National Electrical Contractors Association

N.E.C.A - I.B.E.W. LOCAL 480 HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

Please read this carefully
and keep for future reference.

January 1, 2025

N.E.C.A – I.B.E.W. LOCAL 480
HEALTH AND WELFARE PLAN

QUESTIONS?
Contact Your

PLAN ADMINISTRATOR:
R. Joel Hill
4767 1-55 South,
Jackson, Mississippi 39212-5532
Phone: 601-373-8434
Toll-Free: 1-800-424-8434

CLAIMS ADMINISTRATOR:
American Benefit Corporation
9200 U.S. Route 60
Ona, West Virginia 25545
Phone: 855-445-3927
www.abcwv.com

PPO PROVIDER
ANTHEM BLUE CROSS BLUE SHIELD
Phone: 1-800-810-Blue
www.anthem.com

PHARMACY BENEFIT MANAGER
Sav-Rx Prescription Service
224 N. Park Ave.
Freemont, NE 68025
Phone: 1-866-233-IBEW(4239)
www.savrx.com

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N.E.C.A. - I.B.E.W. LOCAL 480 HEALTH & WELFARE PLAN

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Jackson, Mississippi

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Suwanee, Georgia

CERTIFIED PUBLIC ACCOUNTANTS & AUDITORS
Tann, Brown & Russ Company, PLLC
Jackson, Mississippi

WELCOME

January 1, 2025

Dear Participants:

We are pleased to present you with this updated and revised booklet which describes the benefits offered through the NECA-IBEW Local 480 Health and Welfare Plan. We believe it is important for you to know the health benefits that are available to you. You should also know that despite the rising costs of health care, the Plan continues to provide these benefits with minimal cost to you. These benefits for you and your Eligible Dependents are designed to provide some protection against the high cost of serious illnesses.

This booklet is designed to give you an easy-to-read reference about your Health and Welfare Plan. Read this booklet carefully to learn how you become eligible for benefits, what your benefits are and how to file claims for benefits. Be sure to share this booklet with your family and then keep it in a safe place for future reference. Any notices you receive regarding Plan amendments or changes in benefits should be kept with this booklet as such notices might change some of the information herein. This booklet is a summary of the benefits available to you and is not a substitute for the official Plan Document or insurance policies. If there is a difference between this summary and the Plan Document or insurance policies, the Plan Document or insurance policy will control. You can obtain a copy of the Plan Document by contacting the Plan Administrator, R. Joel Hill.

We believe the continued success of our program is due to the excellent cooperation from you, the Employers, the Union, and the Plan Office. You can be assured the Trustees will continue to administer the Fund so that you can receive the most comprehensive benefits possible with the resources available to the Fund. And, we wish to remind you that your treatment of the Health and Welfare Plan directly affects the Fund's ability to pay your claims. Just as you would prudently spend your own money, we want you to "do your homework" with the health plan when possible. Being cost-effective as you look for the best possible medical care for your family is one of the ways we can provide for the long-term success of the Health and Welfare Plan.

As always, if you have any questions about your eligibility or the benefits to which you are entitled, please contact the Plan Office. We appreciate all the important work you do and thank you for your loyal service.

Sincerely,

Board of Trustees

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CONTACT INFORMATION AND KEY REMINDERS

Who to Contact with Your Questions
If you have a question about the Health Plan, please use the following guide to help you determine who to call:

► **Contact ANTHEM BLUE CROSS BLUE SHIELD at 1-800-Blue or www.anthem.com if:**
- You wish to locate a network provider.
- You wish to determine if your provider is in the Plan's network.

► **Contact Health Link at 1-877-284-0102 if:**
- You wish to contact Case Management about your medical needs.
- You need to pre-certify or authorize treatment, if required.

► **Contact the Plan Office at 1-800-424-8434 or 601-373-8434 if:**
- You have a question about eligibility for you or a dependent.
- You need a replacement Anthem Blue Cross Blue Shield ID Card.
- You have a question about payment of Retiree or COBRA contributions.
- There is a problem with the eligibility/dependent information shown on your ID cards.

► **Contact the Claims Administrator's Office, American Benefit Corporation, at 855-445-3927 if:**
- You have a question about filling out a claim form.
- You have a question about a claim reimbursement.
- You have a question about a dental claim.
- You have a question about a Medical Claim.
- You wish to access your EOB's online—Sign up on our Member Portal at **www.abcwv.com**.
- You are receiving Workers' Compensation Benefits.

► **Contact the Pharmacy Benefit Manager, Sav-Rx Prescription Service, at 1-866-233-IBEW (4239) or www.savrx.com if:**
- You have a question about your pharmacy benefits under the Plan.
- You have a question about your prescription claim.

Your Responsibilities as a Plan Participant in General
The primary purpose of this Plan is to provide benefits to all of those who are entitled to coverage. However, in order for the Trustees and the Plan Office staff to achieve this objective, your cooperation is needed. There are certain responsibilities which you, as a Participant, must assume. Failure to carry out these responsibilities could adversely affect your eligibility, the extent of coverage, or the amount of benefit payment. Please read this section carefully for the benefit of yourself and your family.

1. Read This Booklet
This contains important information you need to know about how to qualify for benefits, what benefits are available, and how to file a claim for benefits. Although this booklet should be read in its entirety over a period of time, some sections will no doubt be of greater interest to you than others. Read those first. Then proceed to the other sections.

CONTACT INFORMATION AND KEY REMINDERS

2. Provide the Plan Office with a Completed Enrollment Card

It is important that the Plan Office has a completed enrollment card for you in the files. You must complete an enrollment card before claims can be processed. **If you have not completed an enrollment card, please contact the Plan Office at: 4767 1-55 South, Jackson, MS 39212-5532, tel. (601) 373-8434 or toll free at 1 (800) 424-8434.**

You should complete a new enrollment card in the event that:

- You change your mailing address.
- You wish to change your Beneficiary.
- There is any change in your family status by reason of marriage, birth of a Child, adoption, death, divorce or similar changes.

Failure to notify the Plan of certain changes may affect your eligibility or right to benefits.

3. Notify the Plan Office Promptly Regarding any Changes of Your Beneficiaries or Eligible Dependents

If your marital status changes or if, for some reason, you wish to change the name of your death benefit Beneficiary, do not forget to put the change in writing and provide the change to the Plan Office. Unless you do, the latest Beneficiary you have on file will generally determine who receives any death benefit to which you are entitled. Failure to change the Beneficiary, even when you want to, is often just an oversight. But such an oversight could be costly to your survivors.

If there is a change in your Eligible Dependents, the Plan Office should be notified regarding the name and age of the new Eligible Dependent(s). Since this Plan does provide certain benefits for Eligible Dependents, the Plan Office must know who your Eligible Dependents are.

4. Use the Correct Claim Forms and Provide All Requested Data to Avoid Delays in Claims Processing

Experience indicates that one of the major reasons for a delay in processing of claims is failure on the part of Participants to provide all of the information requested on the claim form. Before you file any claim, make sure you obtain the correct claim form from the Claim Administrator's Office. Take time to review the form carefully before you mail it to American Benefit Corporation to make sure every question you are asked to answer is answered. Equally important, attach the appropriate bills or receipts to support your claim.

If your claim is related to an accident, certain information pertaining to the accident is required on the claim form.

Filing a claim is not complicated. However, it does require that you follow specific procedures and provide all the data requested on the claim form. This will save you time and will assure prompt processing of your claim. If you need any assistance in completing your claim form, do not hesitate to call the Claim Administrator Office.

CONTACT INFORMATION AND KEY REMINDERS

5. **File All Claims for Reimbursement With the Claims Administrator Within One Year After the Date You Incur the Expense.** **Any Claim that is Submitted for Payment More Than Twelve Months After the Date the Expenses were Incurred Will be Denied.**

6. **Be Sure to Make Your Self Payments or COBRA payments on Time and In the Correct Amount.**
Benefits paid by this Plan are financed primarily by Employer contributions based on the number of hours worked. The Plan also provides that if you do not work enough hours to maintain your eligibility, you may be entitled to self pay in order to retain coverage under certain circumstances as described in this booklet.

7. **Be Sure to Enroll for Medicare**
If you are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and established eligibility for a monthly Social Security benefit. If you have not applied for Social Security benefits, you must file a Medicare application during the three month period prior to the month in which you become age 65 in order for coverage to begin at the start of the month in which you reach age 65. If you have any questions concerning Medicare enrollment, please contact the Plan Office.

8. **Be Sure to Pre-Certify or Authorize Treatment or Procedures When Required.**
The Plan requires pre-certification or authorization for certain admissions, treatment or procedures before they are undertaken. Failure to have such admissions, treatment or procedures pre-certified could affect your benefits or cause you to incur a penalty. To pre-certify, **contact Health Link at 1-877-284-0102**.

HEALTH PLAN SUMMARY OF BENEFITS AS OF JANUARY 1, 2025

Important Terms:

- **Copayments** are fixed dollar amounts (for example, $30) you pay for specified covered health care, usually when you receive the service.

- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.

- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. This is called **balance billing**. (For important additional information regarding balance billing, please carefully review provisions in this booklet regarding the **No Surprises Act**.)

- The overall **deductible** is $500 per individual and $1,500 per family. This does not apply to preventive care, prescription drugs, PPO primary care physician office visits, PPO preventive care services, diagnostic tests billed by a PPO primary care physician's office and dental. Deductibles for specific services, co-payments and charges which are not subject to the deductible do not apply toward the deductible. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Notwithstanding any provision in this booklet or in the Plan Document, any cost-sharing paid by the Participant for services covered by the No Surprises Act, Consolidated Appropriations Act of 2021, including the out-of-network charges enumerated in said Act as addressed in Section 4.7 of the Plan Document, shall be applied to the Participant's Deductible the same as if said payments had been paid by the Participant for in-network services.

- Other **deductibles** for specific services are $100/visit for Hospital admission or Outpatient Surgical Facility; $200/visit for Emergency Room; $100/year for Prescription Drugs; and $50/year for dental. There are no other specific deductibles. You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services

- The **out–of–pocket limit** on your expenses within the PPO is $1,400 per individual ***after your deductible is met***. A family will pay a maximum of three out-of-pocket limits per year, or no more than $4,200. There is no limit on how much you could pay during a coverage period for your share of the cost of Non-PPO covered services. The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services after your deductible is met. The limit helps you plan for health care expenses. ***Other expenses not included in the out-of-pocket limit, in addition to your deductibles, include prescription drugs, dental, copayments, charges which are not subject to the overall deductible, Non-PPO charges, balance billed charges, premiums, penalty amounts, and health care this plan doesn't cover. Even though you pay these expenses, they don't count toward the out-of-pocket limit.*** Notwithstanding any provision in this booklet or the Plan Document, any cost-sharing paid by the Participant for services covered by the No Surprises Act, Consolidated Appropriations Act of 2021, including the out-of-network charges enumerated in said Act as addressed in Section 4.7 of the Plan Document, shall be applied to the Participant's Co-Insurance or Out-of-Pocket Limit the same as if said payments had been paid by the Participant for in-network services.

HEALTH PLAN SUMMARY OF BENEFITS AS OF JANUARY 1, 2025

- Your Plan uses a network of providers. If you use an in-network doctor or other in-network health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. The terms in-network, preferred, or participating are used to refer to providers in the network. See the summary chart starting on the next page to see how your plan pays different kinds of providers. You may also go to www.anthem.com or call 1-800-Blue for more detail or information regarding which providers are in your network. Under federal law contained in the No Surprises Act, certain charges from out-of-network providers may be treated as if the services were provided by an in-network provider. See discussions regarding the No Surprises Act in this booklet for more information.
- You do not need a referral to see a specialist. You can see a specialist without permission from your Plan.
- Before reviewing the Plan's benefits and terms, you should read the following important notice regarding the Patient Protection and Affordable Care Act ("PPACA"), commonly referred to as Obamacare or The Affordable Care Act ("ACA"):

IMPORTANT NOTICE REGARDING GRANDFATHERED STATUS

The NECA-IBEW LOCAL 480 HEALTH AND WELFARE PLAN is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("PPACA"). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered plan means that your plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, 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 Plan at NECA-IBEW Local 480 Health & Welfare Fund, P.O. Box 721119, Byram, MS 39272; phone: (601)373-8434 or 1-800-424-8434; email: jhill@ibew480.org. 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. This website has a table summarizing which protections do and do not apply to grandfathered health plan.

LIVEHEALTH ONLINE BENEFIT (Effective August 1, 2018)

YOUR PLAN NOW OFFERS ONLINE CONSULTATION WITH BOARD-CERTIFIED PHYSICIANS FOR ROUTINE HEALTH QUESTIONS AND CONSULTATIONS *AT NO COST TO YOU.* When you have a health question or routine health condition about which you wish to consult with a physician, you can do so from the comfort of your own computer or mobile device without the inconvenience of having to make an appointment, travel to a physician's office or experience long waits. Using LiveHealth Online, you can see a doctor who can answer questions, make a diagnosis and even prescribe basic medications when needed. With LiveHealth Online, you get immediate doctor visits through live video, your choice of board-certified physicians and private, secure and convenient online visits. ***Plus there is no copay or deductible for LiveHealth Online visits.***

HEALTH PLAN SUMMARY OF BENEFITS AS OF JANUARY 1, 2025

LiveHealth Online physicians consist mostly of primary care physicians who are board-certified, average 15 years practicing medicine and who are specially trained for online visits. Doctors are available 24 hours a day, 365 days a year. Some of the most common conditions which may be treated online include, cold and flu symptoms such as cough, fever and headaches; allergies; sinus infections and more. ***In emergency situations, you should call 911.*** Your LiveHealth Online physician will inform you if your condition requires an in-person physician visit or further care. The online visit has no copay or deductible; however, should you require additional care, or in-person evaluation or tests, those additional services will be subject to the usual copay/deductible applicable to such services.

It's easy to sign up for LiveHealth Online. Just go to livehealthonline.com to register or use the LiveHealth Online App.

HEALTH PLAN SUMMARY OF BENEFITS AS OF JANUARY 1, 2025

Summary of Benefits & Coverage – What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		PPO Provider	Non-PPO Provider	
If you visit a health care provider's office or clinic or use LiveHealth Online	**Primary care visit to treat an injury or illness**	**$30/visit**	**50% coinsurance**	**PPO coverage is limited to $300/visit in eligible expenses. PPO expenses above $300 are subject to deductible and 20% coinsurance.**
	LiveHealth Online Visit	No copay/No Deductible	N/A	If additional evaluation/care required, such additional care subject to usual copay/deductible for such services
	Specialist visit	20% coinsurance	50% coinsurance	---none---
	Other practitioner office visit	20% coinsurance	50% coinsurance	Coverage for chiropractic services is limited to $500/year.
	Preventive care/screening/ Immunizations	$30/visit	Not Covered	PPO coverage is limited to $300/visit in eligible expenses. PPO expenses above $300 are subject to deductible and 20% coinsurance. Routine preventative PPO Colonoscopies and mammograms are covered at 100% and are not subject to the $300 limit, subject to applicable guidelines regarding frequency*.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	---none---

*Colonoscopies and Mammograms performed ***due to diagnosis*** are not included in preventative care and are covered as a major medical expense.

Your plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. If you aren't clear about any of the underlined terms used in this summary, see the Glossary electronically at www.dol.gov/ebsa/healthreform or call the Plan Administrator at 601-373-8434 or 1-800-424-8434 to request a paper copy.

HEALTH PLAN SUMMARY OF BENEFITS AS OF JANUARY 1, 2025

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		PPO Provider	Non-PPO Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com	Generic drugs	$8/prescription at Retail; $25/prescription at Mail Order	Not Covered	Coverage is subject to $100 prescription drug deductible per year and is limited to a 30-day supply per prescription at retail and a 90-day supply per prescription at mail order.
	Preferred brand drugs	$25/prescription at Retail; $50/prescription at Mail Order	Not Covered	
	Non-preferred brand drugs	$35/prescription at Retail; $85/prescription at Mail Order	Not Covered	
	Specialty drugs	20% coinsurance up to a Maximum of $100/prescription	Not Covered	Coverage is subject to $100 prescription drug deductible/year.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Coverage is subject to $100 deductible/visit plus overall deductible. No pre-certification necessary for outpatient surgery
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Coverage is subject to $200 deductible*/visit plus overall deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Coverage is subject to $100 deductible/visit plus overall deductible. Requires preauthorization. Failure to preauthorize or admissions exceeding approved length of stay are subject to $500 penalty.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	

*The emergency room deductible may be waived in emergent situations if you believe the charges were unavoidable under the circumstances. You must petition the Plan Administrator in writing within 180 days of receiving the service. The Plan Administrator shall have total discretion to grant or deny your petition for waiver.

HEALTH PLAN SUMMARY OF BENEFITS AS OF JANUARY 1, 2025

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		PPO Provider	Non-PPO Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 co-pay/office visits and 20% coinsurance/other outpatient services	50% coinsurance	PPO coverage for office visits are limited to $300/visits in eligible expenses. PPO office visit expenses above $300 are subject to deductible and 20% coinsurance.
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Requires preauthorization ($500 penalty)
	Substance use disorder outpatient services	Not Covered	Not Covered	---none---
	Substance use disorder inpatient services	Not Covered	Not Covered	---none---
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	No coverage for pregnancy of dependent child.
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Requires preauthorization ($500 penalty). No coverage for pregnancy of dependent child.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	---none---
	Rehabilitation services	20% coinsurance	50% coinsurance	---none---
	Habilitation services	20% coinsurance	50% coinsurance	---none---
	Durable medical equipment	20% coinsurance	50% coinsurance	Coverage requires written certification by physician of medical necessity (no coverage if not approved).
	Hospice service	20% coinsurance	50% coinsurance	---none---

This is only a summary. Please see the Health Plan Benefits and Excluded Health Plan Services sections of this booklet for greater detail about specific services covered, limitations and exclusions. The Plan Document outlines benefits offered by this Plan in more detail. You are entitled to receive a copy of the Plan Document from the Plan Administrator upon request. If you have questions, or want a copy of the Plan Document, you may call the Plan office at 601-373-8434 or 1-800-424-8434.

DENTAL PLAN SUMMARY OF BENEFITS AS OF JANUARY 1, 2025

Summary of Benefits & Coverage – What this Plan Covers & What it Costs

Benefits and Deductibles	Services		Coverage and Costs
Your Benefits Payable The following percentages of Eligible Expenses which exceed the Calendar Year Deductible.	Type A - Preventive and Diagnostic		100% of Reasonable and Necessary Charges are Covered (after $50 deductible)
	Type B – Basic Restorative, Endodontic, Periodontic, Maintenance of Prosthodontics and Oral Surgery		80% of Reasonable and Necessary Charges are Covered
	Type C – Major Restorative and Installation of Prosthodontics (Non-Orthodontic)		50% of Reasonable and Necessary Charges are Covered
	Type D – Orthodontic Services		Not Covered Under This Plan
Maximum Benefits Payable per Eligible Individual	Child under age 19	Type A and Fillings	Unlimited 1 exam/6 months
		All Other Services Combined	$1,000
	Adult	Types A, B & C Combined per Calendar Year	$1,000
	Type D per Lifetime		Not Covered Under This Plan
Deductible per Eligible Individual	Types A, B & C per Calendar Year		$50
	Maximum Deductibles per Family Coverage per Calendar Year		Three (3)

NOTE: If the course of dental treatment is expected to exceed $200, a request for a Pre-treatment Review must be filed by the Dentist with the Plan to determine the benefits which will be payable under the Dental Plan. Failure to comply with the Pre-treatment Review requirement will result in the denial of all expenses related to such treatment.

This is only a summary. Please see the Dental Plan Benefits and Excluded Dental Plan Services sections of this booklet for greater detail about specific services covered under Types A, B and C, Pre-Treatment Review, limitations and more. If you have questions about your coverage and costs, you may call the Plan Office at 1-800-424-8434 or 601-373-8434.

VISION BENEFITS

The Plan provides coverage for vision benefits through a plan purchased from Group Vision Service (GVS). Phone Number (866)265-4626.

To learn more about this coverage, or to find a Provider covered by the plan, go to **EYEMED.com.** Click on "Find an Eye Doctor" at the top of the page. Choose the Select Network on the drop-down menu.

