IBEW Local 22/NECA Health and Welfare Plan
Amendment No. 5

Pursuant to Article VII, Section 4 of the Restated Agreement and Declaration of Trust of the International Brotherhood of Electrical Workers, Local Union No. 22/NECA Health & Welfare Trust Fund, the Board of Trustees has authority to amend the terms of the IBEW Local 22/NECA Health and Welfare Plan ("Plan") from time to time as may be necessary or desirable in the discretion of said Board. In accordance with this authority, and pursuant to the procedures for amendment or modification of the Plan, the Board of Trustees hereby declare:

The Summary Plan Description effective January 1, 2011 is amended effective September 1, 2013 as follows:

Important Telephone Numbers
The Section titled, "Important Telephone Numbers" shall be amended by deleting the subsection titled, "Fund Office" and inserting in its place the following subsection titled, "Fund Office":

"**Fund Office**

Omaha.....402-592-3753
Toll-Free.....855-330-3242
Website.....22benefits.aibpa.com"

Plan Information
The Section titled, "Plan Information" shall be amended by deleting the subsections titled, "The Plan Sponsor's Address is:", "The Plan Administrator", and "Registered Agent for Service for Legal Process" and inserting in their place the following subsections titled, "The Plan Sponsor's Address is:", "The Plan Administrator", and "Registered Agent for Service for Legal Process":

"The Plan Sponsor's Address is:	Electrical Industry Center 8960 "L" Street, Suite 101 Omaha, NE 68127 (402) 592-3753
The Plan Administrator:	A&I Benefit Plan Administrators 8960 "L" Street, Suite 101 Omaha, NE 68127 (402) 592-3753 (402) 592-2352 fax 22benefits@aibpa.com
Registered Agent for Service of Legal Process:	A&I Benefit Plan Administrators 8960 "L" Street, Suite 101 Omaha, NE 68127 (402) 592-3753

Service of Legal Process may also be made on any Plan Trustee. (Plan Trustees listed on the next page.)"

Attachment A – Other Plan Provisions

Attachment A shall be amended at the first page of such Attachment A by deleting the third and fourth paragraphs of such page and inserting in their place the following third and fourth paragraphs:

> "All questions regarding information presented in this Attachment A should be directed to the Fund Office:
>
> A&I Benefit Plan Administrators
> 8960 "L" Street, Suite 101
> Omaha, NE 68127
> (402) 592-3753"

Attachment A shall be amended at Article I by deleing the last sentence of Article I and inserting in its place the following sentence:

> "If you have questions on these definitions, please contact the Fund Office at (402) 592-3753."

Attachment A shall be amended at Section 2.06 by deleting the current Section 2.06(f) and inserting in its place the following Section 2.06(f):

> "f. Benefits. The coverage provided under COBRA continuation coverage is identical to the medical coverage provided under the Plan to similarly situated beneficiaries with respect to whom a qualifying event has not occurred. Ancillary welfare benefits, such as Life Benefits, Accidental Death and Dismemberment benefits, Dependent Life Benefits, and Accident and Sickness Weekly benefits may not be continued under COBRA.
>
> If you have any questions on eligibility, self-payment provisions, or COBRA, please contact the Fund Office at (402) 592-3753."

Attachment A shall be amended at the Section titled, "GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS" by deleting the subsection titled, "You Must Give Notice of Some Qualifying Events" and inserting in its place the following subsection titled, "You Must Give Notice of Some Qualifying Events":

> **"You Must Give Notice of Some Qualifying Events**
>
> **For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), YOU must notify the Plan Administrator within 60 days after the Qualifying Event Occurs. You must provide this notice to the Plan Administrator, A&I Benefit Plan Administrators, IBEW Local 22/NECA Health & Welfare Plan, Electrical Industry Center, 8960 "L" Street, Suite 101, Omaha, Nebraska 68127-1406. Your notice to the Plan Administrator must be made in writing and must he accompanied hy a copy of any legal documentation (such as a divorce decree or order granting legal separation) related to the Qualifying Event."**

Attachment A shall be amended at the Section titled, "GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS" by deleting the subsection titled, "Plan Contact Information" and inserting in its place the following subsection titled, "Plan Contact Information":

"**Plan Contact Information**

A&I Benefit Plan Administrators
8960 "L" Street, Suite 101
Omaha, NE 68127
(402) 592-3753
(402) 592-2352 fax
22benefits@aibpa.com"

Attachment A shall be amended at Section 3.03 by deleting the current Section 3.03(c) and inserting in its place the following Section 3.03(c):

"Claimant-Beneficiary.

The Fund reserves the right in the sole discretion of the Board of Trustees to withhold payments until all competing claims are resolved or judgment is entered by a court of competent jurisdiction in favor of a claimant-beneficiary.

If you have any questions about Life Benefits for Bargaining or Non-Bargaining Employees, please contact the Fund Office at (402) 593-3753."

Attachment A shall be amended at Section 4.01 by deleting the current Section 4.01(c) and inserting in its place the following Section 4.01(c):

"Facility of Payment. If any beneficiary is a minor or is, in the opinion of the Fund, legally incapable of giving valid receipt for any payment due to him, the Fund reserves the right to make payment in monthly installments not exceeding $50.00 to the person or persons, or institution, who in its opinion has been caring for or supporting the beneficiary, until a claim is made for the remainder by a duly appointed guardian or committee of the beneficiary.

Any such payment made under this subsection c. shall discharge the obligation of the Fund hereunder to the extent of such payment.

If you have any questions about Dependent Life Benefits, please contact the Fund Office at (402) 592-3753."

Attachment A shall be amended at Section 5.02 by deleting the current Section 5.02(c) and inserting in its place the following Section 5.02(c):

"c. any injury or sickness for which you are entitled to receive benefits in whole or in part under any Workers' Compensation Law, Occupational Disease Law, Employers' Law or similar law, to the degree the benefits exceed those payable under the Plan.

If you have any questions on Accident and Sickness Weekly Benefits, please contact the Fund Office at (402) 593-3753."

Attachment B: Health Reimbursement Arrangement

Attachment B shall be amended at the Section, "Allowable Medical Care Expenses" by deleting the current subsection (d)(2) and replacing it with the following subsection (d)(2):

"2) Filing a Claim. You may apply for reimbursement by submitting a claim in writing to the Plan Administrator on a form provided by the Fund Office. You may also apply for reimbursement by submitting a claim to the Fund Office via the Plan's mobile application. For prescription drugs, rather than submitting an application for reimbursement, you may pay for prescription drugs that meet the definition of Allowable Medical Care Expense by using an HRA debit card provided by the Fund Office. If you are seeking reimbursement for an Allowable Medical Care Expense, the claim for reimbursement must be received by the Fund Office no later than March 31st of the calendar year following the close of the Plan Year in which the Allowable Medical Care Expense was incurred.

IN WITNESS WHEREOF, we have affixed our signatures and approved this amendment this 20th day of August 2013.

APPROVED:

John T. McMahon, Chairman

Gary B. Kelly, Secretary

Allan Hale, Trustee

Steve Mayfield, Trustee

Scott Love, Trustee

Michael Stopak, Trustee

IBEW Local 22/NECA Health and Welfare Plan
Amendment No. 4

Pursuant to Article VII, Section 4 of the Restated Agreement and Declaration of Trust of the International Brotherhood of Electrical Workers, Local Union No. 22/NECA Health & Welfare Trust Fund, the Board of Trustees has authority to amend the terms of the IBEW Local 22/NECA Health and Welfare Plan ("Plan") from time to time as may be necessary or desirable in the discretion of said Board. In accordance with this authority, and pursuant to the procedures for amendment or modification of the Plan, the Board of Trustees hereby declare:

The Summary Plan Description effective January 1, 2011 is amended as follows:

Effective March 1, 2013, Article I shall be amended at Section 1.12(a) by replacing that entire section as follows:

a. Hours worked for Contributing Employers by a Bargaining Employee will be credited to the Bargaining Employees Hour Bank Account. Prior to March 1, 2011, when a Bargaining Employee is credited with more than one hundred forty (140) hours during a month, the excess hours will remain in that Employee's Hour Bank Account up to a maximum accrued balance of eight hundred forty (840) hours. Effective March 1, 2011, when a Bargaining Employee is credited with more than one hundred forty (140) hours during a month, the excess hours will remain in that Employee's Hour Bank Account up to a maximum accrued balance of five hundred sixty (560) hours. Effective March 1, 2013, when a Bargaining Employee is credited with more than one hundred forty (140) hours during a month, the excess hours will remain in that Employee's Hour Bank Account up to a maximum accrued balance of seven hundred (700) hours. A Bargaining Employee can accumulate these excess hours to be used to maintain eligibility during periods of slack employment or total layoff.

Effective March 1, 2013, Article II shall be amended at Section 2.01(e)(2) by replacing that entire section as follows:

2.01(e)(2) Continuation of Eligibility
Whenever a Bargaining Employee is credited with more than one hundred forty (140) hours during a month (which is required to furnish one month's coverage), the excess hours will be added to the Bargaining Employee's Hour Bank accumulation. Prior to March 1, 2011, the Bargaining Employee will be allowed to accumulate excess hours in his Hour Bank up to a maximum of eight hundred forty (840) hours. Effective March 1, 2011, the Bargaining Employee will be allowed to accumulate excess hours in his Hour Bank up to a maximum of five hundred sixty (560) hours. Effective March 1, 2013, when a Bargaining Employee is credited with more than one hundred forty (140) hours during a month, the excess hours will remain in that Employee's Hour Bank Account up to a maximum accrued balance of seven hundred (700) hours. This means that when an Employee is credited with more than one hundred forty (140) hours during a month, the excess hours will remain in that Employee's Hour Bank Account up to a maximum accrued balance of seven hundred (700) hours.

IN WITNESS WHEREOF, we have affixed our signatures and approved this amendment this 19th day of February, 2013.

APPROVED:

John T. McMahon, Chairman

Gary B. Kelly, Secretary

Allan Hale, Trustee

Steve Mayfield, Trustee

Scott Love, Trustee

Michael Stopak, Trustee

IBEW Local 22/NECA Health and Welfare Plan
Amendment No. 3

Pursuant to Article VII, Section 4 of the Restated Agreement and Declaration of Trust of the International Brotherhood of Electrical Workers, Local Union No. 22/NECA Health & Welfare Trust Fund, the Board of Trustees has authority to amend the terms of the IBEW Local 22/NECA Health and Welfare Plan ("Plan") from time to time as may be necessary or desirable in the discretion of said Board. In accordance with this authority, and pursuant to the procedures for amendment or modification of the Plan, the Board of Trustees hereby declare:

The Summary Plan Description effective January 1, 2011 is amended as follows:

Summary of Health Benefits
Effective January 1, 2013, the Section titled "Summary of Health Benefits for 1/2012" will be modified by changing the title to "Summary of Health Benefits for 1/2013" and changing the "Annual Maximum (per covered person)" from "$1,250,000" to "$2,000,000."

Effective January 1, 2012, the Summary will be modified by deleting the current, "Emergency Room Visit" row and replacing it as follows:

	BluePreferred Provider	**Non-Preferred Provider**
Emergency Room Visit	A $20 Copayment** applies; any balance of covered charges are subject to the deductible and 20% Coinsurance*.	

Attachment A: Other Plan Provisions
Effective August 21, 2012, Attachment A, Article III shall be amended at Section 3.03 by deleting the current Section 3.03(a) and inserting in its place the following Section 3.03(a):

a. Designation of Beneficiaries. A Bargaining Employee or Non-Bargaining Employee may designate a beneficiary or beneficiaries to receive the Life or Accidental Death Benefit payable under this Article III by forwarding such designation on a form acceptable to the Trustees to the Fund Office. A Bargaining Employee or Non-Bargaining Employee shall have the right to change his designation of beneficiary without consent of the beneficiary, but no such change shall be effective or binding on the Fund unless it is received by the Fund Office prior to the death of the Bargaining Employee or Non-Bargaining Employee.

Notwithstanding the foregoing, in the event a Bargaining Employee or Non-Bargaining Employee has designated his spouse as his beneficiary, the beneficiary designation shall automatically become null and void upon divorce. If the Bargaining Employee or Non-Bargaining Employee gets divorced and would like his ex-spouse to remain his designated beneficiary, the Bargaining Employee or Non-Bargaining Employee must file a new written beneficiary designation with the Fund Office after his divorce. In the event a Bargaining Employee or Non-Bargaining Employee has designated his spouse and another individual as his designated beneficiaries, only the portion of the beneficiary designation that relates to his spouse will automatically become null and void upon divorce.

If a Bargaining Employee or Non-Bargaining Employee designates more than one beneficiary without specifying their respective interests, the Life or Accidental Death Benefit will be paid in equal shares.

Effective August 21, 2012, Attachment A, Article III shall be amended at Section 3.03 by deleting the current Section 3.03(b) and inserting in its place the following Section 3.03(b):

b. Lack of Designated Beneficiary. If no beneficiary has been designated or if a designated beneficiary dies before the Life Benefit or Accidental Death Benefit is paid, the Life Benefit or Accidental Death Benefit shall be paid to the lawful spouse of the Bargaining Employee or Non-Bargaining Employee if then living, or if there is no lawful spouse alive at the time of payment, payment shall be paid to the child or children of the Bargaining Employee or Non-Bargaining Employee in equal shares. If there is no lawful child or children alive at the time of payment, payment shall be made to the Bargaining or Non-Bargaining Employee's parent or parents in equal shares. If there is no parent or parents alive at the time of payment, payment shall be made to the Bargaining Employee or Non-Bargaining Employee's sibling or siblings in equal shares. If there is no sibling or siblings alive at the time of payment, payment shall be made to the executor or administrator of the Bargaining or Non-Bargaining Employees estate. If there is no estate for the Bargaining Employee or Non-Bargaining Employee, payment shall be made in any manner chosen by the Trustees, subject to all applicable law. Under no circumstances will any moneys escheat to the states of Nebraska, Iowa, or any other state.

If a Bargaining Employee or Non-Bargaining Employee designates his spouse as his sole beneficiary, and the beneficiary designation becomes null and void in accordance with Section 3.03(a), the Bargaining Employee or Non-Bargaining Employee shall be treated as though he died without designation a beneficiary unless he files a new beneficiary designation with the Fund Office before his death.

Attachment B: Health Reimbursement Arrangement (HRA)

Effective January 1, 2013, Attachment B, shall be Amended under the Section, "Retiree Health Reimbursement Arrangement ("Retiree HRA")", by deleting the subsection, "Eligibility" and inserting in it's place the following subsection, "Eligibility":

ELIGIBILITY. Each former Bargaining Employee and former Non-Bargaining Employee that has contributions allocated to their Retiree HRA account on or after January 1, 2012 is eligible to participate in the Retiree HRA (i.e. is an Eligible Retiree). Effective January 1, 2013, a former Bargaining Employee or Non-Bargaining Employee will have contributions allocated to his Retiree HRA account in January of each year that he satisfies the following criteria:

- he was retired as of May 31 of the prior year and did not actively seek covered employment in the electrical industry through the following January 1. For purposes of this requirement, a participant is considered retired if he has ceased receiving coverage from the Plan as a Bargaining Employee or a Non-Bargaining Employee and he is not actively seeking covered employment in the electrical industry;
- he maintained coverage under the Plan as a Bargaining Employee or a Non-Bargaining Employee during at least 20 different calendar years preceding retirement. For

purposes of this requirement, a former Bargaining Employee or Non-Bargaining Employee will be credited with one year of service for each calendar year for which they were covered for at least one month as a Bargaining Employee or a Non-Bargaining Employee under the Plan;

- he is not currently receiving a pre-retirement benefit from the IBEW Local 22 Pension Plan A;
- he is at least age 62 and alive as of May 31 of the prior year; his benefits are not currently suspended from the IBEW Local 22 Pension Plan A;
- he did not perform covered employment in the industry for an employer having no obligation to contribute to the Plan during the ten years immediately preceding retirement or at any time after retirement; and
- he maintained coverage under the IBEW Local 22/NECA Health and Welfare Plan for at least 1 month during the 10 years immediately preceding the date of his retirement.

Effective January 1, 2013, Attachment B, shall be Amended under the Section, "Retiree Health Reimbursement Arrangement ("Retiree HRA")", subsection, "Individual Accounts" by deleting the subsection (a) and inserting in its place the following subsection (a):

(a) Crediting of Accounts. The Retiree HRA account will be credited each January based upon the Plan's accumulated Retiree HRA contributions received during the preceding Retiree HRA funding year. The Retiree HRA funding year will begin June 1st of each year and will end May 31st of the following year. This means that the January, 2013 Retiree HRA allocation is based on Retiree HRA contributions remitted on work hours from June 1, 2011 to May 31, 2012. Each year's Retiree HRA contributions will be allocated to Eligible Retirees based upon the following Retiree HRA Allocation formula:

Base Retiree HRA Benefit with 20 Years of Service	Additional Benefit Per Year of Service (21 to 30)	Maximum Annual Retiree HRA Benefit
$ "*X*"	1/10 "*X*"	2 times "*X*"

"*X*" is determined on a prorated basis once the preceding Retiree HRA funding year is completed.

EXAMPLE: January 1, 2013 Retiree HRA Allocation:

During the funding year ending May 31, 2012, Retiree HRA contributions totaled $152,295. Based upon the credited Retiree HRA years of service among that year's Eligible Retiree's who were entitled to an allocation for that year, "*X*" was determined to be $364.00.

Base Retiree HRA Benefit with 20 Years of Service	Additional Benefit Per Year of Service (21 to 30)	Maximum Annual Retiree HRA Benefit
$364.00	$36.40	$728.00

IN WITNESS WHEREOF, we have affixed our signatures and approved this amendment this 27th day of November, 2012.

APPROVED:

John T. McMahon, Chairman

Gary B. Kelly, Secretary

Allan Hale, Trustee

Steve Mayfield, Trustee

Scott Love, Trustee

Michael Stopak, Trustee

IBEW Local 22/NECA Health and Welfare Plan
Amendment No. 2

Pursuant to Article VII, Section 4 of the Restated Agreement and Declaration of Trust of the International Brotherhood of Electrical Workers, Local Union No. 22/NECA Health & Welfare Trust Fund, the Board of Trustees has authority to amend the terms of the Plan from time to time as may be necessary or desirable in the discretion of said Board. In accordance with this authority, and pursuant to the procedures for amendment or modification of the Plan, the Board of Trustees hereby declare:

The Summary Plan Description effective January 1, 2011 is amended effective January 1, 2012 as follows:

Attachment B: Health Reimbursement Arrangement (HRA)
The current Attachment B will be deleted and replaced with the new Attachment B as follows:

Attachment B: Health Reimbursement Arrangement (HRA)

The Plan provides two types of Health Reimbursement Arrangements ("HRAs"), an Active Employee Health Reimbursement Arrangement ("Active HRA"), and a Retiree Health Reimbursement Arrangement ("Retiree HRA").

ACTIVE EMPLOYEE HEALTH REIMBURSEMENT ARRANGEMENT ("ACTIVE HRA"):
Effective June 1, 2008, an Active Employee Health Reimbursement Arrangement ("Active HRA") has been established by the Plan for eligible Bargaining Employees and Non-Bargaining Employees.

ELIGIBILITY. Each Bargaining Employee and Non-Bargaining Employee that has contributions made on their behalf to the Active HRA effective on or after June 1, 2008, is eligible to participate in the Active HRA. Participation in the Active HRA begins on the first day of the month after contributions are first remitted to the Active HRA on your behalf.

TERMINATION OF PARTICIPATION. Termination of participation in the Active HRA occurs when a participant's Active HRA is forfeited. A participant's Active HRA shall be forfeited for the following reasons:

(a) Plan termination.

(b) One-year break-in-Service: Your Active HRA will be forfeited on the later of:

1. the first day of the month following the twelfth consecutive month that you are not covered under the Health and Welfare Plan; or
2. the first day of the month following the twelfth consecutive month that you are not credited with any Employer contributions to the HRA.

(c) Disqualifying employment: If you are employed in the industry by an employer having no obligation to contribute to the Plan, your Active HRA will be forfeited on the first day of the month following the month that the work for the non-contributing employer was first performed. No reimbursements will be made for claims incurred on or after the date of the forfeiture.

INDIVIDUAL ACCOUNTS. The Plan Administrator will establish and maintain separate Active HRA accounts for each eligible Bargaining Employee and Non-Bargaining Employee. This account will be used to receive your contributions and to pay your benefits. Although each participant's account will be separately identified, the combined assets of each account will be held by the Fund in reserves and identified in the Plan's financial statements as the Active HRA reserves. The Active HRA account established for you will merely be a record keeping account with the purpose of keeping track of contributions and available reimbursement amounts from the Plan. The Individual Active HRA Accounts shall not be credited with any interest income earned on the Active HRA reserves. The

Active HRA Accounts will not be charged with any expenses for administration of the HRA. The Active HRA Accounts do not constitute a vested benefit.

(a) Crediting of Accounts. Your Active HRA account will be credited at the end of each month following the month hours were worked for which contributions are being made to your account. In other words, contributions made for hours worked in March will be credited to your account on April 30th. Only amounts actually received by the Plan will be credited to your account.
(b) Debiting of Accounts. Your Active HRA account will be debited during each Period of Coverage for all eligible reimbursements. A "Period of Coverage" is the calendar year.
(c) Available Amount. The amount available for reimbursement to either the Bargaining Employee, Non-Bargaining Employee, or Eligible Dependent for Allowable Medical Care Expenses is that amount credited to your Active HRA.

CARRYOVER OF ACCOUNTS. If any balance remains in your Active HRA Account after all reimbursements are paid for the Period of Coverage, the balance will be carried over to reimburse the participant for medical care expenses incurred during a subsequent Period of Coverage. In addition, any HRA benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the medical care expense was incurred shall be forfeited.

Should the Bargaining Employee or Non-Bargaining Employee die, the account will be made available to pay benefits to the Eligible Dependents of the Bargaining Employee or Non-Bargaining Employee .

If the Bargaining Employee or Non-Bargaining Employee is deceased and there are no surviving Eligible Dependents, any remaining balance in the account shall be forfeited and reallocated to the then existing Active HRA accounts equally.

If a Bargaining Employee or Non-Bargaining Employee loses coverage from the Plan, the actual amount in their account will be available for benefit payment, subject to the forfeiture rules in the Section entitled, "TERMINATION OF PARTICIPATION" above.

BENEFITS. The monies deposited into the Active HRA account will be available to be used by the Bargaining Employee or Non-Bargaining Employee for the payment of Allowable Medical Care Expenses incurred by the Bargaining Employee or Non-Bargaining Employee, the Bargaining Employee or Non-Bargaining Employee's spouse as defined in Internal Revenue Code § 213(d)(8), and/or the Bargaining Employee or Non-Bargaining Employee's eligible, non-spouse Dependents. Benefits will not be provided in the form of cash or any other taxable or non-taxable benefit other than reimbursement of Allowable Medical Care Expenses.

ALLOWABLE MEDICAL CARE EXPENSES AND EXCLUSIONS. See pages 84-88.

RETIREE HEALTH REIMBURSEMENT ARRANGEMENT ("RETIREE HRA"):
Effective January 1, 2012, a Retiree Health Reimbursement Arrangement ("Retiree HRA") has been established by the Plan for Eligible Retiree's. For purposes of this Attachment B, an "Eligible Retiree" is a former Bargaining Employee or Non-Bargaining Employee who has met the requirements below to obtain eligibility from the Retiree HRA.

ELIGIBILITY. Each former Bargaining Employee and former Non-Bargaining Employee that has contributions allocated to their Retiree HRA account on or after January 1, 2012 is eligible to participate in the Retiree HRA (i.e. is an Eligible Retiree). Effective January 1, 2012, A former Bargaining Employee or Non-Bargaining Employee will have contributions allocated to his Retiree HRA account in January of each year that he satisfies the following criteria:

- he was retired as of May 31 of the prior year and did not actively seek covered employment in the electrical industry through the following January 1. For purposes of this requirement, a participant is considered retired if he has ceased receiving coverage from the Plan as a Bargaining Employee or a Non-Bargaining Employee and he is not actively seeking covered employment in the electrical industry;
- he maintained coverage under the Plan as a Bargaining Employee or a Non-Bargaining Employee during at least 20 different calendar years preceding retirement. For purposes of this requirement, a former Bargaining Employee or Non-Bargaining Employee will be credited with one year of service for each calendar year for which they were covered for at least one month as a Bargaining Employee or a Non-Bargaining Employee under the Plan;
- he is not currently receiving a pre-retirement benefit from the IBEW Local 22 Pension Plan A;.
- he is at least age 62 and alive as of May 31 of the prior year; his benefits are not currently suspended from the IBEW Local 22 Pension Plan A; and
- he did not perform covered employment in the electrical industry for an employer having no obligation to contribute to the Plan during the ten years immediately preceding retirement or at any time after retirement.

TERMINATION OF PARTICIPATION. Termination of participation in the Retiree HRA occurs when a participant's Retiree HRA is forfeited. A participant's Retiree HRA shall be forfeited for the following reasons:

(a) Plan termination.

(b) Disqualifying employment: If you are employed in covered employment in the electrical industry by an employer having no obligation to contribute to the Plan, your Retiree HRA will be forfeited on the first day of the month that the work for the non-contributing employer was first performed. No reimbursements will be made for claims incurred on or after the date of the forfeiture.

INDIVIDUAL ACCOUNTS. The Plan's Administrator will establish and maintain separate Retiree HRA accounts for each Eligible Retiree. This account will be used to receive your contributions and to pay your benefits. Although each Eligible Retiree's account will be separately identified, the combined assets of each account will be held by the Fund in reserves and identified in the Plan's financial statements as the Retiree HRA reserves. The Retiree HRA account established for you will merely be a record keeping account with the purpose of keeping track of contributions and available reimbursement amounts from the Plan. The Individual Retiree HRA Accounts shall not be credited

with any interest income earned on the Retiree HRA reserves. The Retiree HRA Accounts will not be charged with any expenses for administration of the Retiree HRA. The Retiree HRA Accounts do not constitute a vested benefit.

(a) Crediting of Accounts. The Retiree HRA account will be credited each January based upon the Plan's accumulated Retiree HRA contributions received during the preceding Retiree HRA funding year.. The Retiree HRA funding year will begin June 1st of each year and will end May 31st of the following year. This means that the January, 2012 Retiree HRA allocation is based on Retiree HRA contributions remitted on work hours from June 1, 2010 to May 31, 2011. Each year's Retiree HRA contributions will be allocated to Eligible Retirees based upon the following Retiree HRA Allocation formula:

	Base Retiree HRA Benefit with 20 Years of Service	Additional Benefit Per Year of Service (21 to 30)	Maximum Annual Retiree HRA Benefit
Age 62 – 64	$ *"X"*	1/10 *"X"*	2 times *"X"*
Age 65+	50% of Pre-65 Benefit	50% of Pre-65 Benefit	$ *"X"*

"X" is determined on a prorated basis once the preceding Retiree HRA funding year is completed.

EXAMPLE: January 1, 2012 Retiree HRA Allocation:

During the funding year ending May 31, 2011, Retiree HRA contributions totaled $153,410. Based upon the credited Retiree HRA years of service among that year's Eligible Retiree's who were entitled to an allocation for that year, *"X"* was determined to be $616.00.

	Base Retiree HRA Benefit with 20 Years of Service	Additional Benefit Per Year of Service (21 to 30)	Maximum Annual Retiree HRA Benefit
Age 62 – 64	$616.00	$61.60	$1,232.00
Age 65+	$308.00	$30.80	$616.00

(b) Debiting of Accounts. Your Retiree HRA account will be debited during each Period of Coverage for all eligible reimbursements. A "Period of Coverage" is the calendar year.

(c) Available Amount. The amount available for reimbursement to either the Eligible Retiree or Eligible Dependent for Allowable Medical Care Expenses is that amount credited to your Retiree HRA under Subsection (a), reduced by prior reimbursements debited under Subsection (b).

CARRYOVER OF ACCOUNTS. If any balance remains in your Retiree HRA Account after all reimbursements are paid for the Period of Coverage, the balance will be carried over to reimburse the Eligible Retiree for medical care expenses incurred during a subsequent Period of Coverage. In addition, any Retiree HRA benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the medical care expense was incurred shall be forfeited.

Should the Eligible Retiree die, the account will be made available to pay benefits to the spouse as defined in Internal Revenue Code § 213(d)(8) of the Eligible Retiree and any Eligible Dependents of

the Eligible Retiree for twelve months following the Eligible Retiree's death. If the Eligible Retiree is deceased and there is no surviving spouse or surviving Eligible Dependents, any remaining balance in the account shall be forfeited and will be allocated to the Eligible Employee's that are entitled to an allocation the following January.

BENEFITS. The monies allocated into the Retiree HRA account will be available to be used by the Eligible Retiree for the payment of Allowable Medical Care Expenses incurred by the Eligible Retiree, the Eligible Retiree's spouse as defined in Internal Revenue Code § 213(d)(8), and/or the Eligible Retiree's non-spouse Eligible Dependents. Benefits will not be provided in the form of cash or any other taxable or non-taxable benefit other than reimbursement of Allowable Medical Care Expenses.

ALLOWABLE MEDICAL CARE EXPENSES – *APPLICABLE TO BOTH ACTIVE AND RETIREE HRA*

You may receive reimbursement for Allowable Medical Care Expenses incurred during the time you have a balance in your HRA.

(a) Incurred. A medical expense is "incurred" at the time the medical care or service giving rise to the expenses is furnished and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Allowable Medical Expenses incurred before you become eligible to participate in the Active HRA are not eligible for reimbursement from the Active HRA. Allowable Medical Expenses incurred before you become eligible to participate in the Retiree HRA are not eligible for reimbursement from the Retiree HRA. An Allowable Medicare Care Expense incurred during one Period of Coverage may be paid during a later Period of Coverage, provided you have a balance in your HRA (i.e. your HRA has not been forfeited).

(b) Allowable Medical Care Expenses. Allowable Medical Care Expenses are all expenses incurred by the Bargaining Employee, Non-Bargaining Employee, or Eligible Retiree and his Eligible Dependents for medical care as that term is defined in Section 213 of the Internal Revenue Code incurred during a calendar year. This includes "medical care" and any other expense which the Internal Revenue Service has recognized as properly deductible under Section 213(d)(1) of the Internal Revenue Code. Self-payments for continued Plan coverage are also Allowable Medical Care Expenses. Eligible Expenses include reimbursement for medicines or drugs only if purchased with a prescription, including "Over-the-Counter Medicines" which do not ordinarily require a prescription. Prescription drugs and prescribed Over-the-Counter Medicines must be for the treatment of illness or injury as defined by the Internal Revenue Code not merely to advance your general good health. However, Allowable Medical Care Expenses and prescribed Over-the-Counter Medicines will only be considered for reimbursement if they are not covered by a health care plan of which you are a participant or, if they are partially covered by a health care plan, to the extent not covered. A partial list of examples of Allowable Medical Care Expenses and prescribed Over-the-Counter Medicines follows.

The following tables on pages 85 and 86 contain only partial lists since the Internal Revenue Service frequently changes the list of deductible medical expenses. You should refer to IRS Publication 502, available upon request from the Fund Office, for a current list of what medical expenses are includible and what expenses are excludible.

Medical Care Expenses Eligible for Reimbursement Under Your Health Reimbursement Arrangement – *Applicable to Both the Active and Retiree HRA*

- Abortions, legal
- Acupuncture
- Alcoholism (substance abuse) treatment
- Ambulance Expenses Nursing home (for medical reason only)
- Amounts exceeding payments made by insurance
- companies for eligible expenses
- Nursing services
- Artificial limbs
- Bandages
- Birth control pills
- Braille books and magazines
- Breast reconstruction surgery after mastectomy
- Car controls for the disabled
- Chiropractors
- Christian Science practitioner's fees
- Contact lenses and solutions
- Crutches
- Deductibles for Medical Insurance Only
- Dental fees
- Dentures
- Diagnostic fees for Medical Diagnoses Only
- Disabled dependent care expenses
- Drug addiction treatment expenses
- Eye glasses Including the examination fee
- Eye surgery
- Fertility enhancement
- Hearing devices
- Home improvements/modifications motivated by medical considerations
- Hospital Bills
- Insulin
- Insurance Copayments
- Laboratory fees
- Laser eye surgery
- Lead-base paint removal (for children with lead poisoning)
- Lifetime care/Advance payments founder's fee
- Long-term care: only qualified long-term care expenses as defined by the IRS and qualified long-term care insurance premiums
- Medical conferences
- Medicare and medical insurance premiums
- Midwife Obstetrical expenses
- Orthopedic shoes
- Oxygen Physicians fees
- Prescription drugs and medical supplies
- Private institution/home cost for mentally or physically handicapped
- Psychiatric care
- Psychoanalysis
- Psychologists' fees
- Radial Keratotomy
- Seeing-eye dog and its upkeep
- Self-payments to IBEW Local 22/NECA Health & Welfare Plan
- Smoking cessation program expenses and related prescription drugs (however excluding nonprescription drugs and products such as nicotine gum or patches)
- Special education costs
- Special home for mentally retarded
- Sterilization fees
- Surgical fees
- Telephone, special for the deaf
- Television audio display equipment for the deaf
- Therapy received as medical treatment
- Transplant/donor medical expenses
- Transportation, meals and lodging expenses, primarily
- in the rendering of medical care
- Tuition at a special school for the handicapped
- Vaccinations/Immunizations
- Vitamins by prescription (pre-natal)
- Weight-loss program, only if for treatment of a specific disease diagnosed by a Physician (such as obesity, hypertension or heart disease), fees for membership in a weight reduction group and attendance in periodic meetings is covered, as well as the cost of special food which exceeds the cost of a normal diet. Please refer to the specific exclusions listed in the next section.
- Wheelchair
- Wigs (for hair loss due to disease)
- X-rays

Medical Care Expenses Eligible for Reimbursement Under Your Health Reimbursement Arrangement (Cont'd)

Over-the-Counter Medicines

Over-the-Counter Medicines must be used for treatment of an illness. This list is not comprehensive. Over-the-Counter Medicines are eligible for reimbursement only if purchased with a prescription. To receive reimbursement for prescribed Over-the-Counter Medicines purchased on and after January 1, 2011, you must provide the Fund Office with one of the following items when you submit your claims:

- A receipt from a pharmacy which identifies the name of the purchase (or the name of the person for whom the prescription applies), the date and amount of the purchase, and an Rx number; or
- A receipt from a pharmacy without an Rx number accompanied by a copy of the related prescription.

TYPE OF EXPENSE	EXAMPLES
Acne medicine:	Clean & Clear, Clearasil, LomaLux, Neutrogena, Noxzema, Oxy, Phisoderm, Stridex
Allergies:	Actifed, Advil, Afrin, Alavert, Allerest, Benadryl, ChlorTrimeton, Claritin, Dimetapp, Diphedryl, Motrin, Nasal Crom, Sudafed, Tavist, Tylenol, Vicks
Asthma:	Bronkaid
Cold Sores:	Abreva, Notriva
Colds:	Actifed, Advil, Aleve, Alka-Seltzer Plus, Cepecol, Chloraseptic, Ciricidin, Cold-Eze, Comtrex, Contac, Dimetapp, Drixoral, Halls, Lumens, Neosynephrine, Profen IS, Riccola, Robitussin, Sucrets, Sudafed, Theraflu, Triaminic, Tylenol, Vicks DayQuil, Vicks VapoRub, Zicam, Zinc Drops
Cuts and Itching:	Bactine, Balmex, Benadryl Anti-Itch Cream, Caladryl, CamphoPhenique, Cortaid, Dermarest, Desitin Diaper Rash Cream, Hydrocortizone, Hydrogen Peroxide, Iodine, Itch-X, Lanacaine, Neosporin, Polysporin, Psoriasin gel, Witch Hazel
Diabetes:	Insulin
Dietary Supplements:	Acidophilus, Coenzyme, Ensure, Q-10
Digestive Remedies:	Alka-Seltzer, Axid AR, Bonine, Carters, Castor Oil, Citrucel, Corectol, Dramamine, Dulcolax, Emetrol, Ex-lax, Fleet Enema, Gas-X, Gaviscon, Imodium, Kaopectate, Lactaid pills, Maalox, Metamucil, Mylanta, Pepcid, Pepto-Bismol, Phillips, Prilosec, Rolaids, Tagamet, Tums, Zantac
Eye & Ear Problems:	OcuHist, Swim-Ear, Visine
Foot Treatments:	Fungi Care, Lotrimin, Micantin
Herbal, Homeopathic or Naturopathic Remedies:	Bilberry, Cholestine, DHEA, Echinacea, Estroven, Fish Oil, Flax Seed Oil, Garlic, Ginseng, Ginkgo Biloba, Glucosamine and Chondroitin, Goldenseal, Grape Seed, Herbs, Joint Juice, Knox Nutra Joint, L-Argine, L-Carnitine, Lecithin, Lutein, Maca, Melatonin, Milk thistle, MSM, Ocuvite, Omega-3,6,9, Osteo Bi-flex, Papaya Enzyme, Sam-e, Shark Cartilage, St. Johns Wort, Vasorect, Venstat

Jock Itch:	Cruex, Lamisil AT, Lotrimin AF, Micantin, Tinactin
Lice:	LiceFree, Nix, Pronto, Rid
Minerals & Vitamins:	Antioxidants, Calcium, Chromium Piclinate, Folic Acid, Iron, Lysine, Magnesium, Menopause Supplements, Multi-Vitamins, Niacin, Potassium, Selenium, Senior Vitamins, Zinc
Pain Relief:	Advil, Aleve, Arth-Rx, Aspercreme, Aspirin, Azo, BenGay, Doan's, Epsom Salts, Excedrin, Flexall, Ibuprofen, IcyHot, Jointflex, Joint-Ritis, Mentholatum, Midol, Motrin, Pamprin, Premysin, PMS, Prodium, Stopain, Tylenol
Smoking Cessation:	Endit, Lite'n Up, NicoDerm CQ, Nicorette, Nicotrol, Smoke-Wasy, Venturi
Toothache:	Orajel, Red Cross, Zilactin
Warts:	Compound W, Dr. Scholls, Pedific, Wart-off
Weight Loss:	Cidermax, Dexatrim, PatentLean, Puralin
Yeast Infection:	Monistat, Mycelex 3, Vaginex, Vagistat3

(c) Medical Care Expense Exclusions. Except as specifically included by this document, expenses that do not meet the definition of "medical care" under Section 213(d)(1) are excluded from reimbursement. The following is a partial list of expenses which are excluded and not eligible for reimbursement:

1) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma or a disfiguring disease.
2) Long term care expenses, except for premiums from long term care policies.
3) Funeral and burial expenses.
4) Massage therapy.
5) Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition.
6) Marijuana and other controlled substances, the possession of which are in violation of federal laws.
7) Maternity clothes, diaper service or diapers, babysitting childcare.
8) Bottled water, cosmetics, toiletries and toothpaste.
9) Vitamins and dietary supplements, except if a statement of medical necessity from Physician or Alternative Healthcare Provider is provided.
10) Automobile insurance premiums and automobile improvements, depreciation of an automobile, general repair or maintenance expenses of an automobile, even if other

transportation expenses are includable when used for transportation to receive medical care; except for car controls for the disabled.

11) Home improvements (unless motivated by medical considerations), household or domestic help.
12) Death benefits, life insurance benefits including the portion of the Plan's COBRA premium that pays for life insurance.
13) Any item that does not constitute "medical care", as defined under Internal Revenue Code Section 213(d)(1).

Excluded Over-the-Counter Medicines
Cosmetics, Hair Growth Treatment, Hemorrhoid Treatment, Illegally Procured Medicines, Sleeping Aids, Sun Block, and Toiletries.

Expenses that Do <u>Not</u> Qualify for Reimbursement

- Unnecessary cosmetic surgery and health care expenses incurred for the primary purpose of enhancing the appearance.
- Marriage or family counseling.
- The salary expense of a nurse incurred in connection with the care of a normal healthy newborn in the home.
- Household and domestic help (even though recommended by a qualified physician due to the inability to perform housework).
- Costs for sending a child to a special school for anticipated benefits the child may receive from the course of study and the disciplinary methods used.
- Any expense incurred in connection with an illegal operation or treatment.
- Health club dues, YMCA dues, steam bath, spa, gym, etc. (even if recommended for weight loss that is treatment for a specific disease diagnosed by a Physician).
- Social activities, such as dance lessons or classes (even if recommended by a physician).
- Programs for the purposes of general health and well being (excluding some programs which are specifically included such as weight loss or smoking cessation programs, but subject to the specific requirements listed in the eligible expense table).
- Diet food or beverages that substitute for normally consumed food or beverages which satisfy nutritional needs (special food can be included medical expenses only if the food does not satisfy normal nutritional needs, alleviates or treats an illness, and the need for the food is substantiated by a Physician).
- Vitamins taken for general health purposes.
- Automobile insurance premiums including the segment of premiums providing medical care for persons injured through the accident.
- Premiums paid for life insurance policies or for policies providing repayment for loss of earnings or for accidental loss of life, limb, sight, etc.

- Vacations for travel taken for purposes of general health, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect.
- Transportation expenses to and from work, even though a physical condition may require special means of transportation.
- PPO discounts or negotiated rates if you are not liable for them.

(d) Claims and reimbursement procedures.

1) Timing. Within thirty days after receipt by the Plan's Administrator of a reimbursement claim from you, the Plan will reimburse you for your Allowable Medical Care Expenses provided the claim form is completed in its entirety and is accompanied by the required documentation and the claim has been approved for payment by the Plan Administrator.

2) Filing a Claim. You may apply for reimbursement by submitting an application in writing to the Plan Administrator on a form provided by the Fund Office. Reimbursement must be sought no later than March 31st following the close of the Plan Year in which the Allowable Medical Care Expense was incurred. The application for reimbursement must include the following information: the person or person on whose behalf the Allowable Medical Care Expenses have been incurred; the nature and date of the expenses incurred; the amount of the requested reimbursement; and a statement of such expenses that would have not otherwise been reimbursed and are not reimbursable through any other source. The application must be accompanied by bills, invoices, and other statements from an independent party showing that the Allowable Medical Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement are at least $50.

3) Claim payments may never exceed the amount remaining in the HRA Account.

4) A participant's Active HRA account must be exhausted before he can receive a reimbursement from his Retiree HRA account.

COORDINATION OF BENEFITS. Benefits under this Plan are intended to pay benefits solely for Allowable Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise Allowable Medical Care Expense is payable or reimbursable from another source, that source shall pay or reimburse prior to payment or reimbursement from this Plan.

