eligible under the Family Health Plan for four (4) consecutive quarters immediately prior to retirement date.
3. You must have a minimum of ten (10) years of eligibility service combined from either one of the two IBEW 613 Pension Plans and, if all service has been earned under the Defined Contribution Pension Plan (the new plan), you must have a minimum of 1,000 hours worked in each one of the ten (10) years.
4. You must have been eligible under the Family Health Plan for 48 months out of the previous 60 months immediately prior to retirement; or you must have a minimum of twenty years of eligibility service from either of the two IBEW 613 Pension Plans.

DISABLED RETIREES

1. You must qualify for the Disability Retirement under the IBEW Local 613 and Contributing Employers Defined Contribution Pension Plan.
2. You must be eligible under the Family Health Plan at the time of your retirement.
3. You must have been eligible under the Family Health Plan for four (4) consecutive quarters immediately prior to retirement date.
4. If you retire as a Disabled Retiree on or after April 1, 2004, your premium will be determined based upon your eligibility for disability benefits under the Social Security Act. Please see the section on Retiree Premiums below for more details.

INSIDE RETIREES (previously Inside Employee)

1. You must be age 55 for early retirement.
2. You must be deemed disabled by the Social Security Administration in order to qualify as a Disabled Retiree.
3. You must have been eligible for coverage under the Family Health Plan for five (5) consecutive years immediately preceding your retirement.
4. You cannot be employed or engaged in business in the electrical contracting industry in any capacity with a contractor that does not have a Collective Bargaining Agreement with the Union.

Please Note: If you do not elect Retiree coverage under the Plan at the time your coverage as an Eligible Employee under the Family Health Plan terminates, or if you terminate your Retiree coverage at any

time, you will not be able to reinstate your Retiree coverage at a later date. The only way a Retiree may re-qualify for coverage is to meet the requirements for Initial Eligibility under the Family Health Plan as an active Eligible Employee and remain eligible as an Eligible Employee for four (4) consecutive quarters (or five (5) consecutive years if requalifying as an Inside Retiree).

TERMINATION OF RETIREE BENEFITS
Your benefits will terminate on the earliest of the following:

a) The last day of the month preceding any month for which a required contribution has not been made;
b) The last day of the month preceding any month in which you return to active employment with an Employer;
c) The date of your death;
d) The date on which the Plan is terminated with respect to all benefits.

DEPENDENT ELIGIBILITY

SPOUSES
Your spouse at the time of your retirement will be eligible for coverage under the Retiree Plan provided that any required contribution is made for dependent coverage. If you marry subsequent to your retirement, please notify the Fund Office within 60 days and provide a copy of the marriage certificate if you wish to add coverage for that spouse under the Plan. Spouses age 65 or older must enroll in the Plan separately from the Retiree.

SURVIVING SPOUSES
If your spouse is an Eligible Dependent under the Plan at the time of your death, that spouse can continue to participate in the Plan as a Surviving Spouse, provided that any required contributions are paid timely.

If a spouse was an Eligible Dependent under the Family Health Plan at the time of death of the Eligible Employee and that Employee would have met the eligibility requirements for participation in the Retiree Health Plan had that Eligible Employee retired immediately prior to the date of death, the spouse can elect to participate in the Plan as a Surviving Spouse by completing and returning an election form choosing retiree coverage prior to termination of coverage under the Family Health Plan.

CHILDREN
Dependent children will only be covered if you qualify as a Disabled Retiree or a Surviving Spouse and you are under age 65.

TERMINATION OF DEPENDENT BENEFITS
Your benefits with respect to Eligible Dependents will terminate on the earliest of the following:

a) The date of termination of your benefits under the Plan, except that, in the event of your death, benefits with respect to your Eligible Dependents will be continued, subject to the other terms of the Plan, during the remainder of the month in which your death occurs.
b) The date the Plan is amended so as to terminate the benefits of all dependents; or
c) The date the dependent ceases to meet the definition of an Eligible Dependent under the Plan; or
d) With respect to dependent children, the last day of the month prior to the month in which you attain age 65.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Federal law requires the Plan, in certain circumstances, to provide coverage for your children when you and your spouse divorce. The Plan must provide this coverage only if the Plan is served a Qualified Medical Child Support Order (QMCSO). If the Plan is served with a Medical Child Support Order, the Plan will review the Order in order to determine whether it is a "Qualified" Order. The Plan will provide to you, upon written request, a detailed statement of the Plan's process for determining whether the Order is qualified and the Plan's requirements for a "Qualified" Order.

A Qualified Medical Child Support Order means any judgment, decree, or order including approval of a settlement agreement which:

1. Issues from a Court of competent jurisdiction pursuant to a States Domestic Relations Law;
2. Requires you to provide only the group health coverage available under the Plan for your children, even though you no longer have custody;
3. Clearly specifies your name and last known mailing address and the names and addresses of each child covered by the Order;
4. Provides a reasonable description of the coverage to be provided;
5. Specifies the length of time the Order applies and;
6. Identifies each plan affected by the Order.

These are the minimum requirements of a QMCSO. The Order must also meet other requirements of the Plan in order to be "Qualified". Please contact the Fund office for more information.

EXTENDED ELIGIBILITY FOR INCAPABLE DEPENDENTS

Eligibility providing benefits for medical care expenses may be continued beyond the limiting age for an Eligible Dependent child who is mentally or physically incapable of earning a living and who is dependent upon you for support and maintenance, provided that you furnish evidence of the dependent's incapacitation at least 31 days before the dependent reaches the limiting age.

Any benefits continued for such dependent children will terminate under any of the conditions described above, or, in any event, when the dependent ceases to be incapacitated, or at the end of the 31-day period after any requested proof of continued incapacity is not furnished.

RETIREE PREMIUMS (RETIREES UNDER AGE 65 ONLY)

For coverage under the Plan, Retirees and Dependents under age 65 must pay a monthly premium. These premiums are established by the Board of Trustees and are subject to change. Premiums are due by the first of the month and coverage will be terminated as of the first day of the month if the premium is not received by the last day of that month.

Please contact the Fund Office for the current premium amounts.

Please Note: While your coverage under the Plan will not terminate until the end of the month for which the premium is due, your name will not be submitted to CIGNA as being eligible until such time as the premium is received and recorded. This may result in the denial of claims and these claims will need to be refiled after your premium has been received. Providers calling to verify eligibility before your premium has been received may be informed that you are not eligible. If your eligibility is not provided to CIGNA before the beginning of the month, you may be sent a new ID card at such time as your eligibility is submitted; however, your old ID card will continue to be valid. **To prevent these issues, please remit your premium at least two weeks prior to the beginning of the month.**

Premiums for Disabled Retirees retired on or after April 1, 2004 will be determined as follows:

1. **If you qualify for disability benefits under the Social Security Act** your premium will be at the Disabled Retiree level for family coverage. You must provide a copy of your determination letter from the Social Security Administration to the Fund Office.
2. **If you have not qualified for disability benefits under the Social Security Act** your premiums will be at the Early Retiree level. For dependent coverage, you must also pay the Spouse Premium shown under the Early Retiree level. If you later receive your disability approval letter under the Social Security Act, your premiums will reduce retroactively to the Disabled Retiree level as of the first of the month following the date that Social Security deemed your disability to have begun. You must provide a copy of your determination letter from the Social Security Administration to the Fund Office in order to qualify for the lowered premium.

For information about Social Security Disability benefits and how to apply, go online to **www.ssa.gov**, call toll-free at 1-800-772-1213, or call or visit your local Social Security Administration office.

Premiums for Disabled Retirees retired prior to April 1, 2004 will be at the Disabled Retiree level.

Special Note for Retirees/Dependents Under Age 65 AND Eligible for Medicare: If you are under age 65 and eligible for Medicare and you choose to transition to the Health Reimbursement Arrangement (HRA) benefit, you will not be required to pay a monthly premium. However, if you have Dependents under age 65 that are continuing in the Plan's medical benefits, a premium will be required to continue that coverage. Please see **page 46** for more details on how a Retiree under age 65 can transition to the HRA benefit.

COBRA CONTINUATION COVERAGE

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This section generally explains COBRA continuation coverage, when it may become available to your family, and what you need to do to protect the right to receive it.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your spouse and/or your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Please note that COBRA continuation is only available to Eligible Dependents who are losing coverage under this Plan due to divorce or death of the Retiree. Retirees cannot continue coverage through COBRA continuation coverage upon termination.

QUALIFYING EVENTS

If you are the spouse of a Retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-retiree or surviving spouse dies;
- The parent-retiree or surviving spouse becomes entitled to Medicare benefits (Part A, Part B, or both) due to age;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

WHEN COBRA COVERAGE BECOMES AVAILABLE

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the retiree or surviving spouse's becoming entitled to Medicare benefits (under Part A, Part B, or both) due to age, the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the retiree and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in within 60 days after the qualifying event occurs. You must provide this notice to: IBEW Local 613 and Contributing Employers Retiree Health Plan, 3715 Northside Parkway, Suite 2-495, Atlanta, Georgia 30327.

HOW COBRA COVERAGE IS PROVIDED

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the retiree, the retiree or surviving spouse's becoming entitled to Medicare benefits (under Part A, Part B, or both) due to age, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the **Fund Office, 3715 Northside Parkway, Suite 2-495, Atlanta, Georgia 30327 (800-922-1613).** 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.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

IBEW Local 613 and Contributing Employers Retiree Health Plan
3715 Northside Parkway, Suite 2-495
Atlanta, Georgia 30327
800-922-1613

THE FOLLOWING SECTION DESCRIBES

MEMBER BENEFITS

FOR:
ELIGIBLE RETIREES UNDER AGE 65,
ELIGIBLE SURVIVING SPOUSES UNDER AGE 65,
AND
ELIGIBLE DEPENDENTS UNDER AGE 65

SCHEDULE OF BENEFITS – UNDER AGE 65

The benefits shown are those which were in effect as of September 1, 2017.
The Schedule of Benefits is subject to change by vote of the Board of Trustees.
Please contact CIGNA with any questions regarding the current level of benefits.