DEATH BENEFITS AS OF JANUARY 1, 2025

Your Plan provides group life and accidental death and dismemberment benefits through separate policies purchased by the Plan from other insurers. This benefit covers only the Employee and not his or her dependents. The life insurance benefit covers Employees who are actively-at-work, retired, disabled or on Self-Pay or COBRA coverage. The Employee will provide the Plan with the identity of the beneficiary or beneficiaries of this coverage. Benefits under this coverage are listed below:

LIFE INSURANCE BENEFIT	**$10,000**

The death benefit is payable only upon the death of an Employee Participant. **The lives of Dependents are not covered under this policy.** The death must occur while the Employee is a Participant in this Plan.

Covered Participants include Employee Participants actively at work, on Self-Pay or COBRA coverage, on family or medical leave under the Family Medical Leave Act, on leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), Bargaining Unit Participants while disabled pursuant to Section 2.7 of the Plan Document and Bargaining Unit Retirees covered by the Plan.

Death benefits will be paid to the Designated or Contingency Beneficiary or Beneficiaries. It is the responsibility of the Employee Participant to make any desired changes to his beneficiary and to make sure the written change is received by the Plan Administrator. A Change of Beneficiary will not be effective until it is received by the Plan Administrator. Once the change has been received and recorded, it will take effect as of the date the Participant signed the Change of Beneficiary form. If the Participant dies before the form requesting a change is received by the Plan Administrator, the prior designation shall control.

If no Beneficiary is designated by the Participant, then the Beneficiary will be determined by the terms of the Plan controlling situations in which no Beneficiary is designated. Those provisions adopt the following priorities:

1) The legal spouse. If no legal spouse, then
2) The Participant's child or children. If no legal spouse or child or children, then
3) The Participant's parents. If no legal spouse, child or children or living parents, then
4) The Participant's brothers and/or sisters. If no legal spouse, child or children, living parents or brothers and/or sisters, then
5) The Estate of the Participant.

Exclusions. There sill be no death benefit upon a Participant's death under the following circumstances:

(a) the death of a Participant which occurs while the Participant is committing an illegal act or which results from or is incidental to a Participant's commission of or involvement in an illegal act; or

(b) the death of a Participant by suicide occurring within the first two years of the date on which said Participant became covered by this Plan: or

(c) death resulting from war or any act of war, whether declared or undeclared; or

(d) death resulting from or incidental to the Participant being under the influence of any drug, except those prescribed by a physician, including alcohol, narcotics, hallucinogens and gas or fumes, which are taken or inhaled voluntarily; or

(e) death arising out of the Participant operating, learning to operate or acting as a pilot or crew member of an aircraft.

Notice of Death Claim: Written notice of death claims must be provided to the Plan Administrator within 90 days of death. If notice is not provided within that time, the claim will not be invalidated if it is shown that Notice

was given as soon as reasonably possible. Such a determination is at the sole discretion of the Board of Trustees. In no event shall a beneficiary be entitled to Death Benefits for a claim first filed more than one year after the Covered Participant's death.

If a claim for death benefits is denied, the beneficiary must comply with the appeal procedures outlined in this Summary Plan Description before resorting to litigation in a court of law.

KNOW YOUR RIGHTS

No Pre-existing Medical Condition Exclusions
As of January 1, 2014, no exclusions for pre-existing conditions will be applied to you or your Eligible Dependent regardless of age. A pre-existing medical condition is a Sickness or injury for which you or your Eligible Dependent received treatment or services, including prescription drugs, during the six calendar month period before becoming covered under the Plan. Claims incurred after the effective date of coverage which resulted from a Pre-Existing Condition are not excluded from coverage under this Plan.

Coverage for Mental and Nervous Disorders
The Plan covers both Inpatient (subject to Utilization Review) and Outpatient treatment of Mental and Nervous Disorders for all illnesses and injuries. Benefits for Inpatient treatment of Mental and Nervous Disorders shall be paid on the same basis as any other hospital confinement with internal limits as specified in the Benefit Summary. Benefits for Eligible Expenses incurred for Outpatient treatment of Mental and Nervous Disorders shall be reimbursed at the coinsurance percentage, except for office visits which require a member co-pay as specified in the Benefit Summary. Coverage for Mental and Nervous Disorders does not include coverage for Substance Abuse Disorders.

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

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable than the earlier portion of the stay. In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours).

Women's Health and Cancer Rights Act
Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all breast, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your Plan Administrator at (601)373-8434 or 1-800-424-8434 for more information.
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Call your Plan Administrator at the phone number above with any questions.

Nondiscrimination on Basis of Genetic Information
Your Plan complies in all respects with the Genetic Information Nondiscrimination Act of 2008 ("the Act"), and does not discriminate on the basis of genetic information, as defined by said Act, with regard to pricing of premiums, underwriting, paying benefits, determination of eligibility, or coverage or other activities related to the

Plan or health benefits provided hereunder. Nor shall the Plan request, require or purchase genetic information as to any group or individual or for underwriting purposes. Such genetic information, as defined by the Act, shall be considered health information for purposes of HIPAA privacy requirements.

The limitations and exceptions to said prohibitions of discrimination based on genetic information, as set forth in the Act, shall apply to the Plan. Nothing in the Act prohibits the Plan from adjusting the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the Plan; however said manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer. The Act does not preclude the Plan from obtaining and using the results of a genetic test in making a determination regarding payment; although the Plan will request only the minimum amount of information necessary to accomplish the intended purposes.

No Rescission

You and your Eligible Dependents will not lose coverage or be non-renewed for coverage because of any illness or diagnosis or because of any claim for benefits filed by or on behalf of you or your Eligible Dependents except in cases of fraud or intentional misrepresentation of a material fact by you. If it is determined that rescission is appropriate because of such fraud or intentional misrepresentation of a material fact, the Plan will provide 30 day notice to you in advance of the rescission. This rescission provision does not affect any other reasons for termination of coverage set forth in any other sections of this booklet or the Plan document and does not affect any caps, limitations or exclusions otherwise outlined in this booklet or the Plan document, all of which remain in effect.

Your Right to Receive Obstetrical or Gynecological Care From a Network Provider of your Choice

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan at (601)373-8434 or 1-800-424-8434 or go to www.anthem.com.

HIPAA Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of coverage or certain life events.

If you are declining coverage at this time for either yourself or your eligible dependents, you may be able to enroll yourself and/or your eligible dependents in coverage at a later date if there is a loss of other coverage. Generally, you must enroll and provide the required supporting documentation within 31 days of the date your other coverage ends.

In addition, you may be able to enroll yourself and your eligible dependents if you have a qualifying life event (e.g. change in your marital status, birth or adoption of a child, death of dependent or change in employment status). You must enroll and provide the applicable required supporting documentation within 31 days of the qualifying life event. Other eligibility requirements of the Plan may govern your ability to enroll.

Furthermore, if you or a dependent loses coverage under the Children's Health Insurance Program (CHIP) or Medicaid, or becomes eligible for State premium assistance under those programs, you may also be able to enroll yourself or your eligible dependent in the Plan. In such an event, you must enroll and provide the applicable required supporting documentation within 60 days after you or your dependent lose such coverage or you or your dependent become eligible for premium assistance. Availability of CHIP premium assistance, if any, is determined

by the State where you live. More information regarding the CHIP program in Mississippi may be obtained by contacting the Mississippi Division of Medicaid at 550 High Street, Suite 1000, Jackson, Mississippi 39201 or by phone at (601)359-6050 or Toll Free at 1-800-421-2408.

For additional information regarding your rights under HIPAA, please visit the US Department of Labor website at the link below:

http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html

Your Right to Receive a Copy of the Plan's Notice of Privacy Practices
The Plan has adopted a Privacy Policy in order to comply with federal laws and regulations regarding your privacy rights. You may request a copy of the Plan's Notice of Privacy Practices at any time by contacting the Plan Administrator at (601)373-8434 or 1-800-424-8434. A copy of the Plan's Notice of Privacy Practices is also included in this booklet.

Your Rights and Protections Against Surprise Medical Bills

Under the No Surprises Act, when you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance and/or deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant

surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

Out-of-network air ambulance services
Out-of-network air ambulance services can't balance bill you if your Plan covers in-network air ambulance services.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.
- Pursuant to the No Surprises Act, the Plan will provide benefits for the following services, supplies or treatment rendered by a ***non-preferred provider or facility*** at the same rate and under the same terms as if they had been provided by a ***preferred provider or facility***:

  a) Emergency treatment or services rendered to a covered person, including post-stabilization care at a non-preferred facility until such time as the covered person is able to be transferred to a preferred facility;

  b) Non-emergency services rendered by a non-preferred provider at a preferred facility;

  c) Emergency and Non-emergency air ambulance services;

  d) Treatment or services from a former preferred provider or facility to a **Continuing Care Patient,** as defined by the Plan Document, after the provider or facility ceases to be a member of the preferred network for reasons other than failure to meet applicable quality standards or fraud. Upon such termination of a provider or facility from the preferred provider network, the Plan shall provide notice to any **Continuing Care Patient** of such provider or facility regarding the right to elect continued transitional care from said provider or facility with coverage to be provided on the same terms as if received from a preferred provider or facility. Coverage on such terms will be provided until the earlier of the end of a ninety (90) day period beginning on the date the Plan informed the Continuing Care Patient of the provider's change in network status or the date upon which the Participant ceases to be a Continuing Care Patient of the provider or facility.

e) Treatment, services or equipment received from a non-preferred provider or facility which was incorrectly listed as a preferred provider or facility in the Plan's Provider Directory and the covered person relied on the provider or facility's inclusion in the Directory in obtaining services, treatment or supplies.

- Any claims paid to non-preferred providers and facilities for treatment, services or supplies which are to be paid on the same terms as those provided by preferred providers and facilities pursuant to the terms of the No Surprises Act, shall be paid in accordance with the specific provisions of the No Surprises Act and related regulations. This will include, but not be limited to, provisions related to the basis for and amount of payments to such non-preferred providers and facilities, the timing of said payments and resolution of any disputes related to said payments through the IDR process established by the No Surprises Act and related regulations. To the extent any of the claims review and appeal procedures contained in this booklet are in conflict with federal law or regulation, those provisions are deemed amended to conform to such laws and/or regulations.

If you have any questions regarding your rights, you may contact the Plan at NECA-IBEW Local 480 Health & Welfare Fund, P.O. Box 721119, Byram, MS 39272; phone: (601)373-8434 or 1-800-424-8434; email: jhill@ibew480.org.

If you believe you've been wrongly billed, you may contact:

The U.S. Centers for Medicare & Medicaid Services (CMS) at **1-800-MEDICARE** (1-800-633-4227) or visit **https://www.cms.gov/nosurprises** for more information about your rights under federal law; or

IMPORTANT NOTICE REGARDING GRANDFATHERED STATUS

The NECA-IBEW LOCAL 480 HEALTH AND WELFARE FUND is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("PPACA"). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered plan means that your plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, 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 Plan at NECA-IBEW Local 480 Health & Welfare Fund, P.O. Box 721119, Byram, MS 39272; phone: (601)373-8434 or 1-800-424-8434; email: jhill@ibew480.org. 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. This website has a table summarizing which protections do and do not apply to grandfathered health plan.

COVERED BENEFITS

What the Plan Pays For
This Plan pays health care benefits subject to the exclusions and limitations described in this section and in the Health Summary of Benefits (Benefit Summary), and all other rules of the Plan.

Deductible
Before this Plan begins to pay benefits for medical expenses, you will have to pay a portion of any such charges that may be incurred. This payment is known as a deductible. Please see the Benefit Summary to determine the amount of costs you need to pay up to the deductible amount before this Plan begins to pay for covered services you use.

Common Accident Deductible Limit
Only one deductible will be applied to the covered medical expenses incurred when two or more members of your family, who are eligible for coverage, are injured in the same accident.

Percentage Payable
After you have satisfied any applicable deductible, the Plan will pay the percentage of eligible expenses outlined in the Benefit Summary. After the out-of-pocket amount stated in the Benefit Summary is paid by you, the Plan will pay additional eligible expenses in accordance with the Benefit Summary. Any expenses in excess of any maximum allowable charge under the Plan, any ineligible expenses, any penalties incurred for failure to pre-certify a Hospital admission or other service for which pre-certification is required, to obtain a second surgical opinion when required by the Plan or for a Hospital admission which exceeds the approved length of stay, will not apply towards the out-of-pocket limit as outlined in the Benefit Summary.

ELIGIBLE BASIC MEDICAL EXPENSES
The Plan will pay up to $300 per visit for eligible Basic Medical expenses (preventative colonoscopies and mammograms exempted from limit) and eligible charges over $300 will be considered under Major Medical coverage. Eligible expenses will be the lesser of Usual and Customary charges or PPO-negotiated charges incurred for PPO Primary Care Physician Office Visits. Except as provided by the No Surprises Act, Covered Basic Medical expenses must be performed and billed by the PPO Primary Care Physician and include:

1. Examination or Office Visit Fee;

2. Minor Surgical Fee performed in office.

3. Diagnostic and Preventative Services including X-Ray, Lab, Pap Smear, PSA and Immunization, when billed by PPO Primary Care Physician's Office.

4. Referrals by a Physician for Mammography Exam when performed and billed by separate PPO Facility.

5. Well Baby Care, provided to age 6, including childhood immunizations, when billed by PPO Primary Care Physician's Office.

6. Routine Physical Exam (limit to one per Calendar Year) when billed by PPO Primary Care Physician's office.

7. Routine, preventative colonoscopies performed by a PPO Provider beginning at age fifty (50) and thereafter, but only with the frequency recommended by the American Cancer Society for preventative purposes. You

will not be charged any out-of-pocket costs for a preventative colonoscopy performed by a PPO provider; although the benefit is subject to usual and customary charges. Colonoscopies performed more frequently than recommended by the American Cancer Society for preventative purposes due to the insured's medical history or for other reasons may be considered for payment under the Major Medical Benefit provisions of the Plan document.

Eligible expenses paid under Basic Medical do not accrue toward Major Medical Maximums, Calendar Year Deductibles or Out-of-Pocket Maximums.

ELIGIBLE MAJOR MEDICAL EXPENSES

Eligible Expenses are payable after any Basic Medical Expenses (after $300 per visit under Basic Medical) and are the lesser of PPO Charges or Usual and Customary Charges incurred for any of the following Medically Necessary services, supplies or treatment which are prescribed by the attending Physician for injury, Illness, or maternity care. Eligible expenses include:

1. A daily allowance for Hospital room and board up to the average semi-private room rate of the confining Hospital will be considered an eligible expense. For intensive care or coronary care unit, the daily rate of the confining hospital shall an eligible expense.

2. Ancillary charges of Hospitals and Surgi-centers for the following:
   a. use of operating room, delivery room, treatment room, recovery room, and emergency room;
   b. anesthesia materials;
   c. laboratory;
   d. oxygen and its administration;
   e. medical and surgical supplies;
   f. all drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the Hospital's formulary at the time of hospitalization, including "take home" drugs, which are approved by the Food and Drug Administration or its successor; blood plasma, blood derivatives, and blood processing;
   g. electrocardiograms;
   h x-ray, nuclear medicine, sonography, and computerized tomography in Plan approved units;
   i. physical therapy;
   j. administration of anesthesia by licensed personnel;
   k. intravenous injections and solutions;
   l. transfusion fee and equipment;
   m. electroencephalograms;
   n. electroshock therapy (subject to any limitations for coverage of Mental and Nervous Disorders);
   o. traction while Hospital confined;
   p. use of intensive care unit, a cardiac unit, or a burn unit approved by the Plan;
   q. heart laboratory, cardiovascular laboratory, or vascular laboratory;
   r. chemotherapy and radioisotope therapy, including use of materials; such as nitrogen mustard, radioactive gold, or radioactive iodine;
   s. radiation therapy and high intensity x-ray therapy, including electrically produced therapy as well as radioactive materials, such as cobalt;
   t. radium and radium implant;
   u. hemodialysis, to include only expenses related to laboratory tests and consumable and expendable supplies, such as dialysis membrane, dialysis solution, tubing and drugs required during dialysis;

v. psychological testing when ordered by the attending Physician and performed by a full-time Employee of the Hospital (subject to any limitations for coverage of Mental and Nervous Disorders); and
w. Breast reconstruction in connection with a mastectomy: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the patient.

3. Blood (if not replaced), blood plasma, plasma expanders, blood derivatives, blood processing and handling charges, equipment and supplies.

4. Services rendered by a licensed Physician or Dentist, for the correction of damage caused by accidental injury to sound natural teeth or prosthetics, including bridges or dentures,
provided that:
   a. the patient was covered under the Plan at the time of the accident;
   b. treatment commences within 90 days from the date of the accident and is completed within 24 months from the date of the accident; and
   c. Coverage remains continuously in effect during the course of treatment.

5. Services of a Physician except for those specifically excluded.

6. Structural Imbalance, Distortion, etc., where treatment is rendered on an Outpatient basis, in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference when such interference is a result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

7. Services of a qualified licensed professional physical therapist who holds, or is eligible for, membership in the American Physical Therapy Association, and who is not related to you or your Dependent by blood, marriage, or adoption.

8. Private duty nursing prescribed by a Physician provided by a Registered Nurse or Licensed Practical Nurse who is not related to you or your Dependent by blood, marriage, or adoption.

9. Durable medical equipment when required for treatment of an Illness or injury when certified in writing to the Plan by the Physician as to the medical necessity for the equipment and the anticipated length of time the equipment will be required for therapeutic use. The Plan will pay for either the purchase or rental of the equipment, not to exceed the cost of the equipment. Equipment that has been lost or damaged due to neglect or use not recommended by the manufacturer will not be replaced. Periodic recertifications may be required by the Plan to determine its continued medical necessity. Such equipment includes wheelchairs, hospital-type beds, durable mechanical or surgical equipment, iron lungs or other respiratory paralysis equipment, pacemakers, trusses, braces hemodialysis machines (including laboratory tests and expendable supplies such as a dialysis membrane, solutions, tubing, and drugs during dialysis).

10. Prosthetic appliances for treatment of conditions caused by an accidental injury or an illness occurring while the patient is eligible for coverage under the Plan, including the purchase of an initial implanted lens, contact lens, or corrective lens, when being used to replace the natural lens removed as a result of injury or disease. Hearing aids, contact lenses and/or corrective lenses, for any purpose other than those stated, are excluded.

11. Professional ambulance service in a vehicle licensed for highway use, to or from the nearest Hospital with facilities to treat an injury or illness, when certified Medically Necessary by a Physician, except in connection with Outpatient care of non-accidental Illness.

12. Outpatient diagnostic x-ray and laboratory tests.

13. Remedial reading, recreational, speech, visual, occupational therapy and pain rehabilitation, when ordered by a Physician because of an illness or accidental injury sustained while covered under this Plan, or when due to a congenital deformity of a Dependent who was born while covered under this Plan.

14. Human organ transplant procedures, as set forth below:

Human Organ Transplant Coverage
To be eligible to receive coverage for a human organ transplant procedure you must receive an opinion from two different board-certified Physicians who are specialized in the field of surgery and who confirm in writing to the Plan that no other treatment would be effective. The transplant procedure must be performed by a surgeon who is board certified in the appropriate medical specialty and performed at a medical center which is duly certified or licensed in the state of its situs and has a governmental approved transplant program. Also, you must follow the Plan's utilization review procedures and have your hospital admission pre-certified by the utilization review contractor. Benefits are available under the Plan for the following human organ transplant procedures: cornea, heart, kidney, pancreas/kidney, lung, heart/lung, bone marrow and liver.

Eligible expenses for human organ transplants include:

- Costs directly related to the donation of an organ used in the transplant procedure, such as the surgical procedure necessary to procure the organ, storage expenses and transportation costs. Any expenses incurred by the donor will be considered as an expense of the recipient, provided the recipient is covered under this Plan. If the recipient is not covered under this Plan, any expenses related to the removal of the organ incurred by a donor who is covered under this Plan will be covered as if the surgery were being performed to treat a disease, but only if the recipient's plan does not cover the donor's expenses.

- Transportation of the covered person and one companion to an approved transplant center, if the covered person lives more than 100 miles from the transplant center. Itemized receipts must be submitted for reasonable and necessary expenses. Daily lodging and meals not to exceed $150 per day. The maximum payment for all transportation, lodging and meal cost not to exceed $5,000.