RIGHTS UPON TERMINATION. The Board of Trustees reserves the right to terminate the Plan and provide for the distribution of the Fund's assets, including the HRA Accounts, to all participants and eligible beneficiaries. It is the intention of the Board to continue the Plan indefinitely. However, it is difficult to predict the future so the Board of Trustees reserves the right to modify or terminate the Plan at any time should it become necessary in the Board of Trustees' sole discretion.

NOT GUARANTEED BY PENSION BENEFIT GUARANTEE CORPORATION. The Pension Benefit Guarantee Corporation is an entity established under ERISA to ensure payment of certain pension benefits. The Active and Retiree HRAs are part of the IBEW Local 22/NECA Health & Welfare Plan, which is not one of the types of plans that the Pension Benefit Guarantee Corporation covers.

QUALIFIED MEDICAL CHILD SUPPORT ORDER. A Qualified Medical Child Support Order ("QMCSO") is a judgment, decree, or order issued by a court of competent jurisdiction requiring that the Fund recognize an eligible child as an Alternate Recipient, as defined by ERISA Section 609(a). Such order must be approved in accordance with procedures adopted by the Board of Trustees. Upon receipt of a Medical Child Support Order or other order designating medical child support, the Fund Office will promptly notify each Alternate Recipient of the receipt of such order and the Plan's procedure for determining whether the order is qualified. Upon review of the order, the participant and all Alternate Recipients will be promptly notified whether the order has been determined to be a QMCSO. The Plan will provide benefits under the Plan to any Alternate Recipients in accordance with the applicable provisions of any QMCSO. Any payment of benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an Alternate Recipient's Custodial Parent or Legal Guardian, shall be made to Alternate Recipient's Custodial Parent or Legal Guardian.

APPEAL PROCEDURE. If you or your beneficiary wants to appeal a decision by the Plan Administrator to deny, or partially deny, any claim for reimbursement, you must follow the procedure contained in Attachment A, Article VIII of this Summary Plan Description.

IN WITNESS WHEREOF, we have affixed our signatures and approved this amendment this 24th day of April, 2012.

APPROVED:

John T. McMahon, Chairman

Dennis F. Regan, Secretary

Allan Hale, Trustee

Gary B. Kelly, Trustee

Scott Love, Trustee

Michael Stopak, Trustee

IBEW Local 22/NECA Health and Welfare Plan
Amendment No. 1

Pursuant to Article VII, Section 4 of the Restated Agreement and Declaration of Trust of the International Brotherhood of Electrical Workers, Local Union No. 22/NECA Health & Welfare Trust Fund, the Board of Trustees has authority to amend the terms of the Plan from time to time as may be necessary or desirable in the discretion of said Board. In accordance with this authority, and pursuant to the procedures for amendment or modification of the Plan, the Board of Trustees hereby declare:

The Summary Plan Description effective January 1, 2011 is amended effective December 1, 2011 as follows:

Eligibility & Enrollment
The Section titled "Newborn Children" will be modified by deleting the first sentence and replacing it with the following:

Coverage shall begin at birth for your newborn child so long as the Dependent child's enrollment form was postmarked or otherwise positively received by the Fund Office within ninety (90) days of such birth.

The Section titled "Adopted Children" will be modified by deleting the first sentence and replacing it with the following:

If you are adopting a child, the effective date of the child's coverage will be the earlier of the date the child is placed with you for adoption, or the date a court order grants custody to you so long as the child's enrollment form was postmarked or otherwise positively received by the Fund Office within ninety (90) days of such date.

The Summary Plan Description effective January 1, 2011 is amended effective January 1, 2012 as follows:

Summary of Health Benefits
The Section titled "Summary of Health Benefits for 1/2011" will be modified by changing the title to "Summary of Health Benefits for 1/2012" and changing the "Annual Maximum (per covered person)" from "$1,000,000" to "$1,250,000."

The Summary will also be modified by removing the following limitations under Mental Illness, Alcoholism and/or Drug Abuse (MIDA) Treatment:

Under Inpatient Treatment, "Limited to 30 days per calendar year" will be deleted.

Under Outpatient Treatment, "Limited to 60 units per calendar year" will be deleted.

IBEW Local 22/NECA Health and Welfare Plan
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Under Inpatient Treatment, "Limited to 30 days per calendar year" will be deleted.

Under Outpatient Treatment, "Limited to 60 units per calendar year" will be deleted.

The Summary will be modified by deleting the current Routine (Preventive) Exam row and replacing it as follows:

	BluePreferred Provider	Non-Preferred Provider
Preventive Services Listed in Attachment D • **See Attachment D for details and frequency limitations.**	0% Coinsurance Calendar Year Deductible does not apply.	Covered charges are subject to the Deductible and 30% Coinsurance.

Understanding Your Health Coverage
The Section titled, "Understanding your Health Coverage" will be modified at the subsection, "Payments Made in Error" by adding the following new paragraph:

> Payments made in error or overpayments may also be recovered as described in Attachment A, Article IX, Section 9.03.

Physician's Services
The Section, titled "Physician's Services" will be modified at the subsection, "Preventive (Routine) Care." Be deleting the subsection and replacing it in its entirety as follows:

> **Preventive (Routine) Care.** Benefits are available for covered preventive (routine care) services.
>
> Covered services include those listed in Attachment D as well as:
> - Routine laboratory testing,
> - Routine radiology, and
> - Routine cardiac stress tests.

Mental Illness, Substance Dependence or Abuse Benefits
The Section titled "Mental Illness, Substance Dependence or Abuse Benefits" will be modified as follows:

> Under Inpatient Care: The first sentence will be deleted and replaced with "Benefits are available for acute inpatient treatment of mental illness, drug abuse or alcoholism."
>
> Under Outpatient Care: The first paragraph will be deleted and replaced with "Benefits are also available, subject to the copayment amount indicated on your Schedule of Benefits and the chart in the front of the book for outpatient treatment of mental illness, drug abuse or alcoholism.

Other Covered Services
The Section, titled "Other Covered Services" will be modified at the subsection, "Routine immunizations" by deleting the subsection.

Noncovered Services And Supplies
The Section titled "Noncovered Services And Supplies" will be modified as follows:

The thirteenth bullet point will be deleted and replaced with "Dietary counseling, except covered diabetic nutrition management or as specifically provided for in Attachment D."

The fourteenth bullet point will be deleted and replaced with "Treatment and monitoring for obesity or for weight reduction, regardless of diagnosis, including but not limited to surgical operations, unless such treatment or monitoring is specifically covered under Attachment D."

The thirty-fourth bullet point will be modified by deleting the last paragraph and replacing it with "Except as specifically provided for in Attachment C or Attachment D, programs of co-dependency, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction are not covered services. Benefits are not available for residential services for mental illness, or halfway house or methadone maintenance programs for substance abuse, nor will they be provided for programs ordered by the Court which are not medically necessary as determined by Blue Cross and Blue Shield of Nebraska."

Attachment A – Other Plan Provisions

Attachment A – "Other Plan Provisions" will be clarified at Article I, Section 1.06 by deleting Section 1.06 and replacing it in its entirety as follows:

1.06. **Dependent**. The term "Dependent" means

a. The Eligible Employee's lawful spouse; or

b. a child of an Eligible Employee who meets the following criteria:

1. He is the child of the Eligible Employee as defined in Section 152(f)(1) of the Internal Revenue Code. This means the child must be the Eligible Employee's natural child, stepchild, a legally adopted child, a child placed for adoption, a child placed under a documented custodial order (including a legal guardianship) or an eligible foster child. A "foster child" means in individual who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. In order for a foster child to be eligible, no parent can claim the child as a "qualifying child" under the tax code and the non-parent Eligible Employee must have a higher adjusted gross income (AGI) than any parent; and

2. He is under age 26, and does not have employer health coverage available through his employer (or spouse's employer, if married), an unmarried full-time student under age 24, even if he has employer health coverage available through his employer, or any age if permanently and totally disabled (provided the disability began before the child would have lost coverage under this Plan if not for this provision).

Upon enrollment of a Dependent child, the Eligible Employee must certify to the Fund Office that the child being enrolled qualifies as the Eligible Employee's Dependent as described above. It shall be the responsibility of each Eligible Employee to notify the Fund Office promptly if a covered dependent child or spouse no longer qualifies as a Dependent under the terms of this Plan. Failure to do so may cause an overpayment of benefits that the Plan may recover in accordance with Article IX, Section 9.03.

c. Notwithstanding 1.06.b., above, if the child is an Alternate Recipient under a Qualified Medical Child Support Order (QMCSO), the Plan will comply with the terms of the QMCSO in accordance with the provisions described on page 4 of this Summary Plan Description and the Plan's QMCSO administrative procedures. In some cases, contributions to this Plan for a child who is an Alternate Recipient under a QMCSO may be taxable to the Eligible Employee. The Fund Office may require additional information from the Eligible Employee to determine tax reporting requirements in such a case.

Proof of dependency status may be requested from time to time by the Board of Trustees.

The fact that a child may be covered as a Dependent under this Plan is not a guarantee that the benefits received by or on behalf of the child are exempt from taxation. You should consult your personal tax or financial advisor for guidance on your own situation.

Except as provided on page 4 of the Summary Plan Description, eligibility for such Dependent children is effective for coverage of claims incurred on or after the date the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office.

No preexisting condition exclusion applies to Dependents under age 19.

Attachment A – "Other Plan Provisions" will be clarified by adding the following new Article IX:

Article IX. Factors that May Affect Benefit Payments

The following rules apply to all claims for benefits:

9.01 Failure to Notify the Fund Office Regarding Change in Marital Status
Failure to notify the Fund Office of divorce, dissolution of marriage, legal separation, or separate maintenance will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If an Eligible Employee does not notify the Plan Administrator of his divorce, dissolution of marriage, legal separation, or separate maintenance, the Plan may recover any payments made for claims incurred by the former spouse after such event (i.e. after the spouse was no longer eligible for coverage from the Plan as a Dependent) in accordance with Attachment A, Article IX, Section 9.03.

9.02 Failure to notify the Fund Office that a child is no longer an eligible Dependent.
Failure to notify the Fund Office that a child no longer meets the Plan's definition of Dependent will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. This means that the failure to notify the Fund Office that a child has other coverage available through his employer or spouse's employer if married, is no longer a full-time student, gets married, or is no longer disabled, as applicable, will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If an Eligible Employee does not notify the Plan Administrator that a child has other coverage available through his employer or spouse's employer if married, is no longer a full-time student, gets married, or is no longer disabled, as applicable, the Plan may recover any payments made for claims incurred by the child after the date of such event (i.e. after the child was no longer eligible

for coverage from the Plan as a Dependent child) in accordance with Attachment A, Article IX, Section 9.03.

9.03. Recovery of Overpayments Made by the Plan.
No person is entitled to any benefit under the Plan except as expressly provided under the Plan. The fact that payments have been made from the Plan in connection with any claim for benefits under the Plan does not establish the validity of the claim, or provide the right to have such benefits continue for any period of time, or prevent the Plan from recovering the benefits paid to the extent the Trustees ultimately determine that in fact, there was no right to payment of the benefits under the Plan.

The Plan reserves the right to recover, by all legal and equitable means, any amounts paid that the recipient was not rightfully entitled to under the terms of the Plan (i.e. overpayments). This right to recovery shall include, but not be limited to, the right to recoup such amounts from future benefits to be paid to or on behalf of the Eligible Employee and his Dependents and the right to recoup such amounts from any benefits to be paid to or on behalf of any survivors of the Eligible Employee or Dependent. This right to recovery shall further include the right to collect additional costs incurred by the Plan to recover the overpayment (for example, attorney's fees). For purposes of this Attachment A, Article IX, Section 9.03, the term "overpayment" shall include payments made on behalf of an individual who was not eligible for coverage from the Plan (for example, if a Dependent child had other coverage available through his employer and the Eligible Employee did not notify the Fund Office of the other coverage, payments made for claims on behalf of the child are considered overpayments).

The Plan's right to recovery shall include, but not be limited to, the following:

a. In the event of an overpayment of benefits to or on behalf of an Eligible Employee (including an individual who ceased to meet the Plan's definition of Eligible Employee), the Plan may recover the overpayment by:

1. A direct recovery from the Eligible Employee;
2. A direct recovery from the medical provider who received the overpayment;
3. Reducing future benefits to or on behalf of the Eligible Employee; or
4. Reducing future benefits to or on behalf of the Eligible Employee's Dependents.

b. In the event of an overpayment of benefits to or on behalf of a Dependent (including an individual who ceased to meet the Plan's definition of Dependent), the Plan may recover the overpayment by:

1. A direct recovery from the Dependent;
2. A direct recovery from the Eligible Employee whose participation in the Plan was the basis for the Dependent's eligibility in the Plan;
3. A direct recovery from the medical provider who received the overpayment;
4. Reducing future benefits to or on behalf of the Dependent;
5. Reducing future benefits to or on behalf of the Eligible Employee whose participation in the Plan was the basis for the Dependent's eligibility in the Plan; or
6. Reducing future benefits to any additional Dependent of the Eligible Employee whose participation in the Plan was the basis for the Dependent's eligibility in the Plan.

Attachment D: Preventative Care Benefits

Covered Preventive Service, As Recommended By U.S. Preventive Services Task Force	Frequency Limit
Abdominal Aortic Aneurysm, Screening	One per lifetime
Alcohol Misuse Screening and Behavioral Counseling Intervention	One per calendar year
Aspirin for the Prevention of Cardiovascular Disease	Subject to plan's retail day supply limit
Asymptomatic Bacteriuria in Adults, Screening	
Breast Cancer, Screening (mammogram)	One per calendar year
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and discussion of BRCA Mutation Testing (based on family risk factors)	
Breastfeeding, Primary Care Interventions to Promote Breastfeeding	
Cervical Cancer, Screening (Pap smear)	One per calendar year
Chlamydial Infection, Screening	
Colorectal Cancer, Screening (Screenings include: colonoscopy, sigmoidoscopy, proctosigmoidoscopy, barium enema, fecal occult blood testing, laboratory tests, and related services)	One every 5 calendar years One per calendar year for fecal occult blood test
Congenital Hypothyroidism Screening (newborn)	
Dental Caries in Preschool Children, Prevention (prescribe oral fluoride if deficient in water)	Subject to plan's retail day supply limit
Depression (Adults) Screening	
Diet, Behavioral Counseling in Primary Care to Promote Healthy Diet (adults with hyperlipidemia and other risk factors)	Up to 9 visits per calendar year
Evaluation and Management Services (E/M) (periodic preventive examination/office visits)	Newborn up to age 6 unlimited; annually thereafter
Gonorrhea, Screening	
Gonorrhea, Prophylactic Eye Medication (newborns)	
Hearing Loss in Newborns, Screening	
Hepatitis B Virus Infection, Screening	
High Blood Pressure, Screening	
HIV, Screening (at risk and all pregnant women)	
Iron Deficiency Anemia, Prevention (at risk 6 to 12 month old babies)	Lab tests are not limited. Drugs are subject to plan's retail day supply limit
Iron Deficiency Anemia, Screening	

Covered Preventive Service, As Recommended By U.S. Preventive Services Task Force	Frequency Limit
Lipid Disorders in Adults, Screening (cholesterol)	One every 5 calendar years
Major Depressive Disorders in Children and Adolescents, Screening	
Obesity in Adults, Screening	
Obesity in Children, Screening	
Osteoporosis in Women, Screening (bone density testing)	One every 2 calendar years
Phenylketonuria (PKU), Screening (newborn)	One per lifetime
Rh (D) Incompatibility, Screening	
Sexually Transmitted Infections, Counseling	
Sickle Cell Disease, Screening (newborns)	
Syphillis Infection, Screening	
Tobacco Use and Tobacco-Caused Disease, Counseling (including tobacco/nicotine cessation drugs and deterrents)	Medical: Up to 8 counseling sessions per calendar year. Drugs and deterrents are subject to plan's retail day supply limit
Type 2 Diabetes Mellitus in Adults, Screening	
Visual Impairment in Children Younger than 5 Years, Screening	One per calendar year
Daily Supplement of Folic Acid	Subject to plan's retail day supply limit
Discuss Chemoprevention when at High Risk for Breast Cancer	
Immunizations	

IN WITNESS WHEREOF, we have affixed our signatures and approved this amendment this 24th day of April, 2012.

APPROVED:

John T. McMahon, Chairman

Dennis F. Regan, Secretary

Allan Hale, Trustee

Gary B. Kelly, Trustee

Scott Love, Trustee

Michael Stopak, Trustee

IBEW LOCAL 22/NECA HEALTH AND WELFARE PLAN

Summary of Material Modifications

The purpose of this Summary of Material Modifications ("SMM") is to provide you a summary of the changes and clarifications that were made to the IBEW Local 22/NECA Health and Welfare Plan ("Plan") since January 1, 2014. We suggest that you keep this SMM with your Summary Plan Description ("SPD"). This SMM is also available at the website www.22benefits.com.

CLARIFIED LANGUAGE

The Plan's medical benefits were clarified as follows:

- The language on page 23 of the SPD regarding home health aide services was clarified to explain that these services are limited to 60 days per calendar year.
- The language on page 24 of the SPD regarding skilled nursing services was clarified to explain that these services are limited to 60 days per calendar year.
- The language on page 24 of the SPD regarding hospice services was clarified to explain that the 30 day limit for Inpatient Hospice Care is replaced with a limit of 180 days for Inpatient and Outpatient Hospice Care combined.
- The language on page 25 of the SPD regarding cochlear implants is clarified to explain that cochlear implants provided by an out-of-network provider are covered at the in-network level.
- The language on page 10 of the SPD regarding respiratory care was clarified to explain that these services are limited to 60 days per calendar year.
- The language on pages 10 and 11 of the SPD regarding therapy services was clarified to explain that chiropractic or osteopathic physiotherapy or manipulative treatments or adjustments are limited to 30 sessions per calendar year. Further, the Plan has a combined limit of 60 sessions per calendar year for physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy or manipulative treatments or adjustments.
- The language on the Summary of Health Benefits regarding Mental Illness, Alcoholism and/or Drug Abuse (MIDA) outpatient treatment is clarified to explain that a $20 Copayment, the deductible and coinsurance (20% for a Preferred Provider and 30% for a non-Preferred provider) apply to outpatient therapy treatment.

CHANGES TO THE OUT-OF-POCKET LIMITS

Effective January 1, 2015, the Summary of Health Benefits was amended by deleting the Coinsurance Limit and Annual Out-of-Pocket Limit rows and replacing it with the following:

	Blue Preferred Provider	**Non-Preferred Provider**
Annual Coinsurance Out-of-Pocket Limit:		
Individual:	$2,500	$5,000
Family Maximum:	$5,000	$10,000

Annual Medical Copayment Out-of-Pocket Limit: Individual: Family Maximum:	 $450 $550	 $900 $1,800
Annual Total Medical Out-of-Pocket Limit: *Includes Deductible, Coinsurance and medical Copayments, combined* Individual: Family Maximum:	 $3,300 $6,600	 $6,250 $12,850
Annual Prescription Copayment Out-of-Pocket Limit: Individual: Family Maximum:	 $3,300 $6,600	 No limit No limit

ROUTINE PREVENTIVE CARE MEDICAL BENEFITS

Since January 1, 2012, the Plan has provided 100% coverage (zero Participant cost share) for all Routine Preventive Services that a non-grandfathered health plan is required to provide under the Affordable Care Act (ACA) when provided by an in-network provider. Covered charges for services received from an out-of-network provider will be subject to the Plan's standard out-of-network deductible and coinsurance levels, except for childhood immunizations for children under 7 which are always covered 100%. The following list is updated as of January 1, 2015 but is subject to change. Please visit https://www.nebraskablue.com/member-services/healthy-living/preventive-care for a current list of covered benefits and services required under the ACA.

Please note, your provider may order tests during your preventive care visit that are not preventive care. These tests may be subject to deductibles, copays, and/or coinsurance. Your provider may also treat an existing condition (or you may have symptoms of an illness at the time of your visit). Treatment or tests for that existing condition, or services in excess of scheduled limits, may not be considered preventive care and may be subject to deductibles, copays, and/or coinsurance.

The following services are Routine Preventive Care Medical Benefits:

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
Abdominal aortic aneurysm screening (Men)	One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 and older who have ever smoked.
Alcohol misuse (screening and counseling)	Clinicians screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. Screenings limited to 1 per calendar year and counseling by a primary care physician is limited to 8 sessions per calendar year.

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
Autism screening, developmental/behavioral assessment	Up to age 3.
Anemia screening (pregnant women)	Routine screening for iron deficiency anemia in asymptomatic pregnant women.
Bacteriuria screening (pregnant women)	Screening for asymptomatic bacteriuria with urine culture in pregnant women.
Blood pressure screening	Screening for high blood pressure.
Blood screening (newborn)	Up to age 1.
BRCA risk assessment and genetic counseling/testing	Primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast cancer screening	Screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women.
Breastfeeding support, supplies, and counseling†	Interventions during pregnancy and after birth to promote and support breastfeeding. Limited to 1 breast pump per pregnancy.
Cervical cancer screening	Annual screening for cervical cancer in adult women. Limited to 1 per calendar year.
Chest x-ray	Preventive screening.
Chlamydial infection screening for men, women and children.	Screening for chlamydial infection in all sexually active men, women and children.
Cholesterol abnormalities screening	Screening for lipid disorders.
Colorectal cancer exams and laboratory tests consisting of a digital rectal exam and the following: • Fecal occult blood test; • Flexible sigmoidoscopy; • Colonoscopy; and • Double contrast barium enema	Limited to 1 every 5 years. Fecal occult blood test limited to 1 per calendar year.
Contraceptive methods and counseling†	All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.
Dental caries prevention (children)	Primary care clinicians prescribe oral fluoride supplementation at currently recommended doses up to age 6 whose primary water source is deficient in fluoride.

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
Depression screening (Adolescents)	Screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
Depression screening (Adults)	Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
Diabetes screening	Screening for type 2 diabetes in asymptomatic adults.
Electrocardiogram (EKG)	Preventive screening.
Falls prevention in older adults (physical therapy)	Physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
Gestational diabetes mellitus screening†	Screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
Glucose screening	
Gonorrhea prophylactic medication (newborns)	Prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
Gonorrhea screening	Clinicians screen all sexually active men, women, children, including those who are pregnant, for gonorrhea infection.
Healthy diet counseling	Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians. Limited to 9 visits per calendar year.
Hearing exams	Preventive.
Hearing loss screening (newborns)	Screening for hearing loss in all newborn infants up to age 1 month.
Hearing sensory screening	Up to age 21.
Hemoglobin/Complete Blood Count (CBC)	Screening.
Hemoglobinopathies screening (newborns)	Screening for sickle cell disease in newborns up to age 1.
Hepatitis B screening	Screening for hepatitis B virus.
Hepatitis C Virus (HVC) screening	Men and women, limited to 1 per lifetime.
HIV† counseling	Counseling and screening for HIV infection for all sexually active women.
HIV screening (nonpregnant adolescents and adults)	Clinicians screen for HIV infection in adolescents and adults who are at risk.

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
HIV screening (pregnant women)	Clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
HPV screening and counseling †	At risk and all pregnant women.
Hypothyroidism screening (newborns)	Screening for congenital hypothyroidism in newborns up to age 1.
Immunizations	Covered Immunizations are limited to the age ranges and gender recommended by the Advisory Committee on Immunization Practices and/or adopted by the Center for Disease Control: • Catch-up for Hepatitis B • Catch-up for varicella • Catch-up for measles, mumps, and rubella • Tetanus boosters as necessary, including tetanus, diphtheria and pertussis; diphtheria and tetanus; and tetanus only • Pneumococcal vaccine • Influenza virus vaccine • Meningococcal vaccine • Catch-up for Hepatitis A • HPV vaccine • Zoster vaccine • Polio vaccine • Haemophilus Influenza Type b (Hib) vaccine
Immunizations (Childhood)	• At least 5 doses of vaccine against diphtheria, pertussis, tetanus; • At least 4 doses of vaccine against polio, Haemophilus Influenza Type b (Hib); • At least 3 doses of vaccine against Hepatitis B; • 2 doses of vaccine against measles, mumps, and rubella; • 2 doses of vaccine against varicella; • At least 4 doses of vaccine against pediatric pneumococcal (PCV7); • 1 dose of vaccine against influenza; • At least one dose of vaccine against Hepatitis A; • 3 doses of vaccine against Rotavirus; and • Such other vaccines and dosages as may be prescribed by the State Department of Health

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
Interpersonal and domestic violence screening†	Clinicians screen women of for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
Iron deficiency anemia, Hemocrit, or Hemoglobin screening (at risk 6 to 12 months old)	Screening up to age 2 (pharmacy to age 1).
Lead Screening (Children)	Up to age 7.
Lung cancer screening	Annual screening for lung cancer with low-dose computed tomography in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Mammograms (if ordered by a Physician)	Includes those performed at the direction of a Physician in a mobile facility certified by CMS.
Metabolic screenings	Preventative.
Obesity screening and counseling (adults)	Screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.
Obesity screening and counseling (children)	Clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Oral health screening (children)	By primary care physician only.
Osteoporosis screening (women)	Screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
Pelvic exams and pap smears	Includes those performed at the direction of a Physician in a mobile facility certified by Centers for Medicare and Medicaid Services (CMS).
Phenylketonuria screening (newborns)	Screening for phenylketonuria in newborns up to age 1, limited to 2 per lifetime.
Physician examinations (Evaluation & Management Services)	Newborn to age 6, no limit. Age 6 and older limited to 2 per calendar year.
Prostate exams and prostate specific antigen (PSA) tests	Preventive screening.
Rh incompatibility screening	Rh (D) blood typing and antibody testing for all pregnant women. Repeated antibody testing as needed.

ADDITIONAL SERVICES	COVERAGE DETAILS & LIMITATIONS
Sexually transmitted infections counseling†	High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs.
Skin cancer behavioral counseling	Counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
Syphilis screening (nonpregnant persons)	Clinicians screen persons at increased risk for syphilis infection.
Syphilis screening (pregnant women)	Clinicians screen all pregnant women for syphilis infection.
Congenital hypothyroidism screening (newborns)	Up to age 1.
Tobacco use counseling and interventions (nonpregnant adults)	Clinicians ask about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Limited to 8 visits per calendar year.
Tobacco use counseling (pregnant women)	Clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke. Limited to 8 visits per calendar year.
Tuberculin testing and screening	Up to age 22.
Urinalysis	Preventive screening.
Vision sensory screening	Up to age 22, limited to 1 per calendar year.
Visual acuity screening in children	Vision screening for all children up to age 5, at least once to detect the presence of amblyopia or its risk factors.

† Indicates services that are provided as part of the Affordable Care Act's Preventive Services for Women.

ROUTINE PREVENTIVE CARE PRESCRIPTION DRUG

Effective April 1, 2014, the Plan will provide 100% coverage (zero Participant copay) for all routine and preventive prescription drugs that non-grandfathered health plans are required to provide under the Affordable Care Act (ACA). The following list is updated as of January 1, 2015, but is subject to change. Please visit http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html for a current list of covered benefits and services required under the ACA.

INCLUDED SERVICES	COVERAGE DETAILS & LIMITATIONS
Aspirin for the prevention of cardiovascular disease	Men and Women ages 45 to 79 up to 100 per 30 day supply.
Colonoscopy bowel preparations	Men and Women ages 50 to 75.

INCLUDED SERVICES	COVERAGE DETAILS & LIMITATIONS
Contraceptives (birth control)	Generic medications, as well as brands with no generic equivalent are considered Routine Preventive Care Benefits. Brand medications with a generic equivalent are not a Routine Preventive Care Benefit and remain covered subject to the Plan's standard co-payment unless your physician has indicated "Dispense as Written" on your prescription. If your physician has indicated "Dispense as Written" on your prescription, the Plan will cover 100% of the cost of a brand medication.
Erythromycin Ophthalmic Ointment	Infants under one year of age.
Falls prevention in older adults: vitamin D	Men and women age 65 and older.
Folic acid supplementation (Rx and OTC)	Women capable of pregnancy ages 13 to 60 up to 100 per 30 day supply.
Iron supplementation in children	Children ages 6 to 12 months.
Oral fluorides	Children ages 6 months to 6 years.
Aspirin for the prevention of Preeclampsia	Pregnant women after 12 weeks of gestation who are at high risk for preeclampsia.
Raloxifene and tamoxifen: Breast Cancer prevention in high risk Women	One per day (for up to 5 years).
Tobacco use cessation drugs (Rx and OTC)	Subject to quantity limit for up to two quit attempts per calendar year.

REQUIRED REVISED CLAIMS AND APPEALS PROCEDURES

The Plan has amended its claims and appeals rules to comply with the requirements affecting non-grandfathered health care plans under the Affordable Acre Act (ACA). The new appeals procedures are set out below. If you have a claim for medical, prescription drug or HRA denied, you will receive information of how to file an appeal and the timeframes thereof with the notice of denial. The main difference is the addition of a right for an external review of a denied claim after you have completed the Plan's internal review process.

In addition to the summary provided below, the following rules will apply to review of each denied claim on appeal.

- You have the right to have of access to, and to request copies of the documentation relevant to your claim and denial thereof, including any new evidence or rationale considered or relied upon in connection with the Claim on review. You may submit additional comments, documents or records relating to your claim at any time during the appeal process.

- If the denial of your claim was based on a medical judgment, including a Medical Necessity or Investigative determination, the Plan will consult with health care professionals with appropriate training and experience in the field of medicine involved in the medical judgment, to make the appeal determination. Identification of the medical personnel consulted, if any,

will be provided to you upon written request. The decision on appeal will be made by individuals who were not involved in the original determination.

- No deference will be given to any prior claim denials.

- The external review is only available to a denial that involves medical judgment (including, but not limited to, those based on the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) or a rescission of coverage (whether or not the rescission has any effect on a particular benefit at that time).

PROCEDURE FOR FILING AN APPEAL

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. In order to make it easier to understand, the process for filing an appeal is outlined below in three sections:

I. Medical Claim Appeals
II. Prescription Drug Benefit Claim Appeals
III. Health Reimbursement Arrangement (HRA) Claim Appeals

I. Medical Claim Appeals

The appeals process for a denial of a medical claim has three levels. The first two levels use an internal review process. If you are still dissatisfied with the result, the third level of appeal is to an outside review board.

- **First Level Appeal:**

  Filing A Request for Appeal

  You must request a first level appeal within 180 days of the date you received the denial of your claim. Your request for appeal should include the following information:

  1) state that it is a request for an appeal;
  2) the name and relationship of the person submitting the appeal;
  3) the reason for the appeal;
  4) any information that might help resolve the issue;
  5) the date of service/claim; and
  6) if possible, a copy of the Explanation of Benefits (EOB).

  This information should be submitted to Blue Cross Blue Shield Nebraska (BCBSNE) at the address listed on your Plan ID card. There is no hearing on the matter, but you may submit additional information for consideration.

  Decision on Appeal:

  You will be provided written notice of the decision on appeal within 15 calendar days after receipt for "pre-service" claims and within 30 calendar days after receipt for "post-service" claims."

  A "*pre-service claim*" is any claim for a benefit under the Plan which requires approval of the benefit in advance of obtaining medical care, and failure to do so will cause benefits to be denied or reduced.

  A "*post-service*" claim is any claim that is not a pre-service claim.

A "*rescission of coverage*" is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

An "*urgent care*" claim is a claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations:

1. could seriously jeopardize the life or health of the person needing treatment or his or her ability to regain maximum function; or
2. would subject the person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Appeal:
In the case of an "*urgent care*" claim, an expedited appeal may be requested orally or in writing. All information, including the decision, will be submitted by telephone, facsimile or the most convenient method available. You will be notified of the decision as soon as possible, taking into account the medical circumstances, but not later than 72 hours after the receipt of your request for review. You will receive written notice of the determination on appeal within said 72-hour period.

In the case of a "*concurrent care*" claim, a request for an expedited appeal of a concurrent care denial must be made within 24 hours of the denial. If an appeal is timely requested, coverage will continue for the health care services until you are notified of the decision on appeal. Appeals for concurrent care will be decided in the same time frame for other expedited appeals.

- **Second Level Appeal:**
  If you are dissatisfied with the decision after the first level of appeal, you may request a second level of appeal. The request must be made in writing within 60 days from the date you receive the denial of your first level of appeal.

  The letter requesting the appeal must be submitted to BCBSNE's Appeals Unit at the address listed on your Plan identification Card.

  You will be provided written notice of the decision on appeal within 15 calendar days after receipt for "pre-service" claims and within 30 calendar days after receipt for "post-service" claims." The decision made at the second level of appeal concludes the internal review process.

- **Request for External Review:**
  If you are dissatisfied with the decisions made by the first and second levels of appeal, you may request an external review of your claim by an Independent Review Organization (IRO). The request for an external review must be submitted in writing within 4 months after the date you receive the notice of denial after the second level of review. You must go through the first and second levels of appeal before you can request an external appeal.

  BCBSNE shall review the request for external review within 5 business days of receipt to determine its completeness and eligibility and will notify you of its decision within one business day and advise of the reasons for its decision and steps you may take.

If the request is eligible for external review, it will be forwarded to the IRO, including the documentation and information considered in making the underlying denials). You will be allowed to submit additional information for consideration by the IRO.

The IRO shall complete its review and provide you with written notification of its decision within 45 days of receipt of the request for review.

- **Expedited External Review**
  You may request an expedited external review if:

  1) the person who is the subject of the claim has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of such person or would jeopardize his or her ability to regain maximum function; or

  2) the denials concerned an admission, availability of care, continued stay or health care service for which the subject person has received emergency services, but has not been discharged from a facility.

An expedited External Review decision shall be made by the IRO as quickly as the person's medical conditions or circumstances require but in no event more than 72 hours after the IRO receives the request for an expedited External Review.

The decision of the IRO is the <u>final</u> review decision, and is binding upon the IBEW Local 22/NECA Health and Welfare Plan and the claimant, except to the extent the claimant has other remedies available under applicable federal or state law.

II. Prescription Drug Claim Appeals

You may file a first level appeal within 180 days of the date you receive a denial of your claim for Prescription drug benefits. Such an appeal has one level of internal review and then an external review option, subject to the restrictions on external review that are set forth above.

This information should be submitted by you in writing to the Fund Office at 8960 L St Suite 101, Omaha, NE 68127. You may submit additional information for consideration and you may also request a hearing (in person or by representative). If you don't request a hearing, this will be considered a waiver of your right to do so and the Trustees will proceed to consider your appeal based on the written information submitted.

If you do request a hearing, you will be notified in writing, of the date, time and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. You will have the right to present any additional information not previously submitted. If you request a hearing and do not appear at the hearing (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written information submitted.

Decision on appeal

The Board of Trustees will conduct the review and the decision will be based on all comments, documents, records and other information that you submit, regardless of whether such information was submitted or considered in the initial benefit determination. The Plan will notify you in writing of the decision on any appeal within 5 calendar days after the determination is made.

The Plan will generally make its decision at the next quarterly meeting of the Board of Trustees; if your appeal is received within 30 days of the meeting, the Plan will generally make the decision at the following quarterly meeting; or in special circumstances, the Plan may make the decision at the third regularly scheduled meeting.

Request for External Review:
You may request that a denial of your Prescription Drug Claim be reviewed by an Independent Review Organization (IRO). You must have exhausted all levels of internal appeal prior to requesting external review. The request for external review must be submitted in writing within 4 months after the date of receipt of a notice of the denial of your appeal of your Prescription Drug Claim.

The Fund Office shall review the request for external review within 5 business days of receipt to determine its completeness and eligibility and will notify you of its decision within one business day and advise of the reasons for its decision and steps you may take.

If the request is eligible for external review, it will be forwarded to the IRO, including the documentation and information considered in making the underlying denials). You will be allowed to submit additional information for consideration by the IRO.

The IRO shall complete its review and provide you with written notification of its decision within 45 days of receipt of the request for review.

The decision of the IRO is the final review decision, and is binding upon the IBEW Local 22/NECA Health and Welfare Plan, and the claimant, except to the extent the claimant has other remedies available under applicable federal or state law.

III. Health Reimbursement Arrangement (HRA) Claim Appeals
You are entitled to an opportunity to appeal a denial of a claim concerning your HRA. Such an appeal has one level of internal review and then an external review option, subject to the restrictions on external review that are set forth above.

This information should be submitted by you in writing to the Fund Office at 8960 L St Suite 101, Omaha, NE 68127. You may submit additional information for consideration and you may also request a hearing (in person or by representative). If you don't request a hearing, this will be considered a waiver of your right to do so and the Trustees will proceed to consider your appeal based on the written information submitted.

If you do request a hearing, you will be notified in writing, of the date, time and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. You will have the right to present any additional information not previously submitted. If you request a hearing and do not appear at the hearing (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written information submitted.

Decision on appeal
The Board of Trustees will conduct the review and the decision will be based on all comments, documents, records and other information that you submit, regardless of whether such information was submitted or considered in the initial benefit determination. The Plan will notify you in writing of the decision on any appeal within 5 calendar days after the determination is made.

The Plan will generally make its decision at the next quarterly meeting of the Board of Trustees; if your appeal is received within 30 days of the meeting, the Plan will generally make the decision at the following quarterly meeting; or in special circumstances, the Plan may make the decision at the third regularly scheduled meeting.

Request for External Review:
You may request that a denial of your HRA claim be reviewed by an Independent Review Organization (IRO). You must have exhausted all levels of internal appeal prior to requesting external review. The request for external review must be submitted in writing within 4 months after the date of receipt of a notice of the denial of your appeal of your HRA claim.

The Fund Office shall review the request for external review within 5 business days of receipt to determine its completeness and eligibility and will notify you of its decision within one business day and advise of the reasons for its decision and steps you may take.

If the request is eligible for external review, it will be forwarded to the IRO, including the documentation and information considered in making the underlying denials). You will be allowed to submit additional information for consideration by the IRO.

The IRO shall complete its review and provide you with written notification of its decision within 45 days of receipt of the request for review.

The decision of the IRO is the final review decision, and is binding upon the IBEW Local 22/NECA Health and Welfare Plan, and the claimant, except to the extent the claimant has other remedies available under applicable federal or state law.

CHANGES TO THE HOUR BANK ACCOUNT

Effective June 1, 2014, the maximum amount of hours an Employee can accumulate in his Hour Bank Account is increased from 700 to 840 hours. This means that when an Employee is credited with more than 140 hours during a month, the excess hours will remain in that Employee's Hour Bank Account up to a maximum accrued balance of 840 hours.

CHANGES TO MAIL ORDER PHARMACY PROGRAM

Effective January 1, 2015, prescriptions for newly-prescribed maintenance drugs must be filled through the LDI Pharmacy Benefit Services mail order pharmacy program. These prescriptions will no longer be covered at retail pharmacies after the first two fills.

CHANGES TO ORAL SURGERY AND DENISTRY

Effective March 1, 2015, the Plan shall be amended to cover pre surgery orthodontia and wisdom teeth removal for treatment of maxillary hypoplasia with mandibular hyperplasia in connection with Le Fort Osteotomy.

Please keep this information with your Plan materials. If you have any questions, please contact the Fund Office.

Board of Trustees,
July, 2015

IBEW LOCAL 22/NECA HEALTH AND WELFARE PLAN

Summary of Material Modifications

The Trustees are committed to providing comprehensive health benefits for you and your dependents. The Trustees have recently amended your Plan. This Notice summarizes these changes which have been previously announced in other communications. This Summary of Material Modifications combines information on these various changes in one place and is provided to you in compliance with federal law.

PLAN ADMINISTRATOR

Effective September 1, 2013, the Plan Administrator changed from Wilson-McShane Corporation to A&I Benefit Plan Administrators, Inc. ("A&I"). The Fund Office is at the same location. To contact A&I:

Local Telephone Number:	402-592-3753
Toll Free Phone Number:	855-330-3242
Website Address:	22benefits.aibpa.com
E-Mail Address:	22benefits@aibpa.com
Benefits Information	access information about your benefits online at http://22benefits.aibpa.com, or through the Local's mobile app

AGENT OF SERVICE FOR LEGAL PROCESS

Effective September 1, 2013, the Agent for Service of Legal Process is:

A&I Benefit Plan Administrators, Inc.
8960 "L" Street, Suite 101
Omaha, NE 68127-1414

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Changes effective September 1, 2013:

Effective September 1, 2013, the following changes were made concerning HRA claims:

- You can receive reimbursement for HRA claims even if the aggregate claims submitted for reimbursement are less than $50. You may still apply for reimbursement by submitting a claim in writing to the Plan Administrator on a form provided by the Fund Office. You may also apply for reimbursement by submitting a claim to the Fund Office via the Plan's mobile application. For prescription drugs, rather than submitting an application for reimbursement, you may pay for prescription drugs that meet the definition of Allowable Medical Care Expense by using an HRA debit card provided by the Fund Office.

Changes Effective January 1, 2014

Effective January 1, 2014, the following changes were made to both Active and Retiree HRA rules:

- You must be a covered Plan Participant to receive an HRA credit or allocation.

- If you are seeking reimbursement for an Allowable Medical Care Expense, the claim for reimbursement must be received by the Fund Office no later than June 30th following the close of the Plan Year in which the Allowable Medical Care Expense was incurred. This is an extension from the prior March 31st deadline.

- If you are a Participant and your coverage from the Plan is terminated, you may elect to permanently opt out of and waive future reimbursements from the HRA. If you make this election, you will permanently forfeit the entire balance of your HRA.

ACTIVE HEALTH REIMBURSEMENT ACCOUNT (ACTIVE HRA)

Effective January 1, 2014, the following change was made to the Active HRA rules:

- If your Active HRA is forfeited, the forfeiture will become part of the general Plan assets.

CHANGES MADE IN COMPLIANCE WITH THE AFFORDABLE CARE ACT

Effective January 1, 2014, the following changes were made to the Plan:

- ANNUAL MAXIMUM

  Effective January 1, 2014, the Plan's $2,000,000 Annual Benefit Maximum has been eliminated. There is no longer an annual limit on the amount of benefits that the Plan will pay on behalf of a Plan Participant.

- DEPENDENT SPOUSE COVERAGE

  Effective January 1, 2014, if you get married, coverage for your spouse will begin on the date of your marriage so long as an enrollment form for your spouse was postmarked or otherwise positively received by the Fund Office within 90 days of the date that you got married. If your spouse's enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days of the date you got married, your spouse shall become eligible for coverage of claims incurred on or after the date that your spouse's enrollment form is postmarked or otherwise positively received by the Fund Office.

  Effective January 1, 2014, a Dependent child under the age of 26 is eligible for coverage from the Plan even if the Dependent child has other health care coverage available from his or her employer (or, his or her spouse's employer, if married).