MAJOR MEDICAL BENEFITS

BENEFIT	CIGNA OPEN ACCESS PLUS IN-NETWORK PROVIDERS
Calendar Year Deductible	
▪ Per Individual	$ 750
▪ Family Maximum	$ 2,500
Emergency Room Deductible	
▪ Per Admission	$100, Waived if admitted to Hospital
Maximum Benefit Per Calendar Year	$100,000
Maximum Out-of-Pocket	
▪ Per Individual	$ 5,000
Coinsurance Percentage	
▪ In-Network Physician Office Visits	
▪ Primary Care Provider	Plan Pays 100%, after $35.00 Co-pay
▪ Specialist	Plan Pays 100%, after $45.00 Co-Pay
▪ Covered In-Network Charges	Plan Pays 70%
▪ Non-Network Life Threatening Emergency*	Plan Pays 70%
▪ Other Non-Network Charges	Not Covered

* Non-Network Charges, with the exception of Life Threatening Emergency will not be considered as a Covered Charge. Charges incurred outside the CIGNA OAP network will not count towards the Calendar Year Deductible or Maximum Out-of-Pocket, nor will they be eligible for coordination of benefits. In the case of a Life Threatening Emergency you should go to the nearest appropriate facility. If this facility is Non-Network, Charges will be covered at 70% until such time as you are medically able to be transported to an In-Network facility. The Fund will cover transport to the In-Network facility.

Preventive Care	
▪ "Preventive and Wellness Services" as defined under the Patient Protection and Affordable Care Act	Plan pays 100%
Mental & Nervous Disorders	
▪ In-Network Physician Office Visits	Plan Pays 100%, after $35.00 Co-pay
▪ Other In-Network Providers or under Case Management	Plan Pays 70% after deductible

BENEFIT	CIGNA OPEN ACCESS PLUS IN-NETWORK PROVIDERS
Chiropractic Benefits	
▪ Coinsurance	Plan Pays 70%, deductible does not apply
▪ Maximum Payment per Visit (incl. X-Rays)	$10.00
▪ Maximum # of Visits per Year	26

PRESCRIPTION DRUG BENEFITS

Calendar Year Deductible – Per Individual	$25.00
In-Network Participant Co-pay for Retail*	
▪ Brand Name Drugs**	Participant pays Greater of $25 or 25%
▪ Generic Drugs	Participant pays $10
In-Network Participant Co-pay for Mail Order	
▪ Brand Name Drugs**	Participant pays Greater of $75 or 25%
▪ Generic Drugs	Participant pays $30
Maximum Days Supply	
▪ Retail	34 days
▪ Mail Order	90 days

* If you choose to go to a Non-Participating pharmacy or fail to present your prescription drug ID card to your pharmacy, you must pay 100% of the cost of the medication to the pharmacy.
**If a brand name drug is requested when there is an equivalent generic alternative available, you will be required to pay the generic Co-pay plus the difference in cost between the brand name and the generic.

NON-MEDICAL BENEFITS

Burial Benefit – Retired Employee Only	
▪ Benefit Payable per Year of Earned Pension Service	
▪ Minimum Benefit Payable	$ 200
▪ Maximum Benefit Payable	$ 1,000
▪ Benefit reduces $100 per year beginning at age 70	$ 2,500

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT

Major Medical Expense Benefits become payable if a Covered Individual incurs Covered Charges that are in excess of the deductible amount(s). All Covered Charges are subject to the Calendar Year Deductible unless otherwise specified. The deductibles, co-pays, and maximum amounts are applied separately for each Covered Individual unless otherwise specified.

The following will describe in more detail the benefits shown in the Schedule of Benefits.

CIGNA Open Access Plus (OAP) In-Network Providers
In-Network providers means a network of health care providers, including Hospitals, Physicians and other facilities, which provide services at discounted or fixed rates to participating members. This Fund has contracted with the CIGNA **Open Access Plus (OAP)** In-Network providers to help insure that you have access to the most cost-effective care without sacrificing quality. To be eligible for the In-Network discounts, present your medical ID card, identifying you as a member of the CIGNA **Open Access Plus (OAP)** network, each time you visit a provider.

Below are some suggestions for obtaining the maximum benefit from your In-Network providers:

- Always use a participating provider. A directory of CIGNA **Open Access Plus (OAP)** providers is available from the Union Hall or your employer. Remember, the In-Network providers continue to be updated, so please check to make sure your doctor is In-Network every time you need care. For more information on finding a CIGNA **Open Access Plus (OAP)** provider, contact CIGNA at **1-800-244-6224** or visit their website at www.cigna.com.
- If hospitalization is necessary, ask your doctor to admit you to an In-Network Hospital.
- If you need to see a specialist, ask your doctor to refer you to another CIGNA **Open Access Plus (OAP)** provider.
- Before a Hospital stay, confirm that the anesthesiologist, pathologist and radiologist providing services to you are also In-Network providers.

This Fund has also contracted with CIGNA to provide Case Management services. The role of a case manager is to help you obtain the most appropriate and cost-effective treatment available. In addition, they can help you to negotiate discounts on Durable Medical Equipment and home health care.

CALENDAR YEAR DEDUCTIBLE
The deductible is the amount to be paid in cash for services or supplies for treatment of an illness or injury or other covered condition before Plan benefits become payable. Only Covered Charges may be used to meet the deductible. Physician Office Visit Co-Pays and non-covered Charges, including Non-Network Charges, are not applied toward the deductible. Certain expenses, as identified in the schedule of benefits, may be payable without application of the Calendar Year Deductible.

The deductible is computed annually for each Covered Individual for whom major medical benefits are claimed. Any Covered Charges incurred during the final three months of a calendar year and

subsequently applied to a Covered Individual's deductible, will be carried over toward satisfaction of the next calendar year's deductible.

EMERGENCY ROOM DEDUCTIBLE

The Emergency Room Deductible is an amount in addition to the Calendar Year Deductible that must be satisfied for each visit to an emergency room before benefits will be payable. This deductible will be waived if the patient is admitted to the Hospital from the emergency room.

COINSURANCE PERCENTAGE

Once a Covered Individual has satisfied all applicable deductibles, the Plan will pay the appropriate Coinsurance Percentage, as specified in the Schedule of Benefits, of remaining Covered Charges incurred by that person during the remainder of the calendar year. The Covered Individual is responsible for payment of any remaining Covered Charges after application of the Coinsurance Percentage.

MAXIMUM BENEFIT PER CALENDAR YEAR

This is the maximum amount of major medical benefits payable for an individual in any one calendar year by the Fund.

MAXIMUM OUT-OF-POCKET

If your eligible out-of-pocket expenses paid during one calendar year reach this level, your remaining major medical eligible expenses will be paid at 100%, not to exceed your Maximum Benefit per Calendar Year. The following expenses do not apply towards your out-of-pocket maximum: In-Network Physician office Co-pays, chiropractic, calendar year and emergency room deductibles, and non-covered Charges (including Non-Network Charges).

COVERED CHARGES

Covered Charges are the amount of expenses to which the benefits available under the Plan will be applied. Covered expenses include only those Medically Necessary Covered Charges, as defined in the booklet, which are furnished upon the recommendation and approval of the attending Physician

Covered Charges are described as follows and are subject to the limitations outlined in the Schedules of Benefits:

- Charges made by a Hospital for:
  (a) Room and Board, including an Intensive Care Unit (ICU) or Critical Care Unit (CCU).
  (b) Other Hospital services or supplies required for medical or surgical care or treatment. The term "Other Hospital Services and Supplies" does not include Hospital Charges for Room and Board, or the professional services of a Physician, private duty Nurse, or any special nursing service.
- Charges incurred for hospitalization of the mother (only if an Eligible Retiree or Eligible Dependent spouse) following childbirth for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a delivery by cesarean section.
- Charges made by a Physician for his services, rendered in or out of a Hospital, including surgical procedures, as well as medical care, treatment and diagnosis. Charges for a second surgical opinion are included.

- Charges made by a professional anesthetist or by a Physician for anesthetics, oxygen and their administration.
- Charges made for x-ray, radiotherapy (including the use of x-ray, radium, cobalt, or other radioactive substances), or diagnostic laboratory examination.
- Charges incurred for "Preventive and Wellness Services" as defined by the Patient Protection and Affordable Care Act, and applicable guidelines issued thereunder.
- Charges made for nursing services by a Registered Graduate Nurse or a Licensed Nurse who (i) is not a relative of the immediate family of the Covered Individual and (ii) does not ordinarily reside in the Covered Individual's home.
- Charges made for the initial purchase or rental up to the initial purchase price of an oxygen concentrator or other Durable Medical Equipment. Charges for maintenance and replacement are not covered.
- Charges actually made by an Ambulance Service which customarily renders Ambulance transportation in the usual course of its business for transportation of a Covered Individual from the place where he or she is injured by an Accident or stricken by an illness to the nearest Hospital where treatment is given for such injury or illness.
- Charges for emergency transportation within the continental United States and Canada, and within Puerto Rico and Hawaii.
- Charges for transportation to transfer from a Non-Network facility to an In-Network facility following treatment for a Life Threatening Emergency.
- Charges for the initial placement of artificial eyes, limbs, or portion of limbs.
- Charges incurred in connection with Cosmetic Surgery which are necessary for (i) the prompt repair of an Accidental Bodily Injury which is a Non-Occupational Injury occurring while the individual is covered, or (ii) repair of an abnormal congenital condition in a child who becomes a Covered Individual at birth and continuously remains a Covered Individual until the Charge is incurred.
- Breast reconstruction in connection with a mastectomy performed as a result of breast cancer. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all states of the mastectomy, including lymphedemas.
- Charges for orthopedic braces, crutches, casts and other medical supplies, excluding dental braces and/or splints.
- Charges for blood and blood plasma, if not replaced.
- Charges for outpatient services rendered in connection with a surgical procedure or emergency treatment.
- Charges for services rendered by a qualified physical therapist who (i) is not a relative of the immediate family of the Covered Individual and (ii) does not ordinarily reside in the Covered Individual's home.
- Charges for speech therapy due to specific injury, illness or congenital disorder. Visits in excess of 20 per calendar year must be pre-approved.
- Charges for legend drugs (which means that the container must be marked "Federal Law Prohibits Dispensing without a Prescription") or injectable insulin requiring a written prescription, provided that such drugs are prescribed and administered in an in-patient or out-patient setting. Charges for In-Home Intravenous Therapy or Chemo Home Treatment, provided this method of treatment is

Medically Necessary, prescribed by the attending Physician and is an alternative to in-patient hospitalization.

- Charges made by a dentist or oral surgeon for treatment of fractures and dislocations of the jaw, cutting procedures, impacted teeth and injuries in the mouth. This does not include tooth extractions or the care of teeth and gums or treatment of TMJ or related conditions.
- Charges made by a trained Nurse for private duty nursing care, provided it is ordered by a doctor.