- All other Medically Necessary Hospital, Medical and Surgical expenses, subject to the Plan's Deductibles, Coinsurance, Exclusions and Limitations.

No coverage will be provided for any type of transplant procedures other than the ones specifically listed above, for artificial or animal organ transplants, for organ procurement or transplantation outside of the continental United States or for procedures for which the cost is covered or funded by governmental sources (except Medicare and Medicaid or as otherwise provided by law), foundations or charitable grants.

EXCLUDED HEALTH PLAN SERVICES

Benefits Not Covered by the Plan
No benefits will be provided for charges in connection with:

1. Except as otherwise provided in the Plan's subrogation provisions, any injury and/or Sickness which is subject, in whole or in part, to reimbursement or recovery under any other applicable law, insurance, or contract, in the event that total medical expenses associated therewith exceed $300 per Illness and/or injury, including, but not limited to:

    a. Any claim or cause of action which may accrue because of the alleged negligent conduct of any third party and/or his insurers, including any claim against the Employee's or Dependent's own insurer arising under the Uninsured Motorists Coverage provisions of a Policy of Insurance or a Homeowner's Policy issued to the Employee or Dependent; and
    b. Any claim or cause of action which may accrue because of an event giving rise to a claim under the Workers' Compensation or liability laws of any state or of the United States;
    c. Any claim or cause of action which may accrue because of an event giving rise to a claim under the Products Liability laws of any state.

2. Hospitalization or medical or surgical treatment provided, either directly or through insurance; by:

    a. The U. S. Government (including Medicare, except as provided in the section on Coordination of Benefits as it pertains to Medicare), or
    b. Any state or political subdivision thereof, except under a state Medicaid Program, or as otherwise provided by law.

3. Any supplies or services for bodily injury or disease provided for the insured while not under the regular care or supervision of a licensed Physician, not ordered by a licensed Physician, or for which charges were not made or required to be paid.

4. Maternity expenses for other than a female Employee or the Dependent spouse of a male Employee.

5. Disease or injuries as a result of War, or any Act of War, whether declared or undeclared.

6. Dental care; i.e., dental x-rays, dental surgery, appliances, treatment, etc., except as provided under Dental Coverage.

7. Any treatment, procedure or surgery which is for cosmetic purposes, including charges for medical complications which arise from any cosmetic treatment, procedure or surgery, with the exception of the repair of accidental traumatic injuries sustained while eligible under the Plan or the correction of defects due to disease occurring while eligible under the Plan.

8. Travel expense, whether or not recommended by a Physician, except where covered in connection with an eligible transplant procedure.

9. Convalescent, custodial, sanitarium, old-age, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a Doctor for you or your Dependent who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical, or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care.

EXCLUDED HEALTH PLAN SERVICES

10. Services payable by a prepaid franchise, group or insurance carrier, except as provided in the Coordination of Benefits.

11. Services of interns, residents, fellows, or others in a residency training program.

12. Hearing aids, detachable portable monitors or stimulators, or the examination for fitting or adjustment of same.

13. Obesity, whether or not associated with or as a result of metabolic, vascular, endocrine, or any other medical condition, and regardless of medical necessity, including by way of illustration and not limitation, any service of a Physician, Registered Nurse, Licensed Practical Nurse, bariatrics clinic, health club, diet foods or drugs, in connection with obesity, surgery for excess fat in any area of the body, or resection of excess skin or fat following weight loss or pregnancy. This exclusion includes, but is not limited to, bariatric surgery, regardless of the purpose for which it is proposed or performed [including Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery], prescription drugs for treatment of obesity, medical complications resulting from any treatment, procedure or surgery for obesity or services at a health spa or similar facility.

14. Completing forms or furnishing medical documents, or other forms of letters, where a fee is charged to the Patient by a provider of service.

15. Abortions and medical complications from abortion, except therapeutic abortions (those recommended by a Doctor because of a dangerous health condition).

16. Treatment for Substance Abuse, including Drug Addiction and Alcoholism.

17. Charges for remedial reading, recreational, speech, visual and occupational therapy, and pain rehabilitation, except when due to an illness or accidental injury sustained while covered under this Plan, or congenital deformity of a Dependent who was born while covered under this Plan.

18. Admit kits, bedside kits, and any personal comfort items.

19. Equipment, supplies, or the installation of the same, which are not broadly accepted professionally as essential to the treatment of disease or injury, including without limitation and by way of illustration: air conditioners, dehumidifiers, Jacuzzi or whirlpool baths, first-aid supplies, air purifiers, arch supports, corrective devices placed in shoes, corrective or orthopedic shoes, heating pads, hot water bottles, home enema equipment, rubber gloves, deluxe equipment, electrical power, water supply, sanitary waste disposal systems, the installation and operation of eligible equipment, and professional medical testing equipment such as thermometers, stethoscopes, sphygmomanometers, etc. with the exception of diabetic supplies for insulin dependent diabetics.

20. Services, surgery or supplies in connection with or related to: gender dysphoria, reverse sterilization; any diagnostic or treatment measures not recognized as orthodox and widely accepted by organized medicine; diastatis recti, Laetrile; checmoendarterectomy; rhinoplasty, induced abortions, including any medical complications resulting from said services, surgery or supplies.

EXCLUDED HEALTH PLAN SERVICES

21. Services of Physician for routine physical examinations, immunizations, the fitting or prescription of eyeglasses or hearing aids, medical screening, in- hospital charges for well newborns and subsequent routine well-baby care, services of a resident or intern, and treatment of teeth other than that included as Eligible Expenses.

22. Treatment which is not incidental to, nor necessary for treatment of injury or illness.

23. Treatment for congenital deformities, except those of an eligible Dependent born to you and your spouse or placed with you for adoption while you or your spouse is covered under the Plan.

24. Services rendered by a Physician not practicing within the scope of his license.

25. Podiatry services, supplies or treatments not constituting, or not in association with, "surgery", within the generally accepted meaning of that term by the medical profession; non-covered services include, but are not limited to, the following: treatment of subluxations of the foot and routine foot care, such as cutting or removal of corns or calluses, the trimming of nails, routine hygiene care and the like.

26. Hospital charges or Inpatient Doctor charges for any period prior to 24 hours before surgery or other medical procedure unless an earlier admission is medically necessary.

27. That portion of any charge which the Plan determines to be in excess of the Usual and Customary charge. This exclusion applies regardless of whether the medical provider is a member of a PPO in which the Plan participates or with which the Plan has entered into any arrangement regarding charges for services to you, including discount arrangements. *The Plan is not authorized under any circumstances to pay benefits in excess of what is Usual and Customary for the services provided.*

28. A charge for or in connection with:

    a. Exams to determine the need for (or changes to) eyeglasses, lenses or hearing aids of any type.
    b. Eyeglasses or lenses of any type except initial replacements for loss of the natural lens.
    c. Eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

29. Services or supplies, including test and check-up exams, that are (1) educational or experimental in nature, (for purpose of this Plan investigation procedures are considered experimental), (2) furnished mainly for the purpose of medical or other research or (3) that are allocable to the scholastic education or vocational training of the patient.

30. Charges for artificial insemination or in-vitro fertilization which involves either a covered person or a surrogate as a donor or a recipient.

31. A charge for Physician's service or x-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums except as provided under the Eligible Expenses. This applies even if a condition requiring any of these services involves a part of the body other than the mouth such as the treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by methods including but not limited to, crowning, wiring or repositioning teeth. This exclusion does not apply to charges made for treatment or removal of a malignant tumor.

EXCLUDED HEALTH PLAN SERVICES

32. Any services, supplies or treatment which are not Medically Necessary.

33. A charge for any illness or injury suffered by the claimant while the claimant is in the course of committing a felony as described under any applicable law.

34. Charges for treatment of infertility which are a result of a prior voluntary sterilization procedure.

35. Fertility drugs including but not limited to clomid, HCG, pergonal or any drugs prescribed for treatment of infertility resulting from a prior voluntary sterilization procedure.

36. For charges for any medical complications which arise as the result of the Participant receiving non-covered medical, surgical or diagnostic services. Examples of non-covered medical, surgical or diagnostic services include, but are not limited to, gastric bypass surgery, liposuction, cosmetic surgery and elective abortions.

In general, services or supplies not specifically listed as eligible expenses under the terms of the Plan are excluded. However, with continued advances in medical science, should any new type of service or equipment not listed in the section on eligible expenses be presented for consideration, the Trustees have the authority to amend the Plan to include it as an eligible expense. The Trustees also have complete authority and discretion to decide whether a particular procedure or Illness is covered by the Plan or not.

COORDINATION OF BENEFITS

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

These coordination of benefits, or COB, provisions have been designed to prevent over-payments. The COB provisions in the IBEW Local 480 Health Plan are integrated with all other group health plans, but not with an individual's personal health insurance policies.

These COB provisions apply to all Plan Benefits, including your prescription drug benefits. It is therefore important for you determine which of your Plans is primary (including your Dependents who have other coverage) before attempting to use your prescription drug card, since coverage may be denied at the time of purchase if this Plan is not primary.

Under the COB provision, if you or your eligible dependents also have coverage under another group health plan, the total benefits received by any one patient from all the plans combined may not amount to more than 100% of the allowable expenses. "Allowable expenses" are any necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that are covered in full or in part by any plan covering you. Payments will be reduced only to the extent necessary to prevent an individual from making a profit on his group health coverage. You must report duplicate health coverage on your Claim Forms which you submit to secure reimbursement of the medical expenses. *In no event shall the amount paid by this Plan exceed the amount which would have been paid if no other Plan were involved.*

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

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

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

COORDINATION OF BENEFITS

The **Secondary Plan** is the Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan for benefits paid on your behalf.

When a Participant is Covered By Two Plans, Which Pays First

If a Plan has no limitation regarding payments made by any other Plan, then that Plan is considered the Primary Plan and will render payment first. If the Plans do have Coordination of Benefits rules, the first of the following rules that applies to the situation will determine which Plan is primary:

- The Plan that covers you as an Employee will be the Primary Plan and pays first, and the plan that covers you as a Dependent will be the Secondary Plan.
- If the claim is for a Dependent child whose parents are not divorced or legally separated, the Primary Plan will be the Plan that covers the parent whose birthday falls first in the calendar year as an enrollee or employee. For example, if your birthday is April 26, and your spouse's birthday is October 13, then claims for your eligible dependent children should be submitted first to your plan. The application of this rule has nothing to do with age, only to the date in the calendar year on which your birthday falls.
- If the claim is for a Dependent of divorced or separated parents, benefits for the Dependent will be determined in the following order:
  1) First, if a court decree (including orders entered in divorce proceedings or Qualified Medical Child Support Orders) states that one parent is responsible for the child's healthcare expenses or health coverage, then the Plan of the financially responsible parent will be the Primary Plan;
  2) Then, the Plan of the parent with custody of the child;
  3) Then, the Plan of the spouse of the parent with custody of the child;
  4) Then, the Plan of the parent not having custody of the child;
  5) Finally, the Plan of the spouse of the parent not having custody of the child.
- When another plan does not contain a COB provision, it will always be considered the Primary Plan. Payment under the Secondary Plan is made after the benefits from the Primary Plan have been paid. Such payment will be limited to the amount necessary to reimburse the individual for not more than 100% of allowable expenses. However, in some cases, the combined benefits may not pay 100% of your bills since you will only receive up to the stated maximums in each plan.
- If none of the above rules apply, then the plan which has covered the Participant for the longer period of time shall be considered the Primary Plan. The exception to this rule is that a plan that covers a Participant other than as a laid-off or retired Employee or as a Dependent of such Participant, shall pay benefits for that Participant first; and the plan that covers the Participant as a laid-off or retired Employee or as a Dependent of such a Participant, shall determine the benefits it shall pay second.

Medicare Coordination of Benefits

Coordination of benefits with Medicare is subject to laws, rules, regulations and guidelines published by the Federal Government. Those laws, rules, regulations and guidelines, as amended, are incorporated into the Plan Document and are adhered to by the Plan. Coordination with Medicare Benefits is determined by the circumstances of each situation and can be confusing. If you have any questions regarding coordination of Plan Benefits with Medicare, call the Plan Administration for assistance.

COORDINATION OF BENEFITS

Effect of Medicaid Coverage

1. Payment for benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant or Beneficiary of the Participant as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to section 1912 (a)(1)(A) of such Act, as in effect of August 10, 1993.

2. In enrolling an Individual as a Participant or Beneficiary or in determining or making any payments for benefits of an Individual as a Participant or Beneficiary, the fact that the Individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

3. To the extent payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

PRESCRIPTION DRUG CARD SERVICE PROGRAM

Prescription Drug Card Service Program
The Prescription Drug Card Service Program will provide you and your Dependents with a card to purchase covered prescription drugs at a Participating Pharmacy.

Most major chains and many local pharmacies participate in the program. Check with the Plan Office if you have a question about a particular pharmacy's participation.

Covered drugs are outlined in the agreement between NECA-IBEW Local 480 Health and Welfare Plan and the Pharmacy Benefit Manager and are incorporated herein by reference.

Prescription Drug claims are independent of Plan maximums.

Prescription Drug Deductible
There is a $100 combined Calendar Year deductible for all prescriptions.

Local Pharmacy Prescriptions
When purchasing a prescription from a Participating Pharmacy, you or your Dependent will be required to pay $8 for Generic drugs; $25 for Preferred Brand Drugs; or $35 for Non-Preferred Brand Drugs.

Mail Order Prescriptions
When purchasing eligible mail order prescriptions, you or your Dependent will be required to pay $25 for Generic drugs; $50 for Preferred Brand Drugs; or $85 for Non-Preferred Brand Drugs (90 day supply).

Specialty Drugs
You or your Dependent will be required to pay a 20% coinsurance up to a maximum of $100 per prescription for specialty drugs.

Coordination of Benefit provisions apply to all Plan Benefits, including your prescription drug benefits. It is therefore important for you determine which of your Plans is primary (including your Dependents who have other coverage) before attempting to use your prescription drug card, since coverage may be denied at the time of purchase if this Plan is not primary.

SUBSTANCE ABUSE TESTING BENEFIT

Substance Abuse Testing Benefit - For Employee and Employee Applicants Only.
These benefits are offered to ensure that the work place is free from the adverse effects of alcohol, prescription and nonprescription drugs, chemical agents or other controlled substances, whether legal or illegal, and to promote the health and safety of Employees.

Who is eligible to receive substance abuse testing?
If you are covered under this Plan as an Employee or if you have signed the Union's out of work list and requested a job referral as an electrical worker, have applied for employment through the Union's hiring hall as an apprentice and are currently enrolled in the NECA-IBEW Apprenticeship Program, or have applied for a job with an Employer who would be required to contribute to this Plan on your behalf if you were hired, then you are eligible to receive the Substance Abuse Testing Benefit. Only Employees and Employee applicants are eligible for the Substance Abuse Testing Benefit. Your spouse and Dependent children are not eligible for this benefit.

What benefits are paid by the Plan?
The Plan will pay 100% of the cost incurred for you to obtain a random or nonrandom substance abuse test if you are requested to obtain one by the Union, a Contributing Employer or the Joint Apprenticeship and Training Committee. The applicant is not required to pay any deductible, nor is there any limitation on the number of tests covered.

When is a substance abuse test covered?
To be covered the substance abuse test must be performed by an approved testing agency which has been selected by the Trustees. The purpose of the test is to determine if you are under the influence of alcohol, drugs and other controlled substances whether through a prescription or not. The results of the test will be reported to your Employer or to an Employer to whom you have applied for a job.

Do I have to file a claim form?
No, there are no claim forms to file. The company which performs the substance abuse tests bills the Plan directly, and the Plan will pay benefits directly to the provider, pursuant to your written assignment of benefits.

What expenses are not covered?
No benefits will be paid for charges incurred in connection with:

- Substance abuse tests to refute test results, unless otherwise requested by the Employer, Union, or Joint Apprenticeship and Training Committee.
- Substance abuse tests incurred after an Employee or Employee applicant refuses to submit to a test after being requested to do so by the Employer, Union, or Joint Apprenticeship and Training Committee.
- Substance abuse tests required for an Employee's employment to be reinstated following termination, probation or suspension.
- Substance abuse tests performed to refute a prior positive Substance Abuse Test.
- Substance abuse tests which the Employee is not requested to obtain by the Employer, Union or Joint Apprenticeship and Training Committee.
- Any type of rehabilitation treatment or therapy.
- Substance abuse tests that are performed by a testing agency that has not been selected by the Trustees.
- Loss of income due to termination, probation or suspension of employment.

SUBSTANCE ABUSE TESTING BENEFIT

Non-Discrimination

The Plan will not discriminate against individuals with a history of illegal drug use who are not currently under the influence of illegal drugs, chemical agents or other controlled substances and who can provide evidence of participation in or completion of a supervised rehabilitation program for substance abuse. Any Applicant or Employee who is terminated, placed on probation or suspended due to positive testing and who subsequently seeks re-employment and provides evidence of successful completion of a supervised drug rehabilitation program and tests negative on a Substance Abuse Test at that time shall be similarly treated as other Applicants and Employees for employment.

DENTAL PLAN BENEFITS

Dentist
The term Dentist means an Individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of your dental benefits, a Physician will be considered a Dentist when he performs any of the dental services described in the Dental Summary of Benefits, and is operating within the scope of his license.

Usual and Customary Charges
A charge made for a dental service will be paid if it is Usual and Customary. Usual and Customary refers to charges made in the location at which the services or supplies essential to the care of the Participant, according to standards and limits adopted by the Trustees are: (a) the most consistent charge by the Dentist for a given procedure; (b) the usual fee for a procedure by the majority of Dentists with similar training and experience within the same locality; and (c) reasonable when such charges meet the criteria in (a) and (b) or when, in the judgment of the Trustees, they merit special consideration based upon the complexity of treatment.

Benefits Payable for You and Your Family Members
If you or your family members, while covered for Dental Expense Benefits, incur Covered Dental Expenses and if the Deductible Amount shown in the Dental Summary of Benefits has been satisfied, payment will be made for each dental service up to the Maximum Payment determined from the Dental Summary of Benefits.

Deductible
The Deductible Amount shown in the Dental Summary of Benefits will be applied to each individual's Covered Dental Expenses once during a Calendar Year. When three or more individuals in a family incur Covered Dental Expenses during the same Calendar Year, and the total expenses used toward satisfying their individual Deductible Amount shown in the Dental Summary of Benefits have been met, no further Deductible Amounts are required for the remainder of the Calendar Year.

Maximum Benefit
The maximum amount payable for each individual for Type A, B, and C Dental Services during a Calendar Year is shown in the Dental Summary of Benefits.

Covered Dental Expenses
Covered Dental Expenses are the expenses incurred by you or any of your family members for charges made by a Dentist for any dental service provided for in the Dental Summary of Benefits, if the dental service is performed by or under the direction of a Dentist, is essential for the necessary care of the teeth, and begins while you or any of your family members are insured for Dental Expense Benefits.

Dental Pre-Treatment Review
Pretreatment Review is a system designed to give you and your Dentist a better understanding of the Covered Expenses payable under this Plan before services are provided. When charges for a proposed dental service or a series of dental services are expected to exceed $200, your Dentist should submit a claim to the Plan's Third Party Administrator, American Benefit Corporation, showing the treatment plan and fees. American Benefit Corporation will then use this Pretreatment Review to determine the benefits which will be payable for each dental service according to the terms of this dental plan and notify your Dentist accordingly. When the treatment plan is finished, your Dentist will resubmit the claim for payment showing the date each service was performed. **If this Pretreatment Review process is not followed, payment will be denied on any expenses which exceed $200.**

DENTAL PLAN BENEFITS

Your Dental Benefits

Covered Dental Expenses will not include any dental service not provided for in the summary shown, unless American Benefit Corporation reviews the services and accepts the expenses as Covered Dental Expenses. The Covered Dental Expense for such dental service will be determined by American Benefit Corporation and will be consistent with those listed in the Summary of Benefits.