  Claims for a Dependent spouse and/or child will not be paid unless a completed enrollment form for such Dependent is on file with the Fund Office. An enrollment form is not considered complete unless it includes copies of all supporting documentation (e.g., marriage certificate, birth certificate, etc.).

- **ELIGIBLITY FOR COVERAGE**

  Effective February 18, 2014, the Plan was amended to allow Bargained Employees and Non-Bargained Employees to waive their Dependent's coverage from the Plan.

  If you waive coverage for a Dependent, and subsequently you would like to reinstate coverage for that Dependent, you must submit a new enrollment form to the Fund Office. Your Dependent will again become eligible for coverage for claims incurred effective the date the new enrollment form is postmarked or otherwise positively received by the Fund Office.

Claims for your Dependent will not be paid until a new enrollment form is on file with the Fund Office.

The following chart summarizes the documents that you must submit to the Fund Office to waive coverage for a Dependent. The waiver of coverage will be effective the first day of the month after all of the required documents are received by the Fund Office.

If your Dependent is…	You must submit…
Your Spouse	A Waiver of Health Care Coverage signed by you **and** a Waiver of Health Care Coverage signed by your spouse.
Your Dependent Child who is at Least 18 Years Old	A Waiver of Health Care Coverage signed by you **and** a Waiver of Health Care Coverage signed by your Dependent child.
Your Dependent Child who is Under Age 18	A Waiver of Health Care Coverage signed by you **and** a Waiver of Health Care Coverage signed by your Dependent child's other parent.

Waivers of Health Care Coverage are available at the Fund Office.

CHANGES RELATED TO THE PLAN'S TRANSITION TO NON-GRANDFATHERED STATUS AS OF APRIL 1, 2014

The following changes were made in connection with the Plan transitioning from a "grandfathered" plan to a "non-grandfathered" plan under the Affordable Care Act as of April 1, 2014:

SUMMARY OF HEALTH BENEFITS

The Summary of Health Benefits is hereby amended by deleting the current Coinsurance and Annual Out-of-Pocket Limit rows and replacing it with the following:

	Blue Preferred Provider	Non-Preferred Provider
Annual Coinsurance Out-of-Pocket Limit:		
Individual:	$2,500	$5,000
Family Maximum:	$5,000	$10,000
Annual Out-of-Pocket Limit: *Includes Deductible, Coinsurance and medical Copayments, combined*		
Individual:	$6,350	$6,350
Family Maximum:	$12,700	$12,700

ANNUAL OUT OF POCKET LIMITS

Effective April 1, 2014, the Plan will have additional out-of-pocket limits. These new out-of-pocket limits are required by health care reform and will include deductibles and medical copayments (in other words, these new limits represent the maximum amount that you can pay during a calendar year when you combine the amounts you pay for co-insurance, deductibles and copayments). These new out-of-pocket limits are:

- Blue Preferred Provider: **$6,350** Individual / **$12,700** Family
- Non-Preferred Provider: **$6,350** Individual / **$12,700** Family

YOUR 2014 CO-INSURANCE OUT-OF-POCKET LIMITS ARE NOT CHANGING. The maximum amount of co-insurance that you can pay during a calendar year will remain:

- Blue Preferred Provider: **$2,500** Individual / **$5,000** Family
- Non-Preferred Provider: **$5,000** Individual / **$10,000** Family

This means that the new out-of-pocket limits will **not** cause you to pay any more than you would have paid with the Plan's prior out-of-pocket limits.

PARTICIPATION IN CLINICAL TRIALS

If an individual is approved to participate in an approved clinical trial, the Plan will cover *routine patient costs that would otherwise be covered if the individual was not in the trial*.

The Plan will not cover: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Please keep this information with your Plan materials. If you have any questions, please contact the Fund Office.

Board of Trustees,
July, 2014

IBEW LOCAL 22/NECA HEALTH AND WELFARE PLAN

Summary of Material Modifications

The Board of Trustees would like to make you aware of recent improvements in the Plan's coverage effective January 1, 2012. This Notice summarizes these improvements, including increasing the annual benefit maximum, increasing wellness and preventive care benefits and removing certain limits on mental illness, alcoholism and substance abuse benefits.

ANNUAL MAXIMUM

The Annual Benefit Maximum has been increased to $1,250,000.

MENTAL ILLNESS, ALCOHOLISM AND/OR DRUG ABUSE (MIDA) TREATMENT

The previous 30 day limit for inpatient treatment for Mental Illness, Alcoholism and/or Drug Abuse (MIDA) as well as the 60 unit limit of outpatient treatment for MIDA have been eliminated. All MIDA treatment remains subject to the requirement of Medical Necessity.

TOBACCO CESSATION COVERAGE

The tobacco cessation benefits available through SimplyWell's Tobacco Cessation Program will no longer be limited to once per year and twice per lifetime.

CHANGES TO THE PLAN'S BENEFITS FOR PREVENTIVE SERVICES

As indicated in the "Grandfathered Status" language on page 4 of this Summary of Material Modifications, the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("PPACA"). This means the Plan is not required by law to provide 100% coverage (i.e. coverage without cost to the Participant) for preventative health services. Although the Plan is not legally required to provide 100% coverage for these in-network preventative health services, the Board of Trustees has decided to go beyond its legal obligations and provide these enhanced benefits. Accordingly, effective January 1, 2012, the Plan's preventive care benefits will be increased to provide 100% Plan coverage (no Participant cost) for the full schedule of preventive services established by PPACA when these services are provided by an in-network provider. **If these services are provided by an out of network provider, they will be subject to the Plan's Participant deductible for an out of network service and the Plan will cover only 70% of the covered services.**

The preventative services are listed on the following pages on the benefit schedule compiled and administered by BlueCross BlueShield of Nebraska.

Covered Preventive Service, As Recommended By U.S. Preventive Services Task Force	**Frequency Limit**
Abdominal Aortic Aneurysm, Screening	One per lifetime
Alcohol Misuse Screening and Behavioral Counseling Intervention	One per calendar year
Aspirin for the Prevention of Cardiovascular Disease	Subject to plan's retail day supply limit
Asymptomatic Bacteriuria in Adults, Screening	
Breast Cancer, Screening (mammogram)	One per calendar year
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and discussion of BRCA Mutation Testing (based on family risk factors)	
Breastfeeding, Primary Care Interventions to Promote Breastfeeding	
Cervical Cancer, Screening (Pap smear)	One per calendar year
Chlamydial Infection, Screening	
Colorectal Cancer, Screening (Screenings include: colonoscopy, sigmoidoscopy, proctosigmoidoscopy, barium enema, fecal occult blood testing, laboratory tests, and related services)	One every 5 calendar years One per calendar year for fecal occult blood test
Congenital Hypothyroidism Screening (newborn)	
Dental Caries in Preschool Children, Prevention (prescribe oral fluoride if deficient in water)	Subject to plan's retail day supply limit
Depression (Adults) Screening	
Diet, Behavioral Counseling in Primary Care to Promote Healthy Diet (adults with hyperlipidemia and other risk factors)	Up to 9 visits per calendar year
Evaluation and Management Services (E/M) (periodic preventive examination/office visits)	Newborn up to age 6 unlimited; annually thereafter
Gonorrhea, Screening	
Gonorrhea, Prophylactic Eye Medication (newborns)	
Hearing Loss in Newborns, Screening	
Hepatitis B Virus Infection, Screening	
High Blood Pressure, Screening	

Covered Preventive Service, As Recommended By U.S. Preventive Services Task Force	**Frequency Limit**
HIV, Screening (at risk and all pregnant women)	
Iron Deficiency Anemia, Prevention (at risk 6 to 12 month old babies)	Lab tests are not limited. Drugs are subject to plan's retail day supply limit
Iron Deficiency Anemia, Screening	
Lipid Disorders in Adults, Screening (cholesterol)	One every 5 calendar years
Major Depressive Disorders in Children and Adolescents, Screening	
Obesity in Adults, Screening	
Obesity in Children, Screening	
Osteoporosis in Women, Screening (bone density testing)	One every 2 calendar years
Phenylketonuria (PKU), Screening (newborn)	One per lifetime
Rh (D) Incompatibility, Screening	
Sexually Transmitted Infections, Counseling	
Sickle Cell Disease, Screening (newborns)	
Syphillis Infection, Screening	
Tobacco Use and Tobacco-Caused Disease, Counseling (including tobacco/nicotine cessation drugs and deterrents)	Medical: Up to 8 counseling sessions per calendar year. Drugs and deterrents are subject to plan's retail day supply limit
Type 2 Diabetes Mellitus in Adults, Screening	
Visual Impairment in Children Younger than 5 Years, Screening	One per calendar year
Daily Supplement of Folic Acid	Subject to plan's retail day supply limit
Discuss Chemoprevention when at High Risk for Breast Cancer	
Immunizations	

GRANDFATHERED STATUS

This group health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office, or you may call the Blue Cross and Blue Shield of Nebraska Member Services Department at the telephone number shown on the back of your I.D. card.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

IBEW LOCAL 22/NECA HEALTH AND WELFARE PLAN

Summary of Material Modifications

The Trustees are committed to providing comprehensive health benefits for you and your Dependents. The Trustees have recently amended your Plan. This Notice summarizes these changes.

Effective January 1, 2012, the Trustees have amended the Plan to include a Retiree Health Reimbursement Arrangement ("Retiree HRA"). The details of the Retiree HRA are included in the following document which replaces Attachment B of your Summary Plan Description.

GRANDFATHERED STATUS

This group health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office, or you may call the Blue Cross and Blue Shield of Nebraska Member Services Department at the telephone number shown on the back of your I.D. card. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

Please keep this information with your Plan materials. If you have any questions, please contact the Fund Office.

Sincerely,

Board of Trustees
January, 2012

Attachment B: Health Reimbursement Arrangement (HRA)

The Plan provides two types of Health Reimbursement Arrangements ("HRAs"), an Active Employee Health Reimbursement Arrangement ("Active HRA"), and a Retiree Health Reimbursement Arrangement ("Retiree HRA").

ACTIVE EMPLOYEE HEALTH REIMBURSEMENT ARRANGEMENT ("ACTIVE HRA"):
Effective June 1, 2008, an Active Employee Health Reimbursement Arrangement ("Active HRA") has been established by the Plan for eligible Bargaining Employees and Non-Bargaining Employees.

ELIGIBILITY. Each Bargaining Employee and Non-Bargaining Employee that has contributions made on their behalf to the Active HRA effective on or after June 1, 2008, is eligible to participate in the Active HRA. Participation in the Active HRA begins on the first day of the month after contributions are first remitted to the Active HRA on your behalf.

TERMINATION OF PARTICIPATION. Termination of participation in the Active HRA occurs when a participant's Active HRA is forfeited. A participant's Active HRA shall be forfeited for the following reasons:

(a) Plan termination.

(b) One-year break-in-Service: Your Active HRA will be forfeited on the later of:

1. the first day of the month following the twelfth consecutive month that you are not covered under the Health and Welfare Plan; or
2. the first day of the month following the twelfth consecutive month that you are not credited with any Employer contributions to the HRA.

(c) Disqualifying employment: If you are employed in the industry by an employer having no obligation to contribute to the Plan, your Active HRA will be forfeited on the first day of the month following the month that the work for the non-contributing employer was first performed. No reimbursements will be made for claims incurred on or after the date of the forfeiture.

INDIVIDUAL ACCOUNTS. The Plan Administrator will establish and maintain separate Active HRA accounts for each eligible Bargaining Employee and Non-Bargaining Employee. This account will be used to receive your contributions and to pay your benefits. Although each participant's account will be separately identified, the combined assets of each account will be held by the Fund in reserves and identified in the Plan's financial statements as the Active HRA reserves. The Active HRA account established for you will merely be a record keeping account with the purpose of keeping track of contributions and available reimbursement amounts from the Plan. The Individual Active HRA Accounts shall not be credited with any interest income earned on the Active HRA reserves. The

Active HRA Accounts will not be charged with any expenses for administration of the HRA. The Active HRA Accounts do not constitute a vested benefit.

(a) Crediting of Accounts. Your Active HRA account will be credited at the end of each month following the month hours were worked for which contributions are being made to your account. In other words, contributions made for hours worked in March will be credited to your account on April 30th. Only amounts actually received by the Plan will be credited to your account.
(b) Debiting of Accounts. Your Active HRA account will be debited during each Period of Coverage for all eligible reimbursements. A "Period of Coverage" is the calendar year.
(c) Available Amount. The amount available for reimbursement to either the Bargaining Employee, Non-Bargaining Employee, or Eligible Dependent for Allowable Medical Care Expenses is that amount credited to your Active HRA.

CARRYOVER OF ACCOUNTS. If any balance remains in your Active HRA Account after all reimbursements are paid for the Period of Coverage, the balance will be carried over to reimburse the participant for medical care expenses incurred during a subsequent Period of Coverage. In addition, any HRA benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the medical care expense was incurred shall be forfeited.

Should the Bargaining Employee or Non-Bargaining Employee die, the account will be made available to pay benefits to the Eligible Dependents of the Bargaining Employee or Non-Bargaining Employee .

If the Bargaining Employee or Non-Bargaining Employee is deceased and there are no surviving Eligible Dependents, any remaining balance in the account shall be forfeited and reallocated to the then existing Active HRA accounts equally.

If a Bargaining Employee or Non-Bargaining Employee loses coverage from the Plan, the actual amount in their account will be available for benefit payment, subject to the forfeiture rules in the Section entitled, "TERMINATION OF PARTICIPATION" above.

BENEFITS. The monies deposited into the Active HRA account will be available to be used by the Bargaining Employee or Non-Bargaining Employee for the payment of Allowable Medical Care Expenses incurred by the Bargaining Employee or Non-Bargaining Employee, the Bargaining Employee or Non-Bargaining Employee's spouse as defined in Internal Revenue Code § 213(d)(8), and/or the Bargaining Employee or Non-Bargaining Employee's eligible, non-spouse Dependents. Benefits will not be provided in the form of cash or any other taxable or non-taxable benefit other than reimbursement of Allowable Medical Care Expenses.

ALLOWABLE MEDICAL CARE EXPENSES AND EXCLUSIONS. See pages 84-88.

RETIREE HEALTH REIMBURSEMENT ARRANGEMENT ("RETIREE HRA"):
Effective January 1, 2012, a Retiree Health Reimbursement Arrangement ("Retiree HRA") has been established by the Plan for Eligible Retiree's. For purposes of this Attachment B, an "Eligible Retiree" is a former Bargaining Employee or Non-Bargaining Employee who has met the requirements below to obtain eligibility from the Retiree HRA.

ELIGIBILITY. Each former Bargaining Employee and former Non-Bargaining Employee that has contributions allocated to their Retiree HRA account on or after January 1, 2012 is eligible to participate in the Retiree HRA (i.e. is an Eligible Retiree). Effective January 1, 2012, A former Bargaining Employee or Non-Bargaining Employee will have contributions allocated to his Retiree HRA account in January of each year that he satisfies the following criteria:

- he was retired as of May 31 of the prior year and did not actively seek covered employment in the electrical industry through the following January 1. For purposes of this requirement, a participant is considered retired if he has ceased receiving coverage from the Plan as a Bargaining Employee or a Non-Bargaining Employee and he is not actively seeking covered employment in the electrical industry;
- he maintained coverage under the Plan as a Bargaining Employee or a Non-Bargaining Employee during at least 20 different calendar years preceding retirement. For purposes of this requirement, a former Bargaining Employee or Non-Bargaining Employee will be credited with one year of service for each calendar year for which they were covered for at least one month as a Bargaining Employee or a Non-Bargaining Employee under the Plan;
- he is not currently receiving a pre-retirement benefit from the IBEW Local 22 Pension Plan A;.
- he is at least age 62 and alive as of May 31 of the prior year; his benefits are not currently suspended from the IBEW Local 22 Pension Plan A; and
- he did not perform covered employment in the electrical industry for an employer having no obligation to contribute to the Plan during the ten years immediately preceding retirement or at any time after retirement.

TERMINATION OF PARTICIPATION. Termination of participation in the Retiree HRA occurs when a participant's Retiree HRA is forfeited. A participant's Retiree HRA shall be forfeited for the following reasons:

(a) Plan termination.

(b) Disqualifying employment: If you are employed in covered employment in the electrical industry by an employer having no obligation to contribute to the Plan, your Retiree HRA will be forfeited on the first day of the month that the work for the non-contributing employer was first performed. No reimbursements will be made for claims incurred on or after the date of the forfeiture.

INDIVIDUAL ACCOUNTS. The Plan's Administrator will establish and maintain separate Retiree HRA accounts for each Eligible Retiree. This account will be used to receive your contributions and to pay your benefits. Although each Eligible Retiree's account will be separately identified, the combined assets of each account will be held by the Fund in reserves and identified in the Plan's financial statements as the Retiree HRA reserves. The Retiree HRA account established for you will merely be a record keeping account with the purpose of keeping track of contributions and available reimbursement amounts from the Plan. The Individual Retiree HRA Accounts shall not be credited

with any interest income earned on the Retiree HRA reserves. The Retiree HRA Accounts will not be charged with any expenses for administration of the Retiree HRA. The Retiree HRA Accounts do not constitute a vested benefit.

(a) Crediting of Accounts. The Retiree HRA account will be credited each January based upon the Plan's accumulated Retiree HRA contributions received during the preceding Retiree HRA funding year.. The Retiree HRA funding year will begin June 1st of each year and will end May 31st of the following year. This means that the January, 2012 Retiree HRA allocation is based on Retiree HRA contributions remitted on work hours from June 1, 2010 to May 31, 2011. Each year's Retiree HRA contributions will be allocated to Eligible Retirees based upon the following Retiree HRA Allocation formula:

	Base Retiree HRA Benefit with 20 Years of Service	Additional Benefit Per Year of Service (21 to 30)	Maximum Annual Retiree HRA Benefit
Age 62 – 64	$ ***"X"***	1/10 ***"X"***	2 times ***"X"***
Age 65+	50% of Pre-65 Benefit	50% of Pre-65 Benefit	$ ***"X"***

"X" is determined on a prorated basis once the preceding Retiree HRA funding year is completed.

EXAMPLE: January 1, 2012 Retiree HRA Allocation:

During the funding year ending May 31, 2011, Retiree HRA contributions totaled $153,410. Based upon the credited Retiree HRA years of service among that year's Eligible Retiree's who were entitled to an allocation for that year, ***"X"*** was determined to be $616.00.

	Base Retiree HRA Benefit with 20 Years of Service	Additional Benefit Per Year of Service (21 to 30)	Maximum Annual Retiree HRA Benefit
Age 62 – 64	$616.00	$61.60	$1,232.00
Age 65+	$308.00	$30.80	$616.00

(b) Debiting of Accounts. Your Retiree HRA account will be debited during each Period of Coverage for all eligible reimbursements. A "Period of Coverage" is the calendar year.

(c) Available Amount. The amount available for reimbursement to either the Eligible Retiree or Eligible Dependent for Allowable Medical Care Expenses is that amount credited to your Retiree HRA under Subsection (a), reduced by prior reimbursements debited under Subsection (b).

CARRYOVER OF ACCOUNTS. If any balance remains in your Retiree HRA Account after all reimbursements are paid for the Period of Coverage, the balance will be carried over to reimburse the Eligible Retiree for medical care expenses incurred during a subsequent Period of Coverage. In addition, any Retiree HRA benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the medical care expense was incurred shall be forfeited.

Should the Eligible Retiree die, the account will be made available to pay benefits to the spouse as defined in Internal Revenue Code § 213(d)(8) of the Eligible Retiree and any Eligible Dependents of

the Eligible Retiree for twelve months following the Eligible Retiree's death. If the Eligible Retiree is deceased and there is no surviving spouse or surviving Eligible Dependents, any remaining balance in the account shall be forfeited and will be allocated to the Eligible Employee's that are entitled to an allocation the following January.

BENEFITS. The monies allocated into the Retiree HRA account will be available to be used by the Eligible Retiree for the payment of Allowable Medical Care Expenses incurred by the Eligible Retiree, the Eligible Retiree's spouse as defined in Internal Revenue Code § 213(d)(8), and/or the Eligible Retiree's non-spouse Eligible Dependents. Benefits will not be provided in the form of cash or any other taxable or non-taxable benefit other than reimbursement of Allowable Medical Care Expenses.

ALLOWABLE MEDICAL CARE EXPENSES – *APPLICABLE TO BOTH ACTIVE AND RETIREE HRA*

You may receive reimbursement for Allowable Medical Care Expenses incurred during the time you have a balance in your HRA.

(a) Incurred. A medical expense is "incurred" at the time the medical care or service giving rise to the expenses is furnished and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Allowable Medical Expenses incurred before you become eligible to participate in the Active HRA are not eligible for reimbursement from the Active HRA. Allowable Medical Expenses incurred before you become eligible to participate in the Retiree HRA are not eligible for reimbursement from the Retiree HRA. An Allowable Medicare Care Expense incurred during one Period of Coverage may be paid during a later Period of Coverage, provided you have a balance in your HRA (i.e. your HRA has not been forfeited).

(b) Allowable Medical Care Expenses. Allowable Medical Care Expenses are all expenses incurred by the Bargaining Employee, Non-Bargaining Employee, or Eligible Retiree and his Eligible Dependents for medical care as that term is defined in Section 213 of the Internal Revenue Code incurred during a calendar year. This includes "medical care" and any other expense which the Internal Revenue Service has recognized as properly deductible under Section 213(d)(1) of the Internal Revenue Code. Self-payments for continued Plan coverage are also Allowable Medical Care Expenses. Eligible Expenses include reimbursement for medicines or drugs only if purchased with a prescription, including "Over-the-Counter Medicines" which do not ordinarily require a prescription. Prescription drugs and prescribed Over-the-Counter Medicines must be for the treatment of illness or injury as defined by the Internal Revenue Code not merely to advance your general good health. However, Allowable Medical Care Expenses and prescribed Over-the-Counter Medicines will only be considered for reimbursement if they are not covered by a health care plan of which you are a participant or, if they are partially covered by a health care plan, to the extent not covered. A partial list of examples of Allowable Medical Care Expenses and prescribed Over-the-Counter Medicines follows.

The following tables on pages 85 and 86 contain only partial lists since the Internal Revenue Service frequently changes the list of deductible medical expenses. You should refer to IRS Publication 502, available upon request from the Fund Office, for a current list of what medical expenses are includible and what expenses are excludible.

Medical Care Expenses Eligible for Reimbursement Under Your Health Reimbursement Arrangement – *Applicable to Both the Active and Retiree HRA*

- Abortions, legal
- Acupuncture
- Alcoholism (substance abuse) treatment
- Ambulance Expenses Nursing home (for medical reason only)
- Amounts exceeding payments made by insurance
- companies for eligible expenses
- Nursing services
- Artificial limbs
- Bandages
- Birth control pills
- Braille books and magazines
- Breast reconstruction surgery after mastectomy
- Car controls for the disabled
- Chiropractors
- Christian Science practitioner's fees
- Contact lenses and solutions
- Crutches
- Deductibles for Medical Insurance Only
- Dental fees
- Dentures
- Diagnostic fees for Medical Diagnoses Only
- Disabled dependent care expenses
- Drug addiction treatment expenses
- Eye glasses including the examination fee
- Eye surgery
- Fertility enhancement
- Hearing devices
- Home improvements/modifications motivated by medical considerations
- Hospital Bills
- Insulin
- Insurance Copayments
- Laboratory fees
- Laser eye surgery
- Lead-base paint removal (for children with lead poisoning)
- Lifetime care/Advance payments founder's fee
- Long-term care: only qualified long-term care expenses as defined by the IRS and qualified long-term care insurance premiums
- Medical conferences
- Medicare and medical insurance premiums
- Midwife Obstetrical expenses
- Orthopedic shoes
- Oxygen Physicians fees
- Prescription drugs and medical supplies
- Private institution/home cost for mentally or physically handicapped
- Psychiatric care
- Psychoanalysis
- Psychologists' fees
- Radial Keratotomy
- Seeing-eye dog and its upkeep
- Self-payments to IBEW Local 22/NECA Health & Welfare Plan
- Smoking cessation program expenses and related prescription drugs (however excluding nonprescription drugs and products such as nicotine gum or patches)
- Special education costs
- Special home for mentally retarded
- Sterilization fees
- Surgical fees
- Telephone, special for the deaf
- Television audio display equipment for the deaf
- Therapy received as medical treatment
- Transplant/donor medical expenses
- Transportation, meals and lodging expenses, primarily
- in the rendering of medical care
- Tuition at a special school for the handicapped
- Vaccinations/Immunizations
- Vitamins by prescription (pre-natal)
- Weight-loss program, only if for treatment of a specific disease diagnosed by a Physician (such as obesity, hypertension or heart disease), fees for membership in a weight reduction group and attendance in periodic meetings is covered, as well as the cost of special food which exceeds the cost of a normal diet. Please refer to the specific exclusions listed in the next section.
- Wheelchair
- Wigs (for hair loss due to disease)
- X-rays

Medical Care Expenses Eligible for Reimbursement Under Your Health Reimbursement Arrangement (Cont'd)

Over-the-Counter Medicines

Over-the-Counter Medicines must be used for treatment of an illness. This list is not comprehensive. Over-the-Counter Medicines are eligible for reimbursement only if purchased with a prescription. To receive reimbursement for prescribed Over-the-Counter Medicines purchased on and after January 1, 2011, you must provide the Fund Office with one of the following items when you submit your claims:

- A receipt from a pharmacy which identifies the name of the purchase (or the name of the person for whom the prescription applies), the date and amount of the purchase, and an Rx number; or
- A receipt from a pharmacy without an Rx number accompanied by a copy of the related prescription.

TYPE OF EXPENSE	EXAMPLES
Acne medicine:	Clean & Clear, Clearasil, LomaLux, Neutrogena, Noxzema, Oxy, Phisoderm, Stridex
Allergies:	Actifed, Advil, Afrin, Alavert, Allerest, Benadryl, ChlorTrimeton, Claritin, Dimetapp, Diphedryl, Motrin, Nasal Crom, Sudafed, Tavist, Tylenol, Vicks
Asthma:	Bronkaid
Cold Sores:	Abreva, Notriva
Colds:	Actifed, Advil, Aleve, Alka-Seltzer Plus, Cepecol, Chloraseptic, Ciricidin, Cold-Eze, Comtrex, Contac, Dimetapp, Drixoral, Halls, Lumens, Neosynephrine, Profen IS, Riccola, Robitussin, Sucrets, Sudafed, Theraflu, Triaminic, Tylenol, Vicks DayQuil, Vicks VapoRub, Zicam, Zinc Drops
Cuts and Itching:	Bactine, Balmex, Benadryl Anti-Itch Cream, Caladryl, CamphoPhenique, Cortaid, Dermarest, Desitin Diaper Rash Cream, Hydrocortizone, Hydrogen Peroxide, Iodine, Itch-X, Lanacaine, Neosporin, Polysporin, Psoriasin gel, Witch Hazel
Diabetes:	Insulin
Dietary Supplements:	Acidophilus, Coenzyme, Ensure, Q-10
Digestive Remedies:	Alka-Seltzer, Axid AR, Bonine, Carters, Castor Oil, Citrucel, Corectol, Dramamine, Dulcolax, Emetrol, Ex-lax, Fleet Enema, Gas-X, Gaviscon, Imodium, Kaopectate, Lactaid pills, Maalox, Metamucil, Mylanta, Pepcid, Pepto-Bismol, Phillips, Prilosec, Rolaids, Tagamet, Tums, Zantac
Eye & Ear Problems:	OcuHist, Swim-Ear, Visine
Foot Treatments:	Fungi Care, Lotrimin, Micantin
Herbal, Homeopathic or Naturopathic Remedies:	Bilberry, Cholestine, DHEA, Echinacea, Estroven, Fish Oil, Flax Seed Oil, Garlic, Ginseng, Ginkgo Biloba, Glucosamine and Chondroitin, Goldenseal, Grape Seed, Herbs, Joint Juice, Knox Nutra Joint, L-Argine, L-Carnitine, Lecithin, Lutein, Maca, Melatonin, Milk thistle, MSM, Ocuvite, Omega-3,6,9, Osteo Bi-flex, Papaya Enzyme, Sam-e, Shark Cartilage, St. Johns Wort, Vasorect, Venstat

Jock Itch:	Cruex, Lamisil AT, Lotrimin AF, Micantin, Tinactin
Lice:	LiceFree, Nix, Pronto, Rid
Minerals & Vitamins:	Antioxidants, Calcium, Chromium Piclinate, Folic Acid, Iron, Lysine, Magnesium, Menopause Supplements, Multi-Vitamins, Niacin, Potassium, Selenium, Senior Vitamins, Zinc
Pain Relief:	Advil, Aleve, Arth-Rx, Aspercreme, Aspirin, Azo, BenGay, Doan's, Epsom Salts, Excedrin, Flexall, Ibuprofen, IcyHot, Jointflex, Joint-Ritis, Mentholatum, Midol, Motrin, Pamprin, Premysin, PMS, Prodium, Stopain, Tylenol
Smoking Cessation:	Endit, Lite'n Up, NicoDerm CQ, Nicorette, Nicotrol, Smoke-Wasy, Venturi
Toothache:	Orajel, Red Cross, Zilactin
Warts:	Compound W, Dr. Scholls, Pedific, Wart-off
Weight Loss:	Cidermax, Dexatrim, PatentLean, Puralin
Yeast Infection:	Monistat, Mycelex 3, Vaginex, Vagistat3

(c) Medical Care Expense Exclusions. Except as specifically included by this document, expenses that do not meet the definition of "medical care" under Section 213(d)(1) are excluded from reimbursement. The following is a partial list of expenses which are excluded and not eligible for reimbursement:

1) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma or a disfiguring disease.
2) Long term care expenses, except for premiums from long term care policies.
3) Funeral and burial expenses.
4) Massage therapy.
5) Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition.
6) Marijuana and other controlled substances, the possession of which are in violation of federal laws.
7) Maternity clothes, diaper service or diapers, babysitting childcare.
8) Bottled water, cosmetics, toiletries and toothpaste.
9) Vitamins and dietary supplements, except if a statement of medical necessity from Physician or Alternative Healthcare Provider is provided.
10) Automobile insurance premiums and automobile improvements, depreciation of an automobile, general repair or maintenance expenses of an automobile, even if other

transportation expenses are includable when used for transportation to receive medical care; except for car controls for the disabled.

11) Home improvements (unless motivated by medical considerations), household or domestic help.
12) Death benefits, life insurance benefits including the portion of the Plan's COBRA premium that pays for life insurance.
13) Any item that does not constitute "medical care", as defined under Internal Revenue Code Section 213(d)(1).

Excluded Over-the-Counter Medicines
Cosmetics, Hair Growth Treatment, Hemorrhoid Treatment, Illegally Procured Medicines, Sleeping Aids, Sun Block, and Toiletries.

Expenses that Do <u>Not</u> Qualify for Reimbursement

- Unnecessary cosmetic surgery and health care expenses incurred for the primary purpose of enhancing the appearance.
- Marriage or family counseling.
- The salary expense of a nurse incurred in connection with the care of a normal healthy newborn in the home.
- Household and domestic help (even though recommended by a qualified physician due to the inability to perform housework).
- Costs for sending a child to a special school for anticipated benefits the child may receive from the course of study and the disciplinary methods used.
- Any expense incurred in connection with an illegal operation or treatment.
- Health club dues, YMCA dues, steam bath, spa, gym, etc. (even if recommended for weight loss that is treatment for a specific disease diagnosed by a Physician).
- Social activities, such as dance lessons or classes (even if recommended by a physician).
- Programs for the purposes of general health and well being (excluding some programs which are specifically included such as weight loss or smoking cessation programs, but subject to the specific requirements listed in the eligible expense table).
- Diet food or beverages that substitute for normally consumed food or beverages which satisfy nutritional needs (special food can be included medical expenses only if the food does not satisfy normal nutritional needs, alleviates or treats an illness, and the need for the food is substantiated by a Physician).
- Vitamins taken for general health purposes.
- Automobile insurance premiums including the segment of premiums providing medical care for persons injured through the accident.
- Premiums paid for life insurance policies or for policies providing repayment for loss of earnings or for accidental loss of life, limb, sight, etc.

- Vacations for travel taken for purposes of general health, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect.
- Transportation expenses to and from work, even though a physical condition may require special means of transportation.
- PPO discounts or negotiated rates if you are not liable for them.

(d) Claims and reimbursement procedures.

1) Timing. Within thirty days after receipt by the Plan's Administrator of a reimbursement claim from you, the Plan will reimburse you for your Allowable Medical Care Expenses provided the claim form is completed in its entirety and is accompanied by the required documentation and the claim has been approved for payment by the Plan Administrator.

2) Filing a Claim. You may apply for reimbursement by submitting an application in writing to the Plan Administrator on a form provided by the Fund Office. Reimbursement must be sought no later than March 31st following the close of the Plan Year in which the Allowable Medical Care Expense was incurred. The application for reimbursement must include the following information: the person or person on whose behalf the Allowable Medical Care Expenses have been incurred; the nature and date of the expenses incurred; the amount of the requested reimbursement; and a statement of such expenses that would have not otherwise been reimbursed and are not reimbursable through any other source. The application must be accompanied by bills, invoices, and other statements from an independent party showing that the Allowable Medical Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement are at least $50.

3) Claim payments may never exceed the amount remaining in the HRA Account.

4) A participant's Active HRA account must be exhausted before he can receive a reimbursement from his Retiree HRA account.

COORDINATION OF BENEFITS. Benefits under this Plan are intended to pay benefits solely for Allowable Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise Allowable Medical Care Expense is payable or reimbursable from another source, that source shall pay or reimburse prior to payment or reimbursement from this Plan.

RIGHTS UPON TERMINATION. The Board of Trustees reserves the right to terminate the Plan and provide for the distribution of the Fund's assets, including the HRA Accounts, to all participants and eligible beneficiaries. It is the intention of the Board to continue the Plan indefinitely. However, it is difficult to predict the future so the Board of Trustees reserves the right to modify or terminate the Plan at any time should it become necessary in the Board of Trustees' sole discretion.

NOT GUARANTEED BY PENSION BENEFIT GUARANTEE CORPORATION. The Pension Benefit Guarantee Corporation is an entity established under ERISA to ensure payment of certain pension benefits. The Active and Retiree HRAs are part of the IBEW Local 22/NECA Health & Welfare Plan, which is not one of the types of plans that the Pension Benefit Guarantee Corporation covers.

QUALIFIED MEDICAL CHILD SUPPORT ORDER. A Qualified Medical Child Support Order ("QMCSO") is a judgment, decree, or order issued by a court of competent jurisdiction requiring that the Fund recognize an eligible child as an Alternate Recipient, as defined by ERISA Section 609(a). Such order must be approved in accordance with procedures adopted by the Board of Trustees. Upon receipt of a Medical Child Support Order or other order designating medical child support, the Fund Office will promptly notify each Alternate Recipient of the receipt of such order and the Plan's procedure for determining whether the order is qualified. Upon review of the order, the participant and all Alternate Recipients will be promptly notified whether the order has been determined to be a QMCSO. The Plan will provide benefits under the Plan to any Alternate Recipients in accordance with the applicable provisions of any QMCSO. Any payment of benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an Alternate Recipient's Custodial Parent or Legal Guardian, shall be made to Alternate Recipient's Custodial Parent or Legal Guardian.

APPEAL PROCEDURE. If you or your beneficiary wants to appeal a decision by the Plan Administrator to deny, or partially deny, any claim for reimbursement, you must follow the procedure contained in Attachment A, Article VIII of this Summary Plan Description.

IBEW LOCAL 22/NECA HEALTH AND WELFARE PLAN

Summary of Material Modification

The Board of Trustees would like to make you aware of a recent change in the eligibility and enrollment rules for Dependent children of active Eligible Employees.

Effective December 1, 2011, the Trustees amended the Plan's Eligibility and Enrollment provisions on page 4 of the Summary Plan Description ("SPD") to allow active Eligible Employees 90 (as opposed to 30) days to enroll a newborn or adopted child.

In accordance with this change, the following provisions replace the "Newborn Children" and "Adopted Children" provisions found on page 4 of your SPD:

Newborn Children

Coverage shall begin at birth for your newborn child so long as the Dependent child's enrollment form was postmarked or otherwise positively received by the Fund Office within **ninety (90)** days of such birth. If the Dependent child's enrollment form was not postmarked or otherwise positively received by the Fund Office on such date, the Dependent shall become eligible for coverage of claims incurred on or after the date the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office.

Adopted Children

If you are adopting a child, the effective date of the child's coverage will be the earlier of the date the child is placed with you for adoption, or the date a court order grants custody to you so long as the child's enrollment form was postmarked or otherwise positively received by the Fund Office within **ninety (90)** days of such date. If the child's enrollment form was not postmarked or otherwise positively received by the Fund Office on such date, the child shall become eligible for coverage of claims incurred on or after the date the child's enrollment form is postmarked or otherwise positively received by the Fund Office.

IMPORTANT NOTICE: These new eligibility and enrollment rules do not apply for the Dependent children of Retirees. If you have questions regarding eligibility and enrollment for Dependent children of Retirees, please contact the Fund Office.

[continued on reverse]

Grandfathered Status

This group health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office, or you may call the Blue Cross and Blue Shield of Nebraska Member Services Department at the telephone number shown on the back of your I.D. card.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

Should you have any questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES
April, 2012

IBEW LOCAL 22/NECA HEALTH AND WELFARE PLAN

Electrical Industry Center / 8960 "L" Street / Suite 101 / Omaha / Nebraska / 68127
(402) 593-7565 / (877) 762-7348 / (402) 593-7609 fax

Summary of Material Modifications

This notice is to inform you of changes to the IBEW Local 22/NECA Health and Welfare Plan ("Plan") and an update in the Plan's Board of Trustees.

Annual Maximum
Effective January 1, 2013, the Annual Benefit Maximum has been increased to $2,000,000.

Emergency Room Visit
Effective January 1, 2012, the 30% Coinsurance for non-Preferred Emergency Room Visits has been changed to 20%.

Hour Bank Account and Continuation of Eligibility
Effective March 1, 2013, the maximum amount of hours an Employee can accumulate in his Hour Bank Account is increased from 560 to 700 hours. This means that when an Employee is credited with more than 140 hours during a month, the excess hours will remain in that Employee's Hour Bank Account up to a maximum accrued balance of 700 hours.

Life and Accidental Death Benefits
Effective August 21, 2012, the Plan has been amended to automatically cancel the designation of your spouse as the beneficiary of your Life and Accidental Death Benefits in the event you are divorced. The cancellation is effective as of the date of your divorce. If you get divorced and you want your ex-spouse to remain your beneficiary, you must file a new Beneficiary Designation Form with the Fund Office after your divorce. If you designate your spouse and another individual as your beneficiaries, only the portion of the beneficiary designation that relates to your spouse will automatically become null and void upon divorce. Beneficiary Designation Forms are available at the Fund Office or at the website www.ibew22benefits.com.

Retiree Health Reimbursement Arrangement ("Retiree HRA")
Effective January 1, 2013, the Trustees have amended the terms of the Retiree HRA regarding eligibility and the crediting of accounts. The details of these amended terms are explained below.

ELIGIBILITY. Each former Bargaining Employee and former Non-Bargaining Employee that has contributions allocated to their Retiree HRA account on or after January 1, 2012 is eligible to participate in the Retiree HRA (i.e. is an Eligible Retiree). Effective January 1, 2013, a former Bargaining Employee or Non-Bargaining Employee will have contributions allocated to his Retiree HRA account in January of each year that he satisfies the following criteria:

- he was retired as of May 31 of the prior year and did not actively seek covered employment in the electrical industry through the following January 1. For purposes of this requirement, a participant is considered retired if he has ceased receiving coverage from the Plan as a Bargaining Employee or a Non-Bargaining Employee and he is not actively seeking covered employment in the electrical industry;

- he maintained coverage under the Plan as a Bargaining Employee or a Non-Bargaining Employee during at least 20 different calendar years preceding retirement. For purposes of this requirement, a former Bargaining Employee or Non-Bargaining Employee will be credited with one year of service for each calendar year for which they were covered for at least one month as a Bargaining Employee or a Non-Bargaining Employee under the Plan;
- he is not currently receiving a pre-retirement benefit from the IBEW Local 22 Pension Plan A;
- he is at least age 62 and alive as of May 31 of the prior year; his benefits are not currently suspended from the IBEW Local 22 Pension Plan A;
- he did not perform covered employment in the industry for an employer having no obligation to contribute to the Plan during the ten years immediately preceding retirement or at any time after retirement; and
- He maintained coverage under the IBEW Local 22/NECA Health and Welfare Plan for at least 1 month during the 10 years immediately preceding the date of his retirement.

(a) Crediting of Accounts. The Retiree HRA account will be credited each January based upon the Plan's accumulated Retiree HRA contributions received during the preceding Retiree HRA funding year. The Retiree HRA funding year will begin June 1st of each year and will end May 31st of the following year. This means that the January, 2013 Retiree HRA allocation is based on Retiree HRA contributions remitted on work hours from June 1, 2011 to May 31, 2012. Each year's Retiree HRA contributions will be allocated to Eligible Retirees based upon the following Retiree HRA Allocation formula:

Base Retiree HRA Benefit with 20 Years of Service	Additional Benefit Per Year of Service (21 to 30)	Maximum Annual Retiree HRA Benefit
$ "*X*"	1/10 "*X*"	2 times "*X*"

"*X*" is determined on a prorated basis once the preceding Retiree HRA funding year is completed.

EXAMPLE: January 1, 2013 Retiree HRA Allocation:

During the funding year ending May 31, 2012, Retiree HRA contributions totaled $152,295. Based upon the credited Retiree HRA years of service among that year's Eligible Retirees who were entitled to an allocation for that year, "*X*" was determined to be $364.00.

Base Retiree HRA Benefit with 20 Years of Service	Additional Benefit Per Year of Service (21 to 30)	Maximum Annual Retiree HRA Benefit
$364.00	$36.40	$728.00

Also, please be advised that the current Trustees for the Plan are as follows:

MANAGEMENT TRUSTEES

John McMahon, Chairman
O.K. Electric Company, Inc.
3112 South 67th Street
Omaha, NE 68106-3664

Scott Love
Miller Electric Company
2501 St. Mary's Avenue
Omaha, NE 68105-1696

Allan Hale
Nebraska Chapter NECA
8960 L Street, Suite 100
Omaha, NE 68127

UNION TRUSTEES

Gary Kelly, Secretary
IBEW Local Union No. 22
8946 "L" Street
Omaha, NE 68127-1406

Mike Stopak
4978 Oaks Lane
Omaha, NE 68137-1917

Steve Mayfield
401 South Cedar, Box 253
Mead, NE 68041

Grandfathered Status

This group health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office, or you may call the Blue Cross and Blue Shield of Nebraska Member Services Department at the telephone number shown on the back of your I.D. card.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/heathreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

You should place this document with your Benefit Booklet for future reference.