EXCLUSIONS AND LIMITATIONS

Applicable to all Medical and Prescription Drug Benefits

No benefits will be payable for or in connection with (a) any Charges which are not specifically included within the definition of "Covered Charges" or (b) any of the following, unless specifically allowed elsewhere in this SPD:

- Charges which are not deemed to be Medically Necessary.
- Charges in excess of Covered Charges.
- Charges incurred which are not necessary for the treatment of an illness or injury, except as specifically provided under "Covered Charges."
- Charges for medical care not recommended and approved by a Physician.
- Charges for any medical care received while not covered under this Plan.
- Charges incurred at a Non-Network provider, except for cases of Life Threatening Emergency or if covered by Medicare where Medicare is the primary plan.
- Charges for treatment (including prescription drugs) for any form of substance abuse (drugs and alcohol).
- Charges for drugs prescribed for cosmetic purposes only, drugs available without a prescription, smoking cessation products, appetite suppressants, or Experimental, Investigative or unproven drugs.
- Charges incurred for Custodial Care.
- Charges incurred in connection with confinement to any institution or part thereof used principally as a rest facility, a facility for the aged, chronically ill, drug addicts or alcoholics, or as a facility providing primarily Custodial, educational or rehabilitory care, except as specifically provided.
- Charges which would not have been made in the absence of this coverage or which the Covered Individual is not legally obligated to pay, or which are furnished without Charge or which are reimbursable by or through a national, state or political subdivision, agency or arm thereof.
- Charges incurred due to Injury or Illness resulting from or sustained as the result of being engaged in (i) an illegal occupation, commission of or attempted commission of an assault or felonious act, (ii) participation in a riot, (iii) duty as a member of the Armed Forces of any State or Country, or (iv) war or act of war whether declared or undeclared.
- Charges for the treatment of an occupational disease or injury.
- Charges incurred due to Injury or Illness arising out of or in the course of any occupation or employment for wage or profit, for which the Covered Individual is entitled to any benefits under a Worker's Compensation Act or similar legislation.
- Charges for any non-emergency treatment rendered outside of the United States.

- Charges incurred for treatment on or to the teeth except as specifically described otherwise in this Summary Plan Description.
- Charges for the treatment of cranio-mandibular disorders which include temporo-mandibular joint dysfunctions (TMJ), oral rehabilitation, orthognathic surgery, orthodontic movement, subteriosteal and endosseous implants.
- Charges for orthodontic treatment.
- Charges incurred for services or supplies which constitute personal hygiene, comfort or beautification items, regardless of intended use or even if prescribed by a Physician, including purchase or rental of supplies of common use such as exercise machines, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattresses, water beds or tanning beds.
- Charges for counseling related to family, marriage, sex or career.
- Charges for vocational, spiritual or pastoral counseling.
- Charges for maintenance, repair or replacement of any Durable Medical Equipment.
- Charges for continued rental of any Durable Medical Equipment once the total amount of rental charges has reached the initial purchase price of said equipment.
- Charges for recreational, educational or occupational therapy, including handbooks, videotapes, etc.
- Charges for speech therapy, except as specifically provided under “Covered Charges.”
- Charges for vision therapy and orthopedic shoes.
- Charges for hearing aids.
- Charges for acupuncture and massage therapy.
- Charges for routine foot care.
- Charges for genetic screening.
- Charges for dental implants.
- Charges for professional services, regardless of type, by a member of the immediate family of the Covered Individual or the Covered Individual’s spouse.
- Charges incurred as the result of diagnosis or treatment of Pregnancy with respect to a Dependent Child.
- Charges for medical and Hospital care costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Charges incurred for the removal of an organ or portion of an organ for donor purposes.
- Charges for medical care, services or supplies received or furnished in connections with, or as a result of, any Cosmetic Surgery, except as specifically provided under “Covered Charges.”
- Charges for nursing expenses, except as provided under “Covered Charges.”
- Charges for infertility services including infertility drugs, surgical or medical treatment programs for infertility.
- Charges for the reversal of sterilization.
- Charges for blood or blood plasma for which the Hospital or other supplier makes a refund of allowance to or on behalf of the Covered Individual, either as a result of a group blood bank, a private donor, or otherwise.
- Charges for Experimental procedures.
- Charges for enrollment in a health, athletic, weight loss, non-smoking, or other such program.
- Charges for Radial Keratotomy or Keratoplasty.

- Any Charges for Hospital Room and Board and general nursing care when the individual is admitted primarily for diagnostic study or medical observation when the necessary care can be provided on an outpatient basis.
- Charges for Hospital Room and Board and general nursing duties for Hospital admittance on a weekend or holiday unless significant medical treatment is provided on those days.
- Charges for medical care in connection with any procedure involving a voluntary embryo transfer.
- Charges relating to a surgical sex transformation, sexual dysfunction or inadequacies.
- Charges relating to services or expenses for biofeedback and any other form of self-care or self-help training.
- Charges related to travel, whether or not recommended by a Physician.
- Charges for the treatment of obesity, weight control or dietary control.
- Charges provided by a Social Worker or the like.
- Charges for vitamins, food extracts or the like.
- Charges for completion of a claim form.
- Charges for failure to keep a scheduled visit.
- Charges which would not have been made if the person had no insurance.
- Charges of any kind for which a claim is submitted for consideration that is more than twenty-four (24) months after the date which services were performed, or for which a claim is not properly submitted.

PRESCRIPTION DRUG CARD BENEFIT

This benefit for retail and mail order prescriptions is available through **CIGNA**. When you become eligible for benefits you will be provided with two identical ID cards listing all eligible family members along with a listing of participating pharmacies and approved benefits.

Benefits are only available for prescriptions purchased at a pharmacy participating in the CIGNA network or through CIGNA's mail order service. Call 1-800-244-6224 for confirmation of any pharmacy's participation.

Please refer to the Schedule of Benefits for **Coinsurance** and **Days Supply** details.

IMPORTANT INFORMATION REGARDING GENERIC DRUGS

If you or your doctor request a prescription be filled with a brand name drug when there is an equivalent generic alternative available, you will be required to pay the generic Coinsurance plus the difference in cost between the brand name and the generic.

FILLING PRESCRIPTIONS THROUGH MAIL ORDER

Mail Order can be used to conveniently obtain up to a 90-day supply of maintenance medications (those medications which you use on a long term basis). Typically a mail order prescription will be slightly less expensive than purchasing three 30-day supplies at a retail pharmacy. For information on CIGNA's **Tel-Drug** mail order program, contact CIGNA at 1-800-244-6224.

Mail Order prescriptions can be submitted to:

CIGNA Healthcare
Pharmacy Service Center
P.O. Box 3598
Scranton, PA 18505-0598

Your physician can call in your prescriptions to Tel-Drug (1-800-835-3784 or 1-800-TEL-DRUG). Refills can be ordered by contacting Tel-Drug at the above phone numbers, through their website at **www.teldrug.com**, or by mailing in a refill form to the above address.

If your doctor is prescribing a maintenance medication that you would like to receive through mail order, be sure to inform him or her to fill out the prescription accordingly. If it is a new prescription, you may wish to have a second prescription for a 30-day supply that you can have filled at a retail pharmacy while submitting your new prescription to CIGNA.

PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

Certain drugs may require prior authorization or be subject to a step-therapy program before a prescription can be processed under the drug card benefit. Certain drugs may also be subject to quantity limits per fill. Please contact as necessary at 1-800-244-6224.

FILING A PAPER CLAIM

If you do not have your card at the time you purchase a prescription, you can send a paper claim to:

CIGNA Healthcare
Pharmacy Service Center
P.O. Box 3598
Scranton, PA 18505-0598

EXCLUSIONS AND LIMITATIONS

- Prescriptions obtained at a pharmacy not participating in the CIGNA network;
- Drugs for cosmetic purposes only;
- Drugs available without a prescription, except insulin;
- Prescription drugs when there is an equivalent available without prescription;
- Prescription smoking cessation products, including nicotine gum and patches;
- Medications prescribed for treatment of a substance abuse disorder (drugs and alcohol);
- Infertility medications;
- Appetite suppressants or diet pills;
- Medical supplies and equipment (except syringes and needles for the administration of insulin and other self-administered injectables);

- Drugs not prescribed by a provider acting within the scope of his or her license;
- Experimental, Investigational or unapproved drugs;
- Replacement prescriptions and relating supplies resulting from loss or theft;
- Injectable drugs that require Physician supervision and are not typically considered self-administered drugs. Examples of physician supervised drugs are injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- Prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products.
- Biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Drugs used to enhance athletic performance;
- Growth hormones;
- Prescriptions more than one year from the original date of issue.

COORDINATION OF BENEFITS FOR PRESCRIPTION DRUGS

The Coordination of Benefits provisions outlined in this SPD do not apply to the prescription drug benefit. This Plan does not cover prescription drugs on a secondary basis, with the exception of prescription drugs which are covered by Medicare Part B and for which Medicare Part B is the "primary" plan. Those Medicare Part B prescription charges can be filed under the Major Medical benefits for secondary payment.

COORDINATION OF BENEFITS (COB)

This section applies if you or any one of your dependents is covered under more than one plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each plan. Because of the growing number of health plans (private and government) and the increasing number of two-income families, more and more people are becoming covered under two health plans.

These coordination of benefits, or COB, provisions have been designed to control over-payments. The COB provisions in the IBEW Local 613 and Contributing Employers Retiree Health Plan are integrated with all other group health plans, as well as with an individual's personal health insurance policies.

Under the COB provision, if you or your eligible dependents also have coverage under another health plan, the total benefits received by any one patient from all the plans combined may not amount to more than 100% of the allowable expenses. "Allowable expenses" are any necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that are covered in full or in part by any Plan covering you. Payments will be reduced only the extent necessary to prevent an individual from making a profit on his health coverage. You must report duplicate health coverage on your Claim Forms which you submit to secure reimbursement of the medical expenses.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to, the following:

- An expense or service or a portion of an expense or service that is not covered by any of the plans is not an Allowable Expense.
- If you are confined to a private hospital room and no plan provides coverage for more than a semiprivate room, the difference in cost between a private and semi-private room is not an Allowable Expense.
- If you are covered by two or more plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one plan that provides services or supplies on the basis of reasonable and customary fees and one plan that provides services and supplies on the basis of negotiated fees, the primary plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the primary plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such plan provisions include second surgical opinions and precertification of admissions or services.