Expenses incurred for precision or semi-precision attachments, surgical implants of any type including any prosthetic device attached to them; instruction for plaque control or oral hygiene, bite registrations, splinting or dental services which do not have uniform professional endorsement will not be accepted by American Benefit Corporation as Covered Dental Expenses. A temporary dental service will be considered an integral part of the final dental service rather than a separate service.

Eligible Dental Charges

A. Type A – Preventive and Diagnostic
   1. Oral Exams – Routine oral examinations including diagnosis, but not more than one such examination with respect to the same covered individual within any six consecutive month period.
   2. Prophylaxis with or without oral examination, including cleaning, scaling and polishing, but no more than one dental prophylaxis with respect to the same covered individual within any six consecutive month period.
   3. Intra-oral x-rays – complete series with or without bitewings (only one series in any 36 consecutive month period).
   4. Bitewing (x-rays) – no more than one charge in any six consecutive month period.
   5. Panoramic x-ray (panorex) and complete mouth survey (FMX) limited to one series within any 36 consecutive month period.
   6. Topical application of stannous fluoride for individuals under age 14 (no more than one application in any 12 consecutive month period).
   7. Space maintainers (not made of precious metals) for individuals under age 19 and limited to initial appliance only (allowance includes all adjustments in the first six months of installation).

B. Type B – Basic Restorative, Endodontics, Periodontics, Maintenance of Prosthodontics and Oral Surgery
   1. Simple (routine) extractions.
   2. Oral Surgery.
   3. Alveolectomy.
   4. Anesthesia, including general anesthesia when Medically Necessary and rendered in connection with a covered oral or dental surgical procedure.
   5. Therapeutic injunctions.
   6. Restorations – fillings of amalgam or synthetic process but specifically excluding posterior or anterior crowns of jackets, and initial placement of full or partial dentures and replacement of dentures and fixed bridge units. Benefits for replacement of an existing amalgam restoration or silicate restoration are only payable if at least 24 months has passed since the existing amalgam was placed.
   7. Denture repair and bridge repair.
   8. Endodontics.
   9. Periodontics.
   10. Apicoectomy (considered a separate service if performed with root canal therapy).
   11. Gingivectomy or gingivoplasty, per quadrant, osseous surgery, per quadrant. If more than one

periodontal surgical service is performed per quadrant, only the inclusive service performed will be considered a Dental Service provided for in this Schedule. Flap entry and closure is considered part of the dental service for osseous surgery and osseous graft. Periodontal scaling – 12 or more teeth.

12. Surgical extraction of impacted wisdom teeth, both partial and complete.
13. Emergency palliative treatment.

C. Type C – Major Restorative and Installation of Prosthodontics (Non-Orthodontic)

1. Inlays
2. Onlays
3. Crowns, but only when regular fillings are not adequate to restore the tooth.
4. Prosthetics – including bridges and dentures:
    a. The initial installation of, or addition to full or partial dentures or fixed bridge work will be eligible provided:
        i. that such installation or addition is required as a result of an extraction of one or more injured or diseased natural teeth on or after the effective date of coverage of the patient,
        ii. that the installation or addition referred to above includes the replacement of such an extracted tooth, and
        iii. that such denture or bridgework is completed within twelve (12) months following the date of the extraction.

    Dentures and bridgework will be considered initially installed only if such dentures and bridgework do not replace any existing dentures or bridgework.

    b. The replacement or alteration of full or partial dentures or fixed bridgework will be considered for payment if the replacement or alteration is necessary, occurred on or after the effective date of the coverage of the patient under the Plan and is completed within twelve (12) months after one of the following:
        i. Surgical treatment required due to accidental injury which did not cause damage to the prosthetics, but which surgery necessitates replacement or alteration of the prosthetics, or
        ii. Oral surgical treatment which involves the reposition of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue.
    c. The replacement of a full or partial denture when the replacement is required as a result of structural change within the mouth provided:
        i. The replacement is made more than five years after the date of the installation of such denture, and
        ii. Any such replacement will in no event be made less than twelve months after the effective date of coverage of the patient under the Plan.

D. Type D Services - Orthodontic Services (Not Covered). ***Type D services, orthodontic services, are not covered under the Plan.***

Date Service Begins and Extension of Dental Benefits

If the dental service is performed on a date other than the date the service was recommended or considered necessary, the dental service will be considered to begin on the date the actual performance of the service begins. Benefits are payable for services rendered following termination of coverage only as follows:

DENTAL PLAN BENEFITS

A. Charges for removal of a partial or complete denture will be considered if the impressions were taken and abutment teeth fully prepared while the individual was covered for dental benefits under this Plan, provided the prosthetic device is installed or delivered to the covered individual within thirty (30) days following termination of such individual's coverage under this Plan.

B. Charges for a fixed partial denture, crown, inlay or onlay required for the restoration of a tooth will be considered if the tooth was prepared for the crown while the individual was covered for dental benefits under this Plan and fixed partial denture, crown, inlay or onlay is installed within thirty (30) days following termination of such individual's coverage under this Plan.

C. Charges for root canal therapy will be considered if the tooth was opened while individual was covered for dental benefits under this Plan and treatment completed within thirty (30) days following termination of such individual's coverage under this Plan.

How to File Your Dental Claim

Your Group program is designed to help process your claim as quickly as possible. Once dental work has been completed for you or a family member, benefit payments will be paid to you unless you have indicated on the claim form that you wish the Plan Administrator to pay the Dentist directly. Your promptness in submitting the required claim forms (which should be fully completed by you and your Dentist) will result in speedy payment of your claim. You may get these forms from your Employer. All completed forms and bills should be submitted directly to the Claims Administrator.

YOU MUST FOLLOW THE PRETREATMENT REVIEW PROCEDURE WHEN IT IS NECESSARY. PROMPT SUBMISSION OF REQUIRED CLAIM FORM RESULTS IN FASTER PAYMENT.

EXCLUDED DENTAL PLAN SERVICES

Dental Expenses Not Covered

Covered Dental Expenses will not include and no payment will be made for expenses incurred:

A. Any services, for which no charge is made to the Employee or eligible Employee or eligible Dependent, or any charges for service or supplies which are, or may be, obtained without cost in accordance with the laws or regulations of any government or government agency, except to the extent, if any, that a charge is made which the Employee or eligible Dependent is legally required to pay; "government" being deemed to include any nation, state commonwealth, territorial or provincial government, or any political subdivision;

B. Any charges for services received from the dental and medical department of any Employer, Union, Employee Benefit Association, Trust or similar organization, or for services of a Dentist or clinic contracted for or by any such organization;

C. Any charges for dental services for cosmetic purposes;

D. Any charges for replacement of teeth extracted prior to the effective date of the Employee or eligible Dependent's coverage under the Plan.

E. Any charges for dentures, crowns, inlays, onlays, bridgework or appliances or services for increasing vertical dimensions;

F. Any charges for dentures or bridgework adjustments within six months of the placement or adjustment of bridgework;

G. Any charges for replacement of a lost or stolen prosthesis, or for a duplicate prosthesis;

H. Any charges for sealants, or any charges for oral hygiene, dietary, or plaque control instructions and programs;

I. Any charge for injury or disease arising out of or in the course of any occupation or any employment for compensation, profit or gain;

J. Any charges for athletic mouth guards;

K. Any charges for a temporary denture or bridge that, when combined with the charge for the permanent denture or bridge, exceeds the Usual and Customary amount payable for the permanent denture or bridge;

L. Any charges made by a Dentist for the patient's failure to appear as scheduled for an appointment;

M. Any charges for implantology, including surgical care and/or treatment of endosseous and/or subperiosteal implants or any complications thereof;

N. Any charges for drugs, other than injectable antibiotics administered by a Dentist or Physician as a result of dental treatment;

O. Any charges for procedures, services, or supplies, which do not meet accepted standards of dental practice, including charges for procedures, services or supplies which are experimental in nature;

P. Any charges for treatment initiated while the Employee or Dependent were not eligible under the Plan;

Q. Personalization or characterization of dentures;

R. Any changes associated with treatment of accidental injury to sound natural teeth (expenses are covered under Section 4.3(e) of the Comprehensive Medical Plan).

S. Splints, braces and any other type of orthodontic appliance, for whatever reason prescribed or utilized;

T. Treatment performed by anyone other than a Dentist as defined herein except, scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist under the supervision and guidance of a Dentist;

U. Any dental services and supplies that are covered under the Comprehensive Medical Plan set forth in Article 4.

V. Services and supplies related to the treatment of TMJ syndrome; or

W. Any dental services or treatment rendered outside of the United States, except emergency treatment, shall be limited to a maximum benefit of $100.

EXCLUDED DENTAL PLAN SERVICES

General Dental Limitations

No benefits will be paid for expenses incurred:

- for occupational accidents; or for Sickness covered by Worker's Compensation;
- to the extent those expenses are in any way reimbursable through any public program including Medicare. Anyone eligible for both Part A and Part B of Medicare will be considered to be covered under both Part A and Part B of Medicare. Anyone eligible for Part B only will be considered to be covered under Part B only;
- for confinement, or treatment received from, a Hospital owned or operated by the United States government;
- for charges which you or your family members are not legally required to pay;
- for charges which would not have been made had benefit coverage not existed;
- in excess of the lesser of what is reasonably Usual and Customary or the PPO charges for the locality in which they are incurred;
- for unnecessary care or treatment;
- to the extent that payment under the Plan is prohibited by any law to which you or your family member is subject to at the time expenses are incurred;
- to the extent that they are otherwise payable as fully described under Coordination of Benefits;
- to the extent those expenses are in any way reimbursable through "no-fault" automobile insurance; and
- for temporomandibular joint dysfunction (TMJ Syndrome).

ELIGIBILITY

HOW TO DETERMINE YOUR ELIGIBILITY

There are four different categories of Employees covered by the Plan. Because of variations in the nature of employment and contractual agreements related to the different Employee categories, the eligibility requirements may differ from category to category. It is, therefore, important for you to determine which category applies to you when determining your eligibility requirements. The four Employee categories are as follows:

TRUST AGREEMENT EMPLOYEES. This category includes employees of the Union, the Central Mississippi Chapter of NECA and related apprenticeship funds.

CONSTRUCTION EMPLOYEES AND ELECTRICAL EMPLOYEES EMPLOYED OUTSIDE THE UNION'S GEOGRAPHICAL JURISDICTION. This category generally includes Employees whose Employer makes contributions to the Plan under the current Collective Bargaining Agreements.

MAINTENANCE EMPLOYEES. This category includes employees covered under the Maintenance Agreement with the Delphi Division of General Motors.

NON-BARGAINING UNIT EMPLOYEES. This category includes non-bargaining unit Employees whose Employer participates in the Plan and makes contributions on your behalf by approval of the Plan's Board of Trustees.

The eligibility requirements for each Employee category are explained in the following pages.

TRUST AGREEMENT EMPLOYEES' ELIGIBILITY RULES

Eligibility Rules for Employees of the Union, the Central Mississippi Chapter of NECA, or Related Apprenticeship Funds

Initial Eligibility: When does coverage go into effect?
If you are a full-time employee of IBEW Local Unions 480 or 917; the NECA-IBEW Local 480 or 917 Joint Apprenticeship Committee and Trust Fund, or the Central Mississippi Chapter of NECA (in either Jackson or Meridian) you may be eligible for coverage under this Plan. A full-time Employee is one who normally works at least 30 hours per week, or the equivalent of 130 hours or more per month. Coverage for a new Employee and his/her Dependents will begin on the first day of the second calendar month following the Employee's 30th day of full-time employment, as set forth in the table below:

MONTH IN WHICH EMPLOYEE COMPLETES 30TH DAY OF FULL-TIME EMPLOYMENT	EFFECTIVE DATE OF COVERAGE
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

If you are already eligible for coverage as of the date you initially qualify for benefits based on the rule in the above paragraph (because you previously worked as a construction Employee) and you have accumulated months of future eligibility, then any unused months of accumulated eligibility will be placed in your Credit Bank. The number of months of unused accumulated eligibility may be used at a future date to extend your eligibility for benefits at the time your coverage as an active Employee would otherwise end. Such unused accumulated eligibility must be used before you may opt to make self payments of any kind.

If you and your spouse are both full-time Employees of an Employer, you must both be covered as Employees.

How Does Eligibility Continue?
Once you are covered under the Plan, you will continue to be eligible provided you remain a full-time Employee of your Employer. Your coverage for a particular month will be determined by whether you worked full-time in the second calendar month prior to the month for which coverage is being determined. For examples, refer to the following table:

TRUST AGREEMENT EMPLOYEES' ELIGIBILITY RULES

MONTH FOR WHICH COVERAGE IS SOUGHT	DETERMINED BY HOURS WORKED IN
January	November
February	December
March	January
April	February
May	March
June	April
July	May
August	June
September	July
October	August
November	September
December	October

When Does Your Coverage Stop?
Your eligibility for benefits will stop on the earliest of the following dates:

- If the Trust Agreement Employee's employment is terminated, the Employee ceases to be a full-time Employee or the Employee no longer meets the Plan's definition of "Employee", the Employee will be eligible for benefits until the last day of the last calendar month for which the Employee is qualified for benefits under the chart above, provided the Employer made a contribution on the Employee's behalf for said period;

- The first date for which your Employer fails to make timely contributions on your behalf;

- The first day of the month for which the Employee fails to make a timely COBRA premium payment;

- The first day of the month for which all accumulated eligibility is exhausted and for which you fail to make timely self-payment under the partial self-pay rules (only in cases where you have or had any accumulated months in a Credit Bank from previous work as a Construction Employee and are entitled to make partial self-payments based on former employment as a Construction Employee);

- The date the Employee enters the Armed Forces of the United States on an active duty basis; or

- The date the Plan is terminated or amended to terminate coverage for the class of Employees to which you belong.

  Thereafter you may be eligible to continue coverage through self-payment/COBRA.

CONSTRUCTION EMPLOYEES' ELIGIBILITY RULES

General Provisions

All Construction Employees and Electrical Employees employed outside the Union's geographical jurisdiction working in a job classification for which Participating Employers are required, under the terms of the current Collective Bargaining Agreements, to make contributions to the N.E.C.A.-I.B.E.W Local 480 Health and Welfare Plan will become and remain eligible upon satisfaction of the Initial Eligibility and Continuing Eligibility provisions set forth below.

Initial Eligibility

An Employee shall become eligible on the first day of the third calendar month following the month in which he reached at least four hundred (400) hours worked in a three (3) consecutive month period or less for which Contributions have been made in his name, as set forth in the table below:

400 HOURS IN QUALIFYING PERIOD:	QUALIFIES EMPLOYEE FOR BENEFIT MONTH:
Aug, Sept, Oct	Jan
Sept, Oct, Nov	Feb
Oct, Nov, Dec	Mar
Nov, Dec, Jan	Apr
Dec, Jan, Feb	May
Jan, Feb, Mar	June
Feb, Mar, Apr	July
Mar, Apr, May	August
Apr, May, June	Sep
May, June, July	Oct
June, July, Aug	Nov
July, Aug, Sept	Dec

Continuing Eligibility

After becoming initially eligible, an Employee shall continue to be eligible so long as he continues to meet the requirements for initial eligibility set forth in the table above (requiring 400 hours worked in a 3 consecutive month period or less for which Contributions have been made in his name) ***or*** so long as the Employee works at least eight hundred (800) hours in a 6 consecutive month period or less for which Contributions have been made in his name, as set forth in the table below:

400 Hours in the Qualifying Period:	800 Hours in the Qualifying Period:	Qualifies Employee for Benefit Month:
Aug-Oct	May-Oct	Jan
Sep-Nov	Jun-Nov	Feb
Oct-Dec	Jul-Dec	Mar
Nov-Jan	Aug-Jan	Apr
Dec-Feb	Sep-Feb	May
Jan-Mar	Oct-Mar	Jun
Feb-Apr	Nov-Apr	Jul

CONSTRUCTION EMPLOYEES' ELIGIBILITY RULES

400 Hours in the Qualifying Period:	800 Hours in the Qualifying Period:	Qualifies Employee for Benefit Month:
Mar-May	Dec-May	Aug
Apr-Jun	Jan-Jun	Sep
May-Jul	Feb-Jul	Oct
Jun-Aug	Mar-Aug	Nov
Jul-Sep	Apr-Sep	Dec

When Does Your Coverage Stop?
Your eligibility for benefits will stop on the earliest of the following dates:

- The first day of the Benefit Month for which your eligibility ends;
- The date for which your Employer has failed to make contributions in a timely manner;
- The last day of the month for which you make timely self-payment under the partial self-pay rules;
- The first day of the month for which you fail to make a timely COBRA premium payment;
- The date the Plan is terminated or is amended to terminate coverage for the class of Employees to which you belong;
- The date the Employee enters the Armed Forces of the United States on an active duty basis;
- The date your Employer and/or Bargaining Unit withdraws from the Plan; or
- The date you start work for a Non-Contributing Employer in the Electrical Industry.

Thereafter you may be able to continue coverage through self-pay/COBRA.

Note: Initial eligibility may be obtained only by working the required number of hours as set forth above. Initial eligibility may not be purchased by payment of the contribution for the necessary hours if those hours have not actually been worked by the employee.

DELPHI DIVISION MAINTENANCE EMPLOYEES' ELIGIBILITY RULES

If you are covered under the Maintenance Agreement with the Delphi Division of General Motors, you and your Eligible Dependents will become and remain eligible upon satisfaction of the Initial Eligibility and Continuing Eligibility provisions set forth below.

Initial Eligibility

You and your Eligible Dependents will be eligible for benefits on the first day of the second calendar month following completion of a 30 day period in which you worked at least 158 hours, as set forth in the table below:

MONTH IN WHICH EMPLOYEE COMPLETES 30 DAY PERIOD WORKING AT LEAST 158 HOURS	EFFECTIVE DATE OF COVERAGE
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

Continuing Eligibility

After becoming initially eligible, you will retain continuing eligibility for any calendar month based on the number of hours worked as an Employee in the second calendar month prior to the month for which coverage is determined. In order to secure coverage for the second calendar month following the month worked, the Employer shall contribute for each hour worked, but for at least 158 hours for work performed in the calendar month, except for the month of February, in which only 150 hours worked shall be required for eligibility in April. The table below provides examples of how to qualify for continuing eligibility:

MONTH FOR WHICH COVERAGE IS SOUGHT:	DETERMINED BY HOURS WORKED IN:
January	November
February	December
March	January
April	February*
May	March
June	April
July	May
August	June

DELPHI DIVISION MAINTENANCE EMPLOYEES' ELIGIBILITY RULES

MONTH FOR WHICH COVERAGE IS SOUGHT:	DETERMINED BY HOURS WORKED IN:
September	July
October	August
November	September
December	October

*Only 150 hours must be worked during the month of February in order to obtain coverage for April.

When Does Your Coverage Stop?
Your eligibility for benefits will stop on the earliest of the following dates:

- If the Employee's employment with the Contributing Employer terminates, then his eligibility termination date shall be determined in accordance with the charts above, provided the Employer made a contribution on behalf of the Employee for the period in question;
- The date for which your Employer has failed to make contributions in a timely manner;
- The last day of the month for which you make timely self-payment under the partial self-pay rules;
- The first day of the month for which the Employee fails to make a timely COBRA premium payment;
- The date the Employee enters the Armed Forces of the United States on an active-duty basis; or
- The date the Plan is terminated or amended to terminate coverage for the class of Employees to which the Employee belongs.

Thereafter you may be eligible to continue coverage through self-pay/COBRA.

Note: Initial eligibility may be obtained only by working the required number of hours as set forth above. Initial eligibility may not be purchased by payment of the contribution for the necessary hours if those hours have not actually been worked by the employee.

NON-BARGAINED EMPLOYEES ELIGIBILITY RULES

Initial Eligibility: When does coverage go into effect?
If you are a non-bargained Employee and work full-time for an Employer contractor whose participation in the Fund on behalf of its non-bargained Employees has been approved by the Board of Trustees, you may be eligible for coverage under this Plan. A full-time Employee is one who normally works at least 30 hours per week, or the equivalent of 130 hours or more per month. Coverage for a new Employee and his/her Dependents will begin on the first day of the second calendar month following the Employee's 30th day of full-time employment.*

MONTH IN WHICH EMPLOYEE COMPLETES 30TH DAY OF FULL-TIME EMPLOYMENT	EFFECTIVE DATE OF COVERAGE
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

*If you are seeking coverage as part of a new group entering the Plan by virtue of your Employer's execution of a Participation Agreement with the Plan, your coverage will go into effect on the first day of the second calendar month following your Employer's initial date of application provided all applicable premiums have been paid, your Employer has executed a Participation Agreement and the Trustees have accepted your Employer for participation.