If you have any questions, do not hesitate to contact the Fund Office at (402) 593-7565 or toll free at (877) 762-9348.

Sincerely,

Board of Trustees

A Guide to Your 1/2011 Health Care Benefits for **IBEW Local 22/NECA** Health and Welfare Plan

BlueCross BlueShield of Nebraska

98-189 rev 01/2011

NOTICE:

RETIRED PERSONS 65 YEARS OF AGE OR OLDER

The IBEW22/NECA group health care coverage administered by Blue Cross and Blue Shield of Nebraska does NOT apply to retired persons 65 years of age or older. Only the Prescription Drug Benefits (page 85) which are administered by LDI Pharmacy Benefit Services (**not** by Blue Cross and Blue Shield of Nebraska) are applicable.

About Your Summary Plan Description

This document is your Summary Plan Description. It has been written to help you understand the International Brotherhood of Electrical Workers Local Union No. 22 and National Electrical Contractors Association Nebraska Chapter (IBEW22/NECA) Health and Welfare Plan administered in accordance with the provisions set forth in the Master Group Contract and Administrative Service Agreement between The Plan and your Contract Administrator, Blue Cross and Blue Shield of Nebraska,* an independent licensee of the Blue Cross and Blue Shield Association. Your rights under the Employee Retirement Income Security Act of 1974 (ERISA) are also described in this document.

This Summary Plan Description is only a partial description of the benefits, exclusions, limitations, and other terms of the Master Group Contract to which it refers. It describes the more important parts of that document in a general way. It is not, and should not be considered a Contract or any part of one. The Master Group Contract controls the coverage for your plan. A copy is available for your review in the IBEW Local 22/NECA Fund Office.

Please share the information found in this Summary Plan Description with your Eligible Dependents. Additional copies of this document or your Schedule of Benefits, are available from Blue Cross and Blue Shield of Nebraska's Customer Service Center. If you have a question about your coverage or claim, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center or the IBEW Local 22/NECA Fund Office.

The information in this Summary Plan Description may be amended or modified or terminated by the Board of Trustees as indicated in the section of this book titled "Plan Information" to reflect changes in benefits, eligibility requirements, or any other provisions, at their discretion, without prior approval. Such changes shall be binding on each covered employee and his or her Eligible Dependents.

Important Notes:

This Plan's Health Reimbursement Arrangement as identified by Attachment B in the back of this book, is administered by the Fund Office, **not** Blue Cross and Blue Shield of Nebraska.

Blue Cross and Blue Shield of Nebraska is not the Contract Administrator for Prescription Drug Benefits as identified by Attachment C, in the back of this book.

Health care benefits for retirees who are eligible for Medicare are provided through a Contract of insurance with Mutual of Omaha; they are **not** administered by Blue Cross and Blue Shield of Nebraska.

This Plan's death benefits, accidental death and dismemberment benefits, and accident and sickness loss of time benefits are all administered directly by the Fund Office, **not** by Blue Cross and Blue Shield of Nebraska.

If there is a discrepancy between this Summary Plan Description and the Master Group Contract, the terms of the Master Group Contract shall control. This Summary Plan Description contains the authoritative governing Plan document with respect to the provisions contained in Attachment A (such as eligibility for participation and for coverage, etc.).

**Blue Cross and Blue Shield of Nebraska provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Blue Cross and Blue Shield of Nebraska liability may occur only under a stop loss provision set forth in the Administrative Services Agreement.*

IBEW Local 22/NECA Health and Welfare Plan

Summary of Health Benefits for 1/2011

Annual Maximum (per covered person):	**$1,000,000**
Total Benefits for Organ and/or Tissue Transplants by Non-Preferred Provider:	**$150,000**

	BluePreferred Provider	Non-Preferred Provider
Calendar Year Deductible Individual: Family Maximum:	 $350 $1,050	 $350 $1,050
Coinsurance*:	20%	30%
Coinsurance* Limit Individual: Family Maximum:	 $2,500 $5,000	 $5,000 $10,000
Annual Out-of-Pocket Limit: *(Deductible and Coinsurance* combined)* Individual: Family Maximum:	 $2,850 $6,050	 $5,350 $11,050
Mental Illness, Alcoholism and/or Drug Abuse (MIDA) Treatment: Inpatient - Limited to 30 days per calendar year. Outpatient - Limited to 60 units per calendar year	 20% Coinsurance* for Inpatient or Outpatient Care $20 Copayment** for Outpatient Therapy	 30% Coinsurance* for Inpatient or Outpatient Care $20 Copayment** for Outpatient Therapy
Routine (Preventive) Exam:	A $20 Copayment** applies; any balance of covered charges are subject to the deductible and to applicable Preferred (20%) Coinsurance* or non-Preferred (30%) Coinsurance*.	
Emergency Room Visit:	A $20 Copayment** applies; any balance of covered charges are subject to the deductible and to applicable Preferred (20%) Coinsurance* or non-Preferred (30%) Coinsurance*.	
Urgent Care Center Visit, and Physician Office Visit:	A $20 Copayment** applies; any balance of covered charges are subject to the deductible and to applicable Preferred (20%) Coinsurance* or non-Preferred (30%) Coinsurance*.	
Retail Clinic Services (clinic housed within a retail store)	$5 Copayment	30% Coinsurance*

*** Coinsurance is the percentage of each allowable charge which you must pay.**
**** Copayments do not apply toward the Deductible or toward the Coinsurance Limits.**

Special Note: Prescription drugs that are prescribed, billed by and administered at/by a hospital or physician (or other professional provider) are covered under the benefit program administered by Blue Cross and Blue Shield of Nebraska. Prescription drugs that are not prescribed, billed by and administered at/by a hospital or physician (or other professional provider) are covered under a separate benefit program administered by LDI Pharmacy Benefit Services. Information about the prescription drug coverage administered by LDI Pharmacy Benefit Services is provided in Attachment C at the back of this book.

Important Telephone Numbers

Blue Cross and Blue Shield of Nebraska

Customer Service:

Omaha 402-390-1820
Toll-free 1-800-642-8980
TTY/TTD (for the hearing impaired) 402-390-1888

Coordination of Benefits:

Omaha 402-390-1840
Toll-free 1-800-462-2924

Subrogation:

Omaha 402-390-1847
Toll-free 1-800-662-3554

Workers' Compensation:

Omaha 402-398-3615
Toll-free 1-800-821-4786

Notification/Certification:

Omaha 402-390-1870
Toll-free 1-800-247-1103

BlueCard Provider Information:

Toll-free 1-800-810-BLUE (2583)
Web site ..... www.bcbs.com

Fund Office

Omaha 402-593-7565
Toll-free 1-877-762-9348
Web site www.ibew22benefits.com

LDI Pharmacy Benefit Services

Toll-free 1-866-516-3121
Web site ..... www.ldirx.com

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Some Important Facts About Your Coverage

This Group Health Plan is a preferred provider organization (PPO) health benefit plan.

Blue Cross and Blue Shield of Nebraska is the Contract Administrator for the Group Health Plan.

BluePreferred is a Preferred Provider Organization (PPO) established by Blue Cross and Blue Shield of Nebraska through Contracts with a panel of hospitals, physicians and other health care providers who have agreed to furnish medical services to you and your family in a manner that will help manage health care costs. These providers are referred to as "Blue*Preferred*" or "Preferred Providers."

Blue Cross and Blue Shield Plans in other states (on-site plans) have also contracted with health care providers in their geographic areas, as "Preferred Providers."

By using Preferred Providers, you benefit from these important advantages:

- Lower coinsurance requirements in most cases.
- Preferred Providers accept your deductible and/or coinsurance plus this group plan's benefit payment as payment in full for a covered service. When a Preferred Provider is used, you are not responsible for charges in excess of the contracted amount for a service.

When this plan pays benefits for services provided to you, it pays directly to the Preferred Provider. This way you do not have to pay a Preferred Provider more than a deductible and/or coinsurance amount at the time covered services are provided. **Preferred Providers will also file claims for you.**

Blue Cross and Blue Shield Plans across the country participate in a national program called the BlueCard Program. Each plan has a network of providers who specifically have agreed to participate as BlueCard Program network (PPO) providers. These providers will also be referred to as "Preferred Providers." The BlueCard Program enables the Blue Cross and Blue Shield Plan servicing the geographic area where treatment is provided to process the claim, and allows you to take advantage of the local plan's Contracting Provider agreements.

USING YOUR BENEFITS WISELY

The Board of Trustees for the IBEW Local 22/NECA Health and Welfare Plan want you to get the most from your group health coverage. You can save yourself a considerable amount of time and money by making efficient use of the health care system.

As you read this document, some "Good Care Tips" for efficient health care will be highlighted in boxes just like this one.

Selecting A Provider

No matter where you are when you require health care services, whether you are in Nebraska or in another state, selection of a provider of care always remains your choice. However, the provider you choose may make a difference in the amount of benefits your coverage provides and, therefore, whether your liability will be more or less.

In the Blue*Preferred* Service Area (Nebraska)

Selection of a provider of care always remains your choice. If you choose a Blue*Preferred* Provider, you are eligible to receive the highest benefit level (preferred) possible under your group health plan. However, if you choose a non-Preferred Provider, the benefit level (non-preferred) will generally be less. For help in locating a Blue*Preferred* Provider, contact Blue Cross and Blue Shield of Nebraska's Customer Service Center at their toll-free number (1-800-642-8980). A directory of *BluePreferred* Providers is available upon request or at the Blue Cross and Blue Shield of Nebraska website: **www.bcbsne.com**.

Outside the Blue*Preferred* Service Area

Selection of a provider of care still remains your choice. If you receive care from a provider who is a Preferred Provider with the on-site Blue Cross and/or Blue Shield Plan, you are eligible to receive the highest benefit level (preferred) possible under your group health plan. However, if you choose a non-Preferred Provider, the benefit level (non-preferred) will generally be less. For help in locating a Preferred Provider in another Blue Cross and/or Blue Shield service area, you may call the special toll-free number of the Blue Cross and Blue Shield BlueCard Program (1-800-810-2583) for assistance.

Also, for help in locating a provider, you can visit the "BlueCard PPO Provider Finder" at the Blue Cross and Blue Shield Association website: **www.bcbs.com.**

BlueCard Program

Blue Cross and Blue Shield plans across the country participate in the BlueCard Program. This program enables the Blue Cross and Blue Shield plan servicing the geographic area where health care services are provided (on-site plan) to receive and process claims for covered services.

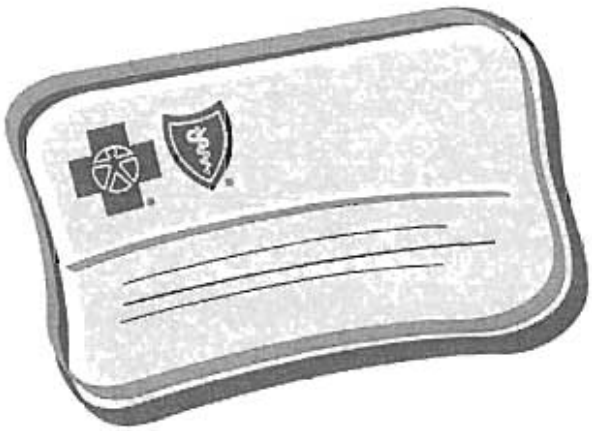
When you obtain health care services through the BlueCard Program outside the geographic area Blue Cross and Blue Shield of Nebraska serves, the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or
- The contracted amount that the on-site Blue Cross and Blue Shield Plan (Host Blue) passes on to Blue Cross and Blue Shield of Nebraska.

Often, this contracted amount will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements with your health care provider or with a specified group of providers. The contracted amount may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The contracted amount may also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered the final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating subscriber liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate subscriber liability calculation methods that differ from the usual BlueCard method noted above, or require a surcharge, Blue Cross and Blue Shield of Nebraska would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Your I.D. Card — A Passport to Health Care



Blue Cross and Blue Shield of Nebraska will issue you an identification card. Your I.D. number is a nine-digit number with an alpha prefix and a numeric suffix. If other members of your family are covered by your membership, their names and dates of birth will also appear on your I.D. card. Each family member will be assigned a different numeric suffix. Only five names can appear on one I.D. card; therefore, you will receive more than one card if there are more than five eligible family members.

Always put your I.D. card in your wallet or purse, along with your driver's license, credit cards and other essential items. With your Blue Cross and Blue Shield of Nebraska I.D. card, U.S. hospitals and physicians can identify your coverage and will usually submit their claims for you.

If you want extra cards for covered family members or need to replace a lost card, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center. Remember, only persons who are eligible for coverage under your membership may use your Blue Cross and Blue Shield of Nebraska I.D. card.

Schedule of Benefits

Your Schedule of Benefits is a personalized document that provides information concerning: Deductible amounts, Preferred and non-Preferred Provider coinsurance amounts, special benefits, and maximums and limitations of your coverage.

Eligibility & Enrollment

Eligibility for Coverage

Employee and Dependent eligibility for coverage is subject to the requirements set forth in the Plan Documents for the IBEW 22/NECA Health and Welfare Plan. Please refer to Attachment A of the Plan Document, Article II, Eligibility for Benefits, in the back of this book, or contact the IBEW Local 22/NECA Fund Office for specific information regarding eligibility.

Non-bargaining unit employees and their Dependents must enroll within 30 days of their initial eligibility, or late enrollment provisions may apply. Please refer to Attachment A in the back of this book for information.

Eligible Dependents

The Plan provides coverage for you, your legal spouse, and your children under age 26 if they meet the definition of Dependent found in Attachment A, Article 1, Definitions, Section 1.06. If you have an unmarried child of any age who is permanently and totally disabled and they meet the definition of Dependent under Section 1.06, they will also be an Eligible Dependent.

If your Dependent child(ren) is not enrolled for coverage on December 20, 2010, enrollment for such Dependent child(ren) is effective for coverage of claims incurred on or after the Dependent child(ren)'s enrollment form is postmarked or otherwise positively received by the Fund Office. You may be required to provide documentation that your eligible child over age 19 has no employer health care coverage available through his/her employer, or his/her spouse's employer if the eligible child is married.

Note: See Attachment A, Article 1, Definitions, Section 1.06, Dependent (on page 53 in the back of this book) for additional information.

Marriage

When you marry, your spouse and any other new Dependents are eligible to enroll for coverage. Please notify the IBEW 22/NECA Fund Office as soon as possible after the marriage so that your records may be updated.

Newborn Children

Coverage shall begin at birth for your newborn child so long as the Dependent child's enrollment form was postmarked or otherwise positively received by the Fund Office within thirty (30) days of such birth. If the Dependent child's enrollment form was not postmarked or otherwise positively received by the Fund Office on such date, the Dependent shall become eligible for coverage of claims incurred on or after the date the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office.

Adopted Children

If you are adopting a child, the effective date of the child's coverage will be the earlier of the date the child is placed with you for adoption, or the date a court order grants custody to you so long as the child's enrollment form was postmarked or otherwise positively received by the Fund Office within thirty (30) days of such date. If the child's enrollment form was not postmarked or otherwise positively received by the Fund Office on such date, the child shall become eligible for coverage of claims incurred on or after the date the child's enrollment form is postmarked or otherwise positively received by the Fund Office.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or paternity disputes. The order may direct the group health plan to enroll the child(ren), and also creates a right for the alternate recipient to submit claims and receive benefits for services.

QMCSOs are specifically defined under the law, and are required to include certain information in order to be considered "qualified." A National Medical Support Notice received by the plan from a state agency, regarding coverage for a child, will also be treated as a QMCSO. The Plan Administrator or its designee, will review the Order or Notice to determine whether it is qualified, and make a coverage determination. The Plan Administrator or its designee will notify affected employees and the alternate recipient(s) if a QMCSO is received.

You have the right to request a copy of the Plan's procedures governing QMCSO determinations from the Plan Administrator, at no charge.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act of 1993, as amended, requires that subject to certain limitations, most employers of 50 or more persons must offer continued coverage to eligible employees and their covered Dependents, while the employee is on an approved FMLA leave of absence. In addition, an employee who has terminated his/her group health coverage while on an approved FMLA leave is entitled to reenroll for group health coverage upon return to work.

Please check with your employer for details regarding your eligibility under FMLA.

Continuation of Coverage (COBRA)

Public Law 99-272 (COBRA), and its subsequent amendments, requires that continued coverage under your group health plan be offered if coverage would otherwise be lost as a result of:

- termination of your employment (other than for gross misconduct),
- a reduction in work hours,
- divorce or legal separation,
- a child losing dependent status,
- you becoming entitled to Medicare, or
- your death.

Special Note: Please refer to Attachment A, Article II Eligibility for Benefits for additional information about you and/or your Dependent's eligibility for COBRA continuation coverage. You may check with the IBEW Local 22/NECA Fund Office for details.

Understanding Your Health Coverage

Your group health coverage consists of a wide variety of benefits:

Hospital Benefits

Physician Medical-Surgical Benefits

Mental Illness, Drug Abuse, and Alcoholism Benefits

Organ/Tissue Transplant Benefits

Oral Surgery and Dentistry Benefits

Home Health Aide, Skilled Nursing Care, Hospice and Skilled Nursing Facility Benefits

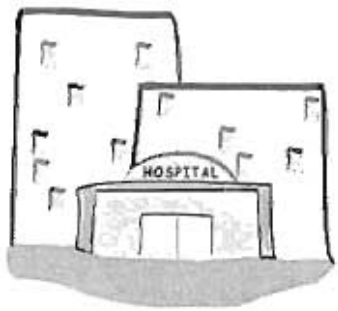
Other Benefits — Including such services as ambulance service, physical therapy, speech therapy, home medical equipment and certain other services.

Remember: *With this plan, it is to your advantage to use the network of BluePreferred or Preferred Providers, but it still remains your choice. If you use a Preferred Provider, you are eligible to receive the highest benefit level (preferred) possible under this plan for covered services. If you use a non-Preferred Provider, you are still eligible to receive benefits for covered services, but the benefit level (non-preferred) for these services will usually be less than if you had gone to a Preferred Provider.*

Exception: *If you receive initial inpatient or outpatient care for an emergency medical condition at a non-Preferred hospital or by a non-Preferred provider, benefits for covered services for the initial care will be provided at the Preferred Provider benefit level.*

Please refer to the section in this book "Notification, Certification and Concurrent Review" for information regarding certification of an emergency admission.

Reminder: *If more than one physician is involved in your care, it is important for you to check the preferred status of each provider. This is especially important when you are receiving services from multiple providers while hospitalized. If you wish to stay within the Preferred Provider network, make sure your attending physician knows this. Ask that you be informed, before the service is performed, if he or she is referring you to a provider outside the Preferred Provider network.*



Important Health Coverage Terms

Allowable Charge — Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by Preferred or Contracting Providers will be a contracted amount for the service. The allowable charge for services by non-Contracting Providers will generally be the lesser of the billed charge or Reasonable Allowance for the service. Please refer to the Definitions found in the back of this document for details.

Reasonable Allowance — The amount determined by Blue Cross and Blue Shield of Nebraska to be payable to non-Contracting Providers for a covered service.

Coinsurance — This is the percentage you must pay, after the deductible is applied. (Your coinsurance payment is generally lower if you receive services from a Preferred Provider.)

Copayment — This is the dollar amount you must pay for specified covered services. This amount does not apply toward either your calendar year Deductible or Coinsurance Limit.

Deductible — There is a calendar year deductible applicable to each covered person before benefits begin. For a family, the maximum deductible amount is limited to three times the individual deductible amount per calendar year. After the deductible is met, benefits for the rest of that calendar year will not be subject to any further deductible.

The amounts applied to the deductible for covered services by either Preferred Providers or non-Preferred Providers will be credited to both deductibles. Charges for noncovered services or amounts in excess of the allowable charge do not count toward your deductible.

Coinsurance Limit — The coinsurance limit is the maximum amount of coinsurance each covered person must pay in a calendar year, except as noted below. When the amount of your eligible coinsurance payments equals the dollar amount specified on your Schedule of Benefits, the coinsurance percentage no longer applies for the rest of the calendar year. For a family, this maximum coinsurance amount is limited to twice the individual maximum coinsurance amount per calendar year. After that, benefits for the rest of that calendar year will not be subject to any further coinsurance amounts.

Certain kinds of expenses do not count toward your coinsurance liability limit. For example:

- Charges in excess of the allowable charge.
- The coinsurance for treatment of mental illness, drug abuse and alcoholism under any part of this group health plan.
- Charges for services that are not covered by this group health plan.
- The calendar year deductible.

Your deductible, coinsurance and coinsurance liability limit amounts are chosen by the IBEW Local 22/ NECA Health and Welfare Plan Board of Trustees and are shown on your Schedule of Benefits.

Annual Maximum Per Covered Person — Your Schedule of Benefits shows a specific annual maximum per covered person for benefits under this group health plan.

Utilization Review

Benefits are available under the group health plan for **medically necessary** and **scientifically validated** services. Services provided by all health care providers are subject to **utilization review** by Blue Cross and Blue Shield of Nebraska. Services will not automatically be considered medically necessary because they have been ordered or provided by a physician. Blue Cross and Blue Shield of Nebraska will determine whether services provided are medically necessary under the terms of the plan, and benefits available. **Please refer to the definitions in the back of this book for a description of these terms.**

NOTICE

Non-Preferred Providers' charges may be higher than the benefit amount allowed by this group plan. You may contact Blue Cross and Blue Shield of Nebraska's Customer Service Center concerning allowable benefit amounts for specified procedures in Nebraska. Your request must specify the service or procedure, including any service or procedure code(s) or diagnosis-related group, and the provider's estimated charge.

Medical Records

In consideration for the processing of claims, Blue Cross and Blue Shield of Nebraska will be entitled to receive such facts, records, and reports about the examination or treatment of Covered Persons as may be needed to process claims or to determine the appropriateness of benefit payment. The Covered Person agrees that in consideration for benefits available, he or she consents to the release of such information to Blue Cross and Blue Shield of Nebraska.

Payments Made in Error

Payments made in error or overpayments may be recovered by Blue Cross and Blue Shield of Nebraska, as provided by law. Payment for a specific service or erroneous payment shall not make Blue Cross and Blue Shield of Nebraska or the group health plan liable for further payment of the same condition.

Under certain circumstances, if Blue Cross and Blue Shield of Nebraska pays a Provider amounts that are the responsibility of the Covered Person under this Contract, Blue Cross and Blue Shield of Nebraska may collect such amounts from the Covered Person.

Notification, Certification And Concurrent Review Requirements

Notification Requirements

Blue Cross and Blue Shield of Nebraska must be notified of all inpatient hospitalizations prior to admission. When you are treated at a BluePreferred hospital notification will be provided by the hospital.

When you are hospitalized in a Non-BluePreferred hospital or in a hospital outside of Nebraska, it is your responsibility to see that Blue Cross and Blue Shield of Nebraska is notified of the admission. Notification may be made by you, your physician, the hospital, or someone acting on your behalf. If the anticipated admission date changes, notification of the change must be made. Make sure you advise the members of your family about these requirements since they apply to you and your covered family members.

Benefits for all services which are determined to be not medically necessary will be denied.

Emergency admission: Blue Cross and Blue Shield of Nebraska must be notified of an admission for an emergency medical condition within 48 hours of the admission (or the next business day). If notification is not received, the 48-hour period prior to the admission and the 48 hour period after such admission will be reviewed to determine if the patient's condition and treatment would have hindered his or her ability to provide notice.

NOTE: Admission through the emergency room does not necessarily constitute an emergency admission.

Maternity admission: Federal law provides for a length of stay of up to 48 hours following a normal vaginal delivery and 96 hours following a cesarean section unless otherwise agreed to by the patient and her physician. Notification or Certification is not required for an initial maternity admission. However, certification is required if the hospitalization extends beyond these times.

Certification Requirements

All inpatient admissions for treatment of mental illness and/or substance abuse, physical rehabilitation, long term acute care, and skilled nursing facility care must be precertified for benefit payment. Precertification is required regardless of the PPO/Preferred status of the hospital or facility and whether it is in or out-of the state of Nebraska.

When Blue Cross and Blue Shield of Nebraska receives a request for certification, the appropriateness of the setting and the level of medical care as well as the timing and duration of the admission is assessed by Blue Cross and Blue Shield of Nebraska (or by persons designated by Blue Cross and Blue Shield of Nebraska).

The physician, hospital, covered person or someone acting on the covered person's behalf may request the certification. Blue Cross and Blue Shield of Nebraska will notify such provider, the covered person or someone acting on the covered person's behalf whether or not benefits will be certified for an inpatient admission and the number of days considered medically necessary.

When possible, admission certification by the facility or physician should be arranged prior to the inpatient admission. Claims may be denied if the covered person's condition or the facility does not meet the criteria for the admission.

Benefits for services determined to be not medically necessary will be denied.

The Concurrent Review Process

Concurrent Review is a review of an ongoing inpatient admission to analyze the medical necessity and appropriateness of your continued inpatient stay.

If additional days are needed beyond the number of days originally certified, benefits for those days must also be certified. The hospital or other facility will be advised to call Blue Cross and Blue Shield of Nebraska to determine if additional days are medically necessary.

If the inpatient care is no longer medically necessary beyond the number of days certified by Blue Cross and Blue Shield of Nebraska, benefits for all services that are determined to be not medically necessary will be denied.

If your physician does not agree with this decision, he or she may submit an appeal to Blue Cross and Blue Shield of Nebraska. Additional information may also be submitted at this time. They will notify both you and your physician of the appeal decision. Please refer to the Appeal Procedures section of your booklet for additional information.

Please remember that notification or certification of an inpatient admission does not guarantee payment. All other group plan provisions apply. For example: deductibles, coinsurance, eligibility, exclusions and waiting periods.

If your benefits are denied due to failure to notify, precertify or a denial of certification,and the hospital, inpatient facility or physician is a BluePreferred or Participating provider with Blue Cross and Blue Shield of Nebraska, they are liable for their services which are determined by Blue Cross and Blue Shield of Nebraska to be not medically necessary. An exception is made if you have agreed in writing to be responsible for such services or the provider has documented in the medical record that you were notified of the determination. You will remain liable for any denied charges.

AVOID WEEKEND ADMISSIONS

Ask your physician to avoid nonemergency weekend admission as most hospitals do not perform surgical or other nonemergency procedures on weekends. Benefits may be denied if this kind of admission is not medically necessary.

Covered Services

Inpatient Hospital Care

If you are hospitalized, benefits are available for the following medically necessary covered services and supplies:

A semiprivate room. If you have a private room, benefits will be based on the allowable charge for a semiprivate room, unless confined for treatment of preeclampsia, toxemia, or required isolation to prevent contagion. You are responsible for the difference.

Cardiac care or intensive care unit.

> **Note:** If you use more than one room during a 24-hour period, benefits will be provided only for one room, based on the most intensive care provided during that period.

Use of operating, recovery and other appropriate treatment rooms and equipment. Benefits are not available for separate rooms used for procedures that are customarily provided in the patient's room.

Anesthesia.

Respiratory care.

FDA-approved drugs, intravenous solutions, vaccines, biologicals and medicines which are prescribed and administered while hospitalized.

Administration and processing of blood, blood plasma, blood derivatives or fractionates.

Supplies, materials and equipment except "take-home" supplies and convenience items.

Radiology (x-ray) and pathology (lab) and other diagnostic services billed by the hospital.

Radiation and chemotherapy, except that "high dose" chemotherapy is limited to procedures which are specifically listed as covered services in the section of this booklet titled: "Organ and Tissue Transplants."

Physical therapy when provided by a licensed physical therapist or a licensed physical therapist's assistant supervised by and assigned to a physical therapist.

Occupational therapy when provided by a licensed occupational therapist, or licensed occupational therapist's assistant supervised by an occupational therapist.

Speech therapy when provided by a licensed speech-language pathologist or registered communications assistant practicing under the direct supervision of a licensed speech-language pathologist.

Reminder: Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospital admissions.

Long Term Acute Care

Long Term Acute Care is specialized acute hospital care for medically complex patients who are critically ill, have multisystem complications and/or failures, and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour seven-day-a week basis.

Benefits must be precertified for all Long Term Acute Care admissions regardless of the facility's Preferred or non-Preferred status.

Physical Rehabilitation Program

Benefits for inpatient physical rehabilitation services must be precertified by Blue Cross and Blue Shield of Nebraska prior to admission. The covered person must be disabled and meet specifications for coverage as determined by Blue Cross and Blue Shield of Nebraska. The inpatient rehabilitation must follow within 90 days of the acute hospitalization for the injury, illness or condition causing the disability. Benefits are not available for Custodial Care.

Physical rehabilitation is defined as the restoration of a person who was disabled as the result of an injury or an acute physical impairment to a level of function that allows a person to live as independently as possible. A person is disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

Benefits are available for covered hospital and physician services, including:

- recreational therapy,
- social service counseling,
- prosthetic devices and fitting, and
- psychological testing.

The covered person must have intense daily involvement in two or more of the following treatment modalities:

- physical therapy,
- occupational therapy, or
- speech therapy.

Benefits for physical rehabilitation will stop when:

- further progress toward the established rehabilitation goal is minimal or unlikely,
- such progress can be achieved in a less intensive setting,
- treatment could be continued on an outpatient basis, or
- the covered person no longer meets criteria for eligibility as previously stated.

For benefits to be available for a physical rehabilitation program, the provider must be accredited for comprehensive inpatient rehabilitation by the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Reminder: All inpatient admissions related to an inpatient physical rehabilitation admission must be precertified for benefit payment by Blue Cross and Blue Shield of Nebraska prior to admission. Precertification may take place at any time prior to admission, or within 48 hours after admission.

Skilled Nursing Facility

Benefits are available for up to 30 days per calendar year for medically necessary skilled nursing care services provided in a semi-private room of a skilled nursing facility. Benefits for all skilled nursing facility admissions must be precertified by Blue Cross and Blue Shield of Nebraska.

The covered person must be confined in a free-standing facility licensed by the state as a Nursing Facility (NF) or licensed by the state and/or certified by Medicare as a Skilled Nursing Facility (SNF) or, part of a hospital with designated beds licensed by state law and/or certified by Medicare as Skilled Nursing or Swing Beds. The facility or such part of the facility must provide medically necessary room, board, and 24-hour-a-day skilled nursing care, as well as other related services for the care and rehabilitation of injured, disabled or sick persons.

Confinement in the skilled nursing facility must be for an unstable health condition which:

- requires daily skilled observation of the patient's medical status;
- requires daily therapeutic treatment by a skilled professional, and
- interferes with the patient's ability to perform the activities of daily living unassisted.

The skilled nursing facility confinement must be ordered by a physician, be medically necessary and the covered person must be receiving skilled nursing care.

A skilled nursing facility does not include:

- a place that is primarily used for rest, care and treatment of mental illness and/or substance abuse,
- a place for custodial care, or
- a place for educational or non-medical personal services.

Skilled nursing care in a skilled nursing facility does not include:

- supportive services of a stabilized condition;
- care which can be learned and given by unlicensed or uncertified medical personnel;
- routine health care services;
- general maintenance or supervision of routine daily activities, or
- routine administration of oral or non-prescription drugs.

Inpatient Mental Illness and Substance Abuse

Benefits will be provided for medically necessary, scientifically validated covered services provided for the treatment of mental illness and/or substance abuse as described in the part of this book titled "Mental Illness And Substance Abuse".

All inpatient admissions to any hospital or treatment center for treatment of Mental Illness and/or Substance Abuse must be precertified regardless of whether care is received at a BluePreferred, Preferred or non-Preferred facility in Nebraska or in another state.

When You Use Outpatient Facilities

If you are treated in a hospital outpatient department, ambulatory surgical facility, urgent care center or other outpatient facility, benefits will be provided for medically necessary services. Benefits will also be provided for an observation room for a period of 24 hours, not to exceed the average cost of a semi-private room. Benefits for a hospital emergency room visit or urgent care center visit charge will be subject to a copayment. The balance of covered charges after the copayment amount has been met will be subject to the applicable deductible and coinsurance amounts. Please refer to your Schedule of Benefits or the summary in the front of this book for copayment, deductible and/or coinsurance amounts.

EMERGENCY ROOMS ARE EXPENSIVE

Hospital emergency rooms are very expensive because they are specifically staffed and equipped to handle accidents, injuries and other emergencies. Using them for Preventive care (or as a substitute for the family physician) can cost you time and money.

Outpatient Cardiac Or Pulmonary Rehabilitation

Benefits will be provided for medically necessary outpatient cardiac or pulmonary rehabilitation services. Benefits for pulmonary rehabilitation must be preauthorized by Blue Cross and Blue Shield of Nebraska.

Benefits are available for covered outpatient hospital and physician services, including:

- initial rehabilitation evaluation,
- exercise sessions, and
- concurrent monitoring during the exercise session for high risk patients.

Benefits are not available for:

- diet or dietetic instructions,
- smoking cessation classes,except as provided for under Tobacco Cessation Coverage as described in Attachment C of this booklet,
- medication instruction,
- weight control and/or instruction,
- recreational or educational therapy, or forms of nonmedical self-help or self-care therapy, or
- environmental control items such as air conditioners and dehumidifiers.

The cardiac or pulmonary rehabilitation program must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations, or as otherwise approved by Blue Cross and Blue Shield of Nebraska.

Cardiac or pulmonary rehabilitation is defined as the use of various modalities of treatment to improve cardiac or pulmonary function as well as tissue perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-illness level of activity or a new and appropriate level of adjustment.

Cardiac Rehabilitation — Benefits will be provided for services at any therapeutic level, limited to 18 sessions, for the following diagnoses occurring during the preceding four months:

- an acute myocardial infarction,
- coronary artery angioplasty, with or without stent placement, or other scientifically validated procedure to clear blocked vessels,
- heart or coronary artery surgery,
- heart transplant,
- heart-lung transplant, or
- cardiac rehabilitation for treatment of congestive heart failure and stable angina initially and after significant changes in clinical status as determined by Blue Cross and Blue Shield of Nebraska.

Pulmonary Rehabilitation — Benefits will be provided prior to and following:

- lung transplant,
- heart-lung transplant,
- lung volume reduction surgery, and
- for severe chronic lung disease patients as reviewed and determined by Blue Cross and Blue Shield of Nebraska.

Pulmonary rehabilitation services will be limited to the following:

- Chronic lung disease patients are limited to 18 sessions (including follow-up home sessions) initially and after significant changes in clinical status. However, no more than 18 sessions will be covered in a single calendar year.
- Lung transplant, heart-lung transplant and lung volume reduction surgery patients are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from the hospital following surgery.
- Pulmonary rehabilitation services will be covered only when under continuing supervision of a physician and in a hospital environment.

Preauthorization Request Procedure: Benefits must be preauthorized by Blue Cross and Blue Shield of Nebraska for a pulmonary rehabilitation program, prior to starting the program. A written request for preauthorization should be directed to Blue Cross and Blue Shield of Nebraska, Attention: Medical Support Department, P.O. Box 3248, Omaha, Nebraska 68180-0001.

Blue Cross and Blue Shield of Nebraska will notify both the covered person and the provider in writing about the approval or disapproval of coverage. If benefits are not preauthorized, claims for such benefits may be denied if the covered person's condition or the program does not meet established criteria.

Physician's Services

Benefits are available for covered services provided by a physician or oral surgeon, a certified nurse midwife, a certified nurse practitioner or certified physician's assistant, within the practitioner's scope of practice, when supervised and billed by a physician.

Covered services include:

Surgical Expenses. The amount payable for a covered inpatient or outpatient surgical procedure includes normal care before and after surgery (preoperative and postoperative care).

When multiple or bilateral surgical procedures are performed which add significant time or complexity at the same operative session, benefits for the primary procedure will be paid as determined by Blue Cross and Blue Shield of Nebraska. For any secondary procedure or additional procedure, the allowable charge will be 50% of the allowable charge had the procedure been primary. When surgery is performed in two or more steps, benefit payment will be made as a single procedure.

Surgical Assistance. Benefits of up to 20% of the amount payable for surgery will be available for surgical assistance by a physician or other approved provider, within his or her scope of practice, who actively assists the operating physician for certain procedures. Benefits for surgical assistance are available for covered procedures specified by Blue Cross and Blue Shield of Nebraska. Please contact their Customer Service Center for specific information.

Anesthesia Services by a physician or certified registered nurse anesthetist. Benefits are also available for an oral surgeon or dentist with a permit issued by the state, to administer general anesthesia. The amount payable for anesthesia services will include the usual preoperative and postoperative visits and the necessary management of the patient, during and after the administration of the anesthesia. Payment will not be made for supervision of the administration of anesthesia. Benefits will not be provided for local infiltration or the administration of anesthesia by the attending or assisting surgeon (except spinal, saddle or caudal blocks related to pregnancy or general anesthesia for covered oral surgery and dentistry procedures under this Plan).

OUTPATIENT SURGERY

Many surgical procedures can be performed as an outpatient. This can save you time and trouble by allowing you to return home on the same day. Ask your physician about outpatient surgery.

Inpatient Hospital Visits for a medical condition for which surgical care is not required.

Concurrent Inpatient Hospital Visits by two or more physicians on the same day if their services are:

- for unrelated nonsurgical medical diagnoses which require the services and skills of two or more physicians with unrelated specialties, or
- necessary because of medical complications requiring additional skills not possessed by the attending surgeon or assistant surgeon.

Consultations by providers with different specialties or sub-specialties when requested by the physician in charge of your care and when your condition requires special care or knowledge not possessed by your attending or other consulting physician(s). The consultation must include a physical examination and written report in the covered person's hospital chart or conveyed to the referring physician.

Intensive Medical Services. Unusual, repeated and prolonged attendance at the covered patient's bedside when required by the illness, injury or pregnancy.

Radiation therapy and chemotherapy, except as excluded (or not specifically listed as covered) under the section titled "Organ and Tissue Transplants."

Radiology (x-ray), pathology (laboratory) and other diagnostic services.

Tissue exams related to covered surgical procedures.

Interpretation of Pap Smears.

Screening mammograms and corresponding fees for technical and professional interpretation of mammograms.

Preventive (Routine) Care. Benefits are available for covered preventive (routine) care services.

Covered services include:

- periodic physical exams,
- routine office visits,
- routine laboratory testing,
- routine radiology,
- routine mammograms,
- routine cardiac stress tests,
- routine pap smears and
- routine immunizations.

The copayment amount indicated on your Schedule of Benefits and on the Summary of Health Benefits in the front of this book, is applicable to the charge for a periodic exam or office visit charge. Remaining charges for covered routine care services will be paid subject to the applicable deductible and coinsurance amounts.

Physician visits for nonroutine care in the patient's home, in the physician's office, the outpatient department of a hospital or an ambulatory surgical facility. Benefits for a physician's office visit charge will be subject to the copayment amount indicated on your Schedule of Benefits and in the front of this book. Any available balance after the copayment amount has been met will be subject to the applicable deductible and coinsurance amounts.

Retail Clinic Services provided by a preferred clinic will be subject to a copayment amount indicated on your Schedule of Benefits or in the front of this book. Approved services include but are not limited to: clinic visits and physical exams, laboratory, drugs administered during the visit, supplies used to treat the patient during the clinic visit and immunizations. Services provided by a non preferred clinic are subject to the applicable deductible and coinsurance amounts.

FDA-approved drugs, intravenous solutions, vaccines, biologicals, and medicines which are prescribed and administered to the covered person in the physician's office.

Allergy tests, allergy extracts and injections of allergy extracts.

PREADMISSION TESTING SAVES TIME AND TROUBLE

Preadmission tests are x-ray and lab tests which are performed in a hospital's outpatient department before you are admitted for surgery. This can save you extra time in the hospital.

Pregnancy And Maternity Care

Benefits are available for hospital, surgical and medical care for pregnancy. Benefits for prenatal and postnatal care (excluding the initial visit) are included in the payment for delivery. Benefits include care for complications of pregnancy or interruptions of pregnancy. These maternity benefits are available to you or your covered spouse.

Benefits are also available for obstetrical care provided by a certified nurse midwife when such obstetrical services are within their scope of practice and such services are supervised and billed for by a physician.

Benefits may not, under Federal law, be restricted for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, benefits may be paid for a shorter stay if the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or newborn earlier. In addition, a plan may not require the provider to obtain authorization from the plan for prescribing a length of stay of up to 48 hours (or 96 hours).

Benefits are also not available for postpartum depression, psychosis or any other mental illness. Limited benefits for this type of condition are provided under you mental illness benefits.

For verification of maternity benefits, please check your Schedule of Benefits, or you may contact Blue Cross and Blue Shield of Nebraska's Customer Service Center for information.

Newborn Care

Benefits will be available at birth for covered services for an eligible newborn infant. Covered services include: room and board, screening tests including the infant hearing exam, physician's services for a newborn well infant while hospitalized including circumcision, newborn screening services for an infant born at home, and medically necessary definitive medical or surgical treatment.

Please notify the IBEW Local 22/NECA Fund Office within 30 days of the birth. As indicated on page 4, coverage will begin at birth for your newborn child so long as the Dependent child's enrollment form was postmarked or otherwise positively received by the Fund Office within thirty (30) days of such birth. If your Dependent child's enrollment form was not postmarked or otherwise positively received by the Fund Office on such date, your Dependent shall become eligible for coverage of claims incurred on or after the date your Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office.

Mental Illness, Substance Dependence or Abuse Benefits

Benefits are available for medically necessary covered services provided as treatment for mental illness, drug abuse or alcoholism (substance abuse). Benefits are subject to satisfaction of any applicable copayment, deductible and/or coinsurance amounts indicated on your Schedule of Benefits and in the front of this book. Remember, these amounts depend on whether the services are provided by a Preferred Provider or a non-Preferred Provider.

Benefits are payable for covered hospital and physician services, including mental health services, psychological or alcoholism and drug counseling services provided by/within the scope of practice of a:

- qualified physician or licensed psychologist,
- licensed special psychologist, licensed clinical social worker, licensed professional counselor or licensed mental health practitioner, or
- auxiliary providers who are supervised, and billed for, by a qualified physician or licensed psychologist or as otherwise permitted by state law.

All licensing or certification shall be by the appropriate state authority. Appropriate supervision and consultation requirements also shall be provided by state law.

Inpatient Care

Benefits are available for acute inpatient treatment of mental illness, drug abuse or alcoholism for up to 30 days per calendar year. A person shall be considered to be receiving inpatient treatment if he or she is confined to a hospital or a licensed alcoholism or drug treatment center and spends less than six hours daily outside of the facility. Services provided by a facility that does not meet these criteria are considered part of a residential treatment program, and are not covered under the group health plan.