DEFINITIONS UNDER COORDINATION OF BENEFITS

The **Primary Plan** is the plan that determines and provides or pays benefits without taking into consideration the existence of any other plan.

The **Secondary Plan** is the plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

The Reasonable Cash Value is an amount which a duly licensed provider of healthcare services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

WHEN A PARTICIPANT IS COVERED BY TWO PLANS, WHICH PLAN PAYS FIRST

If the plan does have a Coordination of Benefits rule, the first of the following rules that applies to the situation is the one to use:

- The plan that covers you as an enrollee will be the Primary Plan and pays first, and the plan that covers you as a Dependent will be the Secondary Plan.
- If an individual is covered under two plans through two jobs, the plan which has covered the employee for the longer period of time is the Primary Plan and pays first.
- If an individual is covered under two plans and one is through active employment and one is as a retiree, the plan that covers the individual as an active employee is the Primary Plan.
- If the claim is for a Dependent child whose parents are not divorced or legally separated, the Primary Plan will be the plan that covers the parent whose birthday falls first in the calendar year as an

enrollee or employee. For example, if your birthday is April 26, and your spouse's birthday is October 13, then claims for your eligible dependent children should be submitted first to your plan. The application of this rule has nothing to do with age, only to the date in the calendar year on which your birthday falls.

- If the claim is for a Dependent of divorced or separated parents, benefits for the Dependent will be determined in the following order:
  1) First, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of the actual knowledge;
  2) Then, the Plan of the parent with custody of the child;
  3) Then, the Plan of the spouse of the parent with custody of the child;
  4) Then, the Plan of the parent not having custody of the child;
  5) Finally, the Plan of the spouse of the parent not having custody of the child.
- When another plan does not contain a COB provision, it will always be considered the Primary Plan. Payment under the secondary plan is made after the benefits from the primary plan have been paid. Such payment will be limited to the amount necessary to reimburse the individual for not more than 100% of allowable expenses. However, in some cases, the combined benefits may not pay 100% of your bills since you will only receive up to the stated maximums in each plan.
- If none of the above rules apply, then the plan which has covered the participant for the longer period of time shall be considered the Primary Plan.

MEDICARE COORDINATION OF BENEFITS

Coordination of benefits with Medicare is subject to regulations and guidelines published by the Federal Government.

1. **End Stage Renal Disease ("ESRD") Beneficiary.** Benefits will be payable under the Plan without regard to an Eligible Retiree's or Eligible Dependent's entitlement to Medicare if such person is entitled to Medicare as an ESRD beneficiary, and not more than 30 months have elapsed since the earliest of the following:
   a) The month in which the Eligible Retiree or Eligible Dependent began a regular course of renal dialysis;
   b) The month in which the Eligible Retiree or Eligible Dependent received a kidney transplant;
   c) The month in which the Eligible Retiree or Eligible Dependent was admitted to a Hospital in anticipation of a kidney transplant that was performed within the next two months; or
   d) The second month before the month in which the kidney transplant was performed, if performed more than two months after Hospital admission.

All Other Circumstances. Under any circumstance other than discussed in 1, 2, and 3 above, the benefits will be reduced by the amount of benefits provided – or which would have been provided had the covered person been enrolled under all parts of Medicare – for those same expenses under Medicare.

BENEFIT CREDIT ACCOUNT

If you have a remaining balance greater than $50 in your Benefit Credit Account under the Family Health Plan at the time you elect coverage under this Plan, that balance will continue to be available to you under this Plan as a Retiree. Retirees will not accumulate any additional Benefit Credit Account allocations after retirement.

COVERED BENEFIT CREDIT ACCOUNT EXPENSES

Each Benefit Credit can be used to reimburse $1.00 of Covered Expenses.

Covered Expenses include:

- Premiums paid to the Family Health Plan for Self-Pay or COBRA coverage.
- Premiums paid to the Retiree Health Plan for Retiree or COBRA coverage.
- Expenses for services or supplies which are covered under the Family Health Plan or Retiree Health Plan but are the financial liability of the participant as a result of the application of deductibles, coinsurance, maximum benefit limits, or termination of eligibility.
- All non-covered vision expenses, limited to professional services and prescription glasses, frames and contact lenses, including Lasik and similar vision procedures.
- All non-covered dental expenses, excluding cosmetic, limited to services of dental professionals (Broadly defined) and materials, including x-rays and dental implants, used by the professionals in carrying out the dental procedures. Examples of covered expenses would include adult orthodontia and treatment by a professional for TMJ.
- Acupuncture
- Charges incurred at an out-of-network provider, which would have been covered by the Family Health Plan or Retiree Health Plan if incurred in-network.
- Charges for repair, maintenance or replacement of durable medical equipment and continuation of rental expense after rental expense has exceeded the purchase price of the equipment.
- Car – The cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.
- Christian Science Practitioner.
- Elastic hosiery (by prescription).
- Experimental medical/surgical treatment.
- Guide Dog or Other Animal – Cost of buying, training and maintaining a guide dog or other animal to assist a visually-impaired or hearing-impaired, or a person with other physical disabilities.
- Hearing Aids, batteries and related exams.
- Orthopedic Shoes and Arch Support (with letter from physician).
- Over-the Counter Drugs – Includes only those drugs that are treating a specific medical condition and not just for “general well-being.” Examples are antacids, allergy medications, pain relievers, sleep aids, motion sickness pills, and calamine lotion.
- Prescription Vitamins.
- Special Education expenses for child’s tutoring by a teacher specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments, including nervous system disorders, when such tutoring is performed upon a doctor’s recommendation.

- Stop-Smoking Programs, excluding amounts paid for drugs that do not require a prescription, such as nicotine gum or patches.
- Telephone (TTY/TDD) equipment for the hearing-impaired – purchase and repair.
- Therapy – including speech and occupational therapy. Also includes costs for "patterning" exercises given to mentally retarded children.
- Weight Loss program if it is treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). Includes fees for membership in a weight reduction group and attendance at periodic meetings. Does not include membership dues in a gym, health club or spa. Cannot include cost of diet food or beverages.
- Wigs following hair loss from disease or treatment of disease.

IMPORTANT LIMITATIONS ON COVERED EXPENSES

In order to qualify for reimbursement, Covered Expenses must meet all of the following:

- As required by Federal Law, to be eligible for reimbursement under this benefit, all expenses **must not have been reimbursed or be eligible for reimbursement** under any other health plan coverage or a Flexible Spending Account; and
- For Covered Expenses incurred prior to May 1, 2012, the Covered Expense must have been incurred while the patient was eligible for benefits under the Family Health Plan (this limitation does not apply to Covered Expenses incurred on or after May 1, 2012); and
- The Covered Expense must have been filed for reimbursement within 24 months of the date it was incurred.

Benefit Credits are not redeemable for cash.

HOW TO USE YOUR BENEFIT CREDITS

Obtain a Benefit Credit Account claim form by contacting CIGNA at 1-800-244-6224. Please note that unpaid balances from the partially reimbursed claims will not be eligible for future reimbursement. To appeal an adverse benefit determination on a Benefit Credit Account claim, please follow the procedures as set forth in the Claims Appeal section for Medical claims.

Please be sure to keep good records of your expenses – save your receipts and EOBs! To file a claim for reimbursement, you will need to complete a claim form as well as provide a complete written statement, receipt or bill from a third party substantiating the expense. For example, if a doctor's charges were applied toward your deductible and you are filing for reimbursement through Benefit Credits, you will need to provide either: 1) a copy of the Explanation of Benefits (EOB) from all applicable health plans showing what, if any, was paid by them and/or 2) a copy of the bill from the doctor's office clearly showing the amount submitted and paid by insurance, if any. A bill from the medical service provider must contain complete information, including patient name, date of service, expense amount and description of service. Claim forms must be signed by the eligible participant, even if the expense was incurred by the Spouse or eligible Dependent(s). Benefit Credit claims submitted absent the participant's signature on the claim form shall be denied. Multiple out-of-pocket expenses may be submitted with one claim form. Benefit Credit claims payments will be issued and mailed by CIGNA on behalf of the Plan directly to the participant only; claims payments will not be sent directly to the medical service provider. As noted on the claim form, Benefit Credit claims are to be mailed to:

CIGNA Healthcare
P.O. Box 182223
Chattanooga, TN 37422-7223

Claims must be submitted by mail and will not be accepted by fax transmission or email.

You may view your Benefit Credit balance online at www.cigna.com or by calling CIGNA at 1-800-244-6224.

WHAT HAPPENS TO YOUR BENEFIT CREDIT BALANCE IN THE EVENT OF YOUR DEATH

If you have a Benefit Credit balance at the time of your death, it will remain available for use by any eligible Dependent(s) to use for Covered Expenses. For example, the balance can be used to pay for COBRA coverage for your eligible Dependent(s). If you do not have any eligible Dependents at the time of your death, your balance will be forfeited and cannot be paid out as a life insurance benefit or any other such payment.

WHAT HAPPENS TO YOUR BENEFIT CREDIT BALANCE WHEN YOU TURN 65 OR OTHERWISE TRANSTION TO THE HEALTH REIMBURSEMENT ARRANGEMENT (HRA) BENEFIT FOR MEDICARE ELIGIBLE RETIREES?

If you have a Benefit Credit balance at the time you transition to the Health Reimbursement Account (HRA) benefit for Medicare Retirees, your remaining balance will be transferred into your HRA account for use under that benefit program.

FORFEITURE RULES

Benefit Credit balances will be forfeited under the following circumstances:

1) If a participant has been without coverage for a period of longer than 24-months, any remaining Benefit Credits will be forfeited January 1st of the year following the 24th month of eligibility loss.
2) If, as of the last day of any Plan Year, a participant's Benefit Credit balance is less than fifty dollars ($50).
3) If a participant dies without an eligible Dependent, any remaining Benefit Credits will be forfeited.

For questions regarding your Benefit Credit Account, contact CIGNA at 1-800-244-6224.

CLAIMS PROCEDURES

PRE-APPROVAL OF A CLAIM

This Fund requires pre-approval or "preauthorization" of most inpatient hospital admissions as well as many outpatient procedures. When you utilize a Participating Provider, it is the provider's responsibility to complete the preauthorization process on your behalf. However, certain treatments and procedures are not covered under the Fund, and we encourage you to contact CIGNA prior to receiving treatment in order to determine that the treatment will be covered, even if preauthorization is not required. The telephone number for preauthorization can be found on the back of your CIGNA ID card.