If you and your spouse are both full-time Employees of an Employer, you must both be covered as Employees.

How Does Eligibility Continue?
Once you are covered under the Plan, you will continue to be eligible provided you remain a full-time Employee of your Employer. Your coverage for a particular month will be determined by whether you worked full-time in the second calendar month prior to the month for which coverage is being determined. For examples, refer to the following chart:

MONTH FOR WHICH COVERAGE IS SOUGHT	DETERMINED BY HOURS WORKED IN
January	November
February	December
March	January
April	February
May	March
June	April

NON-BARGAINED EMPLOYEES ELIGIBILITY RULES

MONTH FOR WHICH COVERAGE IS SOUGHT	DETERMINED BY HOURS WORKED IN
July	May
August	June
September	July
October	August
November	September
December	October

When Does Your Coverage Stop?
Your eligibility for benefits will stop on the earliest of the following dates.

- If the Non-Bargaining Employee's employment is terminated, the Employee ceases to be a full-time Employee or the Employee no longer meets the Plan's definition of "Employee", the Employee will be eligible for benefits until the last day of the last calendar month for which the Employee is qualified for benefits under the chart above, provided the Employer made a contribution on the Employee's behalf for the period in question;

- The last day of the calendar month for which the Employer is obligated to contribute to the Plan and has made timely payment on behalf of its Bargaining Unit Employees;

- The last day of the calendar month for which the Employer has timely paid the required contributions on behalf of the Non-Bargaining Employee;

- The first date for which the Employee fails to make a timely COBRA premium payment;

- The date the Employee enters the Armed Forces of the United States on an active duty basis; or

- The date the Plan is terminated or amended to terminate coverage for the class of Employees to which you belong.

Thereafter you may be eligible to continue coverage through COBRA.

Which Non-Bargaining Unit Employees are not covered?

- Non-Bargaining Unit Employees working outside the geographical jurisdiction of the Union are not covered unless specifically approved by the Plan.

- A Non-Bargaining Unit Employee may not participate in the Plan if he is also an owner of a proprietorship or a partner in a partnership, if such proprietorship or partnership would submit Contributions on his behalf, unless he is determined by the Trustees to be a "Working Owner" under applicable laws, rules or regulations. The Trustees shall have full discretion and authority to deny participation to any owner or partner under this section or to impose requirements or conditions on participation by any owner or partner.

DEPENDENT ELIGIBILITY RULES

When Does Coverage Begin for Your Eligible Dependent?
Coverage for your Eligible Dependent begins on the same day that your coverage begins or, if later, on the date you first acquire the Eligible Dependent.

A family member who qualifies as an Eligible Dependent is:

- Your legal spouse, provided you are not legally separated;

- Your child(ren) up to the age of 26 who are either a:
  - Natural child;
  - Legally adopted child or child placed with you for adoption;
  - Stepchild;
  - Foster child for whom you have legal custody;
  - Your incapacitated child(ren), who is incapable of self-sustaining employment by reason of mental or physical handicap, regardless of age, provided that such incapacity commenced prior to 26 years of age;
  - Child(ren) for whom you are mandated to provide benefit coverage through a Court or Administrative Order, including Qualified Medical Child Support Order (QMCSO), who are less than the 26 years of age or are 26 years of age or over and are mentally or physically disabled and incapable of self-sustaining employment, provided that such disability occurred prior to the age at which said child otherwise would have ceased to be an Eligible Dependent under this Plan. ***(A copy of the Plan's QMCSO policies and procedures will be provided to you free of charge upon request to the Plan Administrator***.); or
  - A Child adjudicated to be a "neglected child" by Order or Decree of a court of competent jurisdiction pursuant to the laws of Mississippi and who is in the custodial care of the Employee or the Employee's spouse pursuant to the provisions of said Order or Decree, with such dependent eligibility to begin 90 days after said adjudication.

- The Child must be a resident of the same country in which the Employee resides.

- No person shall be enrolled as a Dependent of more than one Employee participating in this Plan.

- Dependent coverage is not provided for the spouse of an Employee's Child or for an Employee's grandchild, unless said grandchild qualifies as a Dependent on other grounds.

When Does Coverage for Your Dependent Stop?
Coverage for your Eligible Dependents will stop on the earliest of the following dates:

- The date the Employee's coverage ends;
- The date the person no longer qualifies as an Eligible Dependent as defined above;
- The date required contributions are not made for family coverage;
- The date the Plan is terminated or the date the Plan is amended to terminate coverage for Eligible Dependents; or
- The date specified in a QMCSO.

Upon loss of dependent coverage, you may qualify for coverage through COBRA self-payment.

DEPENDENT ELIGIBILITY RULES

How Long Will Coverage Continue for Your Eligible Dependents in the Event You Die While Covered as an Active Employee?

For Construction and Maintenance Employees, if you die while covered as an active Employee, coverage will continue for your Eligible Dependents until the last day of the calendar month for which you would have been eligible for coverage based on contributions made on your behalf for work you performed up until the date of your death, unless provisions of ERISA §609(a) or regulations pertaining to Qualified Medical Child Support Orders require a different termination date.

For Trust and Non-Bargaining Employees, if you die while covered as an active Employee, coverage for your Eligible Dependents will continue through the last day of the month for which you would have been eligible for coverage; however, if the coverage available does not provide coverage for the Dependents at least through the month following the month in which you die, the Employer will make contributions to provide coverage for said Eligible Dependents at least until the end of the month following the month of death, unless provisions of ERISA §609(a) or regulations pertaining to Qualified Medical Child Support Orders require a different termination date .

Thereafter, coverage for your surviving Eligible Dependents may be continued through self- payment under COBRA.

CONTINUATION OF HEALTH COVERAGE (COBRA)

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. This section 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.

What is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." 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.

Qualifying Events

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."

CONTINUATION OF HEALTH COVERAGE (COBRA)

Providing Notice to the Plan Administrator of a COBRA Qualifying Event
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), you should contact the Plan Administrator as soon as possible to confirm that the Plan Administrator has been made aware of the qualifying event.

You Must Give Notice of Some Qualifying Events Within a Specified Time Period
For 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. ***Failure to do so may cause you to lose your right to continued coverage***. You must provide this notice to the Plan Administrator, Joel Hill, at NECA-IBEW Local 480 Health & Welfare Plan, 4767 1-55 South Jackson, Mississippi, 39212. Phone: (601) 373-8434 or 1-800-424-8434. The Plan Administrator should be notified of the qualifying event within 60 days, starting from the latest of: (1) the date on which the qualifying event occurs; (2) the date on which you lose (or would lose) coverage under the plan as a result of the qualifying event; or (3) the date on which you are informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

How COBRA Coverage is Provided
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered 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 may last 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.

When COBRA Coverage Ends
In cases where the Employee and his Dependents receive COBRA coverage because of loss of eligibility in the Plan due to the Employee's termination from employment (for other than gross misconduct) or a reduction in work hours, COBRA coverage will end on the earliest of the following dates:

- The date the Participant becomes covered under another group health plan (other than a governmental plan) except when the other plan contains a pre-existing condition exclusion or limitation with respect to a medical condition suffered by the Participant prior to the effective date of coverage under the new plan;

- The date the Participant becomes entitled to Medicare coverage;
- The first day of the month for which the Participant fails to make timely COBRA premium payments to the Plan;
- Eighteen (18) months from the date coverage would otherwise have ended had the continuation of coverage option not been available;
- The date upon which your Employer no longer provides group health insurance to any of its Employees; or
- The date the Plan is terminated.

In cases where COBRA coverage is provided to a Dependent Child who no longer meets the definition of eligible Dependent, a divorced or legally separated spouse of an Employee, a surviving widowed spouse of a deceased Employee, or to the Dependents of an Employee due to his eligibility for Medicare, then such COBRA coverage shall end on the earliest of the following dates:

- The date the Participant becomes covered under another group health plan (other than a governmental plan) except when the other plan contains a pre-existing condition exclusion or limitation with respect to a medical condition suffered by the Participant prior to the effective date of coverage under the new plan;
- The date the Participant becomes entitled to Medicare coverage;
- The first day of the month for which the Participant fails to make timely COBRA premium payments to the Plan;
- Thirty-six (36) months from the date coverage would otherwise have ended had the continuation of coverage option not been available;
- The date upon which your Employer no longer provides group health insurance to any of it Employees; or
- The date the Plan is terminated.

Extension of COBRA Benefits
There are two ways in which the 18-month period of COBRA continuation coverage can be extended:

(1) 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 in a timely fashion, 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. Notice of the award of Social Security benefits must be provided to the Plan Administrator ***within 60 days*** of the date of the Social Security determination and before the end of the 18-month period of COBRA continuation coverage. Your coverage of extended COBRA benefits due to disability will end on the earliest of the following dates:

- 30 days after the last day of the month in which the Social Security Administration determines the Participant is no longer disabled; however, a Participant must report any such determination to the Plan ***within 30 days*** after the date of issuance by Social Security;
- 29 months after the date coverage would have otherwise terminated;
- The first day of the month for which the Participant fails to make timely COBRA premium payments;
- The date the Participant becomes covered under another group health plan (other than a governmental plan), except when the other plan contains a pre-existing condition exclusion or limitation with respect to a medical condition suffered by the Participant prior to the effective date of coverage under the new plan;
- The date the Participant becomes entitled to Medicare coverage;
- The date upon which your Employer no longer provides group health insurance to any of its Employees; or
- The date the Plan terminates.

(2) 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 ***within 60 days of the second qualifying event***. 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.

Important Notice Regarding Options Other Than COBRA Coverage

On March 23, 2010, the Patient Protection and Affordable Care Act, was enacted. This law is intended to provide you with additional opportunities for health insurance coverage through the Health Insurance Marketplace. This notice is intended to inform you, in a summary fashion, of opportunities that may be available to you through the Health Insurance Marketplace. As an alternative to electing COBRA coverage under your Plan, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Office, NECA-IBEW Local 480 Health arid Welfare Plan, 4767 1-55 South Jackson, Mississippi, 39212 (Phone: (601) 373-8434 or (800)424-8434). 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.)

CONTINUATION OF HEALTH COVERAGE (COBRA)

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

R. Joel Hill
P.0. Box 721119,
Byram, Mississippi 39272
or
4767 1-55 South,
Jackson, Mississippi 39212-5532
Phone: (601) 373-8434
Toll-Free: (800) 424-8434

UNIFORMED SERVICES LEAVE OF ABSENCE (USERRA)

USERRA

If you are on active duty for less than 31 days, you will continue to receive healthcare coverage as if you had remained employed, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on active duty for more than 30 days, USERRA permits you to continue medical and dental coverage for yourself and your Dependents at your own expense for up to 24 months. This continuation right operates in the same way as Continuation of Coverage (COBRA). In addition, you or your Dependent(s) may be eligible for healthcare coverage under service sponsored insurance.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from "service in the uniformed services," your full eligibility will be reinstated on the day you return to work with an Employer, provided that you return to employment within:

- 14 days from the date of discharge if the period of service was between 31 days and 180 days;
- at the beginning of the first full regularly scheduled working period following discharge (plus travel time and an additional eight hours rest period) if the period of service was less than 31 days; or
- 90 days from the date of discharge if the period of service was 181 days or more.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

You must notify the Plan Office prior to entering military service and again when you are discharged so that the Plan Office may assist you with your rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and any COBRA benefits that may be available to you and/or your Dependents.

CONTINUATION COVERAGE DURING DISABILITY

How Can Coverage be Continued During Disability?
After you become eligible, if you are unable to work because of a certified disability, you will be credited with 30 disability hours for each full week in order to maintain your eligibility. In no event will more than 390 disability hours be credited during a twelve consecutive month period.

A certified disability is one for which you submit satisfactory evidence of total disability, verified by a Physician or is a disability for which you receive Workers' Compensation benefits as a result of a disability incurred on a job for which contributions are paid on your behalf to the Plan.

You must present certified evidence of your disability in order to qualify for any disability hours. The Trustees for the Plan reserve the right to require you to submit to one or more physical examinations by a Physician or Physicians of their choice in order to certify the nature or extent of your disability.

If you cease to be eligible for coverage during a period of disability, you may continue coverage through self-payment under COBRA.

COVERAGE UNDER FAMILY & MEDICAL LEAVE ACT (FMLA)

Leave Under The Family and Medical Leave Act of 1993 (FMLA Leave)
If your Employer has employed at least 50 Employees during 20 weeks or more of the current or preceding Calendar Year, you may be eligible to take FMLA Leave. However, if you are employed at a work site within a 75 mile radius of which your Employer does not employ at least 50 Employees, you will not qualify for leave even though the Employer's total work force is more than 50. To qualify for leave you must have been employed by the same contributing Employer for a minimum of 1,250 hours within the 12 months immediately preceding the commencement of your FMLA Leave. If you qualify for such leave, you may take up to a total of 12 work weeks of FMLA Leave during any 12-month period.

During your FMLA Leave, your Employer is required to contribute to the Fund in order to provide you medical coverage during the term of your FMLA Leave just as if you are actively at work. However, if your Employer's required contribution is insufficient to cover the full premium, you may elect either to make partial self payments (if applicable to you) or to waive coverage entirely. Please refer to the Partial Self-Pay Privileges section of this booklet for more information.

Under What Circumstances Can You Take FMLA Leave?
You may take FMLA Leave for any of the following reasons:

1. the birth and care of a newborn child;
2. for the placement of a newly adopted child or foster child;
3. for the care of your spouse, son, daughter or parent with a "serious health condition"; or
4. for your "serious health condition" that makes you unable to perform your job.

Generally, a "serious "health condition", as defined under FMLA, is an illness, injury, impairment or physical or mental condition that involves any period of incapacity or treatment in connection with Inpatient care in a Hospital, Hospice or residential medical care facility; or any period of incapacity of more than three (3) calendar days that involves the continuing treatment by a health care provider or continuing treatment by a health care provider for a chronic or long-term health condition that is incurable or so serious that if untreated will result in a period of incapacity of more than three (3) calendar days.

How Can You Take FMLA Leave?
If you are eligible for FMLA Leave, you and your Employer must file the following documents with the Plan Office:

1. The Employer for whom you are working must certify to the Plan, in accordance with the Plan's Policies and Administrative Procedures, that it is subject to FMLA and that you are eligible for FMLA Leave.

2. Your Employer must timely notify the Plan, in accordance with the Plan's Policies and Administrative Procedures, of the type and duration of your FMLA Leave requested and must timely furnish the necessary information to support your FMLA Leave. Pursuant to the Plan's Policies and Administrative Procedures, your Employer must generally notify the Plan at least 30 days before your foreseeable FMLA Leave. If unforeseen circumstances require you to take FMLA Leave, i.e. a medical emergency, your Employer must notify the Plan Office as soon as reasonably practicable.

3. You must timely notify the Plan, in accordance with the Plan's Policies and Administrative Procedures, of the type and duration of your FMLA Leave requested and timely furnish the necessary information to

COVERAGE UNDER FAMILY & MEDICAL LEAVE ACT (FMLA)

support your eligibility of FMLA Leave. Pursuant to the Plan's Policies arid Administrative Procedures, you must generally notify the Plan at least 30 days before your foreseeable FMLA Leave. If unforeseen circumstances require you to take FMLA Leave, i.e. a medical emergency, your Employer must notify the Plan Office as soon as reasonably practicable.

If you are considering taking FMLA Leave, you and your Employer should contact the Plan Office to receive a copy of the Fund's Policies and Administrative Procedures and the necessary forms to assure that you receive continued health coverage during your FMLA Leave.

What Happens When Your FMLA Leave Ends and You Return to Active Employment?
When you return to work after your FMLA Leave ends, you will be eligible for the same benefits that were available to you when your FMLA Leave started. You will not be required to requalify for any benefit you previously enjoyed when your FMLA Leave began.

Please contact the Plan Office to notify them of your anticipated date of your return to active employment from your FMLA Leave.

RECIPROCITY AND PARTIAL SELF-PAY

Reciprocity: What Happens if You Work in an Area Covered by Another Electrical Worker's Welfare Plan?

The Trustees reserve the right to create reciprocity and exchange of contributions with other Electrical Workers Welfare Funds so that if you are working in an area covered by another Plan, you may still have contributions made on your behalf to this Fund. These arrangements adopted pursuant to the Electrical Industry Health & Welfare Reciprocal Agreement, also allow electrical workers covered by another Plan who are working in this Plan's jurisdiction to have their contributions transferred back to their Home Fund. However, this Fund does not transfer to other Funds any contributions made to this Fund to cover substance abuse testing. The rules for reciprocity and exchange of contributions are determined by the Trustees. In the event you work in Covered Employment and the rate of contributions transferred on your behalf to this Fund is higher or lower than the highest rate effective in this Plan, hours will be credited towards your eligibility as follows:

Amount of Reciprocal Contributions Transferred	*Divided By*	**This Plan's Highest Hourly Rate**	*Equals*	**Hours of Work to Be Credited Toward Your Eligibility in This Plan (Rounded to the Nearest Whole Number)**

Partial Self-Pay

If you are covered as an active Employee by the Plan, but you do not work enough hours to maintain your eligibility, you may elect to self-pay the difference between the monthly Employer contributions payable on your behalf and the monthly self-pay premium rate ***if you are a Construction Employee, a Maintenance Employee or a Trust Agreement Employee who has hours banked from prior work as a Construction Employee***. Non-Bargaining Employees and Trust Agreement Employees who do not have hours banked as a result of prior work as a Construction Employee are not able to make partial self-payments, although such employees have the right to full Self-Pay under COBRA if there is a Qualifying Event. (See section on Continuation of Health Coverage (COBRA)).

However, if you are a construction Employee, there is a special rule. Construction Employees must partially self-pay on a monthly basis the difference between the Employer contributions payable on their behalf for the applicable three or six month benefit period, divided by three or six, respectively.

Any self-pay options will run concurrently with COBRA time allowances. After self-pay, coverage can be continued for the remainder of the applicable COBRA time allowance through payment of the COBRA premium. Self-pay cannot be accepted to establish initial eligibility or reinstated eligibility.

EXTENDED SELF-PAY FOR CERTAIN RETIRED OR DISABLED EMPLOYEES

Extended Self-Pay Rules for Certain Retired or Disabled Bargaining Unit Employees

For Employees Who Retire With an Early or Normal Pension:
If you retire you will be eligible to self-pay for yourself and your Eligible Dependents beyond the eighteen month COBRA period provided that:

- You have attained age 60 and have been awarded an early or normal retirement pension from the IBEW Local 480 Pension Plan or the National Electrical Benefit Pension Fund (NEBF), or you are receiving Social Security benefits; and

- On the annuity starting date of your pension (as defined by the applicable pension plan) or the effective date of your social security benefits you are covered under this Plan and have been so covered for a period of at least 20 consecutive eligibility quarters.

For Bargaining Unit Disability Retirees:
If you retire due to a disability, you will be eligible to self-pay for yourself and your Eligible Dependents beyond the eighteen month COBRA period provided that:

- You have been awarded a disability pension from the IBEW Local 480 Pension Plan or the National Electrical Benefit Pension Fund (NEBF), or you are receiving Social Security Disability benefits; and

- On the annuity starting date of your disability pension (as defined by the applicable pension plan) or the effective date of your Social Security Award if you are covered under the Plan and have been so covered for a period of at least eight (8) consecutive eligibility quarters; and

- You are Totally and Permanently Disabled to the extent you are unable to perform the normal activities of your occupation, or any other gainful employment.

The Board of Trustees reserves the right to require you to submit to an examination by a Physician of its choice and additionally may require you to submit to reexamination periodically in order to determine your continued eligibility to self-pay in accordance with this provision of the Plan. You will not be eligible to self-pay as a disabled Employee if you are gainfully employed in any manner.