Facilities must be Licensed by the Department of Health and Human Services, Regulation and Licensure (or equivalent state agency) or accredited by the Joint Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Note: Benefits for ALL inpatient admissions must be precertified by Blue Cross and Blue Shield of Nebraska. (Please refer to the Preadmission/ Admission section of this book for details.)

Outpatient Care

Benefits are also available, subject to the copayment amount indicated on your Schedule of Benefits and the chart in the front of this book, for up to 60 units per calendar year for outpatient treatment of mental illness, drug abuse or alcoholism. One "unit" consists of covered services received on one day.

A copayment will apply to each covered service, except one copayment will be applied per each "all-inclusive day" described below.

Outpatient Covered Services Include:

- psychological therapy and/or alcoholism and drug counseling/rehabilitation provided by an approved provider (see above),
- office visit or clinic visit, consultation or emergency room visit,
- an outpatient day or partial hospitalization program for mental illness, that offers all-inclusive services for each outpatient treatment day,
- a certified alcoholism and drug treatment program provided by a facility that offers all-inclusive services for each outpatient treatment day, or
- biofeedback training for treatment of mental illness.

Day treatment, partial care and outpatient programs must be provided in a hospital or facility which is licensed by the Department of Health and Human Services Regulation and Licensure and whose program is certified by the Division of Alcoholism, Drug Abuse and Addiction Services (or equivalent state agency), or the Commission on the Accreditation of Rehabilitation Facilities (CARF).

Benefits are also available for covered hospital and physician outpatient services not listed above. Such covered services include laboratory and diagnostic services, psychiatric/psychological testing and other covered psychiatric services. Benefits for these services are subject to the applicable deductible and coinsurance, as indicated on your Schedule of Benefits.

Oral Surgery And Dentistry

Benefits are available for the following specific kinds of covered oral surgery or dentistry:

Evaluation and treatment of impacted teeth.

Incision and drainage of abscesses, and other non-surgical treatment of infections. This does not include periodontic or endodontic treatment of infections.

Excision of exostoses, tumors and cysts.

Bone grafts to the jaw, including preparation of the mouth for dentures.

Reduction of a complete dislocation or fracture of the temporomandibular (jaw) joint required as a direct result of an accidental injury. Benefits are limited to covered treatment provided within 12 months of the injury. Dislocations or fractures resulting from eating, chewing or biting are not covered.

Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental injury. Benefits are limited to covered treatment provided within 12 months of the date of injury. Injuries resulting from eating, chewing or biting are not covered.

Osteotomy performed for a gross congenital abnormality of the jaw which cannot be treated solely by orthodontic treatment or appliances (only if unrelated to the temporomandibular joint of the jaw).

Dental implants when related to trauma (within one year of injury), cancer and other tumors, benign cysts; also available for persons from puberty through age 23 with two or more adjacent congenitally missing teeth.

Benefits will be provided for hospital inpatient, outpatient or ambulatory facility charges related to covered services for oral surgery and dentistry, if such services are medically necessary. In addition, benefits will be provided for hospital inpatient, outpatient or ambulatory facility charges for covered or noncovered dental procedures if such admission is essential to safeguard the health of the patient who has a specific nondental physical and/or organic impairment.

Benefits are not available for care in connection with the following, except as specifically described above:

- treatment, filling, removal, repositioning or replacement of teeth, including orthodontics or implants.
- root canal therapy or care.
- preparation of the mouth for dentures.
- treatment of the dental occlusion.
- care, services, procedures, supplies or appliances related to diagnosis or treatment of the temporomandibular joint of the jaw unless the result of or directly related to an accidental injury.
- all other procedures involving the teeth or structures directly related to or supporting the teeth, including a) the gums; b) the alveolar processes.

Organ And Tissue Transplant Services

Covered Transplants

Benefits are available to a covered person who is a recipient for medically necessary covered services relating to, or resulting from a transplant of these body organs or tissues:

- liver,
- heart,
- single and double lung,
- lobar lung,
- combination heart-lung,
- heart valve (heterograft),
- kidney,
- combination kidney-pancreas,
- pancreas,
- bone graft,
- cornea,
- parathyroid,
- small intestine,
- small intestine and liver,
- small intestine and multiple viscera, or
- autologous and allogeneic bone marrow transplants for specified conditions listed in this section.

Special Note: For an organ/tissue transplant performed by a non-Preferred provider, benefits are limited to $150,000.

Preauthorization Procedure

All benefit payments for organ and tissue transplant procedures must be preauthorized by Blue Cross and Blue Shield of Nebraska. A written request to Blue Cross and Blue Shield of Nebraska must be made before the procedure is performed and be accompanied by documentation from the covered person's physician demonstrating the medical necessity of the proposed procedure. This request should also indicate at which hospital the transplant procedure will be performed and should be directed to: Blue Cross and Blue Shield of Nebraska, Attn: Medical Support Department, P.O. Box 3248, Omaha, Nebraska 68180-0001.

Blue Cross and Blue Shield of Nebraska will respond in writing advising the provider and the covered person as to whether or not benefits are available.

Autologous and Allogeneic Bone Marrow Transplants

LIMITED BENEFITS ARE AVAILABLE FOR AUTOLOGOUS BONE MARROW TRANSPLANT AND ALLOGENEIC BONE MARROW TRANSPLANT.

WARNING: This section provides initial benefits for allogeneic and autologous bone marrow transplants only for certain diseases or conditions and specifically excludes benefits for those procedures for all other diseases or conditions. You should carefully review the entire Contract, including the definitions of allogeneic and autologous bone marrow transplants, high dose chemotherapy and high dose radiotherapy. The limited benefits provided in this section for allogeneic and autologous bone marrow transplants are an exception to the exclusion for investigative procedures (see section titled "noncovered services and supplies").

The exception of these procedures in limited circumstances from the exclusion for investigative procedures is not intended to, and does not operate as, a waiver of the exclusion for investigative procedures. The limited benefit provided in this section for allogeneic and autologous bone marrow transplants are subject to all of the other conditions and provisions of the Contract including, without limitation, the requirement that the procedure be medically necessary.

Benefits will be provided for Medically Necessary initial myeloablative (high dose) chemotherapy with allogeneic stem cell support only when prescribed for:

- advanced non-Hodgkin's lymphoma.
- advanced Hodgkin's disease (lymphoma).
- advanced neuroblastoma.
- acute lymphocytic leukemia (acute leukemia).
- germ cell tumor of testicular, ovarian, retroperitoneal or mediastinal origin.
- chronic myelogenous leukemia.

Benefits will be provided for Medically Necessary initial myeloablative (high dose) chemotherapy with autologous stem cell support only when prescribed for:

- acute lymphocytic myelogenous leukemia (acute leukemia).
- advanced Hodgkin's disease (lymphoma).
- advanced non-Hodgkin's lymphoma.
- advanced neuroblastoma.
- newly diagnosed multiple myeloma or other multiple myeloma responsive to chemotherapy.
- Wilms' tumor.
- germ cell tumors of testicular, ovarian, retroperitoneal or mediastinal origin.
- Primitive neuroectodermal tumors:
  1) Medulloblastoma,
  2) neuroblastoma arising in the central nervous system,
  3) ependymoblastoma, or
  4) pineoblastoma.
- Ependymoma.
- Ewing's sarcoma.
- primary amyloidosis without widespread organ impairment or congestive heart failure.

Benefits will be provided for initial Medically Necessary Allogeneic Stem Cell Transplantation for primary diseases of the bone marrow, genetic diseases and acquired anemias only when prescribed for:

- severe sickle cell disease;
- aplastic anemias:
  1) hereditary or congenital, including:
     - Farconi's anemia
     - Diamond-Blacktan syndrome
  2) acquired, due to:
     - drug exposure
     - toxin exposure
     - radiation exposure
- Wiskott-Aldrich syndrome;
- severe congenital combined immunodeficiency;
- thalassemia major (homozygous beta-thalassemia);
- infantile malignant osteopetrosis: Albers-Schonberg marble bone diseases;
- mucopolysaccharidoses: Hurler's, Hunter's, Sanfilippo, Maroteaux-Lamy, Morquio's;
- mucolipidoses: Gaucher's, metachromatic leukodystrophy, adrenoleukodystrophy, globoid cell leukodystrophy;
- Kostmann's syndrome;
- leukocyte adhesion deficiency,
- X-linked lymphoproliferative syndrome;
- Chediak-Higashi syndrome;
- myelodysplastic syndrome;
- myeloproliferative disorders; polycythemia vera, essential thrombocytopenia, agnogenic myeloid metaplasia with myelofibrosis (primary myelofibrosis); or chronic myeloid leukemia.

No benefits will be provided for any other use or application of Allogeneic Bone Marrow Transplant or Autologous Bone Marrow Transplant. Salvage or Tandem Bone Marrow Transplants will only be covered when Scientifically Validated.

Additional Benefits For Donation

Benefits are also available for the following medically necessary covered services directly related to or resulting from a covered transplant:

- Hospital, medical, surgical or other covered services provided to a donor are included as part of the recipient's coverage.
- Services provided for the evaluation of organs or tissue including, but not limited to, the determination of tissue matches.
- Services provided for the removal of organs or tissue from nonliving donors.
- Services provided for the transportation and storage of donated organs or tissues.

Limitations

Benefits will NOT be provided for:

- the purchase of human organs or tissues which are sold rather than donated to the recipient;
- donor charges other than those specifically identified in the Contract;
- the transplant of a nonhuman organ or tissue, or the implantation of an artificial/mechanical organ. (This provision does not apply to the implantation of pacemakers);
- high dose chemotherapy or radiation therapy when supported by bone marrow or stem cell transplant procedures for breast cancer, ovarian cancer or diagnoses other than those identified in the previous paragraphs, or
- services for or related to organ or tissue transplants not listed as covered in this section. Related services include administration of high dose chemotherapy or radiation therapy when supported by transplant procedures.

Benefits provided for covered organ and tissue transplant services shall not be subject to the exclusion for "investigative services"; as stated in the section titled "Noncovered Services."

Benefits provided to noncovered persons shall be secondary to those provided by the person's own health insurance coverage.

Definitions for Allogeneic and Autologous Bone Marrow Transplants

Allogeneic Bone Marrow Transplant: A medical and/or surgical procedure comprised of several steps or stages including, without limitation: (a) the harvest of stem cells, whether from the bone marrow or from the blood, from a third party donor; (b) processing and/or storage of the stem cells so harvested; (c) the administration of high dose chemotherapy and/or high dose radiotherapy (this step may be absent in certain applications); (d) the infusion of the harvested stem cells; and (e) hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts. This definition specifically includes and encompasses transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, the high dose chemotherapy and/or high dose radiotherapy.

Autologous Bone Marrow Transplant: A medical and/or surgical procedure comprised of several steps or stages including, without limitation: (a) the harvest of stem cells, whether from the bone marrow or from the blood from the patient; (b) processing and/or storage of the stem cells so harvested; (c) the administration of high dose chemotherapy and/or high dose radiotherapy; (d) the infusion of the harvested stem cells; and (e) hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts. This definition specifically includes and encompasses transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, the high dose chemotherapy and/or high dose radiotherapy.

High Dose Chemotherapy: A form of chemotherapy wherein the dose and/or manner of administration is expected to result in damage to the bone marrow or suppression of its function so as to warrant or require receipt by the patient an allogeneic bone marrow transplant or autologous bone marrow transplant.

High Dose Radiotherapy: A form of radiotherapy wherein the dose and/or manner of administration is expected to result in damage to the bone marrow or suppression of its function so as to warrant or require receipt by the patient an allogeneic bone marrow transplant or autologous bone marrow transplant.

Home Health Aide, Skilled Nursing Care And Hospice Services

Benefits will be provided for medically necessary preauthorized services for home health aide care, skilled nursing care and hospice services, subject to the requirements and limitations as specified below.

Benefits are not available for home health aide, hospice and skilled nursing care services performed by volunteers; services which are primarily for the convenience of the patient or a person other than the covered patient; pastoral services; home delivered meals; financial or legal counseling; maintenance therapy for nonhospice related home health aide services; calls or consultations by telephone or other electronic means.

Preauthorization

All benefits for home health aide care, skilled nursing care and hospice services must be preauthorized as follows:

Initial Preauthorization — An initial notification must be made to Blue Cross and Blue Shield of Nebraska prior to or within five days of the date of initiating services. This written request for preauthorization should be directed to:

Blue Cross and Blue Shield of Nebraska
Medical Support Department
P.O. Box 3248
Omaha, Nebraska 68180-0001

Documentation must be submitted which demonstrates the medical necessity of the services, and indicates the location of the service. If Blue Cross and Blue Shield of Nebraska determines the care is not medically necessary, benefits will not be provided for those days prior to the receipt of the notification.

Extension of Benefits — After the initial approval by Blue Cross and Blue Shield of Nebraska, requests for an extension of benefits must be submitted to Blue Cross and Blue Shield of Nebraska by the covered person or provider of services. The request for an extension of benefits is to be submitted prior to or not later than the day through which benefits have been approved. If the extension request is not received on a timely basis and the extension is not approved by Blue Cross and Blue Shield of Nebraska, benefits will not be guaranteed beyond the previous approval date.

Blue Cross and Blue Shield of Nebraska will notify the provider of services by telephone and in writing about the initial approval or disapproval of coverage, as well as any subsequent approval or disapproval for an extension of benefits. Blue Cross and Blue Shield of Nebraska will also notify the covered person in writing about the initial decision and any subsequent approval or disapproval. **If benefits are not preauthorized, claims for such benefits may be denied if Blue Cross and Blue Shield of Nebraska determines the care is not medically necessary.**

Home Health Aide Services

Benefits are available for home health aide services provided to a homebound covered person by a licensed or Medicare-certified home health agency.

Home health aide services must be related to active and specific medical, surgical or psychiatric treatment of the covered person's condition. Such services include, but are not limited to bathing, feeding and performing household cleaning duties directly related to the covered person. These services must be ordered by a physician and approved by Blue Cross and Blue Shield of Nebraska.

Skilled Nursing Services

Benefits are available for preauthorized physician-ordered nursing care in the covered person's home, which requires the skill, proficiency and training of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), for up to eight hours per day.

Benefits will not be provided for:

- nursing care which is primarily for the convenience of the patient or patient's family;
- time spent bathing, feeding, transporting, exercising or moving the patient, giving oral medication or acting as a companion/ sitter or homemaker to a covered person;
- nursing services provided by an immediate relative of the patient (by blood, marriage, or adoption) or a member of the patient's household, or
- nursing care provided to a patient in a hospital, skilled nursing facility, intermediate care facility or a sub-acute or rehabilitation facility.

Hospice Services

Benefits are available for preauthorized hospice services provided primarily in the patient's home by a Medicare-certified hospice.

A hospice is a program of care provided for a person diagnosed as terminally ill and their families. The patient must have a life expectancy of six months or less and the physician-ordered services must be appropriate for palliative support or management of a terminal illness.

Hospice benefits include:

- Home health aide services.
- Hospice nursing services provided in the home.
- Up to 30 days of Inpatient Hospice Care.
- Respite care, which is short-term inpatient care of a covered hospice patient to give temporary relief to the person who regularly assists with the care at home. This respite care may be provided in the hospice program's designated inpatient unit that is affiliated with the hospice that is providing services to the patient, which may be a skilled nursing facility, or in a hospital. (Benefits for covered hospice respite services may not exceed a maximum of 20 days).
- Medical social services provided by the hospice's medical social worker, which are directly related to the covered hospice patient's medical condition. (Benefits for hospice medical social services may not exceed a maximum of eight one-hour sessions.)
- Crisis care, which is extended skilled nursing care provided in the home or inpatient setting for up to 24 hours per day in lieu of a medically necessary inpatient hospitalization. (Benefits for hospice crisis care services may not exceed a maximum of 15 days.)
- Bereavement counseling, which consists of up to five counseling sessions provided to a covered family member, within six months of the patient's death.

Other Covered Services

Benefits are available subject to applicable deductible and/or coinsurance for the following medically necessary covered services and supplies when not covered elsewhere under your group health plan:

Ambulance service provided to a covered person for:

- transport to the nearest facility for appropriate care for an emergency medical condition.
- transfer of a covered person who has received emergent care or who is an inpatient at an acute care facility to the nearest facility where appropriate care can be provided; or for transporting a covered person who is bedridden to a facility for treatment or to his or her home.
- transporting a respirator-dependent person.
- transporting a covered person to and from the nearest appropriate facility for testing and/or procedures that cannot be performed at the present facility.

Up to 60 outpatient or home sessions per calendar year for physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy or manipulative treatments or adjustments, or any combination of these services. A session is defined as one visit. Benefits are not available for ongoing maintenance therapy once the maximum therapeutic benefit has been achieved for a condition, and continued therapy no longer results in some functional or restorative improvement.

- Physical therapy sessions must be provided by a licensed physical therapist or licensed physical therapist assistant. To be an approved provider, the licensed physical therapist assistant must be assigned to, supervised, and billed for, by a licensed physical therapist. Physical therapy must be ordered or prescribed by a physician.
- Occupational therapy sessions must be provided by a licensed occupational therapist or licensed occupational therapist assistant under the supervision and billing of a licensed occupational therapist. Occupational therapy must be ordered or prescribed by a physician.
- Speech therapy or cognitive training must be provided by a licensed speech-language pathologist or registered communication assistant practicing under the supervision of a licensed speech-language pathologist.
- Chiropractic or osteopathic physiotherapy or manipulative treatments or adjustments must be provided by a licensed practitioner.

Routine immunizations are subject to the deductible and coinsurance except for pediatric immunizations which shall be payable without application of the deductible. Pediatric immunizations include a complete set of vaccinations for children from birth to six years of age for measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, haemophilus influenza type B and chicken pox.

Eyeglasses or contact lenses (or replacement) when ordered by a physician because of a change in prescription as a direct result of covered intraocular surgery or ocular injury. (Purchase must be within 12 months of the surgery or injury.)

Services for renal dialysis, including all charges for covered home dialysis equipment and covered disposable supplies. Benefits will also be provided for up to six sessions of dialysis training or counseling. Such benefits will be paid pursuant to Medicare requirements for group health plans.

Diabetes Education provided by an approved program or a certified diabetes educator for self-management training and patient management, including nutrition therapy.

Podiatric Appliances necessary for the prevention of complications associated with diabetes.

Sleep Studies, when medically necessary.

Home Infusion.

Cochlear Implants, including the cost of the pre-implant evaluation, the implant system, surgery and post-surgical fitting.

Rental or initial purchase (whichever costs less) of certain items of home medical equipment and supplies, when prescribed by a physician, which is determined by Blue Cross and Blue Shield of Nebraska to be medically necessary. Benefits are not available for home medical equipment used, rented or purchased from a hospital, skilled nursing facility, intermediate care facility, a nursing home or any other facility for use during the patient's confinement.

Benefits will be available for subsequent purchases of covered home medical equipment under the following conditions:

- a significant change in the covered person's condition,
- growth of a covered person,
- the item is irreparable and/or the cost of repairs exceeds the expense of purchasing a second piece of equipment,
- the item is five or more years old. (Equipment may be replaced if it is less than five years old, but preauthorization by Blue Cross and Blue Shield of Nebraska will be required.), or
- as otherwise determined to be reasonable and necessary.

Note: *Oxygen and equipment for its administration, respiratory therapy, ventilation equipment, apnea monitors and continuous positive airway pressure devices (CPAP) may be subject to review of the rental versus purchase provision by Blue Cross and Blue Shield of Nebraska.*

In addition, limited benefits will be available for repair, adjustment and maintenance of covered home medical equipment subject to the following restrictions:

- Only **purchased** items will be eligible for benefits for repair, maintenance and adjustment.
- Benefit payment for covered repair, adjustment and maintenance of such items will be made directly to the medical supply company.

Women's Health Act

The Women's Health and Cancer Rights Act of 1998 (Women's Health Act) includes protections for breast cancer patients who elect to have breast reconstruction in connection with a mastectomy.

The law requires that certain coverage be provided, and that notice be given to plan participants and beneficiaries regarding coverage for this care under the group health plan. The Women's Health Act requires that:

A group health plan which provides medical and surgical benefits for mastectomies shall also provide, in the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, coverage for:

- reconstruction of the breast on which the mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prostheses, and
- physical complications resulting from all stages of the mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and patient.

This group health plan is in compliance with the Women's Health Act, and provides benefits as required by the Act, subject to the deductible and coinsurance amounts applicable to other benefits under the plan.

Noncovered Services And Supplies

This group health plan provides benefits for a wide variety of health care expenses. However, there are some services and supplies that are not covered.

Noncovered services include:

- Services not described as covered services in this plan's Master Group Contract.
- Serviced determined by Blue Cross and Blue Shield of Nebraska to be not medically necessary.
- Services which are considered by Blue Cross and Blue Shield of Nebraska to be investigative, or for any directly related services.
- Screening audiological (hearing) exams and testing (except infant exam), audiant bone conductors or hearing aids and their fitting.
- Blood, blood plasma or blood derivatives or fractionates, or services by or for blood donors, except administrative charges for blood furnished to a hospital by the American Red Cross, county blood bank, or other organization that does not charge for blood, and used for a covered person.
- Over-the-counter drugs, including non-prescription vitamins.
- Screening eye examinations, eye refractions, eye exercises or visual training (orthoptics); eyeglasses or contact lenses, except as specifically provided for under the plan.
- Services for or related to any surgical, laser or non-surgical procedures or alterations of the refractive character of the cornea for correction of myopia, hyperopia or astigmatism, including radial keratotomies. (Benefits are not available for eyeglasses or contact lenses following these procedures.)
- Hospital or physician charges for standby availability.
- Personal expenses while hospitalized, such as guest meals, TV rental and barber services.
- Medical supplies, devices or equipment provided for the convenience or personal use of a covered person.
- Custodial care.
- Dietary counseling, except covered diabetic nutrition management.
- Treatment and monitoring for obesity or for weight reduction, regardless of diagnosis, including but not limited to surgical operations.
- Services, including related diagnostic testing, which are primarily of a recreational or educational nature, including music or art therapy, work-hardening therapy; vocational training; medical or nonmedical self-care or self-help training.
- Treatment or removal of corns, callosities, or the cutting or trimming of nails.
- Massage therapy provided by a massage therapist.
- Automated external defibrillator.
- Infertility treatment and related services, which includes: Assisted Reproductive Technology (ART), such as artificial insemination, sperm washing, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and in vitro fertilization; embryo transfer procedures; drug and/or hormonal therapy for fertility enhancement; ultrasounds, lab work and other testing in conjunction with infertility treatment; and reversal of voluntary sterilization.
- Services provided for, or related to, sex transformation surgery.
- Interest, sales or other taxes or surcharges on covered services, drugs, supplies or home medical equipment, other than those surcharges or assessments made directly upon employers or third party payers.
- Charges made for filling out claims forms or furnishing any other records or information or special charges such as dispensing fees, admission charges, Physician's charges for hospital discharge services, after-hours charges over and above the routine charge, administrative fees, technical support or utilization review charges which are normally considered to be within the charge for a service.
- Charges made while the patient is temporarily out of the hospital.
- Genetic treatment or engineering. This includes any services performed to alter or create changes in genetic structure.
- Lodging or travel, even though prescribed by a physician, for the purpose of obtaining medical treatment.
- Nutrition care, supplements, supplies or other nutritional substances, including FDA-exempt formulas such as Neocate or Vivonex.

- Repairs, maintenance or adjustment of home medical equipment, except as previously described in the section "Other Covered Services," or repairs, maintenance or adjustment for home medical equipment by persons other than a medical supply company.
- Equipment for purifying, heating, cooling or otherwise treating air or water.
- The building or remodeling or alteration of a residence; or the purchasing or customizing of vans or other vehicles.
- Exercise equipment.
- Orthopedic shoes and orthotics for the feet, except for podiatric appliances which are necessary for the prevention of complications associated with diabetes, or necessary to treat a congenital anomaly as determined by Blue Cross and Blue Shield of Nebraska.
- Food antigens and/or sublingual therapy.
- The reduction or elimination of snoring, when that is the primary purpose of treatment.
- Mental health services, psychological or alcoholism and drug abuse counseling services which are not within the scope of practice of the provider and services other than by a:

  qualified physician or licensed psychologist, or

  licensed special psychologist, licensed clinical social worker, licensed professional counselor or licensed mental health practitioner, or

  auxiliary providers under the supervision of, and billed for by, a qualified physician, licensed psychologist or as otherwise provided by state law.

  All licensing or certification shall be by the appropriate state authority. Appropriate supervision and consultation requirements also shall be governed by state law.

  Programs of co-dependency, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction (except as specifically provided for under Tobacco Cessation Coverage as described in Attachment C of this booklet) are not covered services. Benefits are not available for residential services for mental illness, or halfway house or methadone maintenance programs for substance abuse, nor will they be provided for programs ordered by the Court which are not medically necessary as determined by Blue Cross and Blue Shield of Nebraska.

- Services which are considered by Blue Cross and Blue Shield of Nebraska to be for cosmetic purpose, or any routine complication thereof, except surgery required as a result of a traumatic injury, to correct a congenital abnormality, or to correct a scar or deformity resulting from cancer or from non-cosmetic surgery.

  Reconstructive surgery is covered only when required to restore, reconstruct or correct any bodily function that was lost, impaired or damaged as a result of Injury or Illness. Breast reconstruction following mastectomy is covered as required by the Women's Health Act.

  Except as stated above, this exclusion applies regardless of the underlying cause of the condition or any expectation that the cosmetic procedure may be psychologically or developmentally beneficial to the patient. Procedures for liposuction, telangiectasias, dermabrasion, protruding ears and spider veins are examples of noncovered services.
- Services which are considered by Blue Cross and Blue Shield of Nebraska to be obsolete, or for any related services. (Procedures will be considered to be obsolete when such procedures have been superseded by more efficacious treatment procedures, and are generally no longer considered effective in clinical medicine.)
- Services provided to or for:

  anyone who does not qualify as an Eligible Dependent;

  anyone before the effective date of coverage, or after the effective date of cancellation or termination of coverage.
- Services for illness or injury related to military service.
- Services provided in or by a Veterans Administration Hospital for a condition related to military service or in a non-participating hospital owned, operated or controlled by a government agency or hospital authorities, unless for care provided to a nonactive duty covered person in medical facilities.
- Services available at governmental expense, except:

  if payment is required by state or federal law, the obligation to provide benefits will be reduced by the amount of payments a covered person is eligible for under such program (except Medicaid), or

for persons entitled to Medicare Part A and eligible for Part B benefits, the obligation to provide benefits will be reduced by the amount of payment or benefits such person receives from Medicare. Services provided for renal dialysis and kidney transplant services will be provided pursuant to federal law.

- Services for which there is no legal obligation to pay, or for which no charge would be made if this coverage did not exist.
- Services arising out of or in the course of employment, whether or not the covered person fails to assert or waives rights to Workers Compensation or Employers Liability Law. This includes services determined to be nonpayable due to noncompliance with a Workers Compensation law or under a Worker's Compensation Managed Care Plan.
- Services provided by a member of your immediate family (by blood, marriage or adoption).
- Services by a health care provider which are not within his or her scope of practice, or charges by a person who is not an approved provider.
- Charges in excess of the Contracted Amount or reasonable allowance.
- Charges billed separately for services, supplies and materials considered by Blue Cross and Blue Shield of Nebraska to be included within the charge for a total service payable by this group plan's Master Group Contract, or if the charge is payable to another provider.
- Services required by an employer as a condition of employment, including, but not limited to immunizations, blood testing, work physicals and drug tests.
- Charges for services resulting from a covered person's engagement in an illegal occupation or in the commission of or an attempt to commit a felony.
- Services for medical treatment and/or drugs, (whether compensated or not) which are directly related to or resulting from a covered person's participation in a voluntary, investigative test or research program or study.
- Services for any allogeneic or autologous bone marrow transplant not specifically covered under "Organ and Tissue Transplants."
- Services by a health care provider that does not meet the licensing or accreditation standards required by Blue Cross and Blue Shield of Nebraska (non-approved facility).
- Charges for which there is no documentation that a service was provided.
- Electron beam computed tomography for vascular screening, including screening for cardiovascular, cerebrovascular and peripheral vascular disease.
- Acupuncture.
- Calls or consults by telephone or other electronic means, video or internet transmissions.
- Preventive (routine) care, or preventive or periodic physical examinations, except as specifically provided for under the plan.
- Pregnancy or maternity services for a covered Dependent daughter.
- Services for diagnosis or treatment of the temporomandibular joint of the jaw (TMJ) unless the result of and directly related to an accidental injury.
- Prescription drugs are not covered by Blue Cross and Blue Shield of Nebraska unless they are prescribed and billed by a provider and administered by the provider. (Refer to the IBEW information; Attachment C at the back of this book.)

Coordination Of Benefits

This Contract includes a Coordination of Benefits provision. This provision limits duplication of benefits when a covered person has coverage under more than one health plan. These provisions also help establish a uniform order in which the plans pay their claims, and for the transfer of information between the plans, to help avoid claim payment delays.

Definitions for Coordination of Benefits

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in whole or in part by any of the plans covering the person, during a claim determination period. When benefits are reduced under a primary plan because the person did not comply with a plan preadmission certification requirement, or because the person did not use a preferred provider, the amount of such reduction will not be considered an allowable expense.

Claim Determination Period: The period of a calendar year during which the covered person is covered under this Contract. It does not include any part of a year before the date this coordination of benefits provision or a similar provision took effect.

Plan: A form of coverage with which coordination is allowed, to include:

- group, blanket or franchise insurance coverage (except student accident-type coverage).
- uninsured arrangements of group or group-type coverage.
- any coverage under labor management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans.
- coverage through HMOs and other prepayment, group practice and individual practice plans.
- individual or family coverage including HMO coverage or subscriber Contracts.

The term "plan" as defined for the purpose of coordination of benefits does not include nongroup or individually underwritten hospital indemnity plans, dread disease or cancer policies, or accidental expense policies. Plan also does not include Plans whose benefits, by law, are in excess to those of any private insurance program or other nongovernmental program.

Primary Plan: The plan which will determine allowable benefits without regard to other covered allowable expenses.

Secondary Plan: The plan which will determine allowable benefits for the balance of the remaining charges in the claim determination period.

Primary Plan/Secondary Plan: The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to the covered person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

Order of Benefits

If benefits are payable under any other plan or coverage which does not provide for coordination of benefits, the insurer or plan providing that coverage shall be the primary carrier.

If benefits are payable under any other plan which does include a coordination of benefits provision, this plan determines its order of benefits using the first of the following rules which applies to the covered person:

- The plan which covers the person as an employee/subscriber is primary to the plan covering the person as a Dependent.
- For a child of parents not separated or divorced, the primary plan is the plan of the parent whose birthday falls earlier in the year. Where both parents have the same birthday, the primary carrier shall be the one which has covered the parent for the longer period of time.
- For a child of parents who are divorced or separated, first shall be the plan of the custodial parent, then the plan of the spouse of the custodial parent, and then the plan of the non-custodial parent. However, if there is actual knowledge that the divorce decree or qualified court order requires one parent to be responsible for health care expenses, the primary carrier shall be the plan provided by that parent.

- The plan of an employee who is neither laid off nor retired (or as that employee's Dependent) is primary to the plan which covers that person as a laid off or retired employee (or that employee's Dependent). If the other health benefit plan coverage does not have this provision and, if as a result, the carriers do not agree on the order of benefits, this section is ignored.
- A plan providing coverage to a person under federal (COBRA) or state continuation law is secondary to a plan providing coverage to that person as an employee, subscriber, retiree (or that person's Dependent).
- If none of the above rules determines the order of benefits, the benefits of the plan which covered a subscriber longer are determined before those of the plan which covered that person for the shorter time.

Administration of Coordination of Benefits

If this plan is the primary plan, there shall be no reduction of benefits paid under this plan--benefits will be paid as if the other plan did not provide benefits.

If this plan is the secondary plan, its benefits will be determined after those of the other plan, and may be reduced because of the other plan's benefits. Payment will not be made for any amount for which the covered person is contractually held harmless by either plan. Payment between the plans shall not exceed the amount paid under this Contract, had it been primary.

Credit Savings: If this plan does not have to pay its full benefits because it is the secondary plan, the savings will be credited to the covered person during a claim determination period. These savings will not exceed the allowable expenses. The amount by which this plan's benefits has been reduced will be used to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, each plan determines its liability and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.
To properly administer coordination of benefits, this plan may obtain from or release to any insurance company or other organization or person, any information necessary to determine whether coordination of benefits applies. Any person who claims benefits under this plan agrees to furnish this plan information that may be necessary to effect coordination of benefits.

If another plan pays benefits which should have been paid under this Contract, then this plan will reimburse such other plan any amounts determined to be necessary. Amounts paid to other plans in this manner will be considered benefits paid under this plan. This plan is also released from liability of any such amount paid in this manner.

If the benefits paid by this plan exceed what should have been paid, this plan has the right to recover any excess from any insurer, any other organization, or any person to or for whom such payments are made, including covered persons under this plan.

This plan's duty regarding coordination of benefits, is limited to making a reasonable effort to avoid liability as the primary plan in appropriate cases brought to its attention; to making reasonable efforts to compute the amount payable under any other plan; and to making reasonable efforts to recover any excess payments made by it.

Subrogation And Contractual Right To Recovery

Subrogation

Subrogation is the right to recover benefits paid for covered services provided as the result of an illness or injury that was caused by another person or organization. If benefits are paid for such covered services under the Master Group Contract, the group health plan shall be subrogated to all of the covered person's rights of recovery against any person or organization to the extent of the benefits paid. The subscriber, the covered person or the person who has a right to recover for the covered person (usually a parent or spouse), agrees to make reimbursement to the plan if payment is received from the person who caused the illness or injury or from that person's liability carrier. This subrogation claim shall be a first priority lien on the full or partial proceeds of any settlement, judgment or other payment recovered by or on behalf of the covered person, whether or not there has been full compensation for all his or her losses. The rights of the group health plan shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

Contractual Right of Recovery

If a covered person receives full or partial proceeds from any other source for covered services for an illness or injury, the group health plan has a contractual right of reimbursement to the extent benefits were paid under the Contract for the same illness or injury. This contractual right to reimbursement shall be a first priority lien against any proceeds recovered by the covered person, whether or not the covered person has been fully compensated for all his or her losses.

Such proceeds may include any settlement, judgment, payments made under auto insurance, including no-fault auto insurance, or medical payments provision; or proceeds otherwise paid by a third party. This contractual right of recovery is cumulative with, but exclusive of the subrogation right. The rights of the group health plan shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

No adult covered person may assign any rights to recover medical expenses from any third party to any minor or other Dependent of such covered person or to any other person, without the express written consent of Blue Cross and Blue Shield of Nebraska. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, incompetent or disabled subscribers or their incompetent or disabled Dependents.

The subscriber agrees to cooperate and assist in any way necessary to recover such payments, including notification to Blue Cross and Blue Shield of Nebraska of a claim or lawsuit filed on his or her behalf or on behalf of his or her Dependents. He or she shall notify Blue Cross and Blue Shield of Nebraska prior to settling any claim or lawsuit to obtain an updated itemization of the amount due. Upon receiving any proceeds, the subscriber, Eligible Dependent or an authorized representative must hold such proceeds in trust until such time as the proceeds can be transferred to the Plan. The party holding the funds that rightfully belong to the Plan shall not interrupt or prejudice the Plan's recovery of such payments.

Whenever payments have been made by the Plan that are in excess of the maximum amount allowed under the Plan or are otherwise not covered under any provision of the Plan, the Fund Administrator will have the right to recover such payments from among one or more of the following:

- Any persons to, for, or with respect to whom such payments were made;
- Any provider of service;
- Any insurance companies; or
- Any other organizations.

Current or future benefit payments may be reduced to satisfy outstanding reimbursements.

Special Note: *This plan shall be entitled to recover any costs incurred in enforcing these provisions, including, but not limited to, attorneys' fees, litigation and court costs and other expenses.*

Workers' Compensation

Benefits are not available for services provided for illness or injury arising out and in the course of employment, whether or not the covered person fails to assert or waive his or her rights to Workers' Compensation or Employer Liability coverage. Benefits are not payable for services determined to be not payable due to noncompliance with the terms, rules and conditions under a Certified or otherwise Licensed Workers' Compensation Managed Care Plan. In addition, benefits are not payable for services that are related to work injury or illness, but are determined to be not necessary or reasonable by the employer or Workers' Compensation carrier.

If a covered person enters into a lump-sum settlement which includes compensation for past or future medical expenses for an injury or illness, payment will not be made under the group plan for services related to that injury or illness.

In certain instances, benefits for such services are paid in error under this group plan. If payment is received by the covered person for such services, reimbursement must be made. This reimbursement may be funded from any recovery made from the employer, or the employer's Workers' Compensation carrier. Reimbursement must be made directly by the subscriber when benefits are paid in error, due to his or her failure to comply with the terms, rules and conditions of Workers Compensation laws or a Certified or Licensed Workers' Compensation Managed Care Plan.

Claim Procedures

Filing a Claim

Contracting Providers and many other hospitals and physicians will file a claim form to Blue Cross and Blue Shield of Nebraska on your behalf. Out-of-state Contracting Providers will file the claim form with their local Blue Cross and Blue Shield plan, for processing through the BlueCard Program.

When Medicare is the primary insurance for you or a covered Dependent, you must normally submit all claims for Medicare-eligible services to Medicare first. After Medicare pays their portion of covered expenses, a copy of your claim, along with an explanation of benefits provided by Medicare is automatically forwarded to Blue Cross and Blue Shield of Nebraska.

You must file your own claim form if your health care provider does not file for you. Claim forms are available at Blue Cross and Blue Shield of Nebraska's Customer Service Center, or at the website, www.bcbsne.com.

All submitted claims must include:

- Correct Blue Cross and Blue Shield of Nebraska ID number, including the alpha prefix.
- Name of patient.
- The date and time of an accident or onset of an illness, and whether or not it occurred at work.
- Diagnosis.
- An itemized statement of services, including the date of service, description and charge for the service.
- Complete name, address and professional status (M.D., R.N., etc.) of the health care provider.
- Prescription number, if applicable.
- The name and identification number of other insurance, including Medicare.
- The primary plan's explanation of benefits, if applicable.

Claims cannot be processed if they are incomplete, and may be denied for "lack of information" if required information is not received.

Claims should be filed as soon as possible. If a claim is not filed, or any revisions or adjustments to a claim are not filed within 12 months of the date of service, benefits will not be allowed. Claims, including revisions or adjustments, that are not filed by a Nebraska Contracting Provider prior to the claim filing limit, will become the Nebraska Contracting Provider's liability.

In Nebraska, claim forms should be mailed to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

If health care services are provided in a state other than Nebraska, claims should be filed to the Blue Cross and Blue Shield plan servicing the area where the services were received. If you need assistance in locating the plan, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center.

Claim Determinations

A "claim" may be classified as "pre-service" or "post-service."

Pre-Service Claims — In some cases, under the terms of the health plan, the covered person is required to precertify or preauthorize benefits in advance of a service being provided, or benefits will be reduced or denied for the service. This required request for a benefit is a "pre-service claim." Pre-service claim determinations will be made within 15 days, unless an extension is necessary to obtain needed information. If additional information is requested, the covered person or his or her provider may be given up to 45 days from receipt of the notification to submit the requested information. A claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day period. You, and/or your provider will be advised of the determination, in writing.

(See also the Inpatient Notification, Certification and Concurrent Review section of this document.)

Urgent Care — If your pre-service claim is one for urgent care, the determination will be made within 72 hours of receipt of the claim, unless further information is needed to process the claim. If more information is needed to make a decision, the covered person or his or her provider will be given no less than 48 hours to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of: our receipt of the information, or the end of the period allowed to submit the information.

Post-Service Claims — A post-service claim is any claim that is not a pre-service claim. In most cases, a post-service claim is a request for benefits or reimbursement of expenses for medical care that has been provided to a covered person. The procedure for filing a post-service claim is outlined above, under "Filing a Claim." Upon receipt of a completed claim form, a post-service claim will be processed within 30 days, unless additional information is needed. If additional information is requested, the covered person may be given up to 45 days to submit the necessary information. A claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day period. You will receive an Explanation of Benefits when a claim is processed, which explains the manner in which your claim was handled.

Concurrent Care — If you request to extend a course of treatment beyond the care previously approved and it involves urgent care, a decision will be made within 24 hours of the request, if you submitted your request at least 24 hours before the course of treatment expires. In all other cases, the request for an extension will be decided as appropriate for pre-service and post-service claims.

Who Receives The Benefit Payment

Benefit payments for covered services provided by Preferred Providers or any providers who are participating with Blue Cross and Blue Shield of Nebraska, will be made directly to the providers unless otherwise provided under state or federal law. Benefits may also be paid to an alternate recipient or custodial parent, pursuant to a qualified medical child support order. In all other cases, payments will be made, at Blue Cross and Blue Shield of Nebraska's option, to the covered person, to his or her estate, or to the provider. No assignment for services, whether made before or after services are provided, of any amount payable according to this group benefit plan shall be recognized or accepted as binding upon Blue Cross and Blue Shield of Nebraska, unless otherwise provided by state or federal law.

Explanation Of Benefits

Every time a claim is processed for you, an Explanation of Benefits (EOB) form will be sent to you. This summary tells you:

- Type of service.
- Date of service.
- Name of provider of care.
- Charges.
- Charges applied toward your deductible or coinsurance.
- Noncovered charges with explanation.
- Benefits paid by other insurance.
- Other explanatory notes.

Also included on your Explanation of Benefits is information regarding your right to appeal a benefit determination.

Save your Explanation of Benefits forms in the event that you need them for other insurance or for tax purposes.


EXPLANATION OF BENEFITS

Appeal Procedures

Blue Cross and Blue Shield of Nebraska has the discretionary authority to determine eligibility for benefits under the health plan, and to construe and interpret the terms of the plan, consistent with the terms of the master group contract.

For appeal procedures involving eligibility for coverage under the Plan, prescription drugs, Dependent Life Benefits, Accidental Death and Dismemberment Benefits, Accident and Sickness Weekly Benefits, and HRA Benefits see the Claims and Appeals Section contained in Attachment A, Section VIII.

The IBEW Local 22/NECA Board of Trustees retains the ultimate authority to make final decisions regarding plan interpretations, eligibility and coverage with respect to this self-funded, ERISA-governed, multi-employer health and welfare benefit plan.

You have the right to seek and obtain a review of any adverse determination made regarding claims, benefit availability, or other complaint arising under this health plan. This includes decisions made by Utilization Review, and those concerning preadmission certification and concurrent review.