The following rules apply to pre-approval of treatment:

1. **Approval of Medically Necessary Treatment –** As explained in this booklet, a charge must be Medically Necessary or be a covered preventive care service to be covered by the Plan. If there is any doubt about whether your expected treatment will be considered Medically Necessary, you may contact CIGNA for an advance decision. As explained in the following pages, you may appeal any adverse decision made by CIGNA regarding Medical Necessity.
2. **Compliance with Plan Provisions, Exclusions and Limitations** – Various plan provisions, Exclusions and Limitations have been adopted and/or included in this Plan in an effort to help control the cost of providing benefits under this Plan. If there is any question as to whether your anticipated treatment will be covered under the Plan, you may contact CIGNA in advance. Once appropriate information is received, CIGNA will let you know whether your expected treatment will be covered under the Plan. If you receive an adverse decision, you may appeal that decision as explained on the following pages.

If you make a request for pre-approval of treatment, the Fund has a responsibility to respond to your request in a timely manner as follows:

1. **Urgent Care Claims** – If proposed treatment is determined to be "urgent" in nature, as defined below, a decision on your request for pre-approval will be made and communicated to you within 72 hours of receipt of your request. If it is determined that additional information is necessary to make a decision on your claim, you will be notified within 24 hours after receipt of the request. You will then be given no less than 48 hours to provide the requested information. You will then be notified of the determination as soon as possible, but in no case later than 48 hours after the earlier of: (i) the Claims Administrator's receipt of the specified additional information, or (ii) the end of the period afforded to you to provide the specified information.

   An "Urgent Care Claim" is a claim which, if treated as a claim for non-urgent care:
   a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
   b) In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
2. **Non-Urgent Care Claims** – If proposed treatment is determined to be of a "non-urgent" nature, a decision on your request for pre-approval will be made and communicated to you within 15 days of receipt of your request. If it is determined that additional information is necessary to make a decision on your claim, the plan may require up to an additional 15 days to make a decision on your request. If such an extension is necessary, you will be notified within 15 days of receipt of your request regarding the extension and a decision will be made as soon as possible. If the extension is required because it was necessary for you to provide additional information, you will be given at least 45 days to provide the requested information.

These procedures for processing requests for pre-approval for urgent and non-urgent care claims have been adopted solely as guidelines. It will continue to be the practice of the Trustees, as the Plan

Administrator, along with CIGNA and the Fund Office staff, to timely process all requests for pre-approval and to respond to all such requests immediately, but always within the time limits prescribed above where possible.

POST-SERVICE and CONCURRENT CARE CLAIMS

For post-service and concurrent (on-going) care claims, the Plan Administrator's designee shall notify the claimant of a benefit determination within the following time periods:

1. **Post Service Claims** – For claims relating to services which have already been rendered, notification of benefit determination shall be made within 30 days after the Plan's receipt of the claim. If additional time is required due to matters beyond the Plan's control, the claimant will be notified before the expiration of the 30-day period of the circumstances requiring the extension of time and of the date by which the Plan expects to render the benefit determination. The extension shall not exceed 15 days beyond the initial 30-day period. If an extension is necessary due to the failure of the claimant to submit sufficient information, the notice shall describe the required information and afford the claimant at least 45 days from receipt of the notice to provide the information.
2. **Ongoing or Concurrent Treatment** – If the Plan has approved an ongoing course of treatment over a period of time or number of treatments, any reduction or early termination of coverage of the treatments constitutes an Adverse Benefit Determination. The Plan Administrator's designee shall notify the claimant sufficiently in advance of the reduction or early termination to allow the claimant to appeal and obtain a review before the benefit is reduced or terminated. If claimant requests at least 24 hours before the expiration to extend the course of treatment beyond the period of time or number of treatments for an Urgent Care Claim, the Plan Administrator's designee shall notify the claimant of the benefit determination within 24 hours after the receipt of the claim by the Plan.

HOW TO OBTAIN BENEFITS

Here are a few suggestions that will help you get the most out of your benefit program and, at the same time, help assure prompt payment of your claims:

- **Use CIGNA Open Access Plus Providers and show your ID card.** When you know that you or one of your Eligible Dependents is going to require medical treatment, this booklet will explain your benefits or you may contact **CIGNA** for assistance. **CIGNA** will help you locate a **CIGNA Open Access Plus** In-Network Provider who will provide quality medical care at a discounted fee and will enable you to take advantage of the highest level of benefits available under the Plan. A Directory of **CIGNA Open Access Plus** providers is available through the Union office and will be provided free of charge upon request, or you can contact **CIGNA** at 1-**800-244-6224**, or search for providers online at **www.cigna.com**. Be sure to have your health benefit identification card with you at all times. It is especially important that you present this card when you are admitted to a Hospital or when you visit a Physician or other service provider. Your ID card supplies the service providers with the name of your Plan, as well as the number to call to verify eligibility and benefits. It also identifies you as a member of the **CIGNA Open Access Plus** network, affording you access to the Preferred Provider discounts. By presenting this ID card to a **CIGNA Open Access Plus Provider**, the provider will also

automatically file your claim for you. This eliminates your need to fill out a claim form and file the claim.

- **Submit all expenses just in case.** The Trustees suggest that you submit medical expenses to CIGNA even if you are not certain if they are eligible for coverage under the Plan. CIGNA will review such expenses and pay the expense that is eligible. By following this procedure, you will avoid inadvertently not receiving benefits for which you were entitled.
- **Include all Necessary Information.** To avoid any confusion as to whom a bill is for, please be sure to list your name and Social Security Number on each item you send to CIGNA or the Fund Office and be certain to include your dependent's Social Security Number as well on any items submitted for them.
- **Additional Materials.** If you receive additional bills or statements that relate to your claim, you should attach a claim form and send them to CIGNA as soon as possible.

KEEP MEDICAL RECORDS!

Accurate medical records are extremely important in the event you want to claim major medical benefits. You will also need copies of bills, receipts and EOBs for filing Benefit Credit Account claims.

- Since the Calendar Year Deductible applies separately to each individual, keep separate medical records for each member of your family.
- Save all bills and/or statements for Covered Charges and in each case record the date the expense was incurred (not the date of the bill) and for whom.
- Keep copies of the Explanation of Benefits (EOB) that you receive from CIGNA or the Fund Office as a record of what expenses have been paid.

HOW TO FILE A CLAIM

TIME LIMIT FOR FILING A CLAIM

You must furnish proof of loss within ninety (90) days after the date of the loss, if reasonably possible. However, in no event will claims delayed in excess of 24 months be acceptable or payable.

MEDICAL claims must be filed with CIGNA at the following address:

CIGNA Healthcare
P.O. Box 5200
Scranton, PA 18505

PRESCRIPTION DRUG claims are processed at the point of service through CIGNA. In some instances you may have to file a paper claim with CIGNA. Prescription claims may be mailed to:

CIGNA Healthcare
Pharmacy Service Center
P.O. Box 3598
Scranton, PA 18505

BURIAL BENEFIT claims must be filed with the Fund Office.

PROCEDURES FOR FILING CLAIMS WITH CIGNA
In most cases your providers will file your claims for you. However, if you need to present a claim:

1. You should first complete the claim form in full. If all questions are not answered it may be necessary to return the claim which will delay settlement.
2. Attach all supporting bills to the claim form. The bill or statement from the medical provider should include the following information:
   a) The Name and Social Security Number of the Covered Employee, and the Social Security Number of the Eligible Dependent if applicable.
   b) The full name of the patient.
   c) Date of each treatment.
   d) Procedure code and description of each service performed during treatment.
   e) Diagnosis and/or code.
   f) Charge amount for each procedure.
3. Mail the completed claim form with attached bills to the appropriate claim address listed above.

If you fail to include **all** requested information, the form will be returned to you as soon as a determination has been made that requested information is missing, but in no event more than 30 days after the claim form was initially received from you.

It is your responsibility to provide the service providers with information about your coverage under the Plan and about their responsibility to file all claims with CIGNA. The information necessary for filing claims appears on the identification card that has been provided to you.

PAYMENT OF CLAIMS
All claims will be processed for payment as soon as possible. However, no claim can be paid until all information necessary to process that claim has been received. If it is determined that additional information is required from you or in your behalf, you will be given 45 days in which to provide any missing information necessary to process the claim.

Once the information required to make a determination as to whether a claim is payable has been received, a decision will be made promptly and you will be notified regarding any benefit payments. In no event will the decision regarding payment be made more than 30 days after the claim has been fully and properly filed.

APPEAL PROCEDURES

FOR MEDICAL/PRESCRIPTION CLAIMS
There is a two level claims appeal procedure. To initiate an appeal, you must submit a request for an appeal verbally or in writing via mail or fax to CIGNA within 180 days of receipt of a denial notice. You

should state the reason why you feel your request should be approved and include any information supporting your appeal.

- **Level One Appeal**
  Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. You will receive a written response with a decision within 15 days after receipt of an appeal for a required Pre-Service or Concurrent care claim and within 30 days after receipt of an appeal for a Post-Service claim. If more time or information is needed to make the determination, you will be notified in writing to request an extension of up to 15 days and to specify any additional information needed to complete the review.

  Expedited Appeal Process
  You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. CIGNA, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

- **Level Two Appeal**
  If you are dissatisfied with the Level One appeal decision, you may request a second review. To initiate a level two appeal you must within 180 days after receipt of the determination of the first level appeal make a written request for a review to the Board of Trustees, IBEW Local 613 and Contributing Employers Retiree Health Plan, 3715 Northside Parkway, Suite 2-495, Atlanta, Georgia 30327. If you fail to make a timely request for review, the last decision on the claim shall be final. If a timely request for review is made, you may submit written comments, documents, records and other information relating to the claim.