As an early, normal or disabled bargaining unit retiree, you may continue to self-pay on yourself and your Eligible Dependents until the earliest of the following dates:

- The first day of the calendar month for which you fail to pay the required premiums. Monthly premium payments must be received by the Plan Office by the first working day of the month. **There is no 30 day grace period for payment of premiums;** or

- The date you and your spouse become eligible for Medicare or for coverage under another group health plan, at which time all coverage provided under this Plan for you, your spouse and any other Eligible Dependents will cease.

However, if you become eligible for Medicare, but not your spouse, then your spouse and any of your other then Eligible Dependents not covered under another group health plan or Medicare may continue coverage on a self-pay

basis until your spouse becomes eligible for Medicare or under another group health plan, after which all coverage provided under this Plan for your spouse and any Dependents will cease; or

- If your spouse becomes eligible for Medicare or under another group health plan, but you do not, then you may continue coverage on a self-pay basis for yourself and any other Eligible Dependents not covered under another group health plan or Medicare until you yourself become eligible for Medicare or under another group health plan, after which all coverage provided under this Plan for you and any Dependents will cease; or

- Sixty (60) months from the date your eligibility would have otherwise terminated under this Plan in the absence of COBRA continuation and the special self-pay rules for bargaining unit retirees. This 60 month period includes any months for which you may have self-paid for COBRA coverage prior to retirement. After the 60 month period is exhausted, neither you nor any of your Dependents will be eligible to continue coverage by self-paying.

In the event you die while self-paying as a bargaining unit retiree or disabled Employee, then your surviving spouse and any of your other Eligible Dependents may self-pay until the earliest of the following dates:

- The last day of the calendar month for which your surviving spouse makes timely self-payments. Monthly payments must be received by the Plan Office by the first working day of the month. **There is no 30 day grace period for payment of contributions; or**

- The date your surviving spouse becomes eligible for Medicare or covered under another group health plan; or

- Sixty (60) months from the date your eligibility would have otherwise terminated under this Plan, had you survived, in the absence of COBRA continuation and the special self-pay rules for bargaining unit retirees. This 60 month period includes any months for which you may have self-paid for COBRA coverage prior to your retirement.

Surviving Dependent Children are eligible for continued coverage only if your surviving spouse remains eligible and covered under the Plan.

In order for Bargaining Unit Retirees or Surviving Spouses to elect this special extended period of self pay, written application to the Plan Administrator must be made ***no later than five days prior to the date self-pay coverage would otherwise end***.

The monthly self-payment amount will be determined by the Board of Trustees, but will not exceed the actual cost of the group health coverage plus any additional administrative costs.

DEFINITIONS

Accident or Accidental Bodily Injury
The term "Accident" or "Accidental Bodily Injury" means a non-occupational accidental bodily injury which requires treatment by a Physician. It must result in loss, while eligible under the Plan, independently of Sickness and other causes.

Active Work
The term "Active Work" and "Actively at Work" means the actual expenditure of time and energy by the Employee, performing each and every duty pertaining to his job in the place where and the manner in which such job is normally performed.

Beneficiary
The term "Beneficiary" means a person designated by a Participant, or by the terms of the Health and Welfare Plan who is or may become entitled to a benefit thereunder.

Benefit Month(s)
The term "Benefit Month(s)" means the period of the Employee's eligibility for benefits--not the period in which the Employee works to become or remain eligible.

Calendar Year
The term "Calendar Year" means the twelve (12) month period beginning January 1 and ending December 31.

Covered Employment
"Covered Employment" means employment of an Employee for which an Employer is obligated to make contributions to the Health and Welfare Plan.

Custodial Care
The term "Custodial Care" means the care which consists of services and supplies, including room and board and other institutional services, furnished to an individual primarily to assist him in activities of daily living, whether or not he is disabled. These services and supplies are Custodial Care regardless of the practitioner or provider who prescribed, recommended or performed them.

Disabled
A person who is "Disabled" means, because of Sickness or injury:

a. As to an Employee, the person is prevented because of a disease, Illness, accident or injury from engaging in his or her regular or customary occupation.

b. As to a Dependent, the person is prevented because of a disease, Illness, accident or injury from engaging in substantially all the normal activities of a person of like age in good health and/or is unable to perform the duties of his or her regular or customary occupation.

Eligible Dependents
The term "Eligible Dependent" means:

a. Employee's legal spouse, provided they are not legally separated;
b. Your child(ren) up to the age of 26 who are either a:
    - Natural child;
    - Legally adopted child or child placed with you for adoption;

- Stepchild;
- Foster child for whom you have legal custody;
- Your incapacitated child(ren), who is incapable of self-sustaining employment by reason of mental or physical handicap, regardless of age, provided that such incapacity commenced prior to 26 years of age;
- Child(ren) for whom you are mandated to provide benefit coverage through a Court or Administrative Order, including Qualified Medical Child Support Order (QMCSO), who are less than the 26 years of age or are 26 years of age or over and are mentally or physically disabled and incapable of self-sustaining employment, provided that such disability occurred prior to the age at which said child otherwise would have ceased to be an Eligible Dependent under this Plan. ***(A copy of the Plan's QMCSO policies and procedures will be provided to you free of charge upon request to the Plan Administrator***.); or
- A Child adjudicated to be a "neglected child" by Order or Decree of a court of competent jurisdiction pursuant to the laws of Mississippi and who is in the custodial care of the Employee or the Employee's spouse pursuant to the provisions of said Order or Decree, with such dependent eligibility to begin 90 days after said adjudication.

Employee
The term "Employee" means the following:

TRUST AGREEMENT EMPLOYEES. This category includes employees of the Union, the Central Mississippi Chapter of NECA and related apprenticeship funds.

CONSTRUCTION EMPLOYEES AND ELECTRICAL EMPLOYEES EMPLOYED OUTSIDE THE UNION'S GEOGRAPHICAL JURISDICTION. This category generally includes Employees whose Employer makes contributions to the Plan under the current Collective Bargaining Agreements.

MAINTENANCE EMPLOYEES. This category includes employees covered under the Maintenance Agreement with the Delphi Division of General Motors.

NON-BARGAINING UNIT EMPLOYEES. This category includes non-bargaining unit Employees whose Employer participates in the Plan and makes contributions on your behalf by approval of the Plan's Board of Trustees.

Employer
The term "Employer" means an or a:

a. Employer who is a member of, or is represented in collective bargaining by an Association and who is bound by a Collective Bargaining Agreement with the Local Union providing for the making of payments to the N.E.C.A.-I.B.E.W. Local 480 Health & Welfare Plan with respect to Employees represented by the Union.

b. Union, which, for the purpose of making the required contributions into the Trust Fund, shall be considered as the Employer of the salaried officers and/or Employees of the Union or Joint Apprenticeship and Training Program of the Unions who contribute to the Trust Fund.

c. Central Mississippi Chapter of the National Electrical Contractors Association (NECA).

d. Employer who, while not generally recognizing the Union as the representative of its Employees, is bound to make contributions on behalf of certain of its Employees.

e. Association of one or more Employers which have Collective Bargaining Agreements with at least one of the Electrical Workers Local Unions having jurisdiction over the Employer's work.

f. The Board of Trustees of the N.E.C.A.-I.B.E.W. Local 480 Health & Welfare Plan, who, with the consent and approval of the Trustees, shall make like payments or contributions to the Trust Fund on behalf of the Employees of the Trust Fund.

g. Employers who are original parties to this Agreement Declaration, or as described in this Section, shall, by the making of payments to the Trust Fund pursuant to such collective bargaining or other written agreements, be deemed to have accepted and be bound by the Trust Agreement.

Expense Incurred or Eligible Charges
An expense will be considered to be incurred at the time the service or the supply is provided for services and supplies. Eligible Charges are those provided by this Plan and the lesser of the Usual and Customary Charges or the PPO Negotiated Charges.

Employer Contributions
The term "Contribution" means payments required of any Employer by a Collective Bargaining Agreement or other such agreement to this Plan.

ERISA
The Employee Retirement Income Security Act of 1974, as amended.

Health and Welfare Plan or Plan
The term "Health and Welfare Plan" or "Plan" means this NECA-IBEW Local 480 Health & Welfare Fund and Trust and the Plan documents governing the eligibility of Employees and Dependents and the benefits to be provided, as the Plan may from time to time be amended.

Hospital
The term "Hospital" shall mean a legally operating institution which:

a. Makes charges for, and is engaged primarily in, providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense which is an institution operating in accordance with the law of the jurisdiction in which it is located pertaining to institutions identified as Hospitals; Is primarily engaged in providing diagnosis, treatment and care of sick persons by or under the supervision of a staff of Physicians or surgeons for compensation from its patients and on an inpatient basis; Maintains facilities on the premises for major operative surgery.
b. Maintains clinical records on all patients; and
c. Has Bylaws in effect with respect to its staff or Physicians; and
d. Provides 24 hour nursing services rendered or supervised by a registered nurse; and
e. Is licensed pursuant to any state or any agent of the state which is authorized to license Hospitals.

Unless specifically provided, the term "Hospital" shall not include any institution or part of any institution which furnishes services or treatment principally as a rest or custodial facility, nursing facility,

convalescent facility, facility for treatment of alcoholism or substance abuse or facility for the aged, a school, or any institution that makes a charge that the eligible Employee is not required to pay.

Hospice
The term "Hospice" means a licensed facility or program whose primary purpose is to provide counseling, medical services and sometimes room and board to terminally ill persons who have less than six (6) months to live. It must provide 24-hour service, be supervised by a Physician and have a registered nurse on staff. It must provide counseling by a licensed social worker and a licensed pastoral counselor.

Individual
An "Individual" means the Employee and/or his Dependents.

Inpatient or Bed Patient
The term "Inpatient" or "Bed Patient" means a person who is a resident patient using and being charged for the Room and Board facilities of a Hospital for a full day.

Joint Apprenticeship and Training Committee
The term "Joint Apprenticeship and Training Committee" means an apprenticeship or training program sponsored by an Employer and Union participating in the Plan.

Medically Necessary

The term "Medically Necessary" shall mean service, supplies or treatment provided to a Participant which the Trustees, in their sole discretion, shall determine are:

a. Appropriate and consistent with the diagnosis and which in accordance with accepted medical standards could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

b. Not primarily custodial care.

This definition of "Medically Necessary" may differ from that of either the patient or the patient's providers and shall be utilized solely by the Trustees to determine coverage of a particular procedure under the Plan; it shall by no means be utilized or interpreted as indicating or proscribing a Physician's or a Hospital's treatment of a Participant.

The Trustees are authorized to employ such utilization review and large claims management services as they deem fit and appropriate to protect and benefit the Plan.

Medically necessary services are:

- consistent with the symptom or diagnosis and treatment of the patient's illness or injury;
- appropriate with regard to standards of good medical practice and recognized by an established medical society in the United States;
- not considered Experimental by an established medical society in the United States;

- not solely for the patient's convenience or that of his Physician of the facility at which the patient receives treatment; and

- specifically allowed by the licensing statutes that apply to the provider who renders the service.

Mental and Nervous Disorder
The terms "Mental and Nervous Disorder", "Mental Illness", and "Nervous Disorder" means all conditions symptomatic of or which necessitate treatment for the diagnostic categories of disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Third Edition, and any subsequent supplements and Editions thereto, excluding all proposed diagnostic categories identified therein as necessitating further study.

N.E.C.A.
N.E.C.A., means the National Electrical Contractors Association, Central Mississippi Chapter.

Network (PPO)
The term "Network" means a Preferred Provider Organization (PPO) or similar organization with which the Plan has contracted to provide Health Care Services to the Plan and its Participants.

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

Outpatient
The term "Outpatient" means a person receiving services or treatment for care of sickness or injury in a Hospital who is not defined as an Inpatient.

Outpatient Hospital or Ambulatory Surgical Facility
A facility which is part of a Hospital or a separate independent surgical facility which provides surgical procedures for Participants as Outpatients.

Participant
The term 'Participant" means any Employee or former Employee of an Employer who is or may become eligible to receive a benefit under this Plan. The term "Participant" shall not include any Employee or former Employee who has not been credited with the required number of hours of Covered Employment in a specified period, under the eligibility rules established by the Trustees.

Physician

The term "Physician" shall include with respect to any particular medical care and services, any holder, including any Physician's Assistant or Nurse Practitioner, of a certificate or license authorizing such holder or licensee to perform the particular medical or surgical services. Notwithstanding the foregoing, licensed chiropractors, licensed ophthalmologists, licensed nurse-midwives (with respect to maternity care), Nurse Practitioners and Physician Assistants are included in the definition of a Physician when performing covered services.

PPO
"PPO" refers to any Preferred Provider Organization or similar organization with which the Plan has contracted to provide Health Care Services to the Plan and its Participants.

DEFINITIONS

Primary Care Physician
"Primary Care Physician" means a General Practitioner, Internist, Pediatrician, or OB/GYN.

Qualified Medical Child Support Order (QMCSO)
A court order or decree issued by a court of competent jurisdiction, that falls within the meaning under federal law that names a Child/ren as an "Alternate Recipient" of benefits under the Plan.

Room and Board
The term "Room and Board" includes all of the charges commonly made by a Hospital on its own behalf for room and meals and for all general services and activities essential to the care of Bed Patients.

Sickness
The term "Sickness" or "Illness" means a non-occupational disease, disorder or condition which requires treatment by a Physician. It includes both childbirth and pregnancy.

Totally and Permanently Disabled
A person who is Totally and Permanently Disabled means because of Sickness or Injury:

a. the Employee is completely and continuously unable to perform the material and substantial duties of any job for which he is qualified; or

b. the Dependent is completely and continuously unable to perform the normal activities of a person of the same age and sex.

Union or Local Union
The term "Union" or "Local Union" means the International Brotherhood of Electrical Workers Locals 480 and 917. The term may also include such other unions which have a Collective Bargaining Agreement with an Employer, or Association, where the Union and Employer may from time to time be accepted to participate and become party to this Trust Agreement under such terms and conditions as may be required by the Trustees.

Urgent Care
A claim involving Urgent Care is any claim for medical care or treatment which could seriously jeopardize the Employee's life or health or their ability to regain maximum function or in the opinion of a Physician with knowledge of the Employee's medical condition, would subject the Employee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Usual and Customary Charges (UC)
The term "Usual and Customary" or "UC" refers to those charges made in the location at which the service is provided for services or supplies essential to the care of the Participant which, according to standards and limits adopted by the Trustees, are:

a. The most consistent charge by the Physician, Dentist or other provider for a given procedure;
b. The usual fee for a procedure by the majority of Physicians, Dentists or other provider with similar training and experience within the same locality; and
c. Reasonable when such charges meet the criteria in (a) and (b) or when, in the judgment of the Trustees, they merit special consideration based upon the complexity of treatment.

DEFINITIONS

If you incur a charge for a medical service or supply that is in excess of what the Plan considers to be Usual and Customary, you will have to pay the excess amount.

Additional terms not listed above are defined in the Plan Document. You can obtain a copy of the Plan Document by contacting the Plan Administrator.

CLAIMS REVIEW AND APPEAL PROCEDURES

HOW TO FILE A CLAIM

Once you become eligible, this Plan has the responsibility for assuring that you receive all the benefits to which you are entitled. In order to receive these benefits as quickly as possible, you must also assume some responsibility.

Claims for benefit payments payable by the Plan shall be filed on a claim form provided by the Trustees. Claim forms may be obtained from the Plan Office and must be completed and filed for processing and payment with the Trustees or the third party claims processor.

Written proof of loss under the coverage upon which the claim is based shall be furnished to the Plan Office within ninety (90) days after the date of service. However, failure to furnish such proof within the required time shall not invalidate or reduce the claim in the event the Trustees determine it was not reasonably possible to furnish proof of loss within that time, provided such proof was furnished as soon as reasonably possible thereafter. In no event, however, shall the Trustees accept proof of loss nor shall a claim be payable after the passage of one (1) year from the date the claim was incurred.

In the event you knowingly make false statements on any document which is the basis for the Plan's payment of claims, the Trustees shall have the authority to deny payment of the claim and/or to secure reimbursement from you, or from any other third party to whom payment was made on your behalf, of any overpayment of erroneous payment previously made. In addition, the Trustees shall have the authority to declare you ineligible for coverage under the Plan for a period not to exceed four (4) consecutive quarters.

If you have any questions about any claim payment, contact the Plan Administrator for an explanation as to how your claim was processed. However, you may wish to follow the Claims Appeal Procedure outlined in the following section.

Deadline for Filing Claims
Within 90 days after the date you incur any eligible expenses you should get a claim form from the Fund Office or the Plan Administrator and submit it, along with required proof, for payment. **In no event will benefits be payable if a claim form is submitted after 12 months from the date on which the expenses were incurred.**

It is important for you to know the Plan Office personnel are always available to assist you with matters concerning your eligibility or the way in which your claim was handled. You are invited to contact them to discuss your problem.

INITIAL CLAIM DETERMINATION

Pursuant to federal law, the Plan recognizes four basic types of health care claims:

1. Urgent Care - An urgent care claim is a claim for medical care or treatment that if non-urgent care determination time periods were applied, (a) could seriously jeopardize the life or health of the Patient or the ability to regain maximum function or (b) in the opinion of a Physician with knowledge of the patient's condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment for which approval is sought.

2. Pre-Service - A pre-service claim is a claim for any benefit under this Plan which requires in whole or in part approval of benefits before obtaining medical care.

3. Post-Service - A post-service claim is any claim for Plan benefits that is not an Urgent or Pre-Service claim. When you file a post-service claim, you have already received the service.

4. Concurrent - A concurrent care claim is a claim that is reconsidered after it is initially approved (such as recertification of the number of days for a Hospital confinement) and the reconsideration results in either (a) reduced benefits; or (b) a termination of benefits.

Information to be provided upon denial of a claim:

1. If a claim is denied or partly denied, you will be notified in writing within a reasonable period of time after receipt of the claim by the Trustees, and given an opportunity to appeal the denial. You may also request a written statement explaining any other action of the Trustees about which you feel aggrieved, such as denial of eligibility, and may request clarification of any benefit to which you believe you may be entitled.

2. The written denial will give: (a) specific reason(s) for denial or other action, (b) a reference to the specific Plan provision(s) on which the denial or other action is based, (c) a description of any additional material or information necessary to perfect the claim or other request and the reason why such material or information is needed, (d) a copy of the Plan's appeal procedures, (e) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) if claimant files an appeal and there is an adverse determination on that appeal, (f) if an internal rule, guideline, protocol or similar criterion was relied upon in making the determination, either a copy of the specific rule, guideline, protocol or criterion, or a statement that it was relied upon and that a copy will be provided free of charge upon request, (g) if the determination is based on Medical Necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the Plan to the claimant's medical circumstances, or a statement confirming that a copy of such scientific or clinical judgment will be provided free of charge upon request.

3. If your claim or other grievance is not acted on within the time period described in the Review Procedure below, from the date it is received by the Administrator (or within the additional days permitted, if you are notified in writing before the first time period expires that special, stated circumstances require extra time), you may proceed to the appeal stage described below, as if the claim or other request had been denied.

4. Initial review procedure: The Plan shall notify you of the Plan's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours of the Plan's receipt of the claim for Urgent Care claims, 15 days for Pre-Service claims, 30 days for Post-Service claims and 45 days for Disability Claims, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify you as soon as possible, but not later than twenty-four (24) hours for Urgent Care claims, 15 days for Pre-Service claims, 30 days for Post-Service claims, and *45* days for Disability Claims after the Plan's receipt of the claim, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours for Urgent Care claims, *45* days for Pre-Service, Post-Service and Disability claims, to provide the specified information. While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify a Participant of the reconsideration of a concurrent claim. However, the Plan will notify a Participant as soon as possible and in time to allow the Participant to have an appeal decided before

the benefit is reduced or terminated. The Plan shall notify you of the Plan's benefit determination as soon as possible, but in no case later than the end of the period afforded to you to provide the specified additional information. By law the Plan must give you written notice within specific time frames if an extension of time is needed to process any claim. These time periods for initial claim determinations are set forth in the chart below:

THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	**Urgent Health Care Claim**	**Pre-Service Health Care Claim (Non-Urgent)**	**Post-Service Health Care Claim**	**Disability Claim**
To make initial claim Determination (either Approve or deny claim)	72 hours (depending on medical circumstances)	15 days (depending on medical circumstances)	30 days (sooner if reasonable)	45 days
To obtain extension of time (if proper Notice given to claimant and delay is beyond Plan control)	None	15 days to notify claimant of extension (of up to 15 days)	30 days to notify claimant of extension (of up to 15 days)	45 days to notify claimant of extension (two extensions of up to 30 days each)
To request missing information from claimant (from receipt of claim by Plan)	24 hours	15 days	30 days	45 days
For claimant to provide missing information (after Plan request)	48 hours	45 days	45 days	45 days

In order to expedite urgent care, pre-service and concurrent claims, Participants should contact the pre-certification company directly at the telephone number on the medical benefit identification card.