First Level Appeal

If you disagree with the determination made on a claim, you may submit an appeal. A request for a first-level appeal must be submitted in writing within one year of the date the claim was processed. The letter must state that it is a request for an appeal, and if possible, include a copy of the Explanation of Benefits (EOB). The appeal should include:

- a general description of the appeal;
- the name of the covered person;
- Blue Cross and Blue Shield of Nebraska I.D. number;
- the date of service and claim number, if any; and
- any additional information that might help resolve the matter.

The written appeal should be sent to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

Written decisions for pre-service claim appeals will be provided within 15 calendar days, and for post-service claim appeals, within 30 calendar days.
An expedited review may be requested for an appeal of an urgent care claim denial, or if the time frame for a standard review would seriously jeopardize the life or health of the covered person. An expedited review decision will be made within 72 hours of receipt of the request, and written confirmation will be sent not later than three days after the oral notification. A request for an expedited review of a concurrent care denial must be made within 24 hours of the initial denial.

Notification of the Appeal Decision – A written notice of the appeal determination will be provided to you (the claimant). If the appeal determination is adverse, this written notice shall include the reasons for the decision, a reference to the Plan provisions upon which the decision is based, a reference to the evidence or documentation used as a basis for the decision, and a statement regarding the claimant's right for further action or appeal. In addition, when applicable, the notice will state that an explanation of the scientific or clinical judgment used in making the decision will be provided to the claimant, free of charge, upon written request.

If the appeal involves medical judgment, Blue Cross and Blue Shield of Nebraska will consult with appropriate medical personnel in order to make the appeal determination. Identification of the medical personnel consulted during the appeal process, if any, will be provided upon written request. The appeal determination shall be made by individuals who were not involved in the original decision.

Second Level Appeal

If you are not satisfied with the first level appeal decision, a second level appeal may be submitted. It must be submitted within six months of receipt of the notice of the first level appeal decision. The letter must be mailed to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

The time frame for a second level **urgent** care appeal requires that the second review take place within the same 72 hours as the first review, if the request is made within 24 hours of receipt of the first level review decision. Second level appeal decisions of all other pre-service claims will be made within 15 days of the request. Second level appeal decisions of post-service claims will be made within 30 days of the request.

No deference will be given to either the initial determination or the first level appeal. The claimant will be provided with a written notification of the appeal decision, as described above.

Voluntary Level of Appeal

If, after following the first and second level appeal process described above, you still disagree with the determination made on your claim, you may submit your dispute to the IBEW Local 22/NECA Fund Office for review. This appeal must be submitted in writing within 60 days of receipt of the second level appeal decision. This appeal step is voluntary on your part, and not required under the terms of the Plan.

The IBEW Local 22/NECA Fund Office will provide, upon request, sufficient information to enable you to make an informed judgment about whether to submit a benefit dispute to this further level of appeal. This information will include the applicable rules and your right to representation. Your decision to pursue this voluntary level of appeal will have no effect on your rights to any other benefits under the plan. No fees may be imposed for a voluntary level of appeal.

The IBEW Local 22/NECA Fund Board of Trustees will review an appeal at the next regularly scheduled quarterly meeting unless the appeal is received within 30 days of the next meeting, in which case the decision may not be made until the second quarterly meeting following the Plan's receipt of the request for review. In special circumstances, the Board may need additional information and so may extend the time for deciding by one quarterly meeting following the quarterly meeting at which the claim and initial adverse benefit determination were first reviewed by the Board. In no event will a decision be made later than the third quarterly meeting following the Plan's receipt of the claimant's request for review. The written decision will include specific reasons for the decision and specific references to the Plan's provisions on which the decision is based.

Any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending.

Legal Actions

You must exhaust the first and second levels of appeal stated above prior to filing a lawsuit. Since the group health plan is subject to ERISA, you have the right to bring a civil action under section 502(a) of ERISA.

A lawsuit may not be filed less than 60 days after the claim is filed; nor more than three years from the time the claim is required to be filed.

Statement Of ERISA Rights

As a participant in this group health and welfare plan, you are entitled to certain rights and protections under ERISA (Employee Retirement Income Security Act of 1974).

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employees Benefits Security Administration.
- 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 and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- 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.

Continue Group Health Plan Coverage

- Continue health coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event (COBRA). You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules regarding your COBRA continuation rights.
- Reduce or eliminate pre-existing condition waiting periods under your new group health plan, if you have creditable coverage from this Plan. You will be provided a certificate of creditable coverage, free of charge, from the Plan 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. You can request a certificate of creditable coverage by calling the Blue Cross and Blue Shield of Nebraska Customer Service Center number shown on the back of your I.D. Card. Without evidence of creditable coverage, your new group health plan may subject you to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the 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. 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 a 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 these costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs or fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Information

The Name of this Plan is:	International Brotherhood of Electrical Workers Local Union No. 22/National Electrical Contractors Association Nebraska Chapter Health and Welfare Plan
The Plan Sponsor is:	Board of Trustees of the International Brotherhood of Electrical Workers Local Union No. 22/National Electrical Contractors Association, Nebraska Chapter Health and Welfare Plan
The Plan Sponsor's Address is:	Electrical Industry Center 8960 "L" Street, Suite 101 Omaha, NE 68127 (402) 593-7565
The Plan Administrator:	Wilson-McShane Corporation 8960 "L" Street, Suite 101 Omaha, NE 68127 (402) 593-7565 (402) 593-7609 fax ibew22benefits@wilson-mcshane.com
Registered Agent for Service of Legal Process:	Administrator IBEW Local No. 22/NECA Health and Welfare Plan 8960 "L" Street, Suite 101 Omaha, NE 68127 (402) 593-7565

Service of Legal Process may also be made on any Plan Trustee. (Plan Trustees are listed on the next page.)

Employer Identification Number:	47-0462667
Plan Number	501
Type of Plan:	Health and Welfare Plan
Plan Year:	January 1, to December 31st of each year.
Plan's Fiscal Year End:	December 31st of each year.
Type of Administration:	Insurer Contract Administration* (Administrative Services Agreement)
Benefits and Funding for this Plan Provided by:	Contributions to a Taft-Hartley Trust
Contract administration* of this Plan is with:	Blue Cross and Blue Shield of Nebraska 1919 Aksarben Drive Omaha, Nebraska 68180-0001 (402) 390-1800

*Blue Cross and Blue Shield of Nebraska provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Blue Cross and Blue Shield of Nebraska liability may occur only under a stop loss provision set forth in the Administrative Services Agreement.

Plan Trustees:

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Omaha, NE 68106
Tel: (402) 393-8200

Dennis F. Regan, Secretary
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Allan Hale
NECA Nebraska Chapter
Electrical Industry Center
8960 L St. Ste 100
Omaha, NE 68127
(402) 397-5105

Additional Information:

A complete list of the employers and employee organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries at the Fund Office during regular business hours.

Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a plan sponsor, the sponsor's address.

The Plan is maintained pursuant to one or more collective bargaining agreements and, upon written request to the Plan Administrator, a copy of any such agreement may be obtained by participants and beneficiaries, and is available for examination by participants and beneficiaries at the Fund Office during regular business hours.

This group health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office, or you may call the Blue Cross and Blue Shield of Nebraska Member Services Department at the telephone number shown on the back of your I.D. card.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. The EBSA website has a table summarizing which protections do and do not apply to grandfathered health plans.

Definitions

ALCOHOLISM OR DRUG (SUBSTANCE ABUSE)TREATMENT CENTER: A facility Licensed by the Department of Health and Human Services Regulation and Licensure, (or equivalent state agency), accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facility is not Licensed as a Hospital, but provides Inpatient or Outpatient care, treatment, Services, maintenance, accommodation or board in a group setting primarily and exclusively for individuals having any type of dependency or addiction to the use of alcohol or drugs.

ALLOWABLE CHARGE: Payment is based on the allowable charge for covered services.

Inpatient Contracting Hospital or other Institutional Facility: The allowable charge for covered services provided by an inpatient contracting institutional facility is the contracted amount for such services.

Outpatient Contracting Hospital or other Institutional Facility: The allowable charge for covered services provided by an outpatient contracting institutional facility is the lesser of the contracted amount or the billed charge.

Noncontracting Hospitals and other Institutional Providers: The allowable charge for covered services provided by either an inpatient or outpatient noncontracting institutional provider will be the reasonable allowance for such services.

Contracting Professional and other Noninstitutional Preferred Providers: The allowable charge for a covered service provided by a professional or other noninstitutional Preferred provider is the lesser of the Preferred Fee Schedule Amount or the billed charge. The allowable charge for covered services in another service area is the amount agreed upon by the on-site plan and its Contracting Providers.

Contracting Professional and other Noninstitutional Participating Providers: The allowable charge for a covered service provided by a non-BluePreferred, but participating provider in Nebraska is the lesser of the maximum benefit amount or the billed charge. The allowable charge for covered services in another service area is the amount agreed upon by the on-site plan and its participating providers.

Noncontracting Professional and other Noninstitutional Providers: The allowable charge for a covered service provided by providers in Nebraska will be the lesser of the maximum benefit amount or the billed charge. In another service area, the allowable charge will be the reasonable allowance.

AMBULATORY SURGICAL FACILITY: A Certified facility that provides surgical treatment to patients not requiring inpatient hospitalization. Such facility must be Licensed as a health clinic as defined by state statutes, but shall not include the offices of private Physicians or dentists whether for individual or group practice.

APPROVED PROVIDER: A Licensed practitioner of the healing arts who provides Covered Services within the scope of his or her License or a Licensed or Certified facility or other health care provider, payable according to the terms of the Contract, Nebraska law or pursuant to the direction of Blue Cross and Blue Shield of Nebraska.

AUXILIARY PROVIDER: A Certified social worker, psychiatric registered nurse, Certified alcohol and drug abuse counselor or other Approved Provider who is performing Services within his or her scope of practice and who is supervised, and billed for, by a qualified Physician or Licensed Psychologist, or as otherwise permitted by state law. Certified Master Social Workers or Certified Professional Counselors performing mental health Services who are not Licensed Mental Health Practitioners are included in this definition.

BLUECARD PROGRAM: This Blue Cross and Blue Shield Association (BCBSA) program is a collection of policies, provisions and guidelines that enables Blue Cross and Blue Shield of Nebraska to process claims incurred by Covered Persons residing or traveling outside its Service Area by utilizing the discounts negotiated by the On-site plan and its Contracting Providers.

BLUEPREFERRED HOSPITAL, PHYSICIAN OR OTHER PROVIDER: A licensed practitioner of the healing arts, a licensed facility or other qualified provider of health care Services who has contracted to provide Services as a part of the *BluePreferred* Provider network in Nebraska.

CERTIFICATION (CERTIFIED): A determination by Blue Cross and Blue Shield of Nebraska or its designee, that an admission, extension of stay or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for Medical Necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Certification also refers to successful voluntary compliance with certain prerequisite qualifications specified by regulatory entities. Agencies and programs may be deemed to be in compliance when they are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),

the Commission on the Accreditation of Rehabilitation Facilities (CARF), American Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF), Medicare or as otherwise provided in the Contract provisions or state law.

COGNITIVE TRAINING: A rehabilitative intervention aimed at retraining or facilitating the recovery of mental and information processing skills including perception, problem-solving, memory storage and retrieval, language organization and expression.

COINSURANCE: The percentage amount the Covered Person must pay for Covered Services, based on the lesser of the Allowable Charge or the billed charge.

COINSURANCE LIMIT: The maximum Coinsurance the Covered Person must pay during each calendar year.

CONGENITAL ABNORMALITY: A condition existing at birth which is outside the broad range of normal, such as cleft palate, birthmarks, webbed fingers or toes. Normal variations in size and shape of the organ such as protruding ears are not considered a congenital abnormality.

CONSULTATIONS: Physician's Services for a patient in need of specialized care requested by the attending Physician who does not have that expertise or knowledge.

CONTENT OF SERVICE: Specific services and/or procedures, supplies and materials that are considered to be an integral part of previous or concomitant services or procedures, or all inclusive, to the extent that separate reimbursement is not recognized. Charges denied as "Content of Service" are the Contracting Provider's liability and may not be billed to the Covered Person.

CONTRACT: The agreement between Blue Cross and Blue Shield of Nebraska and the Group Applicant which includes the BluePreferred Master Group Benefit Contract and any endorsements; the Master Group Application, any Subgroup Application, addenda and the individual enrollment information of Subscribers and any financial agreements.

CONTRACTED AMOUNT: The Allowable Charge agreed to by Blue Cross and Blue Shield of Nebraska or an On-site Plan and their Contracting Providers, for Covered Services received by a Covered Person.

CONTRACTING PROVIDER: A BluePreferred Provider, a Blue Cross and Blue Shield of Nebraska Participating Provider, or an On-site BlueCard Program Preferred or Participating Provider.

COPAYMENT: A fixed dollar amount of the Allowable Charge, payable by the Covered Person for a Covered Service, as indicated in the Master Group Application. Copayments are separate from and do not accumulate to either the Deductible or the Coinsurance Limit.

COSMETIC: Any Services provided to improve the patient's physical appearance, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

COVERED PERSON: Any person entitled to benefits for Covered Services pursuant to the Contract underwritten or administered by Blue Cross and Blue Shield of Nebraska.

COVERED SERVICE: Hospital, medical or surgical procedures, treatments, drugs, supplies, Home Medical Equipment, or other health, mental health or dental care, including any single service or combination of services, for which benefits are payable, while the Contract is in effect.

CREDITABLE COVERAGE: Coverage of the individual under any of the following:

a) a group health plan, as defined by HIPAA
b) health insurance coverage consisting of medical care offered by a health insurance issuer in the group or individual market
c) Part A or Part B of Medicare
d) Medicaid, other than coverage consisting solely of benefits under section 1928 (for pediatric immunizations)
e) Title 10 U.S.C. Chapter 55 (medical and dental care of the uniformed services)
f) a medical care program of the Indian Health Service or a tribal organization
g) a State health benefits risk pool
h) the Federal Employees Health Benefits Program
i) a public health plan, which means a plan providing health coverage that is established by a State, the U.S. government, or a foreign country, or a political subdivision thereof
j) a health plan of the Peace Corps
k) a State Children's Health Insurance Program (SCHIP).

Creditable coverage does not include coverage described in HIPAA as "excepted benefits," including: coverage only for accidents; disability income coverage; liability insurance, including general liability and automobile liability and any supplement thereto; credit only insurance; or coverage for on-site medical clinics.

Other excepted benefits include: limited scope dental or vision coverage or long term care coverage; non-coordinated coverages offered separately, such as specified disease or illness policies, hospital or other fixed indemnity insurance; and supplemental benefits such as Medicare Supplemental health insurance, TRICARE supplemental programs or other similar supplemental coverage.

CUSTODIAL CARE: The level of care that consists primarily of assisting with the activities of daily living such as bathing, continence, dressing, transferring and eating. The purpose of such care is to maintain and support the existing level of care and preserve health from further decline.

Custodial Care is care given to a patient who:

1. is mentally or physically disabled; and
2. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home, and
3. is not under active and specific medical, surgical or psychiatric treatment, ordered by a physician which will reduce the disability to the extent necessary to allow the patient to function outside such environment or without such assistance within a reasonable time, not to exceed one year in any event.

A custodial care determination may still be made if the care is ordered by a physician or services are administered by a registered or licensed practical nurse.

DEDUCTIBLE: An amount of Allowable Charges that must be paid by the Covered Person each calendar year for Covered Services before benefits are payable by the Contract.

ELIGIBILITY WAITING PERIOD: Applicable to new Subscribers only, the period between the first day of employment and the first date of coverage under the Contract. This period may include the probationary period indicated in the Master Group Application.

ELIGIBLE DEPENDENT: Your legal spouse and your children under age 26 if they meet the definition of Dependent found in Attachment A, Article 1, Definitions, Section 1.06. If you have an unmarried child of any age who is permanently and totally disabled and they meet the definition of Dependent under Section 1.06 they will also be an Eligible Dependent.

Note: See Attachment A, Article 1, Definitions in the back of this book for additional information.

EMERGENCY MEDICAL CONDITION: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, 2) serious impairment to such person's bodily functions, 3) serious impairment of any bodily organ or part of such person, or 4) serious disfigurement of such person.

GROUP APPLICANT: The employer or association making application for health coverage under the Contract (that is the IBEW Local 22/NECA Health and Welfare Plan).

HOME (DURABLE) MEDICAL EQUIPMENT: Equipment and supplies which treat an Illness or Injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions that are medical in nature, and able to withstand repeated use. Home Medical Equipment includes such items as prosthetic devices, orthopedic braces, crutches and wheelchairs. Effective December 1, 2010, this includes medically necessary cochlear Implants, which will be covered at 80% of the Allowable Charge. It does not include sporting or athletic equipment or items purchased for the convenience of the family.

HOMEBOUND: An individual will be considered to be essentially Homebound if he or she has a condition due to an Illness or Injury which considerably restricts the ability to leave his or her residence without the assistance of another person, and either the aid of supportive devices or the use of special transportation.

The patient who does leave the residence may still be considered homebound if the absences from the place of residence are infrequent or for periods of relatively short duration and attributable to the need to receive medical treatment that cannot be provided in the home.

Residence is defined as a home, an apartment, a relative's home or retirement center where nursing services are not provided.

HOSPITAL: A Hospital is an institution or facility duly Licensed by the State of Nebraska or the state in which it is located, which provides medical, surgical, diagnostic and treatment Services with 24 hour per day nursing services, to two or more nonrelated persons with an Illness, Injury or Pregnancy, under the supervision of a staff of Physicians licensed to practice medicine and surgery.

ILLNESS: A condition that deviates from or disrupts normal bodily functions or body tissues in an abnormal way, and is manifested by a characteristic set of signs or symptoms.

INJURY: Physical harm or damage inflicted to the body by an external force.

INPATIENT: A patient admitted to a Hospital or other institutional facilities for bed occupancy to receive Services consisting of active medical and nursing care to treat conditions requiring continuous nursing intervention of such an intensity that it cannot be safely or effectively provided in any other setting.

INVESTIGATIVE: A technology, a drug, biological product, device, diagnostic, treatment or procedure is investigative if it has not been Scientifically Validated pursuant to all of the factors set forth below:

- Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that are being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.
- Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

  The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration affects the health outcomes.

  Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments, and United States Food and Drug Administration (FDA) approvals.
- The technology must improve the net health outcome.
- The technology must improve the net health outcome as much as or more than established alternatives.
- The improvement must be attainable outside the investigational settings.

Blue Cross and Blue Shield of Nebraska will determine whether a technology is Investigative.

LATE ENROLLEE: An individual who does not enroll for coverage during the first period in which he or she is eligible, or during a Special Enrollment Period.

LICENSURE (LICENSED): Permission to engage in a health profession that would otherwise be unlawful in the state where Services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

LONG TERM ACUTE CARE (LTAC): Specialized acute Hospital care for medically complex patients who are critically ill, have multi-system complications and/or failures, and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour/seven-day-a-week basis.

MAXIMUM BENEFIT AMOUNT: A maximum amount determined by Blue Cross and Blue Shield of Nebraska to be reasonable. The Maximum Benefit Amount will be the amount agreed upon between Blue Cross and Blue Shield of Nebraska and Participating Providers for the Covered Service. If no amount has been established for a Covered Service, Blue Cross and Blue Shield of Nebraska may consider the charges submitted by providers for like procedures, a relative value scale that compares the complexity of Services provided, or any other factors deemed necessary.

MEDICAID: Grants to states for Medical Assistance Programs, Title XIX of the Social Security Act, as amended.

MEDICALLY NECESSARY: Health care Services ordered by a Treating Physician exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's Illness, Injury or Pregnancy, that are:

1. consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion, and
2. clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's Illness, Injury or Pregnancy. The most appropriate setting and the most appropriate level of Service is that setting and that level of Service, considering the potential benefits and harms to the patient. When this test is applied to the care of an Inpatient, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and

3. not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's Illness, Injury or Pregnancy, without adversely affecting the Covered Person's medical condition; and
4. not provided primarily for the convenience of any of the following:
   a. the covered person;
   b. the physician;
   c. the covered person's family;
   d. any other person or health care provider, and
5. not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

Blue Cross and Blue Shield of Nebraska will determine whether services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Treating Physician.

MEDICARE: Health Insurance for the Aged and Disabled, Title XVIII of the Social Security Act, as amended.

MENTAL HEALTH SERVICES PROVIDER: A qualified Physician, Licensed psychologist, Licensed Special Psychologist, and Licensed Mental Health Practitioners are payable providers under this Contract. A Mental Health Practitioner may also be a Licensed Professional Counselor or a Licensed Clinical Social Worker who is duly Certified/Licensed for such practice by state law. It also includes, for purposes of this Contract, Auxiliary Providers supervised, and billed for, by a professional as permitted by state law. All mental health Services must be provided under appropriate supervision and consultation requirements as set forth by state law.

Licensed Psychologist: Psychologist shall mean a person Licensed to engage in the practice of psychology in this or another jurisdiction. The terms Certified, registered, chartered, or any other term chosen by a jurisdiction to authorize the autonomous practice of psychology shall be considered equivalent terms.

Licensed Special Psychologist: A person who has a doctoral degree in psychology from an institution of higher education accredited by the American Psychological Association but who is not Certified in clinical psychology. Such person shall be issued a special License to practice psychology that continues to require supervision by a Licensed Psychologist or qualified Physician for any practice that involves major mental and emotional disorders. This psychologist may provide mental health Services without supervision.

Licensed Mental Health Practitioner: A person Licensed to provide treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. Mental health practice shall include the initial assessment of organic mental or emotional disorders (as defined by state law), for the purpose of referral to, or consultation with a qualified Physician or a Licensed Psychologist.

Mental health practice shall not include the practice of psychology or medicine, prescribing drugs or electroconvulsive therapy, treating physical disease, Injury, or deformity, diagnosing major mental illness or disorder except in consultation with a qualified Physician or a Licensed Psychologist, measuring personality or intelligence for the purpose of diagnosis or treatment planning, using psychotherapy with individuals suspected of having major mental or emotional disorders except in consultation with a qualified Physician or Licensed Psychologist, or using psychotherapy to treat the concomitants of organic illness except in consultation with a qualified Physician or Licensed Psychologist.

MENTAL ILLNESS: A pathological state of mind producing clinically significant psychological or physiological symptoms (distress) together with impairment in one or more major areas of functioning (disability) wherein improvement can reasonably be anticipated with therapy and which is a condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV).

NONCOVERED SERVICES: Services that are not payable under the Contract.

ON-SITE OR HOST PLAN: A Blue Cross and/or a Blue Shield Plan in another Blue Cross and Blue Shield Association Service Area, which administers claims through the BlueCard Program for Nebraska Covered Persons residing or traveling in that service area.

OUTPATIENT: A person who is not admitted for Inpatient care, but is treated in the Outpatient department of a Hospital, in an observation room, in an Ambulatory Surgical Facility, Urgent Care Facility, a Physician's office, or at home. Ambulance Services are also considered Outpatient.

OUTPATIENT PROGRAM: An organized set of resources and Services for a Substance Abusive or mentally ill population, administered by a Certified provider, which is directed toward the accomplishment of a designed set of objectives. Day treatment, partial care and Outpatient Programs which provide primary treatment for Mental Illness or Substance Abuse must be provided in a facility which is Licensed by the Department of Health and Human Services Regulation and Licensure, (or equivalent state

agency) or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF).

This definition does not include programs of co-dependency, family intervention, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction. It also does not include Residential Treatment Programs or day rehabilitation programs for Mental Illness; or Residential Treatment Programs, halfway house or methadone maintenance programs for Substance Abuse. Benefits will not be provided for programs or services ordered by the Court that are not Medically Necessary as determined by Blue Cross and Blue Shield of Nebraska.

PARTICIPATING PROVIDER: A Licensed practitioner of the healing arts, or qualified provider of health care Services, who has contracted with Blue Cross and Blue Shield of Nebraska, under its traditional program, or who is a Participating Provider in the BlueCard Program Participating network.

PHYSICAL REHABILITATION: The restoration of a person who is disabled as the result of an Injury or an acute physical impairment to a level of function that allows the person to live as independently as possible. A person is disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

PHYSICIAN: Any person holding an unrestricted License and duly authorized to practice medicine and surgery and prescribe drugs.

PREAUTHORIZATION: Preauthorization of benefits is prior written approval of benefits for certain Services such as organ transplants, cardiac and pulmonary rehabilitation, subsequent purchases of Home Medical Equipment, prescription drugs, skilled nursing care, home health and hospice services. Preauthorization is based on the information submitted to Blue Cross and Blue Shield of Nebraska and is subject to the terms of the Contract. It may be effective for a limited period of time.

PREFERRED PROVIDER: A health care provider (Hospital, Physician or other health care provider) who has contracted to provide Services as a part of the BluePreferred Provider network in Nebraska, or if in another state, who is a Preferred Provider with the BlueCard Program PPO network.

PREFERRED PROVIDER ORGANIZATION: A panel of Hospitals, Physicians and other health care providers who belong to a network of Preferred Providers, which agrees to more effectively manage health care costs.

PREGNANCY: Includes obstetrics, abortions, threatened abortions, miscarriages, premature deliveries, ectopic pregnancies, cesarean sections or other conditions or complications related to the Pregnancy. For purposes of this Plan, Pregnancy also includes a condition or complication caused by Pregnancy, but separate from, and not part of the Pregnancy if it occurs prior to the end of the Pregnancy and is adversely affected by it. Postpartum depression and similar diagnoses are not considered complications of Pregnancy.

REASONABLE ALLOWANCE: The amount determined by Blue Cross and Blue Shield of Nebraska to be payable to non-Contracting Providers for a covered service. This amount will be one of the following amounts, not to exceed billed charges:

- a Maximum Benefit Amount, or
- an amount determined to be reasonable for similar service by similar providers in Nebraska or in another state, or
- a percentage or other discounted amount based on the billed charge, or
- an amount otherwise determined to be reasonable by Blue Cross and Blue Shield of Nebraska.

RESIDENTIAL TREATMENT PROGRAM: Services or a program organized and staffed to provide both general and specialized nonhospital-based interdisciplinary services 24 hours a day, seven days a week for persons with behavioral health disorders. Residential treatment may be provided in freestanding, nonhospital-based facilities or in units of larger entities, such as a wing of a hospital. Residential Treatment Programs may include nonhospital substance abuse treatment centers, intermediate care facilities, psychiatric treatment centers, or other nonmedical settings.

SCHEDULE OF BENEFITS: A summarized personal document which provides information about Copayments, Deductibles, percentages payable, special benefits, maximums and limitations of coverage. It also indicates the type of Membership Unit selected and whether or not Waiting Periods are in effect.

SCIENTIFICALLY VALIDATED: A technology, a drug, biological product, device, diagnostic, treatment or procedure is Scientifically Validated if it meets all of the factors set forth below:

- Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that is being

evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.

- The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

  The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration affects the health outcomes.

  Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments, and United States Food and Drug Administration (FDA) approvals.
- The technology must improve the net health outcome.
- The technology must improve the net health outcome as much as or more than established alternatives.
- The improvement must be attainable outside the investigational settings.

Blue Cross and Blue Shield of Nebraska will determine whether a technology is Scientifically Validated.

SERVICE AREA: The geographic area in which a Blue Cross and Blue Shield plan is authorized to use the Blue Cross and Blue Shield brands pursuant to its license agreement with Blue Cross and Blue Shield Association.

SERVICES: Hospital, medical or surgical procedures, treatments, drugs, supplies, Home Medical Equipment, or other health, mental health or dental care, including any single service or combination of such services.

SKILLED NURSING CARE: Medically Necessary Skilled Nursing Services for the treatment of an illness or injury that must be ordered by a Physician, and performed under the supervision of a registered nurse (R.N.) or a Licensed practical nurse (L.P.N.). The classification of a particular nursing service as skilled is based on the technical or professional health training required to effectively perform the service.

SUBSCRIBER: An individual who enrolls for health coverage and is named on an identification card issued pursuant to the Contract, and who is:

1. An employee hired by an employer who makes application for health coverage for its employees.
2. A retiree qualified to receive benefits as defined in Attachment A.

SUBSTANCE ABUSE: For purposes of this Contract, this term is limited to alcoholism and drug abuse. The term does not include tobacco dependence or addiction.

TREATING PHYSICIAN: A Physician who has personally evaluated the patient. This may include a Physician or oral surgeon, a Certified nurse midwife, a Certified nurse practitioner or Certified Physician's assistant, within the practitioner's scope of practice, when supervised and billed for, by a Physician.

UTILIZATION REVIEW: The evaluation by Blue Cross and Blue Shield of Nebraska or its designees, of the use of Services, including medical, diagnostic or surgical procedures or treatments, the utilization of medical supplies, drugs, or Home Medical Equipment or treatment of Mental Illness, Substance Abuse or other health or dental care, compared with established criteria in order to determine benefits. Benefits may be excluded for such Services if found to be not Medically Necessary.

WORK-HARDENING: Physical therapy or similar Services provided primarily for strengthening an individual for purposes of his or her employment.

Attachment A - Other Plan Provisions

HEALTH AND WELFARE PLAN FOR

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS (IBEW) LOCAL UNION NO. 22

AND

NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION (NECA) NEBRASKA CHAPTER

This Attachment A provides information regarding eligibility and effective dates for coverage under the Plan, as well as conditions under which Coverage will terminate and rights for continuing coverage under COBRA. Attachment A also describes Life Benefits, Dependent Life Benefits, and Accident and Sickness Weekly Benefits provided under the Plan.

Retired participants are not eligible for Loss-of-Time (Accident and Sickness Benefits) or Life/Dependent Life Benefits.

All questions regarding information presented in this Attachment A should be directed to the Fund Office:

Administrator
IBEW Local 22/NECA Health & Welfare Plan
Electrical Industry Center
8960 "L" Street, Suite 101
Omaha, Nebraska 68127
(402) 593-7565

ARTICLE I. DEFINITIONS

1.01 Bargaining Employee. The term "Bargaining Employee" means any employee who meets the Hour Bank Eligibility Requirements for Bargaining Employees as set forth in Section 2.01 of Article II hereof.

1.02 Board of Trustees. The term "Board of Trustees" means the Board of Trustees established by the Trust Agreement.

1.03 COBRA. The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985. This act was signed into law on April 7, 1986. It amended the Internal Revenue Code, ERISA, and the Public Health Service Act to require most employers to offer continuation coverage to employees and Dependents who would otherwise lose group health plan coverage because of certain qualifying events.

1.04 COBRA Participant. COBRA Participant means an individual who, on the day before a Qualifying Event described in Section 2.06(a), is a Bargaining Employee, a Non-Bargaining Employee, a Self-Pay Employee, a Retired Employee or a Dependent of any of these employee or retiree classifications and who does not qualify for coverage under Section 2.04 of Article II, Self-Payment Provisions.

1.05 Contributing Employer. The term "Contributing Employer" means any employer who is required by a collective bargaining agreement with the Union, the Trust Agreement, or any other agreement, to make contributions to this Plan or who, in fact, makes one or more contributions to the Plan. The term "Contributing Employer" shall also include the Union for the purpose of providing benefits hereunder for the full-time salaried officials of the Union for whom the Union is obligated to contribute. The term "Contributing Employer" shall also refer to any employer whose employees are participants in this Plan pursuant to Section 2.05 below.

1.06. Dependent. The term "Dependent" means:

a. the Eligible Employee's lawful spouse; or

b. a child of an Eligible Employee who meets the following criteria:

1. he is the child of the Eligible Employee as defined in Section 152(f)(1) of the Internal Revenue Code. This means the child must be the Eligible Employee's natural child, stepchild, a legally adopted child, a child placed for adoption, a child placed under a documented custodial order (including a legal guardianship) or an eligible foster child. A "foster child" means an individual who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. In order for a foster child to be eligible, no parent can claim the child as a "qualifying child" under the tax code and the non-parent Eligible Employee must have a higher adjusted gross income (AGI) than any parent;

2. he is under age 26, and does not have employer health coverage available through his employer (or spouse's employer, if married), an unmarried full-time student under age 24, even if he has employer health coverage available through his employer, or any age if permanently and totally disabled (provided the disability began before the child would have lost coverage under this Plan if not for this provision); and

3. he qualifies as a Dependent of the Eligible Employee under the Internal Revenue Code section 152 (without regard to sub-sections (b)(1), (b)(2), (d)(1)(B), (d)(1)(C), and (d)(1)(D) thereof). If section 152(e) applies to the child and the Eligible Employee is the child's parent, the child can be covered even if the Eligible Employee would not be entitled to claim a dependency exemption for that child under I.R.C. section 151.

Upon enrollment of a Dependent child, the Eligible Employee must certify to the Fund Office that the child being enrolled qualifies as the Eligible Employee's Dependent as described above. It shall be the responsibility of each Eligible Employee to notify the Fund Office promptly if a covered dependent child no longer qualifies as a Dependent child under the terms of this Plan. Failure to do so may cause benefits paid on behalf of the non-qualifying child to be taxable to the Eligible Employee.

c. Notwithstanding 1.06.b., above, if the child is an Alternate Recipient under a Qualified Medical Child Support Order (QMCSO), the Plan will comply with the terms of the QMCSO in accordance with the provisions described on page 4 of this Summary Plan Description and the Plan's QMCSO administrative procedures. In some cases, contributions to this Plan and benefits provided by this Plan for a child who is an Alternate Recipient under a QMCSO may be taxable to the Eligible Employee. The Fund Office may require additional information from the Eligible Employee to determine tax reporting requirements in such a case.

Proof of dependency status may be requested from time to time by the Board of Trustees.

The fact that a child may be covered as a Dependent under this Plan is not a guarantee that the benefits received by or on behalf of the child are exempt from taxation. You should consult your personal tax or financial advisor for guidance on your own situation.

Except as provided on page 4 of the Summary Plan Description, eligibility for such Dependent children is effective for coverage of claims incurred on or after the date the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office.

No preexisting condition exclusion applies to Dependents under age 19.

1.07 Disabled Employee. The term "Disabled Employee" means an employee who became disabled while eligible under this Plan and who has a minimum of five (5) consecutive years of service of not less than 1,000 hours of employment per year under a collective bargaining agreement and who:

a. is receiving or is entitled to receive a disability pension under the International Brotherhood of Electrical Workers Local No. 22 Restated Pension Plan; or

b. who is receiving a Social Security Disability Benefit.

1.08 Eligible Employee. The term "Eligible Employee" means each Bargaining Employee, Disabled Employee, Non-Bargaining Employee, Retired Employee or Self-Pay Employee.

1.09 Fund Office. The "Fund Office" is the Fringe Benefit Fund Office that performs the day-to-day administrative functions of the Plan and other related plans.

1.10 HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191.

1.11 HIPAA Privacy Rule. See "Privacy Rule."

1.12 Hour Bank Account.

The term "Hour Bank Account" means an account that is established for a Bargaining Employee to establish and maintain Plan eligibility.

Hours will be added to the Hour Bank Account as follows:

a. Hours worked for Contributing Employers by a Bargaining Employee will be credited to the Bargaining Employees Hour Bank Account. Prior to March 1, 2011, when a Bargaining Employee is credited with more than one hundred forty (140) hours during a month, the excess hours will remain in that Employee's Hour Bank Account up to a maximum accrued balance of eight hundred forty (840) hours. Effective March 1, 2011, when a Bargaining Employee is credited with more than one hundred forty (140) hours during a month, the excess hours will remain in that Employee's Hour Bank Account up to a maximum accrued balance of five hundred sixty (560) hours. A Bargaining Employee can accumulate these excess hours to be used to maintain eligibility during periods of slack employment or total layoff.

b. When a Bargaining Employee is receiving a Pre-Retirement Pension, the maximum reporting credits added to the Hour Bank Account shall not exceed 140 hours per full month of approved Pre-Retirement Pension, up to a maximum of 1,400 hours. This credit is applied to the Bargaining Employee's Hour Bank Account as if he were working as an Active Employee.

c. When an Apprentice is credited with time spent attending day school, but only to the extent necessary to grant initial eligibility or to maintain eligibility.

Each month, 140 hours will be deducted from the Bargaining Employee's Hour Bank Account to maintain eligibility. Eligibility using the Hour Bank Account is terminated on the first day of the calendar month following a calendar month in which the balance of the Hour Bank Account falls below a positive balance after the deduction of 140 hours for the current month's coverage. A former Bargaining Employee may elect to continue coverage under the Self-Payment Provisions.

If a Bargaining Employee does not elect to continue coverage under the Self-Payment provisions, any hours remaining in the Bargaining Employee's Hour Bank Account that are not sufficient to maintain coverage without self-payment will be forfeited if the Bargaining Employee is not credited with any Employer Contributions on his behalf by the Plan during the twelve months following the last date the Bargaining Employee maintained

coverage under the Plan. Such forfeiture shall occur on the 1st day following the end of the twelve month period during which no Employer Contributions are earned by the Bargaining Employee.

1.13 Non-Bargaining Employee. The term "Non-Bargaining Employee" means any employee who meets the Non-Bargaining Participation provisions as set forth in Section 2.05 of Article II.

1.14 Plan or Fund. The terms "Plan" or "Fund" mean the International Brotherhood of Electrical Workers Local Union No. 22/NECA, Nebraska Chapter, Health and Welfare Plan.

1.15 Privacy Rule. Part 160 and Subparts A and E of Part 164, of Title 45, Code of Federal Regulations, comprising the regulations promulgated by the Department of Health and Human Services pursuant to section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191.

1.16 Retired Employee. The term "Retired Employee" means (1) a Bargaining Employee who has been covered under the Fund immediately prior to retirement, who is not working in the industry, and who is receiving a pension benefit under the provisions of the International Brotherhood of Electrical Workers, Local No. 22 Amended and Restated Pension Plan "A"; or (2) a Bargaining Employee who was covered under the Fund immediately prior to retirement pursuant to a Residential Agreement or Sound and Communications Agreement, who has retired from work in the industry and is not working in the industry, and who is at least fifty-five (55) years of age; or (3) a Non-Bargaining Employee who has been covered under the Fund for at least five (5) consecutive years immediately prior to retirement, who is not working in the industry, and who is at least fifty-five (55) years of age.

1.17 Self-Pay Employee. The term "Self-Pay Employee" means a Bargaining Employee who subsequently loses eligibility under the Hour Bank provisions and elects to continue coverage under this Plan under Section 2.04 of Article II.

1.18 Trust Agreement. The term "Trust Agreement" or "Trust" means the Restated Agreement and Declaration of Trust of the International Brotherhood of Electrical Workers Local Union No. 22/NECA Health & Welfare Trust Fund, as modified or amended.

1.19. Union or Local Union. The term "Union" or "Local Union" as used in this document means the International Brotherhood of Electrical Workers (I.B.E.W.) Local Union No. 22.

If you have questions on these definitions, please contact the Fund Office at (402) 593-7565.

ARTICLE II. ELIGIBILITY FOR BENEFITS

2.01 Hour Bank and Eligibility for Bargaining Employees.

a. General Provisions. Bargaining Employees will become eligible for coverage in accordance with the following rules, provided sufficient contributions have been made by a Contributing Employer. No medical examination is required in order to become covered under the Plan.

b. Hour Bank Eligibility. Eligibility for benefits provided by the Plan will be established under an "Hour Bank" System. The "Hour Bank" System is a plan in which the hours reported by a Contributing Employer are accumulated for credit in an employee's "Hour Bank Account." Under this system, an employee can accumulate additional hours of eligibility to be used during periods of slack employment or total layoff.

c. Eligibility - Presently Eligible Employees. A Bargaining Employee eligible on the date this document is ratified by the Board of Trustees will continue to remain eligible until he fails to meet the requirements as set forth under "Termination of Eligibility" in subsection f. of this Section 2.01.

d. Initial Eligibility. A Bargaining Employee not eligible on the date this document is ratified by the Board of Trustees will become eligible on the first day of the second month following the month in which the Bargaining Employee's credited hours of employment with one or more contributing employers total two hundred-eighty (280) hours or more, within a three (3) consecutive calendar month period or less. The first two hundred-eighty (280) hours will not be credited to the Bargaining Employee's Hour Bank.

e. Continuation of Eligibility.

1. Hours worked for Contributing Employers by a Bargaining Employee will be credited to the Bargaining Employee's Hour Bank Account. One hundred forty (140) hours of reported credit will be deducted from the Bargaining Employee's Hour Bank Account for each month of coverage.

2. Whenever a Bargaining Employee is credited with more than one hundred forty (140) hours during a month (which is required to furnish one month's coverage), the excess hours will be added to the Bargaining Employee's Hour Bank accumulation. Prior to March 1, 2011, the Bargaining Employee will be allowed to accumulate excess hours in his Hour Bank up to a maximum of eight hundred forty (840) hours. Effective

March 1, 2011, the Bargaining Employee will be allowed to accumulate excess hours in his Hour Bank up to a maximum of five hundred sixty (560) hours.

3. Whenever a Bargaining Employee is eligible for and elects a Pre-Retirement Pension as outlined in the Pension Plan SPD, they will receive up to one hundred forty (140) hours of reporting credit per month (or each fraction thereof that they are on Pre-Retirement Pension). The maximum reporting credits for any Bargaining Employee on a Pre-Retirement Pension shall not exceed 140 hours per full month of approved Pre-Retirement Pension up to a maximum of 1,400 hours. This credit is applied to the Bargaining Employee's Hour Bank Account as if he were working as an Active Employee.

f. Termination of Eligibility. A Bargaining Employee's coverage under the Hour Bank will terminate on the first day of the calendar month following a calendar month in which the work credits in his Hour Bank Account falls below a positive balance after deduction of one hundred forty (140) hours for the current month's coverage. A former Bargaining Employee may elect to continue coverage under the Self-Payment provisions.

If a Bargaining Employee does not elect to continue coverage under the Self-Payment provisions, any hours remaining in the Bargaining Employee's Hour Bank Account that are not sufficient to maintain coverage without Self-Payment will be forfeited if the Bargaining Employee is not credited with any Employer Contributions on his behalf by the Plan during the twelve months following the last date the Bargaining Employee maintained coverage (under either the Hour Bank or Self-Payment provisions above) under the Plan. Such forfeiture shall occur on the 1st day following the end of the twelve month period during which no Employer Contributions are earned by the Bargaining Employee.

g. Reinstatement of Eligibility. A Bargaining Employee whose eligibility has terminated (under either the Hour Bank or Self-Payment provisions) and a period of twelve (12) months has not elapsed since their termination, shall again become eligible if their accumulated hours total at least one hundred-forty (140) hours within a two (2) consecutive calendar month period or less. Such reinstatement will take place on the first day of the second month following the month in which said one hundred-forty (140) hours have been accumulated. If the employee is not reinstated, any reserve hours in their Hour Bank Account will be forfeited in accordance with the rules in Section 2.01, subsection f. above. A Bargaining Employee will then become eligible upon completion of the eligibility requirements as set forth in this Section 2.01, subsection d., "initial eligibility".