  The Board of Trustees shall make a benefit determination on review no later than (i) the date of the first (1st) meeting of the Board of Trustees that immediately follows receipt by the Fund Office of a written request for review or (ii) if such written request for review was not received by the Fund Office more than seven (7) days before such meeting, the date of the second (2nd) meeting of the Board of Trustees following the date the Fund Office received the written request for review. If special circumstances require a delay in the decision, the Board of Trustees shall, prior to commencement of the extension, send a written notice to you setting forth the special circumstances requiring an extension and the date by which the benefit determination is expected to be rendered, and the Board of Trustees shall issue its decision no later than the date of the third (3rd) meeting next following the date the Fund Office received the written request for review. The Fund Office shall notify you of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

  Notification of Decision on Level Two Appeal
  The Board of Trustees, or their committee, shall review any facts and information submitted by you, make a final decision, and notify you in writing of their decision within the time period outlined above. If the adverse benefit determination is upheld, the notification will set for the following in a manner calculated to be understood by the claimant:

1. The specific reason(s) for the adverse determination;
2. Reference to the specific plan provisions on which the determination is based;
3. 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 relative to the claimant's claim for benefits;
4. A statement of any additional voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures, should the Board of Trustees adopt such procedures, and a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended; and
5. The following information where applicable:
   a) If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that copy of such rule, guideline, practice or procedure will be provided free of charge to the claimant upon request;
   b) If the adverse benefit determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment applied to the terms of the plan with respect to the claimant's medical circumstances used in making the determination; and
   c) A statement that you and your plan may have other voluntary dispute options, such as mediation. While this Plan does not currently offer voluntary alternative dispute resolution options, you can contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency to see what options might be available to the Plan.

- **External Review**

  If you are dissatisfied with the Level Two appeal decision regarding a claim that involves medical judgment (excluding those claims that involve only contractual or legal interpretation without any use of medical judgment) or a rescission of coverage, you have four (4) months from receipt of the Level Two denial notice in which you may apply in writing to the Fund Office for an external review of the Board of Trustees' decision. An external review will then be conducted, and the results of that external review will be communicated to you. All external review procedures will be completed in accordance of the provisions of the Patient Protection and Affordable Care Act, and applicable guidance issued thereunder.

FOR BURIAL BENEFIT CLAIMS

There is a one level claims appeal procedure. To initiate an appeal, you must submit a request for an appeal verbally or in writing via mail or fax to the Fund Office within 180 days of receipt of a denial notice. You should state the reason why you feel your request should be approved and include any information supporting your appeal. The Board of Trustees shall make a benefit determination on review no later than (i) the date of the first (1st) meeting of the Board of Trustees that immediately follows receipt by the Fund Office of a written request for review or (ii) if such written request for review was not received by the Fund Office more than seven (7) days before such meeting, the date of the second (2nd) meeting of the Board of Trustees following the date the Fund Office received the written request for review. If special circumstances require a delay in the decision, the Board of Trustees shall, prior to commencement of the extension, send a written notice to you setting forth the special

circumstances requiring an extension and the date by which the benefit determination is expected to be rendered, and the Board of Trustees shall issue its decision no later than the date of the third (3rd) meeting next following the date the Fund Office received the written request for review. The Fund Office shall notify you of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made. Notification of an upheld adverse benefit determination shall include all information as set forth in Notification of Decision on Level Two Appeal above.

ACCESS TO PLAN DOCUMENTS

At any time during the course of these appeal proceedings a claimant will be granted access to, and copies of, documents, records and other information relied upon by the Trustees, or their committee, in making their decision, as requested by the claimant.

No legal action may be commenced or maintained against the Plan or Fund, or to recover any benefits under the Plan, unless the participant (or his legal representative, if any) has first fully complied with and timely exhausted all of the application of benefits, claims review procedures and appeal procedures under the Plan, and in no event may any such action be brought later than 120 days following the Trustees' final decision on review or, if 120 days is not reasonable under the circumstances, such extended time that is reasonable not to exceed, in any event, one (1) year following the Trustees' final decision on review.

CONTACT INFORMATION FOR APPEALS

Level One Appeals
CIGNA Healthcare
P.O. Box 5200
Scranton, PA 18505
Phone: 1-800-244-6224

Level Two & Burial Benefit Appeals
Board of Trustees
IBEW Local 613 and Contributing
Employers Retiree Health Plan
3715 Northside Pkwy, Suite 2-495
Atlanta, GA 30327
Phone: 800-922-1613
Fax: 678-705-0205

IF YOU HAVE QUESTIONS

If you have a question about the Retiree Health Plan, please use the following guide to help you determine who to call:

▶ **Contact CIGNA at 1-800-244-6224 or www.cigna.com if:**

- You have a question about a medical, prescription or vision claim.
- You need to locate a network provider.
- You have a question about your Benefit Credit Account.
- You wish to contact Case Management about your medical needs.
- You are interested in enrolling in a disease management program.
- You need a replacement CIGNA ID card.
- You are receiving Workers' Compensation Benefits.

▶ **Contact CIGNA at 1-800-481-1213 or www.cigna.com if:**

- You have a question about a dental claim. If the claim is regarding your dependent child you will need to have your child's dental ID or social security number available.

▶ **Contact the Fund Office at 800-922-1613 if:**

- You have a question about eligibility for you or a dependent.
- You have a question about a Burial Benefit Claim.
- You have a question about payment of Retiree or COBRA contributions.
- There is a problem with the eligibility/dependent information shown on your ID cards.

MEDICARE TRANSITION ASSISTANCE

The Plan has partnered with a company called "OneExchange" to help you with the transition from the Plan's medical and prescription coverage to Medicare when you reach age 65. Starting on your 64th birthday, you begin to receive communication from OneExchange with information on how they can help you enroll in individual Medicare supplemental coverage, such as Medigap, Medicare Advantage or Medicare Part-D prescription drug plans. If you are already enrolled in Medicare supplemental coverage or under other group coverage but would like to learn about your options in the individual marketplace, OneExchange can help you evaluate your health coverage options to determine your best coverage solution.

Once you reach Medicare eligibility due to age, you will no longer be eligible for the medical and prescription drug benefits offered under this Plan. Instead, you will become eligible for the Health Reimbursement Account (HRA) benefit, which will provide you a set amount of money each year that can be used to pay for your Medicare Part B premiums, your individual Medicare supplemental coverage, or certain other qualified medical expenses.

IF YOU ARE UNDER AGE 65 AND ARE ALREADY ELIGIBLE FOR MEDICARE due to disability or ESRD you have the option of continuing your medical and prescription coverage under this Plan until you reach age 65 by continuing to pay your monthly premiums for coverage OR you can elect to transition to the HRA benefit. To determine which option makes sense for you, you should contact OneExchange to speak to a Benefit Advisor by calling 855-389-4390.

FOR HELP WITH YOUR MEDICARE TRANSITION CONTACT ONEEXCHANGE AT 855-389-4390.

THE FOLLOWING SECTION DESCRIBES

MEMBER BENEFITS

FOR
ELIGIBLE RETIREES AGE 65 & OVER
ELIGIBLE SURVIVING SPOUSES AGE 65 & OVER
AND
ELIGIBLE DEPENDENT SPOUSES AGE 65 & OVER

AND MEDICARE-ELIGIBLE RETIREES/WIDOWS OR ELIGIBLE SPOUSES UNDER 65 WHO ARE ELIGIBLE FOR MEDICARE AND HAVE CHOSEN TO TRANSITION TO THE HRA BENEFIT

SCHEDULE OF BENEFITS – AGE 65 & OVER

And Medicare-Eligible Retirees/Spouses Under Age 65 who elect to transition to HRA Benefit

The benefits shown are those which were in effect as of September 1, 2017.
The Schedule of Benefits is subject to change by vote of the Board of Trustees.
Please contact Fund Office with any questions regarding the current level of benefits.

HRA BENEFITS

Benefit Credit to HRA Account

- Eligible Retirees $100 per month
- Eligible Spouses $75 per month
- Widows/Widowers of Former Eligible Retirees* $100 per month

* Widow/Widower benefit level is only available if the Retiree was participating in the HRA at the time of death.

BURIAL BENEFIT

Retired Employee Only

- Benefit Payable per Year of Earned Pension Service
- Minimum Benefit Payable $ 200
- Maximum Benefit Payable $ 1,000
- Benefit reduces $100 per year beginning at age 70 $ 2,500

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

If you are over age 65 at the time of retirement or once you transition from the under age 65 retiree program, you will have an HRA account established in your name. If you have a covered spouse and you are both participating in the HRA, you will have a joint account.

Your HRA account is merely a bookkeeping account on the Plan's records and is not an actual, separate bank account. Your account does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Fund's general assets. If you cease participating in the Fund, you cannot take your HRA account with you.

ACCOUNT ALLOCATION AMOUNTS AND TIMING

The amount credited to your HRA account is determined periodically by the Board of Trustees and will be reflected in the Schedule of Benefits. Currently the amounts are credited on a monthly basis.

ELIGIBLE MEDICAL EXPENSES FOR REIMBURSEMENT

In general, your HRA account can be used to reimburse your out-of-pocket expense for medical care, as that term is defined in IRS Code Section 213(d). Some common examples of Eligible Medical Expenses include:

- Premiums for medical, prescription drug, dental, vision, or long-term care insurance (including Medicare Part B premiums);
- Abdominal supports
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses, used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids; and
- Wheelchairs

If you have a question about whether or not a certain expense will be covered, contact OneExchange at 855-389-4390.

EXCLUSIONS AND LIMITATIONS

Only Eligible Medical Expenses incurred while you are Covered Individual under the HRA can be reimbursed from your HRA account. Eligible Medical Expenses are "incurred" when the medical care is provided, not when you are billed, charged or pay for the expense. Thus, an expense that has been paid but not incurred (e.g., pre-payment to a physician or dentist) will not be reimbursed until the services or treatment has actually been provided.

The following expenses may not be reimbursed from your HRA account:

- Prescription drugs;
- Expenses incurred *prior to the date* that you became a Covered Individual in the HRA;
- Expenses incurred *after the date* that you cease to be a Covered Individual in the HRA;
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- Expenses that are not for medical care, as that term is defined in IRS Code Section 213(d).

Some examples of common items that are not included in the definition of medical care in Code Section 213(d) are:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

WHY PRESCRIPTION DRUGS ARE NOT A COVERED EXPENSE

If prescriptions are reimbursed through an HRA Account, it can interfere with how those drugs are covered

HOW TO USE YOUR HRA ACCOUNT – FILING A CLAIM

Once you are eligible for the HRA you will receive a Funding Guide from OneExchange with details on how to file a claim online, by fax or through the mail. They can also set you up to receive automatic reimbursements for certain premium expenses. The Guide will include a claim form or you can request additional forms by calling OneExchange at 855-389-4390. **Please be sure to save all of your receipts and supporting documentation for an expense so that you can submit with the claim form.**

Suggestions for filing a claim:

- Do not mail original documents; just provide copies of receipts and other documents and retain the originals for your records.
- Instructions with steps for submitting your claims by mail or fax are printed on the back of each claim form – check off each step as you fill out the form.
- When reviewing receipts, we don't look for a specific document; we look for the information required to verify the claim:
    - Who the expense was for;
    - Who provided the service you paid for;
    - What service was provided;

  - When the service was provided; and
  - Proof you have paid or must pay the expense.