Death Claims: The Plan will provide written notice of a decision on a death claim (or the need for an extension of time) within 90 days after receipt of the claim. If an extension is needed, the notice will state any 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.

CLAIMS REVIEW AND APPEAL PROCEDURES

APPEALING THE INITIAL CLAIM DETERMINATION

ERISA requires that the following formal claims appeal procedures be set forth herein for your reference in the event you wish to employ this type of procedure.

Where there has been an adverse benefit determination, you have the right to file an appeal with the Plan regarding any denial of benefits or the amount of benefits paid. The procedures for filing such an appeal are described below. **You must file an appeal with the Plan using these procedures before you file suit against the Plan in court.**

Within 180 days after receipt of the initial determination, you or your representative may make a written request for an appeal to the Board of Trustees, N.E.C.A - I.B.E.W. Local 480 Health and Welfare Plan. For urgent claims, the appeal may be made orally. Oral appeals may be recorded. You may notify the Plan that a representative is authorized to act on your behalf with regard to the appeal. If you fail to make a timely request for review, the initial decision on the claim shall be final. If a timely request for review is made, you may submit written comments, documents, records and other information relating to the claim, specifically stating why you disagree with the initial determination. You may submit any documentation which you think is relevant to your appeal. You may also obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information "relevant" to your claim, and, for disability benefits, identification of any medical or vocational experts whose advice was obtained by the Plan. A document, record or other information is "relevant" to the claim if:

a. it was either relied upon in making the determination or it was submitted, considered or generated in the course of making the determination; or

b. it relates to administrative processes and safeguards used to ensure and verify that claim determinations are consistent with the Plan and consistently applied with respect to similarly situated claimants; or

c. in the case of disability benefits it is a statement of Plan policy or guidance concerning the denied benefit without regard to whether it was relied upon.

In the case of a failure by you or your authorized representative to follow the Plan's procedures for filing a Pre-Service claim, you or your representative shall be notified of the failure and the proper procedures to be followed in filing the claim for benefits. This notification shall be provided to you or your authorized representative, as appropriate, as soon as possible, but not later than 5 days (24-hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by you or your representative. **This paragraph shall only apply to communications by you or your representative that is received by a person or organizational unit customarily responsible for handling benefit matters and is a communication that names you specifically, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.**

With regard to a claim for disability benefits, no deference shall be given to the initial determination. If the initial determination is based in whole or part on a medical judgment, the individual(s) deciding the appeal shall consult

with a health care professional, with appropriate medical training and experience, who was not consulted in connection with the initial determination and who is not a subordinate of any individual who was consulted.

A decision on appeal shall be made as soon as reasonably possible after the request for appeal is received. The Plan shall attempt to make a determination within 72 hours (depending on medical circumstances) with regard to Urgent Health Care Claims and within 30 days with regard to Pre-Service Health Care Claims. With regard to Post-Service Health Care Claims and Disability Claims, the Plan will consider the appeal at the next quarterly meeting of the Plan's Board of Trustees (or 2nd quarterly meeting if the appeal is filed within 30 days of the next Board of Trustees meeting). The Plan has the right to notify the appealing party if more time is needed to consider the appeal and the Plan may obtain an extension of one meeting if it notifies the Claimant before the next scheduled meeting. These time limits are set forth in the chart below:

THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	Urgent Health Care Claim	Pre-Service Health Care Claim	Post-Service Health Care Claim	Disability Claim
For claimant to request appeal	180 days	180 days	180 days	180 days
To make determination on appeal	72 hours (depending on medical circumstances)	30 days	Next quarterly Trustees meeting after appeal filed (or 2nd quarterly meeting if filed within 30 days of meeting) Claimant to be notified within 5 days of Plan decision.	Next quarterly Trustees meeting after appeal filed (or 2nd quarterly meeting if filed within 30 days of meeting) Claimant to be notified within 5 days of Plan decision.
To obtain extension of time (if proper notice given to Claimant and delay is due to special circumstances)	None	None	Plan may obtain an extension of one meeting if Plan notifies Claimant before next scheduled meeting.	Plan may obtain an extension of one meeting if Plan notifies Claimant before next scheduled meeting

The decision on appeal shall be in writing and shall set forth the following information:

a. the specific reasons for the decision on appeal;

b. a reference to the specific Plan provisions on which the determination is based; and

c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information "relevant" to the claim and a statement of the claimant's right to bring an action under ERISA Section 5029(a).

d. Additionally, for health care claims, the notice will include:

1. If an internal rule, guideline, protocol or other similar criteria was relied upon in making the adverse

determination, either the specific rule, guideline, protocol, or other similar criteria will be provided to the claimant free of charge upon request;

2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the Plan will provide an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or will provide a copy of such explanation to the claimant free of charge upon request; and

3. The claimant will be notified of the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State Insurance regulatory agency."

Appeal of Initial Determination on Death Claim: Appeals of Death Claim determinations must be submitted within ***60 days*** of the date of the initial determination on the claim.

Subject to the stated purposes of the Trust Fund and the provisions of this Plan, the Trustees shall have full and exclusive authority and discretion to determine all questions of coverage and eligibility under the Trust, the Plan, and all associated documents, including the power and discretion to construe disputed, doubtful, or ambiguous terms, and to determine all methods of providing and arranging for benefits and all other related matters. They shall also have sole authority and full power and discretion to interpret and construe the provisions of the Plan of Benefits and the Agreement and Declaration of Trust as adopted, amended, and rewritten from time to time and all the terms used therein, including any disputed, doubtful or ambiguous terms. Any such determination, interpretation, or construction adopted by the Trustees in good faith shall be conclusive and binding upon all of the parties hereto, including without limitation the Employers participating in the Plan and the Trust, the Union, the Plan, its Participants and Beneficiaries.

Optional Arbitration: If a claim is denied on appeal, you have the option to have the matter settled by arbitration in accordance with the Employee Benefit Plan Claims Arbitration Rules of the American Arbitration Association instead of filing a lawsuit. You may only request arbitration after you have exhausted your right to appeal as set forth above. If you choose this option, you or your representative must make a written request for arbitration to the Board of Trustees, N.E.C.A.-I.B.E.W. Local 480 Health and Welfare Plan at the Fund Office address provided in this book. The impartial arbitrator will decide your claim based on the same legal standards and precedents which would be considered in a court of law. The decision of the arbitrator shall be final and binding on all parties, and judgment of the arbitrator's award may be entered in any court of competent jurisdiction. The Plan Administrator will provide you with any additional information you may need in order to decide if you want to request optional arbitration.

OTHER IMPORTANT INFORMATION

Amendment and Termination

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Participants, the Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time on a non-discriminatory basis:

A. to terminate or amend either the amount or condition with respect to any benefits even though such termination or amendment affects claims which have already accrued;
B. to alter or postpone the method of payment of any benefit; and
C. to amend or rescind any other provisions of the Plan's Rules and Regulations and Summary Plan Description.

Circumstances under which the Plan may be terminated include, but are not limited to:

A. When there are no longer sufficient assets to continue the benefits of the Plan. In this regard, the Board of Trustees will first attempt to amend the Plan's benefits, alter or postpone the method of paying benefits or take other actions consistent with its obligation to maintain the maximum possible benefits within the limits of the Plan's resources;
B. When there are no longer any Employers who are required to make contributions under the appropriate Collective Bargaining Agreement or other written agreement;
C. When the last surviving Participant or Beneficiary entitled to receive benefits has died;
D. With respect to a particular Employer, when that Employer ceases to be a contributing Employer according to the Plan's Trust Agreement; or
E. With respect to a particular Employee, when that Employee ceases to be an eligible Employee according to the Plan's Rules and Regulations.

If the Plan were to terminate, the Board of Trustees shall, within the limits of the Plan's resources, implement procedures to discharge all outstanding obligations and to provide that all remaining Plan assets be used in a manner which best carries out the basic purpose for which the plan was established.

Subrogation

If you and/or your Eligible Dependent accrue a cause of action against a third party that would otherwise be non-covered under Exclusion (1) of the "Exclusions Not Covered by the Plan" section, and the third party disclaims liability for payment of your claim, the Trustees may, at their sole discretion, elect not to apply the Exclusion, if, to the extent of the Plan's payment, you and/or your Eligible Dependent agree to reimburse the Plan in the event you recover from the third party for any of the following claims, if the total amount of medical expenses incurred exceeds $300 per illness and/or injury:

1. Any claim or cause or action which may accrue because of the alleged negligent conduct of any third party and/or his insurers, including any claim against you or your Eligible Dependent's own insurer arising under the Uninsured Motorists Coverage provisions of a Policy of Insurance;
2. A Homeowner's Policy issued to you or your Eligible Dependent;
3. Any claim or cause of action which may accrue because of an event giving rise to a claim under the Workers' Compensation or liability laws of any state or of the United States; and
4. Any claim or cause of action which may accrue because of an event giving rise to a claim under the Products Liability laws of any state.

In the event the Trustees elect to waive the exclusion, the Plan will make payment of any such claims only if you and/or your Eligible Dependent certify that you have not yet received payment from any other source, that you or

your Eligible Dependent's Workers' Compensation claim or any other claim assertable against a third party is being disputed, that the Employer or other tortfeasor and/or his insurer are withholding payment pending resolution of that dispute, and only if you and your Eligible Dependent sign a written Subrogation, Assignment & Reimbursement Agreement, along with your attorney, providing the following:

1. To reimburse the Fund out of the proceeds of any recovery received from any third party, including you or your Eligible Dependent's own Uninsured Motorist Insurer, whether by way of litigation, settlement or otherwise;
2. To reimburse the Fund from any gross amount recovered by you or your Eligible Dependent, before any payment of attorneys' fees and costs by you or your Eligible Dependent, whether the Employee or his Dependent has been or would have been made whole by the amounts received from a third party or parties;
3. To provide to the Fund all information and documents necessary and reasonable, in the Trustees' sole discretion, and to otherwise assist the Trustees in recovering all amounts paid out by the Fund that are subject to the Agreement;
4. To execute and deliver all necessary instruments as the Fund may require to facilitate the enforcement of its rights;
5. To recognize that the Fund has no obligation to pay to you, your Eligible Dependent or your attorneys any amounts expended by you in attorneys' fees and costs of litigation in pursuing their claims against others, including their own Insurers;
6. To reimburse the Fund and otherwise make the Fund whole for any and all attorneys' fees and costs expended by the Trustees and/or the Fund and Plan in pursuing litigation or other actions, in whatever forum, to enforce the terms of the Plan and/or the Subrogation, Reimbursement and Assignment Agreement executed by the claimant;
7. That no settlement of the claim will be made with nor release granted to any third party or insurer without the written consent of the Trustees; and
8. To protect the Fund's right to recovery under the Subrogation, Reimbursement and Assignment Agreement and to do nothing that would in any way prejudice these rights.

Physical Examinations
The Fund has the right and opportunity, at its own expense, to examine the person or any Individual who is the subject of any claim at all reasonable times while that claim is pending, and to make an autopsy in case of a death claim, where not forbidden by law.

Recovery of Benefits After Payment
The Fund has the right to recover any amounts it has paid out as benefits, including any overpayment, whether the payment was made in error or on any other basis, from any person to or for or with respect to whom such payments were made.

False or Erroneous Claims
The Trustees may withhold or deny payment of any claim which they reasonably believe may be based on erroneous or misstated facts or representations by any claimant or supplier of covered services or supplies, and shall have the right to recover any payments made on the basis of such false or erroneous representation.

Authority of Trustees
The Board of Trustees has full and exclusive authority and discretion to determine all questions of eligibility and coverage under the Plan and its associated documents, including the Plan document, Trust Agreement and any Rules and Regulations adopted by the Trustees. They also have the power to construe any disputed, doubtful or

ambiguous provisions contained in these documents and to determine how and which benefits are to be offered. The Trustees' determinations, interpretations and constructions are conclusive and binding upon the Fund's contributing Employers, its Participants, Employees and Beneficiaries. The Trustees have the exclusive authority, freedom and discretion to discontinue the Plan either as to all Participants or a particular class of Employees, to refuse or terminate participation of an individual Employer or Employee, if their participation may adversely impact the Fund, to change the benefits offered at any time and amend or limit the Plan, even though claims may have already accrued, and to limit benefit coverage for a particular illness or procedure in the event the Trustees determine a failure to take such action may affect the Plan's financial viability.

Law Applicable
This Plan is created and accepted in, and this Plan and its related Trust are domiciled in the State of Mississippi, and all questions pertaining to the validity or construction of the Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Mississippi, except as to matters governed by Federal law or pre-empted by Federal law. This Plan is governed by the federal Employee Retirement Income Security Act ("ERISA").

Legal Actions
No legal action may be commenced or maintained against the Plan for the Fund, or to recover any benefits under the Plan, unless the Participant (or his legal representative, if any) has first fully complied with and timely exhausted all of the application of benefits, claims review and appeal procedures under the Plan.

Assignment of Right to Defend or Bring Claims
If requested by the Plan, you will execute an assignment of your right to defend claims brought by a medical provider to recover amounts for services covered by the Plan and which amounts are in excess of the Usual and Customary Charge covered by the Plan. The assignment will be executed in a form approved by the Plan Administrator. This provision will not obligate the Plan to request such an assignment, to defend you or to take any other action but the decision whether to request such an assignment and to act on it will be at the total discretion of the Plan Administrator. By executing such an assignment at the request of the Plan, you will assign to the Plan the right to defend any claims brought by the medical provider to recover amounts which are in excess of the Usual and Customary Charge for the service(s) provided and the assignment will include the power to bring any counterclaims which you or the Plan may have against the provider for making improper or unreasonable claims for services provided or to recover benefits mistakenly paid by the Plan for unreasonable or excessive charges. The assignment will grant the Plan full Power of Attorney and total discretion to settle, compromise, prosecute or resolve legal actions as the Plan deems appropriate. Failure to execute the assignment upon request or to cooperate with the Plan in defending or asserting any claim will result in a forfeiture of coverage for any of the services at issue in the actions.

This booklet is a summary of the main features of the NECA-IBEW Local 480 Health and Welfare Plan. The benefits offered are described fully in the Plan itself. If anything has accidentally been misstated or left out of this booklet, the Plan document will govern. If you have any question about the terms of the Plan or about proper payment of benefits, please contact the Plan Office for more information. The Fund hopes to continue this Plan indefinitely but, as with all group plans, the Plan may be changed or discontinued.

Miscellaneous
Savings Clause — Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such legal finding shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of this Plan.

OTHER IMPORTANT INFORMATION

Construction — All questions of interpretation of this Plan shall be decided by the Trustees under the express authority granted to them by the Restated Agreement and Declaration of Trust as may be amended from time to time. The Trustees shall be the sole arbiter of all questions arising under or out of this Plan, including those of Plan interpretation, eligibility, and the amounts of benefits. This Plan is intended to comply with the terms and conditions of the Agreement and Declaration of Trust as may be amended from time to time. The Trustees reserve the right to amend this Plan as they deem necessary.

Gender — Except as the context may specifically require otherwise, use of masculine (feminine) gender shall be understood to include both masculine and feminine genders.

Qualified Medical Child Support Orders — Benefits shall be paid in accordance with a Qualified Medical Child Support Order as defined in Section 609 of the Employee Retirement Income Security Act of 1974 as amended (ERISA), and with written procedures adopted by the Trustees in connection with such Orders, which shall be binding on all Participants, Beneficiaries and other parties. In no event shall the existence or enforcement of a Qualified Medical Child Support Order with respect to a Participant require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to the medical child support including the exclusion of any pre-existing provision. This law is described in Section 1908 of the Social Security Act (as added by Section 13823 of the Omnibus Budget Reconciliation Act of 1993).

NOTICE OF PRIVACY PRACTICES

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

This notice is provided to you by the NECA-IBEW Local 480 Health and Welfare Plan (the "Plan") to describe how we, our Business Associates and their subcontractors may use and/or disclose your Protected Health Information ("PHI") to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice will also inform you of your rights regarding your Protected Health Information, including but not limited to gaining access to your health information, placing restrictions on the use of your health information and learning with whom we have shared your health information.

If you have any questions about this Notice, your rights or our use of your health information, please contact the Plan's Privacy Officer, R. Joel Hill, at P.O. Box 721119, Byram, MS 39272; Phone: (601)373-8434 or (800)424-8434; email jhill@ibew480.org.

Protected Health Information ("PHI") is information about the Participant, including demographic information, which may identify the Participant and which relates to past, present or future physical or mental health conditions related to health care as well as billing and payment for services. ***PHI specifically includes the Participant's genetic information as defined by the Genetic Information Nondiscrimination Act of 2008***. The term "Participant" as used throughout this notice includes not only the Employee/Participant, but also any spouse or other dependents receiving coverage through the Employee/Participant.

Federal law requires the Plan to maintain the privacy of your protected health information, to provide you with notice of its legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information.

We may change the terms of this Notice at any time and the new Notice will be effective for all PHI we maintain at the time of the revision. You are entitled to receive a copy of any revised version of this notice at any time.

In order to provide you with insurance coverage, it is necessary for the Plan to collect personal information about you from many different sources. These sources might include, among others, you, your employer, the Plan Sponsor, other insurers, third party administrators and health care providers. The law regulates how we may and may not use the Participant's medical information.

HOW WE MAY USE OR DISCLOSE THE PARTICIPANT'S HEALTH INFORMATION: We may use electronic record systems to manage your benefits and care. These electronic systems have safeguards to protect the Participant's information. We also have privacy policies and train our employees to limit the use of the Participant's information to those who need it to do their jobs. Following are ways the Plan may use the Participant's medical information:

- ***To provide care and treatment.*** We will use and disclose the Participant's PHI as allowed to provide, coordinate and manage the Participant's health care, benefits and related services. Doctors, hospitals, nurse practitioners and other people who are not employed by the Plan may share information they have about the Participant with the Plan to enable the Plan to provide and manage benefits for the Participant. Likewise, the Plan may share the Participant's PHI with healthcare providers such as doctors, hospitals, clinics, pharmacies, labs and therapists to assure the healthcare provider has the necessary information to

diagnose and treat the Participant and to see that benefits are provided under the Plan. We may also communicate with healthcare providers for other treatment-related reasons.

- ***For billing and payment.*** We may use and share the Participant's information so that those who have provided care and services to the Participant can bill and collect payment for those services. For example, we may, among other things, give or receive your information to or from a healthcare provider in order to give approval before a procedure is performed or to make sure the provider has been paid the correct amount for its services; to determine if a procedure is medically necessary; to obtain payment for any mail order pharmacy services provided to you; to conduct utilization reviews; to coordinate care; to determine eligibility; to determine formulary compliance; to collect premiums; to calculate cost-sharing amounts; and to respond to complaints and appeals.

- ***For business reasons and for health care operations.*** We may use and share your information for business reasons and to operate the Plan's health care operations. When we do this, we may, when possible, remove information that identifies the Participant. Some of the business reasons for which we may use or share the Participant's information include: to follow laws and regulations applicable to the Plan; to train and educate our staff; for Plan administration; for credentialing, licensure, certification and accreditation; to improve the services we provide; to prepare budgets and business planning; to perform audits; to maintain our computer systems; to evaluate the Plan's staff; to decide any additional services or benefits we should offer; to provide disease management for participant's with specific diseases or conditions; to provide preventative care, case management and care coordination; to administer re-insurance and stop-loss insurance; to perform underwriting; to detect and investigate fraud; to implement data and information systems management; to provide customer service; and to find out how satisfied our Participants and their families are. Anyone we share the Participant's information with in order to perform any of these tasks on our behalf must also protect the use of the Participant's medical information. When required, the Plan enters into written agreements with such people or organizations to assure the Participant's information is protected by them and their subcontractors.