For the year beginning January 1, 2011 and ending December 31, 2011, the Reinstatement of Eligibility rules are as follows. A Bargaining Employee whose eligibility has terminated (under either the Hour Bank or Self-Payment provisions) and a period of twelve (12) months has not elapsed since their termination, shall again become eligible if their accumulated hours from January 1, 2011 though December 31, 2011 total at least one hundred-forty (140) hours. Such reinstatement will take place on the first day of the second month following the month in which said one hundred-forty (140) hours have been accumulated. If the employee is not reinstated, any reserve hours in their Hour Bank Account will be forfeited in accordance with the rules in Section 2.01, subsection f. above. A Bargaining Employee will then become eligible upon completion of the eligibility requirements as set forth in this Section 2.01, subsection d., "initial eligibility".

h. Reciprocity Agreements. The Board of Trustees have entered into Reciprocity Agreements with other health funds, whereby eligibility may be continued for a Bargaining Employee working out of the jurisdiction of the local union, provided contributions are made to the Fund in accordance with the provisions of the Reciprocity Agreements.

i. Termination of Eligibility Due to Non-Bargaining Unit Employment. Notwithstanding any other provision herein to the contrary, a Bargaining Employee employed in the industry by an employer having no obligation to contribute to the Plan shall forfeit his Hour Bank and his eligibility for coverage under the Plan both for himself and his Dependents. The loss of coverage for the Bargaining Employee and his Dependents shall be effective as of the first day of the month following the month during which the work for the non-contributing employer was first performed. The loss of coverage will continue until the Bargaining Employee discontinues employment with a non-contributing employer and thereafter reestablishes initial eligibility under the rules of the Plan. All hours in the Bargaining Employee's Hour Bank as of the effective date of the loss of coverage shall be permanently forfeited. Neither the Bargaining Employee nor his Dependents shall be entitled to use the Bargaining Employee's Hour Bank or to make self-payments (other than under any continuation rules required by applicable law). No benefits will be payable as of the date of the loss of coverage regardless of any precertification or the initiation of provider services prior to such date. The Bargaining Employee and/or his Dependent(s) shall be solely responsible to reimburse the Plan for any benefits paid by the Plan on or after the date of the loss of coverage.

2.02 Eligibility for Dependents.

a. Eligibility Date. The eligibility date with respect to any Dependent shall be determined as follows:

1. If an Eligible Employee has a Dependent spouse on the date he becomes eligible for coverage in accordance with the Eligibility for Benefits provisions in Article II, Section 2.01, the Dependent Spouse shall become eligible on the same date. If an Eligible Employee gets married after that date, the Dependent spouse shall become eligible on the date of marriage.
2. If an Eligible Employee has a Dependent child on the date he becomes eligible for coverage in accordance with the Eligibility for Benefits provisions in Article II, Section 2.01, the Dependent child shall become eligible on the same date so long as the Dependent child's enrollment form was postmarked or otherwise positively received by the Fund Office on such date. If the Dependent child's enrollment form was not postmarked or otherwise positively received by the Fund Office on such date, the Dependent shall become eligible for coverage of claims incurred on or after the date the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office.
3. Except as provided on page 4 of this Summary Plan Description, if an Eligible Employee acquires a Dependent child (through marriage, legal adoption or otherwise), the Dependent child shall become eligible on the date acquired so long as the Dependent child's enrollment form was postmarked or otherwise positively received by the Fund Office on such date. If the Dependent child's enrollment form was not postmarked or otherwise positively received by the Fund Office on such date, the Dependent shall become eligible for coverage of claims incurred on or after the date the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office.

b. Termination of Dependent Eligibility. A Dependent's eligibility shall automatically terminate upon the occurrence of the first of the following events:

1. when the Dependent ceases to meet the criteria set forth under the definition of Dependent; or
2. when the Eligible Employee's eligibility terminates for any reason except death.

In the event of termination of coverage, Dependents may continue coverage through COBRA. See Section 2.06.

c. Coverage for Dependents of a Deceased Bargaining Employee. Coverage for Dependents of a deceased Bargaining Employee shall remain in effect until one (1) year after the date of death. Coverage may be continued as provided under Section 2.04, Subsection d.4.

2.03 One-Time Temporary Waiver of Coverage for Spouses of Retirees

Effective March 1, 2009, spouses of retirees who have coverage under an employer-sponsored health plan may waive coverage for the spouse under this Plan. For this waiver to become effective, the spouse must provide the Fund Office with written evidence of employer-sponsored health plan coverage. The waiver will last until the spouse's employer-sponsored coverage terminates. The spouse must notify the Fund Office when the spouse's employer-sponsored coverage terminates. The spouse will then become covered under this Plan again, provided the Fund Office is notified of the termination of coverage within 31 days of the date the coverage terminated. During the time that the waiver is in effect, the retiree will pay the self-pay rate based only on the age of the retiree. Once the spouse is again covered by this Plan the retiree must begin paying the self-pay rate based on the ages of both the retiree and spouse.

IMPORTANT: A retiree may only waive coverage for his/her spouse one time.

2.04 Self-Payment Provisions (for Bargaining Employees).

a. Participation. In order to participate under the Self-Payment Provisions, the Bargaining Employee must have become covered under Initial Eligibility or the provisions of this Summary Plan Description and qualify under a classification listed under Subsection d., Those Eligible, of this Section 2.04.
b. Notice of Loss of Eligibility. The Fund Office will advise those former Bargaining Employees who have lost their eligibility under the Hour Bank Plan.

c. Payment of Premium. It will be the responsibility of each Self-Pay Employee to remit his own contribution in the event he loses eligibility. The first (1st) payment must be paid no later than the thirtieth (30th) day of the month following the month in which the Bargaining Employee lost eligibility. Each subsequent payment must be in the Fund Office no later than the thirtieth (30th) day of the month for which the coverage is intended.

d. Those Eligible.

1. A Self-Pay Employee who initially qualified for coverage by meeting the Initial Eligibility requirements of the Hour Bank Eligibility for Bargaining Employees in Section 2.01 of this Article II may make self-payments in accordance with the following provisions:

(a) The Self-Pay Employee may pay the difference between the hours in his Hour Bank Account and one hundred forty (140) hours at the current contribution rate.

(b) Once the Self-Pay Employee's Hour Bank is depleted, he may continue to make monthly self-payments for the full amount for eighteen (18) consecutive months. If the Self-Pay Employee ceases to make payments at anytime during the eighteen (18) months, or if the Self- Pay Employee exhausts the eighteen (18) months of Self Pay, the Self-Pay Employee is considered eligible for COBRA.

2. A Disabled Employee may continue to make consecutive monthly self-payments for eighteen (18) months, or until he is no longer disabled, or until he is eligible to retire under the provisions of the International Brotherhood of Electrical Workers, Local No. 22 Amended and Restated Pension Plan, whichever should occur first.

3. A non-Medicare eligible Retired Employee may continue coverage for himself and his Dependents as long as such Retired Employee meets the definition of Retired Employee in Article I, Section 1.16.

4. A surviving spouse of a deceased Bargaining Employee may continue coverage, including coverage for Dependent children, by making consecutive monthly self-payments following the one (1) year of free coverage until terminated for any one (1) of the following reasons, whichever should occur first:

(a) the surviving spouse remarries; or

(b) the surviving spouse or Dependent children become eligible for any group policy; or

(c) the surviving spouse fails to pay the required premium; or

(d) the date of the surviving spouse's death.

5. A surviving spouse of a deceased non-Medicare eligible Retired Employee may continue coverage by making consecutive monthly self-payments following one (1) year of free coverage until the occurrence of the first of the following events:

(a) the surviving spouse remarries; or

(b) the surviving spouse becomes eligible for any group policy; or

(c) the surviving spouse fails to pay the required premium; or

(d) the date of the surviving spouse's death.

6. A Medicare eligible Retired Employee or a surviving spouse may continue coverage provided one of the following classifications is met:

(a) the Retired Employee or surviving spouse is enrolled in Parts A and B of Medicare, with no other Dependents;

(b) the Retired Employee and spouse are both enrolled in Parts A and B of Medicare, with no other Dependents;

(c) the Retired Employee or spouse is enrolled in Parts A and B of Medicare, with Dependents.

e. Amount of Self-Payment Premium. The amount of the monthly self-payment for retirees, surviving spouses, and Dependents will be established by the Board of Trustees.

f. Benefits. A Self-Pay Employee may make self-payments for all benefits provided under the Plan. A surviving spouse of a deceased Bargaining Employee or deceased Retired Employee may make self-payments for benefits to which the surviving spouse is entitled.

g. Termination of Self-Payment. Coverage will terminate for any one (1) of the following reasons, whichever should occur first:

1. an individual fails to make the required self-payment within the specified time, or the maximum self-payment period has been exhausted;

2. coverage will terminate for Dependents on the date the Self-Pay Employee's coverage terminates or for Dependents of a deceased Active Employee or Retired Employee when:

(a) the surviving spouse remarries; or

(b) the children are no longer considered Dependents under the definition of Dependent; or

(c) the spouse's coverage terminates; or

(d) the spouse becomes eligible for any group policy; or

(e) the date of the surviving spouse's death.

h. COBRA Continuation Coverage. In the event of termination of Self-Pay coverage, Bargaining Employees may continue coverage through COBRA. See Section 2.06.

i. Termination of Prescription Drug Coverage for Medicare Eligible Retired Employees and Dependents, or a Surviving Spouse. Prescription Drug coverage will terminate for any Medicare eligible Retired Employee, Disabled Employee, Covered Dependent, or a surviving spouse who elects Medicare Part D Prescription Drug coverage. The termination of coverage shall be effective on the date the coverage under Medicare Part D Prescription Drug Coverage is effective. Said Retired Employee and Dependents, or a surviving spouse shall again be eligible for Prescription Drug coverage if said individual can provide proof to the Fund Office that the Medicare Part D coverage is no longer in effect, provided that said individual remains eligible for Medical benefits.

2.05 Non-Bargaining Participation (Effective January 1, 1989).

a. Contributing Employer Participation. A Contributing Employer must make application to the Board of Trustees for Non-Bargaining Participation. An application must be completed for each company requesting participation. The Board of Trustees reserves the right to accept or reject any Non-Bargaining application.

When a Contributing Employer's participation has been approved by the Board of Trustees, the Contributing Employer will be notified in writing by the Fund Office.

A Contributing Employer must contribute on all full-time Non-Bargaining personnel who do not sign a waiver of benefit coverage card and who are eligible for coverage under Section 2.05(c) below.

b. Employee Application for Participation. Each Non-Bargaining Employee must complete an application form (available at the Fund Office), which will be submitted by the Contributing Employer to the Board of Trustees for consideration. The Non-Bargaining Employee application form must include the following information for each Non-Bargaining Employee:

1. name of Non-Bargaining Employee and each Dependent;

2. marital status of Non-Bargaining Employee;

3. date of birth of the Non-Bargaining Employee and each Dependent;

4. Social Security number of the Non-Bargaining Employee and each Dependent;

5. sex of the Non-Bargaining Employee and the relationship of each Dependent to the Non-Bargaining Employee; and

6. date of employment.

c. Classes of Non-Bargaining Employees Eligible.

1. Employees of the proprietorship (including the proprietor),
2. Employees of a partnership (including the partners),
3. Employees of corporations,
4. Employees of the association,
5. Employees of the Local Union, Fund Office, affiliated Electrical Joint and Apprenticeship Training Programs, and affiliated Credit Unions, and
6. Retired Employees.

Notwithstanding the above, the Plan shall exclude from participation any employee who is not entitled to participate in this Plan under the Internal Revenue Code, the Employee Retirement Income Security Act (ERISA), the Labor-Management Relations Act (LMRA), or any other applicable law, or whose participation could jeopardize the Plan's qualified status under any applicable law. The Board of Trustees shall have full authority and discretion to determine whether an individual is entitled to participate or whether an individual's participation could jeopardize the Plan's qualified status, and such decision shall be final and binding on all persons.

d. Benefits. The group making application will be entitled to all benefits provided by the Fund, i.e., Dependent Life, Comprehensive Major Medical, Accident and Sickness Weekly Benefits, Life and Accidental Death and Dismemberment Benefits. (Separate entitlements apply to retirees and their Dependents. For further information please contact the Fund Office.)

e. Contributing Employer Non-Bargaining Participation Effective Date. The effective date of Contributing Employer Non-Bargaining Participation shall be the first date the application has been approved by the Board of Trustees.

f. Non-Bargaining Employee Effective Date of Coverage. All full-time Non-Bargaining Employees and their Dependents, excluding those Non-Bargaining employees who have executed a waiver of coverage card, will become eligible for coverage on the initial effective date of Contributing Employer Non-Bargaining Participation, subject to the Board of Trustees' approval. Non-Bargaining Employees hired on or after the initial effective date of Contributing Employer Non-Bargaining Participation must complete an application for participation or execute a waiver of coverage card within thirty (30) days from their original date of employment. The date of coverage, subject to the Board of Trustees' approval, shall be the first day of the month next following thirty (30) days of full-time employment with the Contributing Employer. The Board of Trustees shall not refuse coverage to any employee or Dependent based on any of the following health status-related factors: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability, regardless of whether such individual enrolls when initially eligible or during a special enrollment period.

Any Non-Bargaining Employee (including Eligible Dependents) who declines coverage because he or she has other group health plan coverage or other health insurance coverage shall be entitled to revoke the waiver of coverage and enroll in this Plan upon losing eligibility for such other coverage (regardless of the reason for the loss of eligibility) or upon the cessation of employer contributions to such other coverage. In addition, any Non-Bargaining Employee or eligible Dependent who declines coverage may enroll upon marriage, birth, adoption, or placement for adoption. The Non-Bargaining Employee may enroll himself or herself, along with any and all eligible Dependents. In addition, a Non-Bargaining Employee may request to revoke a waiver and enroll at other times, at the discretion of the Board of Trustees, as set forth in the Non-Bargaining Participation Agreement. Such late enrollment will be effective upon a date requested by the Employee and approved by the Trustees, but not earlier than the first day of the month following the month in which the request for late enrollment is received by the Fund Office.

Waiver of coverage cards shall provide the following notice to Non-Bargaining Employees:

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

A special enrollment period of 60 days is allowed for:

- Enrollment of eligible persons who were covered under Medicaid or State Child Health Insurance Program (SCHIP), which has been terminated due to loss of eligibility.
- Enrollment of eligible persons who have become eligible for premium assistance for this group health Plan coverage under Medicaid or SCHIP.

Please contact the IBEW Local 22/NECA Fund Office for additional information.

g. Monthly Premium Payment. The amount of the monthly premium to be remitted by the Contributing Employer on each participating Non-Bargaining Employer or on each participating Non-Bargaining Employee will be established by the Board of Trustees. The premium must be remitted to the Fund Office no later than the fifteenth (15th) day of each calendar month for which coverage is intended.

h. Termination of Coverage. A Non-Bargaining Employee's Coverage will terminate upon the earliest of the following events:

1. If a Non-Bargaining Employee's employment terminates, coverage will terminate on the last day of the month following the date such termination occurs; or

2. once the Contributing Employer fails to make the required premium payments within the specified time; or

3. on the date the Plan is discontinued (please refer to Article VII of the Attachment A, Other Plan Provisions, for a description of your rights upon plan termination); or

4. on the date the Non-Bargaining Employee enters full-time military service (subject to the provisions of Section 2.08 below); or

5. upon termination of participation of the Non-Bargaining group, by the Board of Trustees at their discretion, for any of the following reasons;

i. for non-payment of contributions;

ii. for fraud or other intentional misrepresentation of material fact by the employer;

iii. for noncompliance with material Plan provisions;

iv. because the Plan is ceasing to offer any coverage in the geographic area in which the employer is located;

v. if there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of this Plan's network - the Board of Trustees will apply this sub-section uniformly without regard to the claims experience of employers or any health status-related factor in relation to such individuals or their Dependents; or

vi. if the Contributing Employer fails to meet the terms of its collective bargaining agreement with the Local Union, if the Contributing Employer is no longer signatory to any collective bargaining agreement with the Local Union, if the Contributing Employer fails to comply with or fails to renew its participation agreement with the Fund, or if the Contributing Employer fails to employ any employees covered by an agreement with the Local Union or the Fund; or

6. at the end of the month in which death occurs; or

7. in the event a Contributing Employer is delinquent in remitting contributions or submitting monthly reports for Non-Bargaining Employees, coverage will terminate for Non-Bargaining Employees on the first (1st) day of the month for which the Contributing Employer is delinquent; or

8. at the end of the month the Contributing Employer is no longer a Contributing Employer subject to a written agreement calling for contributions to be made into the Fund on behalf of bargaining employees.

i. Termination of Dependent Coverage. A Dependent's coverage shall automatically terminate upon the occurrence of the first of the following events:

1. the date the Non-Bargaining Employee's coverage terminates; or
2. the date the Dependent ceases to qualify under the Plan's definition of Dependent; or
3. the date the Dependent enters full-time military service; or
4. termination of participation of the Non-Bargaining group for any lawful reason.

j. Non-Medicare Retired Employee Coverage. A non-Medicare eligible Retired Non-Bargaining Employee may continue coverage for himself and his Dependents as long as such Retired Employee meets the definition of Retired Employee in Article I, Section 1.16.

k. Medicare Retired Employee or Survivors' Coverage. A Medicare eligible Retired Non-Bargaining Employee or his surviving spouse and/or surviving Dependent children may continue coverage provided one of the following classifications is met:

1. the Retired Employee or surviving spouse is enrolled in Parts A and B of Medicare, with no other Dependents;

2. the Retired Employee and spouse are both enrolled in Parts A and B of Medicare, with no other Dependents;
3. the Retired Employee or spouse is enrolled in Parts A and B of Medicare, with Dependents.

l. Survivors' Coverage. A surviving spouse and/or surviving Dependent children of a Non-Bargaining Employee may continue coverage by making monthly self-payments following one (1) year of free coverage until terminated for any one of the following reasons, whichever should occur first:

1. the surviving spouse remarries; or
2. the surviving spouse or Dependent children become eligible for any group policy; or
3. the surviving spouse or Dependent children fail to pay the required premium; or
4. death.

A surviving spouse of a deceased non-Medicare eligible Retired Non-Bargaining Employee may continue coverage by making consecutive monthly self-payments following one (1) year of free coverage until the occurrence of the first of the following events:

1. the surviving spouse remarries; or
2. the surviving spouse becomes eligible for any group policy; or
3. the surviving spouse fails to pay the required premium; or
4. death.

m. Amount of Self-Payment Premium. The amount of the monthly self-payment premium will be established by the Board of Trustees.

n. Benefits. All classes of Non-Bargaining Employees and survivors of all classes of Non-Bargaining Employees may make self-payments for benefits to which they are entitled.

o. Termination of Self-Payment. Coverage will terminate for any one (1) of the following reasons, whichever should occur first:

1. An individual fails to make the required self-payment within the specified time, or the maximum self-payment period has been exhausted.
2. Dependent coverage terminates because of:
   (a) the Non-Bargaining Employee's coverage terminates; or
   (b) the spouse remarries; or
   (c) the children are no longer considered Dependents under the definition of Dependent; or
   (d) the spouse or Dependent children become eligible for any group policy; or
   (e) death.

p. COBRA Continuation Coverage. In the event of termination of self-payment, Non-Bargaining Employees may continue coverage through COBRA. See Section 2.06.

q. Reinstatement Provision. Once a Non-Bargaining group and/or Non-Bargaining Employee thereof terminates their coverage, they must reapply before their coverage shall again become effective.

r. Termination of Prescription Drug Coverage for Medicare Eligible Retired Employees and Dependents, or a Surviving Spouse. Prescription Drug coverage will terminate for any Medicare eligible Retired Employee, Disabled Employee, Covered Dependent, or a surviving spouse who elects Medicare Part D Prescription Drug coverage. The termination of coverage shall be effective on the date the coverage under Medicare Part D Prescription Drug Coverage is effective. Said Retired Employee and Dependents, or a surviving spouse shall again be eligible for Prescription Drug coverage if said individual can provide proof to the Fund Office that the Medicare Part D coverage is no longer in effect, provided that said individual remains eligible for Medical benefits.

2.06 Self-Payment Provisions for Coverage -- COBRA.

a. Eligibility. A COBRA Participant may continue coverage under this Section for the maximum periods specified below, by making election to do so with the Fund Office, and submitting the applicable self-payment contribution. The amount of the monthly self-payment contribution will be established by the Board of Trustees, and will not exceed 102% of the total cost of coverage for similarly situated Bargaining Employees, Non-Bargaining Employees, or Retired Employees.

Qualifying Events for Continuation of Coverage (COBRA):

The term "Qualifying Event" means any of the following:

1. termination of coverage due to the death of the Eligible Employee;

2. termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours;

3. termination of coverage because of divorce or legal separation;

4. termination of coverage because of the Eligible Employee's commencement of entitlement to Medicare coverage; or

5. a Dependent child ceasing to be a Dependent child as defined in Section 1.06 above.

b. Classification -- Those Eligible -- Maximum Self-Payment Period.

1. Eighteen-Month Continuation Coverage. A COBRA Participant may elect 18 months of continuation coverage if Coverage would otherwise terminate because of a Qualifying Event as described in 2.06 (a)(2) above.

Qualified Beneficiaries who are Social Security disabled at any time during the first 60 days of continuation coverage can request an extension in the maximum coverage period from 18 to 29 months. Persons must notify the Plan Administrator of Social Security's disability determination within 60 days of the determination or the date on which COBRA continuation coverage began, if later, and within 18 months of the qualifying event. Payments required for continuation coverage after 18 months can increase to 150% of the full cost of coverage. A person with extended coverage must notify the Plan Administrator within 30 days of any final determination made by Social Security that the person is no longer disabled.

2. Thirty-Six Month Continuation Coverage. A COBRA Participant who is a spouse or child may elect 36 months of continuation coverage if coverage would otherwise terminate because of a Qualifying Event as described in Section 2.06 (a)(1, 3, 4 or 5) above.

3. Second Qualifying Event. If a spouse or Dependent child has a second Qualifying Event, the maximum COBRA coverage period will be extended from 18 months to 36 months. This is only available if the spouse or Dependent child is already on COBRA continuation coverage because of the Employee's termination of employment or reduction in hours, and one of the following happens while the spouse or Dependent child is on COBRA coverage: the Employee's divorce or legal separation, the Employee becoming entitled to Medicare, the Employee's death, or a Dependent child's loss of Dependent status under the Plan.

The 36-month maximum COBRA Self-Payment period is measured from the date active or Self-Pay coverage terminated on account of the first Qualifying Event.

4. Extended Benefits for Totally Disabled Individuals. In the event of termination of eligibility, coverage for health services described in the prior information of this Summary Plan Description will be extended until the Participant is no longer totally disabled, subject to Self-Payment Provisions.

c. Procedures to Elect Self-Payment for Continuation Coverage.

1. In the case of a Qualifying Event described in Section 2.06 (a) (1, 2 or 4), a COBRA Participant will receive information concerning continuation coverage, including the self-payment rates, within 14 days of termination of coverage due to such Qualifying Event.

2. In the case of a Qualifying Event described in Section 2.06 (a) (3 or 5), for an enrolled Dependent, the employee or Dependent must notify the Fund Office within 60 days of the Qualifying Event. If notice is not received within 60 days of a Dependent's Qualifying Event, Dependents will not be eligible for continuation coverage.

Following receipt of timely notice of a Qualifying Event and within 14 days of receipt of such notice, the Fund Office will provide the Eligible Dependent with information concerning continuation coverage and rates.

3. After notification of continuation coverage, the COBRA Participant will have until 60 days after the later of:

(a) the date that the COBRA Participant would lose coverage on account of the Qualifying Event; or

(b) the date that the COBRA Participant is sent notice of his or her right to elect continuation coverage to elect or waive continuation coverage.

A waiver of continuation coverage will be effective on the date that the waiver is sent to the Fund Office.

A COBRA Participant who, during the election period, waives continuation coverage can revoke the waiver at any time before the end of the election period. However, if a COBRA Participant who waives continuation coverage later revokes the waiver, coverage will be effective on the date that the revocation of the waiver and election to continue is sent to the Fund Office, and will not be retroactive to the initial termination of coverage.

4. The first monthly payment (which will include premiums for all months since coverage terminated) must be received by the Fund Office within 45 days of the date the COBRA Participant elects to continue coverage. Each subsequent payment is due by the 1st of the month for which Coverage is intended, and shall be considered timely if received within 30 days of the date due.

5. If premiums are not received in a timely manner, Coverage will terminate. No claims will be paid until premium payment is received by the Fund Office in accordance with paragraph 4 above.

d. Termination of Continuation Coverage. Continuation coverage as provided under this Section will terminate on the earliest of the following dates:

1. the date the COBRA Participant first becomes covered under any other group health plan, but only if the COBRA Participant was not covered under that other group health plan when he or she went on COBRA coverage, and only if the COBRA Participant will not be subject to a pre-existing condition exclusion or limitation under the other group health plan; or

2. the end of the period for which the last payment was made for coverage in a timely manner; or

3. the maximum continuation period (18 months, 29 months, or 36 months) has been exhausted; or

4. the date the COBRA Participant first becomes, after the date of election of COBRA continuation coverage, eligible for Medicare (however, continuation coverage will not be terminated in this instance for any person who, prior to electing COBRA continuation coverage, was the spouse of an Eligible Employee, the Dependent child of an Eligible Employee, or the surviving spouse of an Eligible Employee); or

5. if coverage was extended up to 29 months due to disability, the first date of the month following the month in which the Social Security Administration determines that the COBRA participant is no longer disabled.

6. the date the Plan ceases to provide any group health plan.

e. Compliance with COBRA. Continuation coverage under this section shall be terminated under this Fund, for COBRA Participants of a Contributing Employer, on the date of termination of participation in the Fund, by the Contributing Employer.

f. Benefits. The coverage provided under COBRA continuation coverage is identical to the medical coverage provided under the Plan to similarly situated beneficiaries with respect to whom a qualifying event has not occurred. Ancillary welfare benefits, such as Life Benefits, Accidental Death and Dismemberment benefits, Dependent Life Benefits, and Accident and Sickness Weekly Benefits may not be continued under COBRA.

If you have any questions on eligibility, self-payment provisions, or COBRA, please contact the Fund Office at (402) 593-7565.

2.07 COBRA Continuation Coverage Procedures

General

A participant or beneficiary with respect to whom a qualifying event has occurred shall be a qualified beneficiary entitled to elect COBRA continuation coverage. Any person who has properly elected continuation coverage shall remain a qualified beneficiary until continuation coverage is terminated.

Notice of Qualifying Events

Participating employers are not required to provide notice of qualifying events to the Plan Administrator. The Plan Administrator shall determine whether a qualifying event has occurred due to the employee's termination of employment or reduction in hours of employment, the employee's death, or the employee's becoming entitled to Medicare.

In order to make a determination whether a qualifying event has occurred as a result of termination of employment or reduction of hours of employment, the Plan Administrator shall review the monthly employer contribution reports to determine the number of hours to be credited to the employee based on the number of hours worked and whether full contributions are received for all hours worked. If employer contributions

reports are submitted timely, the Plan Administrator will generally have sufficient information to determine whether an employee will lose coverage as a result of a termination of employment or reduction of hours of employment within 45 days after the last day of the qualification period in which the employee does not have sufficient hours or contributions credited to maintain coverage.

The Plan Administrator shall determine whether an employee has become entitled to Medicare and whether such entitlement constitutes a qualifying event. If the Plan Administrator so determines, he shall send a COBRA election notice to all qualified beneficiaries within 30 days following the date of the qualifying event.

The Plan Administrator shall send notice of the qualifying event and all qualified beneficiaries' rights to elect COBRA continuation coverage as soon as possible after determining that an employee has died. Unless the Plan Administrator has no reason to know of the employee's death, the COBRA election notice shall be sent to all qualified beneficiaries within 14 days after such qualified beneficiaries would lose coverage as a result of the qualifying event.

The Plan Administrator shall send notice of the qualifying event and the qualified beneficiaries' rights to elect COBRA continuation coverage within 14 days after having determined that a qualified event has occurred as described above.

An employee must give written notice to the Plan Administrator within 60 days after the occurrence of a qualifying event that is a divorce or legal separation of the employee (or retiree) and spouse or a Dependent child's ceasing to meet the Plan requirements for an Eligible Dependent. The notice shall be provided in writing, mailed or delivered to the Fund Office. The Plan will provide forms to participants and beneficiaries which may be used to provide this notice. Use of the Plan's form is not required as long as the written notice of qualifying event contains all of the necessary information and is accompanied by documentation of the qualifying event, if applicable. The Plan Administrator will then send notice of the qualified beneficiaries' rights to elect COBRA continuation coverage, or the unavailability of COBRA continuation coverage, within 14 days after receiving such notice.

Second Qualifying Event and Disability

If a qualified beneficiary experiences a second qualifying event while on COBRA continuation coverage that is subject to a maximum period of 18 or 29 months, the qualified beneficiary must provide written notice to the Plan Administrator within 60 days of the second qualifying event in order to extend the maximum COBRA continuation coverage period to 36 months.

If a qualified beneficiary or any member of the qualified beneficiary's family is disabled, as determined by the Social Security Administration, at any time within the first 60 days of COBRA continuation coverage, the qualified beneficiary must provide written notice of such disability to the Plan Administrator within the first 60 days of COBRA continuation coverage or, if later, within 60 days from the Social Security Administration's determination that the qualified beneficiary or family member is disabled. The notice must be accompanied by a copy of the Social Security Administration's determination letter. A qualified beneficiary may, but is not required to, use a form provided by the Fund Office to provide this notice. If the Social Security Administration determines that the person's disability has ended while the person is on COBRA continuation coverage, the qualified beneficiary must provide a copy of the Social Security Administration's letter stating that the person is no longer disabled, to the Plan Administrator within 30 days after the Social Security Administration's determination.

The Plan Administrator shall send notice of right to elect an extended period of continuation coverage, or notice of the unavailability of an extension of continuation coverage, within 14 days after receiving notice from the qualified beneficiary.

Unavailability of COBRA Continuation Coverage

When the Plan Administrator receives a notice from an employee or beneficiary relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration regarding a covered employee, qualified beneficiary, or other individual, and the Plan Administrator determines that the individual is not entitled to COBRA continuation coverage or an extension of COBRA continuation coverage, the Plan Administrator shall provide a notice to the person sending the notice explaining why the individual is not entitled to COBRA continuation coverage. The unavailability notice shall be sent within 14 days from receipt of the notice from the employee or other individual.

Early Termination of COBRA Continuation Coverage

Whenever COBRA continuation coverage is terminated prior to the latest date shown on the Election Notice (that is, prior to the end of the 18, 29, or 36 month maximum period), notice must be sent to all affected

qualified beneficiaries explaining the reason for the termination, the date of termination, and any rights the qualified beneficiary may have under the plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right. The termination notice will be provided as soon as practicable following the Administrator's determination that continuation coverage shall terminate.

Change of Premium Rate

In the event COBRA premiums change, the Plan Administrator shall send notice of such change to all qualified beneficiaries at least one month prior to the effective date of the change.

Deficient Premium Payment

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is less than the full premium amount due, and the deficiency is not more than $50.00 (or the deficiency is not more than 10% of the applicable premium amount, if 10% of the premium is less than $50.00), the Plan Administrator shall provide notice of deficiency to the qualified beneficiary, demanding payment of the deficiency in full within 30 days from the date of the notice of deficiency. The deficient premium will be considered full payment until the end of the 30 day period. If the Plan Administrator fails to provide notice of the deficiency to the qualified beneficiary within 30 days after receipt of the payment, the amount paid will be deemed to constitute full payment of the applicable premium. In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is significantly less than the full amount due (that is, the deficiency exceeds the lesser of $50.00 or 10% of the applicable premium), no additional time will be granted to make up the deficiency. If the deficiency is not paid within the initial 30 day grace period, coverage will be retroactively terminated as of the first day of the month for which full payment was not made.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
I.B.E.W. Local Union No. 22/NECA Health & Welfare Plan

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

You are receiving this notice because you have recently become covered under the International Brotherhood of Electrical Workers (I.B.E.W.) Local Union No. 22/National Electrical Contractors Association (NECA), Nebraska Chapter, Health & Welfare Plan, a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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 notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and 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.

If you are an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, 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;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- 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-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "Dependent child."

When is COBRA Coverage 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 end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator will make the determination of the Qualifying Event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), YOU must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to the Plan Administrator, Wilson-McShane Corporation, IBEW Local 22/NECA Health & Welfare Plan, Electrical Industry Center, 8960 "L" Street, Suite 101, Omaha, Nebraska 68127-1406. Your notice to the Plan Administrator must be made in writing and must be accompanied by a copy of any legal documentation (such as a divorce decree or order granting legal separation) related to the Qualifying Event.

How is COBRA Coverage 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 employees 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 employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), 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. When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of the Social Security Administration's determination letter or within 60 days after your COBRA continuation coverage begins, whichever is later, but no later than 18 months after your COBRA continuation coverage begins, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event extension of 18-month period of continuation coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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

Wilson-McShane Corporation
8960 "L" Street, Suite 101
Omaha, NE 68127
(402) 593-7565
(402) 593-7609 fax
ibew22benefits@wilson-mcshane.com

2.08 Continuation of Coverage During a Period of Uniformed Service.

Under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) or other applicable Federal law, an Employee and his Dependents may be entitled to continued eligibility and coverage or COBRA benefits during certain periods of service in the United States Uniformed Services. Employees should contact the Plan Administrator for more details. Employees should contact the Plan Administrator immediately upon receiving notification that they are being called to duty in the Uniformed Services. The Board of Trustees shall establish and maintain a written policy and set of procedures to be followed with respect to service of Employees in the Uniformed Services, which shall be consistent with the following general principles.

a. Uniformed Services refers to the Armed Forces; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; any other category of persons designated by the President in time of war or national emergency; and to any other category of persons as may be designated by Congress under USERRA. An Employee performs service in the Uniformed Services if he performs duty on a voluntary or involuntary basis in a Uniformed Service under competent authority. Such service includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty, and a period for which a person is absent from employment for the purpose of performing funeral honors duty as authorized by section 12503 of Title 10, U.S.C. or section 115 of Title 32, U.S.C.

b. An Employee must provide advance written or oral notice to his Employer and the Plan Administrator of his service in the Uniformed Services, unless the giving of such notice is precluded by military necessity or, under all of the relevant circumstances, the giving of such notice is otherwise impossible or unreasonable. Military necessity shall be determined with respect to regulations prescribed by the Secretary of Defense.

c. Continuation of eligibility and coverage shall be available to Employees whose cumulative absence from employment with a Participating Employer for the purpose of performing service in the Uniformed Services does not exceed five years, subject to certain exceptions as may be required by Federal law. All periods of absence for the purpose of performing service in the Uniformed Services shall be aggregated for the purpose of determining the five year maximum.

d. An Employee must return to work, or must re-apply for employment (by notifying his last Employer and/or the Local Union and requesting either reinstatement or listing on the out-of-work list, and providing a copy of the returning service member's Form DD-214, if applicable) within the following maximum timeframes:

i. if the absence due to Uniformed Service was for less than 31 days, not later than the first business day following completion of the period of service (completion of the period of service is deemed to occur upon the completion of eight hours following a period allowing for the safe transportation of the person from the place of service to his place of residence following his discharge);

ii. if the absence is more than 30 days but less than 181 days, within 14 days following discharge; or

iii. if the absence was for more than 180 days, within 90 days following discharge.

e. Provided that advance notice is provided or is excused, and provided the Employee returns to work within the above-stated time frames, an Employee's eligibility, and his hours worked credited to him, shall be "frozen" from the date the Employee's absence begins until the date the Employee returns to work, re-applies for work, or notifies his last Employer, the Local Union, and/or the Fund that he intends not to return to work.

f. The Employee shall be offered continuation of coverage under this Plan for up to 24 months from the date the absence begins, pursuant to the same rules governing COBRA continuation coverage, as set forth in Article II, Section 2.06. However, if the Employee's period of service is less than 31 days, no continuation coverage premium shall be required. In addition, no continuation coverage premium shall be required with respect to Dependents of a member of the military reserves for the period beginning the date of the Employee's absence for active duty service in the reserves until the date on which the Employee's Dependents are eligible for dependent health care coverage through the military. USERRA continuation coverage shall end upon the earlier of:

i. 24 months from the date the Employee's absence began;

ii. the date the Employee notifies his last Employer, the Local Union, and/or the Plan Administrator that

he intends not to return to covered employment; or

iii. the day following the last day on which the Employee may return to work or re-apply for work as set out in Article II, Section 2.08(d) above.

iv. If the Employee or any of his Dependents experiences a Qualifying Event for purposes of COBRA continuation coverage during a period of USERRA continuation coverage, he shall be entitled to elect COBRA continuation coverage as set forth in Article II, Section 2.06.

g. In appropriate circumstances, as determined by the Plan Administrator, the Plan may recognize a family member or other person as the personal representative of an Employee performing service in the Uniformed Services. Any action taken by such deemed personal representative shall be binding on the Employee and any affected Dependents.

ARTICLE III. LIFE BENEFITS

3.01 Life Benefit for Bargaining Employees and Non-Bargaining Employees.

a. Maximum Benefit. If a Bargaining Employee or Non-Bargaining Employee dies while eligible or within thirty-one (31) days following the termination of his eligibility, the Fund will, subject to the provisions hereafter stated, pay to the designated beneficiary $2,000.00.

b. Facility of Payment. If any beneficiary is a minor or is, in the opinion of the Fund, legally incapable of giving valid receipt for any payment due him, the Fund reserves the right to make payment in monthly installments not exceeding $50.00 to the person or persons, or institution, who in its opinion has been caring for or supporting the beneficiary, until claim is made for the remainder by a duly appointed guardian or committee of the beneficiary. The Fund also reserves the right in the sole discretion of the Board of Trustees to withhold payments until all competing claims are resolved or judgment is entered by a court of competent jurisdiction in favor of a claimant-beneficiary.

Any payment made under this subsection b. shall discharge the obligation of the Fund hereunder to the extent of such payment.

3.02 Accidental Death and Dismemberment Benefits for Bargaining and Non-Bargaining Employees.

a. Accidental Death Benefit. If a Bargaining Employee or Non-Bargaining Employee sustains bodily injuries solely through external, violent, and accidental means, and dies within ninety (90) days following the accident in which the injuries were sustained, the Fund will, subject to the provisions hereafter stated, pay an Accidental Death Benefit of $2,000.00.

b. Accidental Dismemberment Benefit. If a Bargaining Employee or Non-Bargaining Employee sustains bodily injuries solely through accidental means, and within ninety (90) days following the accident in which the injuries were sustained suffers one of the losses enumerated below, the Fund will, subject to the provisions hereafter stated, pay to the Bargaining Employee or Non-Bargaining Employee a Dismemberment Benefit in the following amount:

1. $1,000.00 for:

   (a) the loss of a hand by severance at or above the wrist joint, or

   (b) the loss of a foot by severance at or above the ankle joint, or

   (c) the irrecoverable loss of sight of any eye.

2. $2,000.00 for the loss of more than one of the members enumerated in the foregoing paragraph (1).

c. Limitations. Not more than $2,000.00 is payable under the foregoing subsections a. and b. as a result of any one accident.

No benefits are payable for any loss resulting from bodily injuries sustained as a result of:

1. disease or bodily or mental infirmity, or medical or surgical treatment thereof, ptomaine or bacterial infections (except infections occurring through an accidental cut or wound); or

2. suicide while sane or insane, or intentionally self-inflicted injury; or

3. war or an act of war, or service in any military, naval or air force of any country while such country is engaged in war, or police duty as a member of any military, naval or air organization; or

4. participation in, or as the consequence of having participated in, the commission of a crime; or

5. injuries received while operating or riding in or descending from any aircraft except while riding as a fare-paying passenger on a commercial airline which is on a regularly scheduled passenger flight.

3.03 Beneficiaries of Bargaining Employees and Non-Bargaining Employees.

a. Designation of Beneficiaries. A Bargaining Employee or Non-Bargaining Employee may designate a beneficiary or beneficiaries to receive the Life or Accidental Death Benefit payable under this Article III by forwarding such designation on a form acceptable to the Board of Trustees to the Fund Office. A Bargaining Employee or Non-Bargaining Employee shall have the right to change his designation of beneficiary without consent of the beneficiary, but no such change shall be effective or binding on the Fund unless it is received by the Fund Office prior to the time any payments are made to the beneficiary whose designation is on file with the Fund.

If more than one beneficiary is designated, and their respective interests are not specified, they will share alike.

b. Lack of Designated Beneficiary. If no beneficiary has been designated or if a designated beneficiary dies before the Life Benefit or Accidental Death Benefit is paid, the Life Benefit or Accidental Death Benefit shall be paid to the lawful spouse of the Bargaining Employee or Non-Bargaining Employee if then living, or if there is no lawful spouse alive at the time of payment, payment may be made to one or more of the following surviving relatives of the Bargaining Employee or Non-Bargaining Employee: child or children, mother, father, brothers or sisters, or to the Bargaining Employee's or Non-Bargaining Employee's estate, as the Board of Trustees in its sole discretion may designate.

c. Claimant-Beneficiary. The Fund reserves the right in the sole discretion of the Board of Trustees to withhold payments until all competing claims are resolved or judgment is entered by a court of competent jurisdiction in favor of a claimant-beneficiary.

If you have any questions about Life Benefits for Bargaining or Non-Bargaining Employees, please contact the Fund Office at (402) 593-7565.

ARTICLE IV. DEPENDENT LIFE BENEFITS

4.01 Life Benefit for Dependents of Bargaining Employees and Non-Bargaining Employees.

a. Maximum Benefit. If a Bargaining Employee or Non-Bargaining Employee's Dependent dies, the Plan will, subject to the provisions hereafter stated, pay a Benefit of:

Dependent Spouse	$1,000.00
Children--14 days but less than six (6) months	$ 100.00
Children--Six (6) months but less than nineteen (19) years	$1,000.00

b. Beneficiary. The Dependent Life Benefit payable by the Plan due to the death of a Dependent shall be paid to the Bargaining Employee or Non-Bargaining Employee, if living, or if the Bargaining Employee or Non-Bargaining Employee is not living at the time of payment, payment may be made to the executors or administrator of the survivor of the Bargaining Employee or Non-Bargaining Employee and such Dependent as the Board of Trustees, in its sole discretion, may designate.

c. Facility of Payment. If any beneficiary is a minor or is, in the opinion of the Fund, legally incapable of giving valid receipt for any payment due him, the Fund reserves the right to make payment in monthly installments not exceeding $50.00 to the person or persons, or institution, who in its opinion has been caring for or supporting the beneficiary, until claim is made for the remainder by a duly appointed guardian or committee of the beneficiary.