  Be sure to provide documentation that shows all five items above. It is okay if it takes more than one document to provide all the information.
- The instructions on the claim form and OneExchange customer service (855-389-4390) can help you determine if you have all of the information you need for your claims.

If you submit a claim for an amount greater than your available HRA account balance, you will be partially reimbursed for the balance that you have available. If additional benefit credits become available, you will automatically receive additional reimbursement on that claim, up to the full amount requested.

When your claim is processed, you will receive an Explanation of Payment (EOP) statement from OneExchange. Each OAP statement will include a summary of your paid claims, your available funding balance, and the amounts you have been reimbursed for. In the case of denied claims, your EOP will list the reason for denial. If a claim is denied, you may be required to take action in order to receive reimbursement, such as resubmitting the paperwork or providing additional documentation. For more information on why a claim was denied, you can contact OneExchange at 855-389-4390.

You can elect to have your reimbursements processed through direct deposit into a bank account. If you have not elected direct deposit, a paper check will be attached to the EOP.

WHAT HAPPENS TO YOUR HRA ACCOUNT BALANCE IN THE EVENT OF YOUR DEATH

If you die and you do not have a spouse who is also a Covered Individual in the HRA, your account is immediately forfeited upon your death. However, your estate or representative can submit claims for Eligible Medical Expenses that were incurred prior to your death, provided that such claims are filed within 180 days of the date of death.

If you die and your spouse is also a Covered Individual in the HRA, your remaining balance will rollover to your spouse's account.

WHAT HAPPENS IF YOU DON'T USE YOUR HRA ACCOUNT BALANCE BY THE END OF THE YEAR

Any available balance that is not used by the end of the year will roll-over to be available in the following year.

IF YOU HAVE QUESTIONS

If you have a question about the Retiree Health Plan, please use the following guide to help you determine who to call:

▶ **Contact OneExchange at 1-855-389-4390 or www.medicare.oneexchange.com if:**

- You have a question your Medicare supplement insurance or you need to shop for Medicare supplement insurance.
- You have a question about your HRA account.

▶ **Contact the Fund Office at 800-922-1613 if:**

- You have a question about eligibility for you or a dependent.
- You have a question about a Burial Benefit Claim.

BURIAL BENEFIT FOR ELIGIBLE RETIREES

Eligible Retired Employees Only

For all eligible retirees, the Plan will provide your estate a burial benefit based on your earned service with the National Electrical Benefit Fund (NEBF). The benefit will be based on $200 per year of Pension Service (with a $1,000 minimum and a $2,500 maximum). The benefit will reduce $100 per year beginning at age 70.

The Burial Benefit is administered by the Fund Office, to file a claim or for questions regarding a claim, you should contact the Fund Office at:

IBEW Local 613 and Contributing Employers Retiree Health Plan
3715 Northside Parkway, Suite 2-495
Atlanta, GA 30327
800-922-1613

EMPLOYEE ASSISTANCE PROGRAM
COUNSELING CONNECTION, INC.

ABOUT YOUR EMPLOYEE ASSISTANCE PROGRAM

Sometimes it is difficult to handle problems. Your Plan has an Employee Assistance Program (EAP) to help when the going gets tough. The EAP provides professional confidential assessment and referral services to help you or your family member resolve personal difficulties. The EAP addresses many issues that might affect your ability to do the best job. Examples include marital and family problems, stress or emotional difficulties, alcohol or other drug problems, financial, legal or occupational concerns. Here are some of the questions we usually hear about the Employee Assistance Program:

Why Have an EAP?

When personal problems keep you from doing the best job, it is in your employer's best interest to have a confidential program to help employees. The EAP helps you and your family receive appropriate professional services to help solve problems.

How Does the EAP Work?

It all begins with a phone call. When you think you have a problem that you might need assistance with, all you have to do is call Counseling Connection. EAP services are available to all employees and their family members. A trained, professional EAP counselor will talk with you and find the resources that you need, and work with you toward finding solutions in solving the problem.

Do I Have to Go to the EAP?

No, participation in the EAP is voluntary. Most people call Counseling Connection EAP on their own. Sometimes, your supervisor may talk with you about a job problem and recommend that you call the EAP, but it's still up to you.

Can my Supervisor Recommend I Go to the EAP?

Yes, actually it's a good idea for your supervisor to recommend that you contact the EAP for help. It's free to you, confidential, and helps the supervisor when your problems do not interfere with your job performance.

How Much Will it Cost?

The EAP is free to all employees and family members. However, if you need further assistance outside of the EAP, it will be your financial responsibility. The EAP counselor will assist in finding low or no cost services if you do not have insurance. We will also try to find a resource referral that is close to where you work or live.

How Do I Take the First Step?

Actually, the first step is to recognize that a problem exists. How would you know that? When you have tried and tried to solve the problem and the solutions are just not working. The next step is to call the EAP to get additional assistance. Most people feel their problem is unique. However, many problems such as depression, stress or alcohol or other drug abuse are very common in the workplace. There are many resources available to help solve everyday problems.

What are the EAP Office Hours?

We operate our EAP to have appointments that are convenient for you or your family member. Many times an evaluation is conducted on the phone if that is more convenient for you. You may also come in to one of our offices for a personal appointment. All EAP counselors are on call to respond to any

message within 30 minutes. After normal business hours, counselors are available through our telephone secretary service.

The Counseling Connection Employee Assistance Program can be reached at:

770-516-0941 or toll-free at 1-800-516-0941, outside Georgia

One of our EAP professionals will be happy to assist you or your family member in person or by telephone. All appointments are free, confidential, and voluntary. So why wait? Don't let a personal problem cause you to have problems on the job or with your family. Calling is the first step to a healthy beginning – and a new start.

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.

Effective Date of Notice: ***January 1, 2014***

This Notice of Privacy Practices ("Notice") is made in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The *IBEW Local 613 and Contributing Employers Retiree Health Plan* (the "Plan") is required by law to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI"), as defined below, and to inform you about:

1. the Plan's uses and disclosures of PHI;
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and with the Secretary of HHS; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "**Protected Health Information**" (PHI) includes all "Individually Identifiable Health Information" transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

The term "**Individually Identifiable Health Information**" means information that:

- Is created or received by a health care provider, health plan, employer or health care clearinghouse;
- 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
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Section 1. Notice of PHI Uses and Disclosures

1.1 Required PHI Disclosures

Upon your request, the Plan is required to give you access to certain PHI to inspect and copy it and to provide you with an accounting of disclosures of PHI made by the Plan. For further information pertaining to your rights in this regard, see Section 2 of this Notice.

The Plan must disclose your PHI when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards.

1.2 Permitted uses and disclosures to carry out treatment, payment and health care operations

The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose PHI without your consent, authorization or opportunity to agree or object, to carry out treatment, payment and

health care operations. The Plan will disclose PHI to a business associate only if the Plan receives satisfactory assurance that the business associate will appropriately safeguard the information.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose PHI to The *IBEW Local 613 and Contributing Employers Retiree Health Plan* ("Plan Sponsor") for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by the Privacy Standards. The Plan Sponsor will obtain an authorization from you if it intends to use or disclose your PHI for purposes unrelated to treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services by one or more health care providers. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. Payment includes, but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations.

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill might be paid by the Plan.

Health care operations means conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, contacting health care providers and patients with information about treatment alternatives, reviewing the competence or qualifications of health care professionals, evaluating health plan performance, underwriting, premium rating and other insurance activities relating to creating, renewing or replacing health insurance contracts or health benefits. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

1.3 Uses and disclosures that require your written authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations 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 without authorization when needed by the Plan to defend against litigation filed by you.

1.4 Disclosures that require that you be given an opportunity to agree or disagree prior to the disclosure

The Plan may disclose to a family member, other relative, close personal friend of yours or any other person identified by you PHI directly relevant to such person's involvement with your care or payment for your health care when you are present for, or otherwise available prior to, a disclosure and you are able to make health care decisions, if:

- The Plan obtains your agreement;
- The Plan provides you with the opportunity to object to the disclosure and you fail to do so; or
- The Plan infers from the circumstances, based upon professional judgment, that you do not object to the disclosure.

The Plan may obtain your oral agreement or disagreement to a disclosure.

However, if you are not present, or the opportunity to agree or object to the disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Plan may, in the exercise of professional judgment, determine whether the disclosure is in your best interests, and, if so, disclose only PHI that is directly relevant to the person's involvement with your health care.

1.5 Uses and disclosures for which authorization or opportunity to agree or object is not required

Use and disclosure of your PHI is allowed without your authorization or opportunity to agree or object under the following circumstances:

a) When required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.
b) When permitted for purposes of public health activities, including disclosures to (i) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect and (ii) a person subject to the jurisdiction of the Food and Drug Administration (FDA) regarding an FDA-regulated product or activity for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity, including to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI also may be disclosed to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.
c) Except for reports of child abuse or neglect permitted by part (b) above, when required or authorized by law, or with your agreement, the Plan may disclose PHI about you to a government authority, including a social service or protective services agency, if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless (i) the Plan believes that informing you would place you at risk of serious harm or (ii) the Plan would be informing your personal representative, and the Plan believes that your personal representative is responsible for the abuse, neglect or other injury, and that informing such person would not be in your best interests. For the purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure generally may be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

d) The Plan may disclose your PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of: (i) the health care system, (ii) government benefit programs for which health information is relevant to beneficiary eligibility, (iii) entities subject to government regulatory programs for which health information is needed to determine compliance with program standards, or (iv) entities subject to civil rights laws for which health information is needed to determine compliance.

e) The Plan may disclose your PHI in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the Plan discloses only the PHI expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court of administrative tribunal if certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection, and the time to object has expired and either no objections were raised or any objections were resolved in favor of disclosure by the court or tribunal.

f) The Plan may disclose your PHI to a law enforcement official when required for law enforcement purposes. The Plan may disclose PHI as required by law, including laws that require the reporting of certain types of wounds. Also, the Plan may disclose PHI in compliance with (i) a court order, court-ordered warrant, or a subpoena or summons issued by a judicial officer, (ii) a grand jury subpoena, or (iii) an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, provided certain conditions are satisfied. PHI may be disclosed for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose your PHI in response to a law enforcement official's request if you are, or are suspected to be, a victim of a crime. Further, the Plan may disclose your PHI if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Plan's premises.

g) The Plan may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

h) The Plan may use or disclose PHI for research, subject to certain conditions.

i) When consistent with applicable law and standards of ethical conduct, the Plan may use or disclose PHI if the Plan, in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public and is to person(s) able to prevent or lessen the threat, including the target of the threat, or (ii) is needed for law enforcement authorities to identify or apprehend an individual, provided certain requirements are met.

j) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke an authorization at any time, provided your revocation is done in writing, except to the extent that the Plan has taken action in reliance upon the authorization, or if the authorization was obtained as a condition of obtaining

insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Section 2: Rights of Individuals

2.1 Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your requested restriction.