- ***To contact the Participant about appointments, insurance, billing and other matters.*** We may contact the Participant by mail, phone, text or email to discuss a scheduled procedure or treatment; benefits for a procedure or treatment; billing or payment; or to discuss case management. We may leave voice messages at the number provided for such communications. We may also use and disclose medical information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

- ***For fundraising.*** Although unlikely, the Plan has the right to use limited information to contact you for fundraising purposes. You have the right to ask not to be contacted for such fundraising purposes. If we contact you, we will tell you how to prevent future contacts if you so desire.

- ***To inform family members or friends involved in your care or paying for your care.*** The Plan may share the Participant's information with family members and friends who are involved in the Participant's care or who are paying for the Participant's care, but only to the extent the information is directly relevant to such person's involvement with your care or payment for your care. For example, if a family member or caregiver calls us with prior knowledge of a claim, we may confirm whether the claim has been received and paid. When possible, the Plan will allow the Participant to tell us who is involved in the Participant's care. However, in emergency situations or other situations in which it is not possible for the Participant to provide such information, the Plan will use its best judgment and share only information that others need to know in order to see that the Participant gets the care that he or she needs. Unless you tell us not to, we may also share information about the Participant with a public or private agency during a disaster so the agency

can help contact the Participant's family or friends to tell them where the Participant is and how the Participant is doing.

- ***For research.*** Under certain circumstances, the Participant's medical information may be used or disclosed for research to improve public health and develop new knowledge. For example, a research project may involve comparing the health and recovery of patients receiving one medicine for an illness to those who received a different medicine for the same illness. We only use and share your information for research as allowed by federal and state law. Each research project is approved through a special process that balances the research needs with the patient's need for privacy. In most cases, if the research involves your care or the sharing of medical information that can identify you, we will first explain to you how the information will be used and ask for your consent to use your information. The Plan may access the Participant's medical information before the approval process to design the research project and provide the information needed for approval. Health information used to prepare a research project will not leave the Plan.

- ***As required by law.*** We will disclose the Participant's health information when required to do so by federal, state or local law. The use or disclosure will be made in compliance with the relevant law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such use or disclosure. Disclosure required by law might include responding to a court order, subpoena, warrant, summons or similar process; to identify or find a suspect, fugitive, material witness or missing person; situations in which the Participant is suspected to be a victim in a crime; disclosure because of a death we believe may have been caused by a crime; disclosure because of suspected criminal conduct; disclosure in an emergency to report a crime, the location of the crime or victims or to identify, describe or give the location of the person believed to have committed the crime; situations in which the Participant is in the custody of the police or other law enforcement officials; and situations in which the law requires us to report abuse, suspected abuse, neglect, suspected neglect, injuries to Participants, or domestic violence.

- ***For public health.*** We may use and disclose the Participant's information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Such disclosures will only be made to someone who may be able to prevent the threat such as public health authorities or other authorities with authority to collect such information. Such disclosures may be made for the purpose of preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or neglect or domestic violence, we will inform the Participant promptly unless, in our best professional judgment, we believe such notification would place the Participant at risk of serious harm or would require informing the party we believe is responsible for the abuse, neglect or harm. We may also share the Participant's information with coroners, medical examiners and funeral directors so they can carry out their duties and federal officials for national security and intelligence activities.

- ***For health oversight.*** We may disclose the Participant's medical information to a health oversight agency for activities authorized by law, such as surveys, audits, investigations and inspections. Oversight agencies seeking this information include governmental agencies that oversee the health care system, government benefits programs, licensure proceedings, other government regulatory programs and civil rights laws.

- ***Judicial and Administrative Proceedings.*** The Plan may be required by law to disclose the Participant's medical information in the course of an administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about the Participant in

response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and provide you with a chance to object to disclosure in the appropriate forum, if possible.

- ***Organ and tissue donation.*** If the Participant is an organ or tissue donor, we may disclose the Participant's medical information to organizations involved in procuring, banking or transplanting organs and tissue.

- ***Military Veterans.*** If the Participant is or was a member of the armed forces, we may release medical information as required by military command authorities. We may also release information for the purpose of determination of eligibility for veterans' benefits. We may disclose such information to a foreign military authority if the Participant is or was a member of that foreign military service for the same purposes.

- ***Workers' Compensation.*** We may disclose the Participant's medical information as authorized to comply with workers' compensation laws and other similar legally-established programs. We may make periodic reports to your employer about your condition to the extent your care is covered by workers' compensation laws. We are may also be required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

- ***Inmates or individuals in custody.*** If the Participant is an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release medical information to the correctional institution or law enforcement official. This disclosure would be if necessary: (1) for the institution to provide the Participant with health care; (2) to protect the Participant's health and safety or the health and safety of others; or (3) to protect the safety and security of the correctional institution.

- ***Breach notification.*** In the case of a breach of unsecured protected health information of the Participant, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate with you related to the breach. In some cases, our business associate may provide the notification. We may also provide notification by other appropriate methods. We may also use the Participant's medical information to provide legally required notices of unauthorized access to or disclosure of the Participant's health information to appropriate government officials as required by law.

- ***Business Associates.*** We may disclose the Participant's health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such function or services. All of our business associates are obligated by contract and by law to protect the privacy of the Participant's health information and are not allowed to use or disclose any information other than as specified in this Notice.

- ***To other covered entities such as other health plans.*** We may in certain situations disclose your information to other covered entities, such as other health care plans which provide you benefits, to coordinate your care and benefits with such other entities as allowed by law.

- ***To the Plan Sponsor.*** In certain circumstances as allowed by law, we may provide certain parts of your information to the Plan's Sponsor, but only as expressly allowed.

PERMITTED AND REQUIRED USES AND DISCLOSURES THAT REQUIRE THE PLAN TO PROVIDE YOU WITH AN OPPORTUNITY TO OBJECT TO THE USE OR DISCLOSURE

NOTICE OF PRIVACY PRACTICES

As discussed above, there are certain situations in which the Plan is allowed or required to use or disclose the Participant's health information, but in which the Plan must give the Participant an opportunity to object to such use or disclosure. Those include:

- ***Individuals involved in the Participant's care or payment for the Participant's care.*** Unless the Participant objects, the Plan may disclose to a family member or close friend or any other person the Participant identifies information directly related to that person's involvement in the Participant's care and payment for said care. If the Participant is unable to agree or object to such disclosure, we may disclose such information as necessary if we determine it is in the Participant's best interest based on our professional judgment.

- ***Disaster Relief.*** We may provide protected health information to disaster relief organizations that seek such information to coordinate the Participant's care or to notify family members and friends of the Participant's location or condition during or after a disaster. The Participant will be given an opportunity to object to such disclosure whenever we can practically do so.

- ***Disclosure of protected health information in response to legal process, subpoena or discovery in a legal proceeding.*** When practical for us to do so, we will notify the Participant or authorized representative when a Participant's protected health information is sought by a third party through legal process such as a subpoena or discovery requests. If we are informed the Participant has taken timely steps to object to such disclosure and are provided written evidence of such objection filed in the appropriate forum, we will refrain from disclosing such information until otherwise ordered by the Court or other tribunal to disclose said information notwithstanding the Participant's objection. We may also inquire from the requesting party what steps, if any, have been taken to notify the Participant of the request or to protect or limit use of the Participant's health information.

- ***For fundraising purposes.*** You will be given an opportunity to inform us you do not wish for your health information to be used for fundraising purposes.

WHEN THE PLAN MAY NOT USE OR DISCLOSE THE PARTICIPANT'S PROTECTED HEALTH INFORMATION

- ***Without your written authorization.*** Except for the permitted uses and disclosures set forth above, the Plan will not use or share the Participant's protected health information unless the Participant or authorized representative agrees to such use or disclosure in writing. Any such authorization by the Participant or authorized representative may be revoked in writing at any time. If the Plan receives such a written revocation of authorization, it will no longer use or disclose the protected health information for reasons covered by the written authorization. You should understand that the Plan is unable to take back any disclosures already made with your authorization prior to your revocation.

- ***Marketing.*** Without your written authorization, we are expressly prohibited from using or disclosing your protected health information for marketing purposes.

- ***Selling your information.*** We may not sell your health information without your written authorization.

- ***Genetic information.*** We will not use or disclose any of your protected health information that contains genetic information for underwriting purposes or any other purposes prohibited by law.

- ***Psychotherapy notes.*** We may not generally use or disclose the Participant's psychotherapy notes without written authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- ***Right to review and get a copy of your medical information.*** You have the right to look at and get a copy of your medical information, including billing records, in paper or electronic format. This information will generally be contained in a "designated record set"—medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management and other decisions. Your request to do so must be made in writing by forwarding your request to the Privacy Officer identified in this Notice. We will act on your request no later than 30 days following receipt of your request. If we need more time, we will inform of that need and provide a reason why we need the additional time. The Plan may charge a fee to cover copying, mailing and other costs and supplies as allowed by law. You may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or used in, a civil, criminal or administrative action or proceeding; protected health information restricted by law; information that is related to medical research in which you have agreed to participate; information the disclosure of which may result in harm or injury to you or another person; or information that was obtained under a promise of confidentiality. In certain cases, we may deny your request and in those cases we will give you the reason for our denial in writing. Under certain circumstances you may have a right to have our decision not to allow you to inspect or obtain a copy of certain health information reviewed. Please contact the Privacy Officer identified in this notice to ask questions about such situations.

- ***Right to ask for a change in your medical information.*** If you think our information about you is not correct or complete, you may ask us to correct your record by writing to the Privacy Officer identified in this notice. Your written request must say why you are asking for the correction. We will respond within 60 days of our receipt of your request. If we need additional time to respond, we will notify you of that need and provide a reason why the extension is needed. If we agree, we will tell you and correct or amend your record. The Plan is unable to remove anything from your record, but can only add new information to correct or complete the existing information. With your help, we will notify others who have the incorrect or incomplete medical information. If your request is denied, we will tell you why in writing. You will have a right to submit a written statement up to 250 words that tells us why you believe your information is incorrect or missing and we will add your written statement to your record and include it whenever we share the part of your record the written statement applies to. If we prepare a rebuttal to your written statement, we will provide you with a copy and may also include our rebuttal when your information is shared.

- ***Right to a list or accounting of when your medical information was shared.*** You have a right to ask for a list of when your health information was shared without your written consent. The Plan does not have to account for disclosures provided with your written authorization; for your treatment, payment or for the Plan's business operations; for notification and communication with family; related to specialized government functions or for purposes of research or public health which exclude direct patient identifiers or which are incidental to a use or disclosure otherwise permitted or authorized by law; to a health oversight agency or law enforcement official to the extent the Plan has received notice from that agency or official that providing the accounting would be reasonably likely to impede its activities; or disclosures made before April 14, 2003. You must request the accounting of disclosures in writing to the Privacy Officer identified in this notice. Your request must state the time period for which you want the list. That time period may not be longer than 6 years back from the date of your request. The first list you ask for within a 12 month period will be free, but you may be charged a fee if you request another accounting of disclosures in that same 12-month period. We will respond to your request within 60 days of our receipt of the request. If we

need more than 60 days, we will inform you of the need for an extension and provide a reason why the extension is needed.

- ***Right to notice in case of a breach.*** You have a right to be notified if there is any breach of your unsecured protected health information. If such a breach occurs, we will notify you of such breach in accordance with applicable federal law. We will also follow applicable laws in notifying governmental entities of the breach if required.

- ***Right to request restrictions or limitations on the use and sharing of your medical information.*** You have the right to request a restriction or limitation on the health information that we use for treatment, payment or health care operations. You also have the right to ask that we limit the health information we disclose to someone involved in your care or payment for your care, such as a family member or friend. For example, you may request that we not share information about a particular diagnosis or procedure with your spouse, family member or friend. To request such a restriction, you should make the request in writing to the Privacy Officer identified in this notice. Your request should specifically identify the information you wish to have restricted and the person(s) to which the restriction should apply. In certain circumstances, we may not agree to your request except for those cases in which you ask us not to disclose protected health information to another health plan when you have paid for the particular service in full out-of-pocket and are not looking to the other health plan to pay for the particular service, as set forth in the next section. Otherwise, if we agree to your request, we will comply with the request unless the disclosure is necessary to provide you with emergency treatment.

- ***Right to limit sharing of information with health plans.*** If you paid for a particular service in full out-of-pocket (in other words, you requested that the medical provider not bill us for the service), you have the right to ask that your protected health information related to that item or service not be shared or disclosed to the Plan for purposes of payment or health care operations. Your request must be honored by the medical provider. You should notify the provider of your desire to limit such information before the service is received since pre-authorization from the Plan might require the provider to share information with the Plan before the actual service is provided. We cannot prevent such information from being provided before a procedure if the provider has not received such instructions from you at that time.

- ***Right to request confidential communications.*** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular address or email account. We will comply with all reasonable requests sent in writing to the Privacy Officer identified in this notice. We will not ask you why you have requested that your communications be delivered in a specific way or to a specific location.

- ***Right to get a paper copy of this notice.*** You have a right to get a paper copy of this notice even if you have already agreed to receive it electronically. You may obtain a paper copy by contacting the Privacy Officer identified in this notice.

- ***Underwriting decisions.*** You have the right to know the reasons for an unfavorable underwriting decision. Previous underwriting decisions may not be used as the basis for future underwriting decisions unless we make an independent evaluation of the basic facts. Your genetic information cannot be used for underwriting purposes or other purposes expressly prohibited by law.

- ***Right not to be subjected pretext interviews.*** You have the right with very limited exceptions not to be subjected to pretext interviews. This Plan does not engage in pretext interviews.

- ***Right to file a complaint.*** You have the right to file a complaint regarding the use or disclosure of your protected health information. If you believe your privacy rights have been violated, you may file a complaint with the Plan's Privacy Officer identified in this Notice. You may also file a complaint with the Office of Civil Rights at the following address:

  Office of Civil Rights, Region IV
  U.S. Department of Health & Human Services
  Sam Nunn Atlanta Federal Center
  Suite 16T70
  61 Forsyth Street, S.W.
  Atlanta, GA 30303-8909

  The form of the Complaint to submit to the Office of Civil Rights can be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.

  You may not be retaliated against for filing a complaint.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

The Plan reserves the right to amend its privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required to comply with this notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted at the Plan Office and you have a right to receive a copy of the most current policy upon request from the Privacy Officer. Revisions to our Notice of Privacy Practices may also be posted on the Plan's website.

Please note that we do not destroy personal information about you when you terminate coverage with the Plan. It may be necessary to use and disclose this information for the purposes described in this Notice even after your coverage terminates; however, policies and procedures will remain in place to protect against inappropriate use or disclosure.

IF YOU HAVE ANY QUESTIONS, WANT TO MAKE A REQUEST, OR WANT TO FILE A COMPLAINT, please contact our Privacy Officer, R. Joel Hill at P.O. Box 721119, Byram, MS 39272; phone: (601)373-8434 or (800)424-8434; email: jhill@ibew480.org.

STATEMENT OF RIGHTS UNDER ERISA

As a participant in the N.E.C.A.-I.B.E.W. Local 480 Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time.

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

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. **(Note: the Plan eliminated all pre-existing condition exclusions effective January 1, 2014.)**

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 health benefit or exercising your rights under ERISA.

If your claim for a health benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal Court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen

STATEMENT OF RIGHTS UNDER ERISA

that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

INFORMATION TO HELP YOU IDENTIFY YOUR PLAN

1. The Plan is administered and maintained by the joint Board of Trustees at the following address: NECA-IBEW Local 480 Health arid Welfare Plan, 4767 1-55 South Jackson, Mississippi, 39212. Phone: (601) 373-8434.

2. The Employer Identification Number (EIN) issued to the Board of Trustees by the Internal Revenue Service is 51-0204433. The Plan Number is 501.

3. The persons designated as Agents for service of legal process are: Plan Administrator R. Joel Hill or The Board of Trustees at NECA-IBEW Local 480 Health and Welfare Plan, 4767 1-55 South, Jackson, Mississippi, 39212. Phone (601) 373-8434 or 1-800-424-8434. Service may also be made on any individual Trustee. Trustee addresses are listed in paragraph 5 below.

4. The date of the end of the year for financial experience is December 31.

5. The names and addresses of the Trustees are listed below:

EMPLOYEE TRUSTEES

Brooks E. Martin, Co-Chairman
P.O. Box 721119, Byram, MS 39272

David Henley
4801 W. Crescent Lake Dr., Meridian, MS 39301

Mike Morgan
145 Clear Branch Rd., Florence, MS 39073

Brad Wallace
872 Athens Rd., Mendenhall, MS 39114

EMPLOYER TRUSTEES

Brad Fountain, Chairman
1655 Clubhouse Rd., Utica, MS 39175

David Kelly
1479 Misty Lane, Terry, MS 39170

Glade McInnis
P.O. Box 176, Clinton, MS 39056

Mike Russum
1709 Elm St., Flowood, MS 39232

6. The Plan Administrator, Claims Administrator, PPO Provider and Pharmacy Benefits Manager may be contacted as follows:

PLAN ADMINISTRATOR
R. Joel Hill
NECA-IBEW Local 480 Health and Welfare Plan
P.O. Box 721119, Byram, Mississippi 39272 or
4767 1-55 South, Jackson, Mississippi 39212-5532
Phone: (601) 373-8434 or (800) 424-8434

CLAIMS ADMINISTRATOR
American Benefit Corporation
9200 U.S. Route 60
Ona, West Virginia 25545
Phone: (855) 445-3927
www.abcwv.com

INFORMATION TO HELP YOU IDENTIFY YOUR PLAN

PPO PROVIDER
ANTHEM BLUE CROSS BLUE SHIELD
Phone: 1-800-810-Blue
www.anthem.com

PHARMACY BENEFIT MANAGER
Sav-Rx Prescription Service
224 N. Park Ave.
Freemont, NE 68025
Phone: 1-866-233-IBEW(4239)
www.savrx.com

7. Your Plan is funded by Collective Bargaining Agreements which provide that those Employers who are parties to the agreement will make monthly contributions to the Health and Welfare Fund. When the Health and Welfare Fund receives those contributions, they are credited toward your eligibility requirements for the Welfare Plan. You may obtain a copy of any Collective Bargaining Agreements related to the Plan by requesting a copy from the Plan Administrator. You may also review a copy of the Collective Bargaining Agreements at the Plan Office or Local Union Office upon ten days' advance written notice to the Plan Administrator.

8. The NECA-IBEW Local 480 Health and Welfare Trust became effective on December 23, 1974. It authorized a welfare plan providing benefits in the event of illness or death. Your Plan was established and is administered by a Board of Trustees composed of an equal number of Trustees representing contributing Employers and the Union. The Board of Trustees has appointed a Plan Administrator to perform certain administrative services. The Fund and Plan are governed in accordance with the Fund's Agreement and Declaration of Trust as amended from time to time and in accordance with applicable federal and state laws. The Trust Agreement provides that Fund assets may be used only to provide death and medical benefits to eligible Participants and their families and administrative costs as defined in the Trust Agreement and Plan.

9. The Fund's assets and reserves are invested by the Trustees.

10. You may obtain a complete list of the Employers and Employee organizations sponsoring your Plan by submitting a written request to the Plan Administrator. You may also examine the list at your Plan Office or Local Union office upon ten days' advance written notice to the Plan Administrator. You may also receive from the Plan, upon written request to the Plan Administrator, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if so, the sponsor's address.

11. There may be a reasonable charge for the provision of certain documents, but only if allowed by law.

It is IMPORTANT that you notify the Plan Office whenever:

1. You change your home address.
2. You wish to change your Beneficiary; a new Beneficiary card must be turned into the Plan Office.
3. New Eligible Dependents are to be covered.
4. You enter or are discharged from the Armed Forces.
5. You are receiving Worker's Compensation benefits.
6. You change your marital status or change your name.
7. An injury resulting in a total and permanent disability is suffered.
8. You are injured due to an accident for which someone else is responsible.
9. You intend to take a leave of absence from work which may qualify under the Family and Medical Leave Act.
10. You are moving from or to another Health Plan.
11. You have qualified for COBRA.

NECA-IBEW Local 480
Pension Plan
P.O. Box 721119
Byram, MS 39272

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