The Fund also reserves the right in the sole discretion of the Board of Trustees to withhold payments until all competing claims are resolved or judgment is entered by a court of competent jurisdiction in favor of a claimant-beneficiary.

Any payment made under this subsection c. shall discharge the obligation of the Fund hereunder to the extent of such payment.

If you have any questions about Dependent Life Benefits, please contact the Fund Office at (402) 593-7565.

ARTICLE V. ACCIDENT AND SICKNESS WEEKLY BENEFITS

5.01 Accident and Sickness Weekly Benefit for Bargaining Employees and Non-Bargaining Employees.

a. Weekly Benefit. If a Bargaining Employee or Non-Bargaining Employee is Totally Disabled due to an accidental bodily injury or sickness, and under the care of a qualified Physician (M.D. or D.O.), for such total disability, the Fund will pay a weekly benefit in the amount of two hundred fifty dollars ($250). Upon receipt of the claim, which includes an M.D.'s or D.O.'s certification that the Bargaining Employee or Non-Bargaining Employee is Totally Disabled, satisfactory to the Board of Trustees, benefits will be payable to the Bargaining Employee or Non-Bargaining Employee beginning on the first (1st) day of a disability caused by an accident and on the eighth (8th) day of disability caused by a sickness. Benefits are payable for a maximum of twenty-six (26) weeks.

If total disability is caused by an occupational injury, the amount of the Accident and Sickness Weekly Benefit together with Workers' Compensation benefits, if any, shall not exceed two hundred-fifty ($250) dollars per week. In the event a Bargaining Employee or Non-Bargaining Employee returns to work within the first seven (7) days of disability, benefits will be paid at the daily rate of one-seventh (1/7) of the weekly benefit.

The weekly benefit will also be payable to a Bargaining Employee or Non-Bargaining Employee for pregnancy resulting in childbirth or miscarriage.

b. Totally Disabled. The term "Totally Disabled" shall mean the eligible Bargaining Employee or Non-Bargaining Employee is unable to perform all of the duties of his job classification. The Bargaining or Non-Bargaining Employee may not be engaged in any other occupation for pay or profit. For purposes of certification, the disability must be certified in writing by an M.D. or D.O. The Trustees have the right to request initial or ongoing certification by an independent physician if there is a question about the disability. If this happens, the Fund will pay for the expense of the second opinion.

In the event you are able to work on a partial or part-time basis, you will not be eligible for accident and sickness weekly benefits under this Plan.

c. Successive Periods of Disability. Two (2) or more periods of disability are considered as one (1) unless between periods of disability the employee has returned to active full-time work for at least two (2) weeks, unless the disabilities are due to causes entirely unrelated and begin after the employee has returned to work on a full-time basis or is available for work for at least one (1) day.

5.02 Limitations.

Weekly Disability Benefits are not payable for or on account of an accidental bodily injury or sickness for:

a. which the Bargaining Employee or Non-Bargaining Employee is not under the regular care of a Physician (M.D. or D.O.); or

b. which is a result of participation in or the consequences of the commission of a "felony or misdemeanor" or otherwise being "outside the law," excluding traffic violations, or participation in a riot; or

c. any injury or sickness for which you are entitled to receive benefits in whole or in part under any Workers' Compensation Law, Occupational Disease Law, Employers' Law or similar law, to the degree the benefits exceed those payable under the Plan.

If you have any questions on Accident and Sickness Weekly Benefits, please contact the Fund Office at (402) 593-7565.

ARTICLE VI. PRIVACY OF PROTECTED HEALTH INFORMATION

6.01. The Plan will use and/or disclose protected health information only to the extent and in accordance with the provisions of the HIPAA Privacy Rule. The Plan does not perform any treatment activities, but may disclose information to health care providers treating a participant in order to facilitate the providers' treatment of the participant. The Plan has a need to use and/or disclose protected health information in the course of health care operations and payment activities.

6.02. The Board of Trustees, as Plan Sponsor, is permitted to use and/or disclose protected health information for the purpose of making benefit claims determinations on review. The Board shall receive and use only the minimum information necessary to decide the appeal, and shall avoid making any disclosure of the information unless necessary to the claim determination, such as for the purpose of obtaining medical, legal, or actuarial advice regarding the claim determination that is being reviewed. When disclosing any such information, the

Board shall obtain adequate assurance from the party to whom the information is being disclosed. Any business associate agreement entered into between the third party and the Plan shall protect the Board of Trustees to the same extent it protects the Plan.

6.03. The Board of Trustees, as Plan Sponsor, shall use and/or disclose protected health information when specifically compelled by law, including, but not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a government or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits; and pursuant to requests of the Secretary of HHS or his or her designee. Unless specifically directed by the governing legal document or authority, the Plan Manager and other employees of the Fund Office will ordinarily respond to legal process compelling the disclosure of PHI, without the necessity of any action on the part of the Plan Sponsor.

6.04. The Board of Trustees is further permitted to use and disclose de-identified or summary health information for the following purposes, and is permitted to use and/or disclose personally identifiable health information in connection with the following activities only when the Board is unable to carry out its responsibility to administer the Plan without the particular personally identifiable health information being requested:

a. administering the Plan or amending its provisions, including but not limited to:

i. management activities relating to implementation of and compliance with the requirements of the Privacy Rule and other legal compliance matters,

ii. customer service, including the provision of data analyses for participants, participating unions, and contributing employers, provided that protected health information is not provided to the participants (except as otherwise permitted), unions, or employers,

iii. resolution of internal grievances,

iv. the sale, transfer, merger, or consolidation of the Plan with another employee welfare benefit plan, and due diligence related to such activity, and

v. creating de-identified health information or a limited data set;

b. developing protocols, policies, and procedures for the administration of the plan;

c. conducting quality assessment and improvement activities;

d. reviewing the competence or qualifications of health care providers and institutions contracting with the Plan;

e. actuarial and related activities relating to the creation, renewal or replacement of health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

f. conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

g. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

h. to carry out payment activities (as the term "payment" is defined in 45 C.F.R. § 164.501) of the Plan that cannot be delegated to Fund Office staff.

6.05. Neither the Plan nor any business associate servicing the Plan will disclose protected health information to the Board of Trustees unless and until the Plan receives a certification by the Board of Trustees that the Plan documents have been amended to incorporate the following provisions, and that the Board of Trustees agrees to each of the following provisions. The Board of Trustees shall:

a. not use or further disclose the information other than as permitted or required by the Plan documents or required by law;

b. ensure that any agent, including a sub-contractor, to whom it provides protected health information received from the Plan agrees to the same restrictions and conditions that apply to the Board of Trustees with respect to the information and agrees to implement reasonable and appropriate security measures to protect the information;

c. not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan established pursuant to the collective bargaining agreements that establish this Plan;

d. report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

e. make available protected health information in accordance with 45 C.F.R. § 164.524;

f. make available protected health information for amendment and to incorporate any amendments to protected health information in accordance with 45 C.F.R. § 164.526;

g. make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

h. make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of HHS for purposes of determining compliance with the Privacy Rule by the Plan;

i. if feasible, return or destroy all protected health information received from the Plan that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

j. ensure that the adequate separation between the Plan and the Board of Trustees, as required by 45 C.F.R. § 164.504(f)(2)(iii), is established and is supported by reasonable and appropriate security measures;

k. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Board or the Plan create, receive, maintain, or transmit on behalf of the Plan; and

l. report to the Plan any security incident of which the Board becomes aware.

6.06. All employees of the Fund Office (that is, employees of the Plan), including the Plan Administrator, claims processor(s), and customer service representative(s), do and shall have access to protected health information in the course of the services they perform for the Plan. These individuals are employed by the Plan itself, and are not employees of the Board of Trustees, which is the Plan Sponsor. No employees of the Board of Trustees, or of any member of the Board of Trustees, shall have any access to PHI held by the Plan. All Plan employees shall protect the privacy of personally identifiable health information received, created, or maintained in the course of their employment, and shall use and/or disclose such information only in accordance with the terms of this Plan document.

6.07. Plan employees, including the Plan Administrator, will have access to Plan participants' protected health information only to perform the Plan administration functions that the Fund Office provides for the Plan.

6.08. Any Plan employee who fails to comply with the preceding paragraph shall be subject to the disciplinary procedures and sanctions, up to and including termination of employment or affiliation with the Plan, in appropriate circumstances, as established by the Plan or by the Board of Trustees relating to unauthorized use or disclosure of protected health information, for any use or disclosure of Plan participants' protected health information in violation of or noncompliance with the provisions of this Amendment to the Plan Documents.

6.09. The Plan shall develop and distribute to all participants a Notice of Privacy Practices, which shall comply with 45 C.F.R. § 164.520, shall be approved by the Board of Trustees, shall describe the uses and disclosures of protected health information that may be made by the Plan, and shall describe the policies and procedures that the Plan will follow with respect to protecting the privacy of protected health information.

6.10. It is expected that the Board of Trustees will not have a need for access to protected health information except in connection with review of an adverse benefit determination or in unusual circumstances. The Board has delegated the daily responsibility for administering the Plan to the Plan Administrator and his or her staff. The Plan Administrator and Fund Office staff will carry out their administrative duties on behalf of the Plan, such as claims processing and regular Plan administration, without disclosing protected health information to the Board of Trustees unless such a disclosure is necessary, and then shall disclose only the minimum information necessary to carry out the purpose of the disclosure to the Board of Trustees, and only in accordance with the terms of the Privacy Rule and this Plan document.

6.11. The following terms are specifically defined in the HIPAA Privacy Rule, and the definitions set forth in the Privacy Rule shall govern the meaning of those terms in this document:

- Business associate (45 C.F.R. § 160.103)
- Designated record set (45 C.F.R. § 164.501)
- Disclosure (45 C.F.R. § 160.103)
- Health care (45 C.F.R. § 160.103)
- Health care operations (45 C.F.R. § 164.501)
- Health care provider (45 C.F.R. § 160.103)
- Health information (45 C.F.R. § 160.103)
- Health oversight agency (45 C.F.R. § 164.501)
- Individual (45 C.F.R. § 160.103)
- Individually identifiable health information (45 C.F.R. § 160.103)
- Law enforcement official (45 C.F.R. § 164.501)
- Payment (45 C.F.R. § 164.501)
- Plan Sponsor (45 C.F.R. § 164.103)
- Protected health information (45 C.F.R. § 160.103)
- Required by law (45 C.F.R. § 164.103)
- Treatment (45 C.F.R. § 164.501)
- Use (45 C.F.R. § 160.103)
- Workforce (45 C.F.R. § 160.103)

6.12 Additional Definitions. The term electronic protected health information, as used in this Plan Document, means protected health information that is transmitted by electronic media or that is maintained in electronic media. The term security incident, as used in this Plan Document, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in an information system.

ARTICLE VII PLAN AMENDMENT AND TERMINATION

The Board of Trustees, as the Plan Sponsor, reserve the right and have been given the discretion in the Restated Agreement and Declaration of Trust to amend, change, add to, or terminate all or part of the Plan whenever, in their sole judgment, conditions so warrant.

The Board of Trustees expects that the Plan will be permanent. However, the Trustees have the authority to increase, decrease, or change benefits, eligibility rules, or other provisions of the Plan as they determine to be in the best interests of Plan Participants and Beneficiaries. Any such amendment, which will be communicated in writing, will not affect valid claims that originated before the date of the amendment.

This Plan may be discontinued or terminated under certain circumstances, as described in the Trust Agreement that established and maintains this Plan. In such event, all coverage for covered individuals will end immediately. Any such discontinuation will not affect valid claims that originate before the termination date of the Plan as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets and benefit payments will be limited to the assets available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the documents governing this Plan.

ARTICLE VIII CLAIMS AND APPEALS

Claims and Appeals Not Determined by Blue Cross and Blue Shield of Nebraska:

This Claims and Appeals Section discusses the process for determining claims and appeals for the following benefits:

- Life, Dependent Life, and Accidental Death and Dismemberment (AD & D) benefit claims;
- Accident and Sickness Weekly Disability Benefit Claims
- Termination of eligibility or denial of initial eligibility;
- HRA benefits;
- Prescription Drug benefits.

These benefit determinations are not determined by Blue Cross and Blue Shield of Nebraska. The provisions in this Attachment A, Article VIII, rather than those on pages 37 and 38 of this Plan, govern the determination for the benefits listed above.

Life, Dependent Life, and Accidental Death and Dismemberment (AD&D) Benefit Claims

In the event of you or your Dependent's death, you or your Beneficiary should call the Fund Office for help in filing a claim. If you have an injury covered under the AD & D program, you should file the claim and any benefits will be paid to you.

Accident and Sickness Weekly Disability Benefit Claims

Be sure to notify your Employer and the Fund Office if you are sick or injured and are unable to work. The Fund Office will send you a claim form. Have your physician complete the form. Then send the completed form to the Fund Office as soon as possible. Benefits are not payable until you apply for and submit the required information.

Timing of Claim Decisions and Benefit Payments

When you submit a claim for benefits to the Fund Office, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits, if any, that are payable. In some situations, the Fund has the right to request a physical exam by a physician of its choice or an autopsy in the event of death.

Notification

Life, Dependent Life, and AD&D Benefit Claims

Generally, you will receive written notice on a decision on your claim within 90 days after the Plan receives your claim. If circumstances require an extension of time for processing your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

If for any reason the claim is denied, in whole or in part, the Fund Office will, within 90 days (or within 180 days under special circumstances) after the claim is received, provide a written notice containing the information outlined in the next section.

Accident and Sickness Weekly Disability Benefit Claims

Generally, you will receive written notice of a decision on your initial claim within 45 days of receipt of your claim. If additional time is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this time. The Plan may extend this 45-day period up to an additional 60 days maximum. However, if a determination is not made within the first 75 days, you will be notified that an additional 30 days is necessary.

In some instances, the Plan may require additional information to process and make a determination on your claim. If such information is required, the Plan will notify you within 45 days of receiving your request. You then have up to 45 days in which to submit the additional information. If you do not provide the information within this time, then your claim may be denied.

If a Claim is Denied

If your claim is denied (in whole or in part), the Plan will:

- Provide you with certain information about your claim; and
- Notify you of its denial of your claim within certain timeframes

Information Requirements

When the Plan notifies you of its initial denial on your claim, it will provide:

- The specific reason(s) for the decision;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed; and
- A copy of the Plan's review procedures and the time periods to appeal your claim, plus a statement that you may bring a lawsuit under Section 502(a) of ERISA following an adverse benefit determination on review of your claim.

In addition, for Accident and Sickness Weekly Disability Benefit Claims, the notice will include:

- A copy of any internal rule, guideline, protocol, or similar criteria if such information was relied on; and
- An explanation of any scientific or clinical judgment used for a determination that is based on medical necessity or experimental treatment (or similar exclusion) or a statement that such explanation is available to you at no cost upon request.

Termination of Eligibility or Denial of Initial Eligibility in the Plan

If you or your Dependent is denied eligibility under the Plan, or has coverage terminated, you may appeal this to the Board of Trustees in accordance with the procedures below.

Denial of Claims under the HRA

If your claim is denied for benefits under the HRA, you may appeal it to the Board of Trustees in accordance with the procedures below.

Denial of Claims for Prescription Drug Benefits

LDI makes the initial determination regarding claims for Prescription Drug benefits. However, if your claim is denied, you may appeal this to the Board of Trustees in accordance with the procedures below.

Appealing a Denied Claim for Life Benefits, Dependent Life Benefits, AD & D Benefits, Accident and Sickness Weekly Disability Benefits, Eligibility, HRA Benefits, and Prescription Drug Benefits

The Claims and Appeals procedures included below apply to the benefits described in this Article VIII.

Appealing a Denied Claim

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedures before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Plan Administrator at the Fund Office as soon as possible. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within 180 days from the date of the denial.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- Submit additional materials, including comments, statements, or documents; and
- Request to review all relevant information (free of charge).

In addition, if your claim is for Accident and Sickness Weekly Disability Benefits and is denied based on:

- An internal rule, guideline, protocol, or other similar criteria, you have the right to request a copy of such information free of charge; and
- Medical necessity or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

You may request a hearing (in person or by representative). If you don't request a hearing, this will be considered a waiver of your right to do so and the Trustees will proceed to consider your appeal based on the written information submitted.

If you do request a hearing, you will be notified in writing, of the date, time, and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. You will have the right to present any additional information not previously submitted. If you request a hearing and do not appear at the hearing (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written information submitted.

Appeal Decisions

If you file your appeal on time and follow any applicable required procedures, a new, full, and independent review of your claim will be made without deference given to the initial benefit decision. The Board of Trustees will conduct the review and the decision will be based on all comments, documents, records, and other information that you submit, regardless of whether such information was submitted or considered in the initial benefit determination.

The Plan will notify you in writing of the decision on any appeal within 5 days after the determination is made.

Appeal Timeframes

The Plan's determination on your appeal will be made within certain timeframes. The deadlines are as follows:

- The Plan will generally make its decision at the next quarterly meeting of the Board of Trustees;
- If your appeal is received within 30 days of the meeting, the Plan will generally make the decision at the following quarterly meeting; or
- In special circumstances, the Plan may make the decision at the third regularly scheduled meeting.

If such an action is taken, notice will be sent to the claimant no later than five days after the meeting (if the need for the extension is first discovered at the meeting) or before the meeting (if the need for the extension is known before the meeting).

Medical Judgments

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity, upon request, or any medical experts consulted in making a determination of your appeal.

Information Requirements

If your appeal is granted, the Plan will provide you a written notification that contains sufficient information to fully apprise you of the Plan's decision to approve the requested benefit. If your appeal is denied, the Plan will provide you a written notification that includes:

- The specific reason(s) for the decision, including reference to the Plan provisions on which the decision was based;
- A statement notifying you that you have the right to request a free copy of all documents, records, and relevant information;
- Information relating to any additional voluntary appeal procedures offered by the Plan; and
- A statement that you may bring a civil action under Section 502(a) of ERISA.

In addition, for Accident and Sickness Weekly Disability Benefit Claims the notice will include:

- A copy of any internal rule, guideline, protocol, or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request; and
- An explanation of any scientific or clinical judgment used for a determination that is based on medical necessity or experimental treatment (or similar exclusion) or a statement that such explanation is available to you at no cost upon request.

Attachment B: Health Reimbursement Arrangement (HRA)

Effective June 1, 2008, a Health Reimbursement Arrangement ("HRA") has been established by the IBEW Local 22/NECA Health & Welfare Plan (the "Plan") for eligible Participants.

ELIGIBILITY. Each Employee having contributions made on their behalf to the HRA effective on or after June 1, 2008, is eligible to participate in the HRA. Participation in the HRA begins on the first day of the month after contributions are first remitted to the HRA on your behalf.

TERMINATION OF PARTICIPATION. Termination of participation in the HRA occurs when a Participant's HRA is forfeited. A participant's HRA shall be forfeited for the following reasons:

(a) Plan termination.

(b) One-year break-in-Service: Your HRA will be forfeited on the later of:

1. the first day of the month following the twelfth consecutive month that you are not covered under the Health and Welfare Plan; or
2. the first day of the month following the twelfth consecutive month that you are not credited with any Employer Contributions to the HRA.

(c) Non-Bargaining Unit Employment: If your Hour Bank and eligibility from the Health & Welfare Plan are forfeited for non-bargaining employment in accordance with Attachment A Section 2.01(i), your HRA will simultaneously be forfeited. The forfeiture shall occur on the same day that your Hour Bank is forfeited. No reimbursements will be made for claims incurred on or after the date of the forfeiture.

INDIVIDUAL ACCOUNTS. The Plan's Administrator will establish and maintain separate HRA accounts for each Participant. This account will be used to receive your contributions and to pay your benefits. Although each Participant's account will be separately identified, the combined assets of each account will be held by the Fund in reserves and identified in the Plan's financial statements as the HRA reserves. The HRA account established for you will merely be a record keeping account with the purpose of keeping track of contributions and available reimbursement amounts from the Plan. The Individual HRA Accounts shall not be credited with any interest income earned on the HRA reserves. The HRA Accounts will not be charged with any expenses for administration of the HRA. The HRA Accounts do not constitute a vested benefit.

(a) Crediting of Accounts. Your HRA account will be credited at the end of each month following the month hours were worked for which contributions are being made to your account. In other words, contributions made for hours worked in March will be credited to your account on April 30th. Only amounts actually received by the Plan will be credited to your account.

(b) Debiting of Accounts. Your HRA account will be debited during each Period of Coverage for all eligible reimbursements. A "Period of Coverage" is the calendar year.

(c) Available Amount. The amount available for reimbursement to either the Participant or Eligible Dependent for Allowable Medical Care Expenses is that amount credited to your HRA under Subsection (a), reduced by prior reimbursements debited under Subsection (b).

CARRYOVER OF ACCOUNTS. If any balance remains in your HRA Account after all reimbursements are paid for the Period of Coverage, the balance will be carried over to reimburse the Participant for medical care expenses incurred during a subsequent Period of Coverage. In addition, any HRA benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the medical care expense was incurred shall be forfeited.

Should the Participant die, the account will be made available to pay benefits to the spouse as defined in Internal Revenue Code § 213(d)(8) of the Participant and any Eligible Dependents of the Participant.

If the Participant is deceased and there is no surviving spouse or surviving Eligible Dependents, any remaining balance in the account shall be forfeited and reallocated to the then existing HRA accounts equally.

If a Participant loses coverage from the Plan, the actual amount in the Participant's account will be available for benefit payment, subject to the forfeiture rules in the Section entitled, "TERMINATION OF PARTICIPATION" above.

BENEFITS. The monies deposited into the HRA account will be available to be used by the Participant for the payment of Allowable Medical Care Expenses incurred by the Participant, the Participant's spouse as defined in Internal Revenue Code § 213(d)(8), and/or the Participant's eligible, non-spouse Dependents. Benefits will not be provided in the form of cash or any other taxable or non-taxable benefit other than reimbursement of Allowable Medical Care Expenses.

ALLOWABLE MEDICAL CARE EXPENSES.

Under the HRA, you may receive reimbursement for Allowable Medical Care Expenses incurred during the time you have a balance in your HRA.

(a) Incurred. A medical expense is "incurred" at the time the medical care or service giving rise to the expenses is furnished and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Allowable Medical Expenses incurred before you become eligible to participate in the HRA are not eligible for reimbursement. An Allowable Medicare Care Expense incurred during one Period of Coverage may be paid during a later Period of Coverage, provided you have a balance in your HRA (i.e. your HRA has not been forfeited).

(b) Allowable Medical Care Expenses. Allowable Medical Care Expenses are all expenses incurred by the Participant or the Participant's spouse or the Participant's Eligible Dependents for medical care as that term is defined in Section 213 of the Internal Revenue Code incurred during a calendar year. This includes "medical care" and any other expense which the Internal Revenue Service has recognized as properly deductible under Section 213(d)(1) of the Internal Revenue Code. Self-payments for continued Plan coverage are also Allowable Medical Care Expenses. Eligible Expenses include reimbursement for medicines or drugs only if purchased with a prescription, including "Over-the-Counter Medicines" which do not ordinarily require a prescription. Prescription drugs and prescribed Over-the-Counter Medicines must be for the treatment of illness or injury as defined by the Internal Revenue Code not merely to advance your general good health. However, Allowable Medical Care Expenses and prescribed Over-the-Counter Medicines will only be considered for reimbursement if they are not covered by a health care plan of which you are a participant or, if they are partially covered by a health care plan, to the extent not covered. A partial list of examples of Allowable Medical Care Expenses and prescribed Over-the-Counter Medicines follows.

The following tables contain only partial lists since the Internal Revenue Service frequently changes the list of deductible medical expenses. You should refer to IRS Publication 502, available upon request from the Fund Office, for a current list of what medical expenses are includible and what expenses are excludible.

Medical Care Expenses Eligible for Reimbursement Under Your Health Reimbursement Account

Abortions, legal	Medical conferences
Acupuncture	Medicare and medical insurance premiums
Alcoholism (substance abuse) treatment	Midwife
Ambulance Expenses	Nursing home (for medical reason only)
Amounts exceeding payments made by insurance companies for eligible expenses	Nursing services
Artificial limbs	Obstetrical expenses
Bandages	Orthopedic shoes
Birth control pills	Oxygen
Braille books and magazines	Physicians fees
Breast reconstruction surgery after mastectomy	Prescription drugs and medical supplies
Car controls for the disabled	Private institution/home cost for mentally or physically handicapped
Chiropractors	Psychiatric care
Christian Science practitioner's fees	Psychoanalysis
Contact lenses and solutions	Psychologists' fees
Crutches	Radial Keratotomy
Deductibles for Medical Insurance Only	Seeing-eye dog and its upkeep
Dental fees	Self-payments to IBEW Local 22/NECA Health & Welfare Plan
Dentures	Smoking cessation program expenses and related prescription drugs (however excluding nonprescription drugs and products such as nicotine gum or patches)
Diagnostic fees for Medical Diagnoses Only	Special education costs
Disabled dependent care expenses	Special home for mentally retarded
Drug addiction treatment expenses	Sterilization fees
Eye glasses including the examination fee	Surgical fees
Eye surgery	Telephone, special for the deaf
Fertility enhancement	Television audio display equipment for the deaf
Hearing devices	Therapy received as medical treatment
Home improvements/modifications motivated by medical considerations	Transplant/donor medical expenses
Hospital Bills	Transportation, meals and lodging expenses, primarily in the rendering of medical care
Insulin	Tuition at a special school for the handicapped
Insurance Copayments	Vaccinations/Immunizations
Laboratory fees	Vitamins by prescription (pre-natal)
Laser eye surgery	Weight-loss program, only if for treatment of a specific disease diagnosed by a Physician (such as obesity, hypertension or heart disease), fees for membership in a weight reduction group and attendance in periodic meetings is covered, as well as the cost of special food which exceeds the cost of a normal diet. Please refer to the specific exclusions listed in the next section
Lead-base paint removal (for children with lead poisoning)	Wheelchair
Lifetime care/Advance payments founder's fee	Wigs (for hair loss due to disease)
Long-term care: only qualified long-term care expenses as defined by the IRS and qualified long-term care insurance premiums	X-rays

Medical Care Expenses Eligible for Reimbursement Under Your Health Reimbursement Account (Con'd)

Over-the-Counter Medicines

Over-the-Counter Medicines must be used for treatment of an illness. This list is not comprehensive. Over-the-Counter Medicines are eligible for reimbursement only if purchased with a prescription. To receive reimbursement for prescribed Over-the-Counter Medicines purchased on and after January 1, 2011, you must provide the Fund Office with one of the following items when you submit your claims:

- A receipt from a pharmacy which identifies the name of the purchase (or the name of the person for whom the prescription applies), the date and amount of the purchase, and an Rx number; or
- A receipt from a pharmacy without an Rx number accompanied by a copy of the related prescription.

TYPE OF EXPENSE	EXAMPLES
Acne medicine	Clean & Clear, Clearasil, LomaLux, Neutrogena, Noxzema, Oxy, Phisoderm, Stridex
Allergies	Actifed, Advil, Afrin, Alavert, Allerest, Benadryl, ChlorTrimeton, Claritin, Dimetapp, Diphedryl, Motrin, Nasal Crom, Sudafed, Tavist, Tylenol, Vicks
Asthma	Bronkaid
Cold Sores	Abreva, Notriva
Colds	Actifed, Advil, Aleve, Alka-Seltzer Plus, Cepecol, Chloraseptic, Ciricidin, Cold-Eze, Comtrex, Contac, Dimetapp, Drixoral, Halls, Lumens, Neosynephrine, Profen IS, Riccola, Robitussin, Sucrets, Sudafed, Theraflu, Triaminic, Tylenol, Vicks DayQuil, Vicks VapoRub, Zicam, Zinc Drops
Cuts and Itching	Bactine, Balmex, Benadryl Anti-Itch Cream, Caladryl, CamphoPhenique, Cortaid, Dermarest, Desitin Diaper Rash Cream, Hydrocortizone, Hydrogen Peroxide, Iodine, Itch-X, Lanacaine, Neosporin, Polysporin, Psoriasin gel, Witch Hazel
Diabetes	Insulin
Dietary Supplements	Acidophilus, Coenzyme, Ensure, Q-10
Digestive Remedies	Alka-Seltzer, Axid AR, Bonine, Carters, Castor Oil, Citrucel, Corectol, Dramamine, Dulcolax, Emetrol, Ex-lax, Fleet Enema, Gas-X, Gaviscon, Imodium, Kaopectate, Lactaid pills, Maalox, Metamucil, Mylanta, Pepcid, Pepto-Bismol, Phillips, Prilosec, Rolaids, Tagamet, Tums, Zantac
Eye and Ear Problems	OcuHist, Swim-Ear, Visine
Foot Treatments	Fungi Care, Lotrimin, Micantin
Herbal, Homeopathic or Naturopathic remedies	Bilberry, Cholestine, DHEA, Echinacea, Estroven, Fish Oil, Flax Seed Oil, Garlic, Ginseng, Ginkgo Biloba, Glucosamine and Chondroitin, Goldenseal, Grape Seed, Herbs, Joint Juice, Knox Nutra Joint, L-Argine, L-Carnitine, Lecithin, Lutein, Maca, Melatonin, Milk thistle, MSM, Ocuvite, Omega-3,6,9, Osteo Bi-flex, Papaya Enzyme, Sam-e, Shark Cartilage, St. Johns Wort, Vasorect, Venstat
Jock Itch	Cruex, Lamisil AT, Lotrimin AF, Micantin, Tinactin
Lice	LiceFree, Nix, Pronto, Rid
Minerals and Vitamins	Antioxidants, Calcium, Chromium Piclinate, Folic Acid, Iron, Lysine, Magnesium, Menopause Supplements, Multi-Vitamins, Niacin, Potassium, Selenium, Senior Vitamins, Zinc
Pain Relief	Advil, Aleve, Arth-Rx, Aspercreme, Aspirin, Azo, BenGay, Doan's, Epsom Salts, Excedrin, Flexall, Ibuprofen, IcyHot, Jointflex, Joint-Ritis, Mentholatum, Midol, Motrin, Pamprin, Premysin, PMS, Prodium, Stopain, Tylenol
Smoking Cessation	Endit, Lite'n Up, NicoDerm CQ, Nicorette, Nicotrol, Smoke-Wasy, Venturi
Toothache	Orajel, Red Cross, Zilactin
Warts	Compound W, Dr. Scholls, Pedific, Wart-off
Weight Loss	Cidermax, Dexatrim, PatentLean, Puralin
Yeast Infection	Monistat, Mycelex 3, Vaginex, Vagistat3

(c) Medical Care Expense Exclusions. Medical Care Expenses do not include expenses covered by any other benefit plan. Medical Care Expenses can only be reimbursed to the extent that you and any other person incurring the expense were not reimbursed for the expense through other insurance including any other accident or health plan. Except as specifically included by this document, expenses that do not meet the definition of "medical care" under Section 213(d)(1) are excluded from reimbursement. The following is a partial list of expenses which are excluded and not eligible for reimbursement:

1) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma or a disfiguring disease.
2) Long term care expenses, except for premiums from long term care policies.
3) Funeral and burial expenses.
4) Massage therapy.
5) Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition.
6) Marijuana and other controlled substances, the possession of which are in violation of federal laws.
7) Maternity clothes, diaper service or diapers, babysitting childcare.
8) Bottled water, cosmetics, toiletries and toothpaste.
9) Vitamins and dietary supplements, except if a statement of medical necessity from Physician or Alternative Healthcare Provider is provided.
10) Automobile insurance premiums and automobile improvements, depreciation of an automobile, general repair or maintenance expenses of an automobile, even if other transportation expenses are includable when used for transportation to receive medical care; except for car controls for the disabled.
11) Home improvements (unless motivated by medical considerations), household or domestic help.
12) Death benefits, life insurance benefits including the portion of the Plan's COBRA premium that pays for life insurance.
13) Any item that does not constitute "medical care", as defined under Internal Revenue Code Section 213(d)(1).

Excluded Over-the-Counter Medicines

Cosmetics, Hair Growth Treatment, Hemorrhoid Treatment, Illegally Procured Medicines, Sleeping Aids, Sun Block, and Toiletries.

Expenses that Do Not Qualify for Reimbursement

- Unnecessary cosmetic surgery and health care expenses incurred for the primary purpose of enhancing the appearance.
- Marriage or family counseling.
- The salary expense of a nurse incurred in connection with the care of a normal healthy newborn in the home.
- Household and domestic help (even though recommended by a qualified physician due to the inability to perform housework).
- Costs for sending a child to a special school for anticipated benefits the child may receive from the course of study and the disciplinary methods used.
- Any expense incurred in connection with an illegal operation or treatment.
- Health club dues, YMCA dues, steam bath, spa, gym, etc. (even if recommended for weight loss that is treatment for a specific disease diagnosed by a Physician).
- Social activities, such as dance lessons or classes (even if recommended by a physician).
- Programs for the purposes of general health and well being (excluding some programs which are specifically included such as weight loss or smoking cessation programs, but subject to the specific requirements listed in the eligible expense table).
- Diet food or beverages that substitute for normally consumed food or beverages which satisfy nutritional needs (special food can be included medical expenses only if the food does not satisfy normal nutritional needs, alleviates or treats an illness, and the need for the food is substantiated by a Physician).
- Vitamins taken for general health purposes.
- Automobile insurance premiums including the segment of premiums providing medical care for persons injured through the accident.

- Premiums paid for life insurance policies or for policies providing repayment for loss of earnings or for accidental loss of life, limb, sight, etc.
- Vacations for travel taken for purposes of general health, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect.
- Transportation expenses to and from work, even though a physical condition may require special means of transportation.
- PPO discounts or negotiated rates if you are not liable for them.

(d) Claims and reimbursement procedures.

1) Timing. Within thirty days after receipt by the Plan's Administrator of a reimbursement claim from you, the Plan will reimburse you for your Allowable Medical Care Expenses provided the claim form is completed in its entirety and is accompanied by the required documentation and the claim has been approved for payment by the Plan Administrator.

2) Filing a Claim. You may apply for reimbursement by submitting an application in writing to the Plan Administrator on a form provided by the Fund Office. Reimbursement must be sought no later than March 31st following the close of the Plan Year in which the Allowable Medical Care Expense was incurred. The application for reimbursement must include the following information: the person or person on whose behalf the Allowable Medical Care Expenses have been incurred; the nature and date of the expenses incurred; the amount of the requested reimbursement; and a statement of such expenses that would have not otherwise been reimbursed and are not reimbursable through any other source. The application must be accompanied by bills, invoices, and other statements from an independent party showing that the Allowable Medical Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement are at least $50.

3) Claim payments may never exceed the amount remaining in the HRA Account.

COORDINATION OF BENEFITS. Benefits under this Plan are intended to pay benefits solely for Allowable Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise Allowable Medical Care Expense is payable or reimbursable from another source, that source shall pay or reimburse prior to payment or reimbursement from this Plan.

RIGHTS UPON TERMINATION. The Board of Trustees reserves the right to terminate the Plan and provide for the distribution of the Fund's assets, including the HRA Accounts, to all Participants and Eligible Beneficiaries. It is the intention of the Board to continue the Plan indefinitely. However, it is difficult to predict the future so the Board of Trustees reserves the right to modify or terminate the Plan at any time should it become necessary in the Board of Trustees' sole discretion.

NOT GUARANTEED BY PENSION BENEFIT GUARANTEE CORPORATION. The Pension Benefit Guarantee Corporation is an entity established under ERISA to ensure payment of certain pension benefits. The HRA is part of the IBEW Local 22/NECA Health & Welfare Plan, which is not one of the types of plans that the Pension Benefit Guarantee Corporation covers.

QUALIFIED MEDICAL CHILD SUPPORT ORDER. A Qualified Medical Child Support Order ("QMCSO") is a judgment, decree, or order issued by a court of competent jurisdiction requiring that the Fund recognize an eligible child as an Alternate Recipient, as defined by ERISA Section 609(a). Such order must be approved in accordance with procedures adopted by the Board of Trustees. Upon receipt of a Medical Child Support Order or other order designating medical child support, the Fund Office will promptly notify each Alternate Recipient of the receipt of such order and the Plan's procedure for determining whether the order is qualified. Upon review of the order, the Participant and all Alternate Recipients will be promptly notified whether the order has been determined to be a QMCSO. The Plan will provide benefits under the Plan to any Alternate Recipients in accordance with the applicable provisions of any QMCSO. Any payment of benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an Alternate Recipient's Custodial Parent or Legal Guardian, shall be made to Alternate Recipient's Custodial Parent or Legal Guardian.

APPEAL PROCEDURE. If you or your beneficiary wants to appeal a decision by the Plan Administrator to deny, or partially deny, any claim for reimbursement, you must follow the procedure contained in Attachment A, Article VIII of this Summary Plan Description.

Attachment C: Prescription Drug Benefits - LDI Pharmacy Benefit Services and Tobacco Cessation Coverage

This Plan provides benefits for prescription drugs, including prescription vitamins. In addition, benefits are available for insulin and other injectables (except home infusion therapy), and both diabetic and ostomy supplies. Medications that are available without a prescription ("over-the-counter" drugs) are not covered under this Plan. In order to be covered, drugs and other products must be dispensed by a registered pharmacist pursuant to a valid prescription written by a licensed health care provider (such as a doctor or dentist).

The amount of money you are required to pay for your prescription (your copayment) is based on the type of medication prescribed by your doctor, the cost of the drug, and whether your prescription is filled by a retail pharmacy or the mail-order pharmacy. The Plan has adopted a Formulary, or preferred drug list, that is carefully designed by a panel of health care experts (including physicians and pharmacists) to best serve the health interests of the patients as well as the financial interests of the Fund. LDI Pharmacy Benefit Services will provide you with a copy of the Formulary. Please share this with your health care providers to ensure that you receive the most appropriate and cost-effective drugs and supplies. Using generic drugs (or drugs on the Formulary if no generic is available) and using the mail-order pharmacy will save you money.

Your copayment schedule at a participating **retail pharmacy** is as follows. Note: When you purchase your prescriptions at a retail pharmacy, you can obtain up to a 30-day supply for each copayment. You may still purchase up to a 90-day supply at a time if you pay 3 copayments. You may not refill your prescription at a retail pharmacy until you have a 25% or less supply of your medication.

If your prescription is for a:	**Your copayment will be:**
Generic drug	$10, or 10% of the cost of the prescription, if greater (but never greater than 100% of the cost of the drug).
Brand name drug listed on the Formulary	$25, or 20% of the cost of the prescription, if greater *
Brand name drug NOT listed on the Formulary	$40, or 40% of the cost of the prescription, if greater *

* plus the difference in the ingredient cost if your prescription is for a brand name drug when a generic is available.

Smoking Cessation Drugs	
Chantix	$25 per month member copayment
Bupropion (generic Wellbutrin)	$10 per month member copayment

If you purchase your prescription at a retail pharmacy that is not an LDI Pharmacy Benefit Services participating pharmacy, you must pay the full retail price of the prescription and submit a claim for reimbursement to LDI Pharmacy Benefit Services. This is likely to result in a higher copayment being required from you because you will not have the advantage of the discounts available through LDI Pharmacy Benefit Services participating pharmacies.

Please note, LDI Pharmacy Benefit Services also offers the convenience of having a 90-day supply of medication filled at your local Walgreens for the same copayment available through the mail order program.

Prescriptions that you use on a regular basis are available through the LDI Pharmacy Benefit Services **mail order pharmacy program.** The same Formulary will apply to purchases made through the mail program. Here is the schedule for copayments that will apply to purchases made through the mail-order program. **Important: You may purchase up to a 90-day supply with one copayment.** This copayment schedule also applies to a 90-day supply purchased at your local Walgreens. You may not refill your prescription through the mail-order service until you have 34 or fewer days left on your prior prescription.

If your prescription is for a:	Your copayment will be:
Generic drug	$20 (but never greater than 100% of the cost of the drug)
Brand name drug listed on the Formulary	$50 or 20% of the cost, if greater*
Brand name drug NOT listed on the Formulary	$80 or 40% of the cost, if greater*

* plus the difference in the ingredient cost if your prescription is for a brand name drug when a generic is available.

Things That You Should Do

1. Check to see if the prescription drugs that you are taking are on the Formulary. If they are not, contact your doctor before you need to refill your prescription to determine if there is a drug on the Formulary that will meet your medical needs.

2. Share the Formulary with your doctor.

3. Ask your doctor if a generic drug is available that will meet your medical needs.

4. Ask your doctor or pharmacist if it makes sense to begin using the mail order program for prescription drugs that you take on a regular basis.

Benefits are not available under your Plan for the following items:

- Over-the-counter medications, including non-prescription vitamins or dietary or nutritional supplements.
- Any drugs classified by the FDA as experimental or investigative (or which otherwise have not been approved for use by the FDA), and including prescription medications determined to be "less than effective" by the Drug Efficacy Study Implementation Program (DESI).
- Drugs or other prescription products used for the treatment of fertility/infertility.
- Home medical equipment or devices of any type (other than diabetic supplies or ostomy supplies), including, but not limited to, contraceptive devices, therapeutic devices, or artificial appliances.
- Cosmetic drugs and products, including, but not limited to, health or beauty aids, Renova, or topical Minoxidil (Rogaine).
- Weight loss or weight management products, including, but not limited to, diet or appetite-suppressant drugs.
- Home infusion therapy and growth hormone therapy.
- Medications whose primary purpose is to treat nicotine addiction, except as provided for under Tobacco Cessation Coverage.
- Any Prescription Drugs for any Medicare eligible Retired Employee, Disabled Employee, Covered Dependent, or a surviving spouse who elects Medicare Part D Prescription Drug coverage.

Tobacco Cessation Coverage

Plan benefits are payable for telephonic counseling and support when provided through SimplyWell's Tobacco Cessation Program offered through SimplyWell. The Plan will pay 100% of the cost for a Participant and/or Spouse for participation in SimplyWell's Tobacco Cessation Program. The Plan will also provide prescription drug benefits for the following prescribed tobacco cessation drugs. Specifically, the Plan will cover the prescription drug Chantix, subject to a $25 per month member copayment, or the prescription drug Bupropion (generic Wellbutrin), subject to a $10 per month member copayment. The tobacco cessation benefits will be available up to one time per calendar year and up to two times per lifetime.