If the Plan agrees to a requested restriction, the Plan may not use or disclose PHI in violation of such restriction, except that, if you requested a restriction and later are in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, the Plan may use the restricted PHI, or it may disclose such information to a health care provider, to provide such treatment to you. If restricted PHI is disclosed to a health care provider for emergency treatment, the Plan must request that such health care provider not further use or disclose the information.

A restriction agreed to by the Plan is not effective to prevent uses or disclosures when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards or uses or disclosures that are otherwise required by law.

The Plan may terminate its agreement to a restriction, if:

- You agree to or request the termination in writing;
- You orally agree to the termination and the oral agreement is documented; or
- The Plan informs you that it is terminating its agreement to a restriction, except that such termination is only effective with respect to PHI created or received after the Plan has informed you of the termination.

If the Plan agrees to a restriction, it will document the restriction by maintaining a written or electronic record of the restriction. The record of the restriction will be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.

You or your personal representative will be required to request restrictions on uses and disclosures of your PHI in writing. Such requests should be addressed to the following individual: *Privacy Officer, c/o National Employee Benefits Administrators, Inc., 3715 Northside Parkway, Suite 2-495, Atlanta, GA 30327.*

2.2 Right to Request Confidential Communications of PHI

You may request to receive communications of PHI from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. The Plan will accommodate all such reasonable requests. However, the Plan may condition the provision of a reasonable accommodation on:

- When appropriate, information as to how payment, if any, will be handled; and
- Specification by you of an alternative address or other method of contact.

You or your personal representative will be required to request confidential communications of your PHI in writing. Such requests should be addressed to the following individual: *Privacy Officer, c/o National Employee Benefits Administrators, Inc., 3715 Northside Parkway, Suite 2-495, Atlanta, GA 30327.*

2.3 Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains PHI in the designated record set.

"**Designated Record Set**" means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The Plan will act on a request for access no later than 30 days after receipt of the request. However, if the request for access is for PHI that is not maintained or accessible to the Plan on-site, the Plan must take action no later than 60 days from the receipt of such request. The Plan must take action as follows: if the Plan grants the request, in whole or in part, the Plan must inform you of the acceptance and provide the access requested. However, if the Plan denies the request, in whole or in part, the Plan must provide you with a written denial. If the Plan cannot take action within the required time, the Plan may extend the time for such action by no more than 30 days if the Plan, within the applicable time limit, provides you with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

If the Plan provides access to PHI, it will provide the access requested, including inspection or obtaining a copy, or both, of your PHI in a designated record set. The Plan will provide you with access to the PHI in the form or format requested if it is readily producible in such form or format; or, if it is not, in a readable hard copy form or such other form or format as agreed to between you and the Plan. The Plan may provide you with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided in certain circumstances. The Plan will arrange with you for a convenient time and place to inspect or obtain a copy of the PHI, or mail a copy of the PHI at your request. If you request a copy of PHI or agree to a summary or explanation of PHI, the Plan may impose a reasonable, cost-based fee.

If the Plan denies access to PHI in whole or in part, the Plan will, to the extent possible, give you access to any other PHI requested, after excluding PHI as to which the Plan has grounds to deny access. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, if applicable, a statement of your review rights, including a description of how you may exercise those review rights and a description of how you may complain to the Plan or to the Secretary of the HHS. If you request review of a decision to deny access, the Plan will refer the request to a designated licensed health care professional for review. The reviewing official will determine, within a reasonable period of time, whether to deny the access requested. The Plan will promptly provide you with written notice of that determination.

If the Plan does not maintain the PHI that is the subject of your request for access, and the Plan knows where the requested information is maintained, the Plan will inform you where to direct the request for access.

You or your personal representative will be required to request access to your PHI in writing. Such requests should be addressed to the following individual: *Privacy Officer, c/o National Employee Benefits Administrators, Inc., 3715 Northside Parkway, Suite 2-495, Atlanta, GA 30327.*

2.4 Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan may deny your request for amendment if it determines that the PHI or record that is the subject of the request:

- Was not created by the Plan, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- Is not part of the designated record set;
- Would not be available for your inspection under the Privacy Standards; or
- Is accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply within that deadline provided that the Plan, within the original 60-day time period, gives you a written statement of the reasons for the delay and the date by which it will complete its action on the request. If the Plan accepts the requested amendment, the Plan will make the appropriate amendment to the PHI or record that is the subject of the request by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. The Plan will timely inform you that the amendment is accepted and obtain your identification of and agreement to have the Plan notify the relevant persons with which the amendment needs to be shared as provided in the Privacy Standards.

If the request is denied in whole or part, the Plan must provide you with a written denial that (i) explains the basis for the denial, (ii) sets forth your right to submit a written statement disagreeing with the denial and how to file such a statement, (iii) states that, if you do not submit a statement of disagreement, you may request that the Plan provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment, and (iv) includes a description of how you may complain to the Plan or to the Secretary of HHS. The Plan may reasonably limit the length of a statement of disagreement. Further, the Plan may prepare a written rebuttal to a statement of disagreement, which will be provided to you. The Plan must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link your request for an amendment, the Plan's denial of the request, your statement of disagreement, if any, and the Plan's rebuttal, if any, to the designated record set. If a statement of disagreement has been submitted, the Plan will include the above-referenced material, or, at the Plan's election, an accurate summary of such information, with any subsequent disclosure of the PHI to which the disagreement relates. If you do not submit a written statement of disagreement, the Plan must include your request for amendment and its denial, or an accurate summary of such information with any subsequent disclosure of the PHI only if requested by you.

You or your personal representative will be required to request amendment to your PHI in a designated record set in writing. Such requests should be addressed to the following individual: *Privacy Officer, c/o National Employee Benefits Administrators, Inc., 3715 Northside Parkway, Suite 2-495, Atlanta, GA 30327.* All requests for amendment of PHI must include a reason to support the requested amendment.

2.5 Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date on which the accounting is requested. However, such accounting need not include PHI disclosures made: (a) to carry out treatment, payment or health care operations; (b) to individuals about their own PHI; (c) incident to a use or disclosure otherwise permitted or required by the Privacy Standards; (d) pursuant to an authorization; (e) to certain persons involved in your care or payment for your care; (f) to notify certain persons of your location, general condition or death; (g) as part of a "Limited Data Set" (as defined in the Privacy Standards), which largely relates to research purposes; or (h) prior to the compliance date of April 14, 2003. You may request an accounting of disclosures for a period of time less than six years from the date of the request.

The accounting will include disclosures of PHI that occurred during the six years (or such shorter time period, if applicable) prior to the date of the request for an accounting, including disclosures to or by business associates of the Plan. Except as otherwise provided below, for each disclosure, the accounting will include:

- The date of the disclosure;
- The name of the entity or person who received the PHI and, if known, the address of such entity or person;
- A brief description of the PHI disclosed; and
- A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure, or, in lieu of such statement, a copy of a written request for disclosure.

If during the period covered by the accounting, the Plan has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures, provide the above-referenced information for the first disclosure; the frequency, periodicity or number of the disclosures made during the accounting period; and the date of the last disclosure.

If during the period covered by the accounting, the Plan has made disclosures of PHI for a particular research purpose for 50 or more individuals, the accounting may, with respect to such disclosures for which your PHI may have been included, provide certain information as permitted by the Privacy Standards. If the Plan provides an accounting for such research disclosures, and if it is reasonably likely that your PHI was disclosed for such research activity, the Plan shall, at your request, assist in contacting the entity that sponsored the research and the researcher.

If the accounting cannot be provided within 60 days after receipt of the request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You or your personal representative will be required to request an accounting of your PHI disclosures in writing. Such requests should be addressed to the following individual: *Privacy Officer, c/o National Employee Benefits Administrators, Inc., 3715 Northside Parkway, Suite 2-495, Atlanta, GA 30327*

2.6 The Right To Receive a Paper Copy of This Notice Upon Request

You have a right to obtain a paper copy of this Notice upon request. To request a paper copy of this Notice, contact the following individual: *Privacy Officer, c/o National Employee Benefits Administrators, Inc., 3715 Northside Parkway, Suite 2-495, Atlanta, GA 30327*.

2.7 A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may include, but is not limited to, the following:

a) a power of attorney for health care purposes, notarized by a notary public;
b) a court order of appointment of the person as the conservator or guardian of the individual; or
c) an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3: The Plan's Duties

3.1 Notice

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective beginning on the effective date set forth on Page 1 of this Notice, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change the terms of this Notice and to make the new revised notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan prior to the date of the revised notice. If a privacy practice is changed, a revised version of this Notice will be provided to all individuals then covered by the Plan. If agreed upon between the Plan and you, the Plan will provide you with a revised Notice electronically. Otherwise, the Plan will mail a paper copy of the revised Notice to your home address. In addition, the revised Notice will be maintained on any web site maintained by the Plan to provide information about its benefits.

Any revised version of this Notice will be distributed within 60 days of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice. Except when required by law, a material change to any term of this Notice may not be implemented prior to the effective date of the revised notice in which such material change is reflected.

3.2 Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

a) disclosures to or requests by a health care provider for treatment;
b) uses or disclosures made to the individual;
c) disclosures made to the Secretary of HHS.
d) uses or disclosures that are required by law;
e) uses or disclosures that are required for the Plan's compliance with the Privacy Standards; and
f) uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan, and from which identifying information has been deleted in accordance with the Privacy Standards.

Section 4: Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: *Privacy Officer, c/o National Employee Benefits Administrators, Inc., 3715 Northside Parkway, Suite 2-495, Atlanta, GA 30327.*

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, by writing to him at the following address: The Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5: Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following individual: *Privacy Officer, c/o National Employee Benefits Administrators, Inc., 3715 Northside Parkway, Suite 2-495, Atlanta, GA 30327* or by calling *800-922-1613.*

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standards.