

NECA-IBEW Welfare Trust Fund Summary Plan Description (SPD) and Plan Document

SCHEDULES OF BENEFITS

Revised March 2023

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Base Plan for Active Employees

Schedule of Benefits for Active Employees and Their Eligible Dependents with Base Plan Coverage

Effective June 1, 2022

DEATH BENEFITS – EMPLOYEE ONLY	
Active Employees' Death Benefit	\$20,000
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – EMPLOYEE ONLY	
Active Employees' Accidental Death and Dismemberment Benefit	\$20,000
WEEKLY INCOME BENEFIT	
Weekly Benefits	
• First 6 Weeks	\$390
• 7th through 12th Week	\$520
• 13th through 26th Week	\$650
Maximum Number of Weeks Payable	26 Weeks
Benefits begin:	
• Disability due to Injury	1st day of Disability
• Disability due to Sickness	8th day of Disability
<ul style="list-style-type: none"> • If Disability due to Sickness lasts more than 8 weeks, the Plan will retroactively pay benefits for the first week of Disability. • Treatment resulting from an Accident must occur within 14 days of the Accident. • Disabilities lasting longer than 13 weeks are subject to large case management review. 	
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Benefits are payable for the Allowable Charges for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after the individual meets the Calendar Year Deductible.	
Calendar Year Maximum (applies to Covered Expenses)	Unlimited
Calendar Year Deductible	
• Individual Deductible	\$600
• Family Maximum Deductible	\$1,800
Coinsurance	
• PPO Provider	90% of first \$19,000 of Individual Allowable Charges, 100% thereafter
• Non-PPO Provider	75% of first \$7,600 of Individual Allowable Charges, 100% thereafter
Calendar Year Out-of-Pocket Maximum, after Deductible	
• Individual	\$1,900
• Family Maximum	\$3,800
Non-Accident Emergency Room Deductible (does not apply to Deductible or Out-of-Pocket Maximum)	\$60 per visit after first two visits per Calendar Year

<p>Physician Office Visits</p> <p>Copayment (does not apply to Deductible or Out-of-Pocket Maximum)</p>	\$15 per visit
<p>Specialist Office Visits</p> <p>Copayment (does not apply to Deductible or Out-of-Pocket Maximum)</p>	\$15 per visit
<p>Chiropractic Treatment</p> <ul style="list-style-type: none"> • Coinsurance paid by Plan • Calendar Year Maximum • Calendar Year Out-of-Pocket Maximum 	<p>50%</p> <p>48 visits</p> <p>None</p>
<p>Temporomandibular Joint Dysfunction (TMJ)</p> <ul style="list-style-type: none"> • Coinsurance Plan Pays • Lifetime Maximum (The TMJ lifetime maximum applies to appliances, manipulation, and other non-surgical, non-diagnostic charges for Participants and Dependents age 18 and older. There is no lifetime maximum for Dependent children up to age 18.) 	<p>75%</p> <p>\$3,500</p>
<p>Testosterone Replacement Therapy</p> <p>Calendar Year Maximum (requires verification of Medical Necessity and lab results showing deficiency)</p>	\$2,500
<p>Growth Hormone Therapy</p> <ul style="list-style-type: none"> • Lifetime Maximum (subject to Medical Necessity) • Lifetime Maximum for Dependent Child (subject to Medical Necessity) 	<p>No maximum</p> <p>No maximum</p>
<p>Physical/Massage/Speech/Occupational/Acupuncture Therapy</p> <ul style="list-style-type: none"> • Physical/Massage/Acupuncture Therapy Calendar Year Maximum • Speech Therapy Calendar Year Maximum • Occupational Therapy Calendar Year Maximum <p>(Limits are for Eligible individuals age six and older; benefits for Dependents younger than age six are unlimited as long as the Dependent is making ongoing therapeutic progress.)</p>	<p>48 visits</p> <p>48 visits</p> <p>48 visits</p>
<p>Hearing Aid Benefit</p> <ul style="list-style-type: none"> • For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) • EPIC Hearing Service Plan 	<p>\$1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020)</p> <p>Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries</p>

ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
<p>Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.</p>	
Organ Transplant Calendar Year Deductible Individual Deductible	Major Medical Deductible of \$600
Organ Transplant Coinsurance <ul style="list-style-type: none"> • COE Facility • Non-COE Facility 	90% of first \$15,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges
Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible <ul style="list-style-type: none"> • COE Facility • Non-COE Facility 	Major Medical Out-of-Pocket Maximum of \$1,900 No Out-of-Pocket Maximum
Organ Transplant Immunosuppressive Medications	See "Specialty Medications"
Organ Procurement Benefit	\$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities (effective October 1, 2020) Not subject to Deductible
Organ Transplant Transportation/Lodging	\$10,000 (effective October 1, 2020)
BEHAVIORAL HEALTH BENEFITS	
<p>Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).</p>	
EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 EAP Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Prescription Drug Deductible per Calendar Year per Person	\$60
Participating Retail Pharmacy Copayment up to a 34-day supply:¹ <ul style="list-style-type: none"> • Generic Prescription • Brand Name Prescription 	\$15 \$20 ²
Non-Participating Retail Pharmacy Coinsurance	50%
Mail-Order Program Copayment up to a 90-day supply: <ul style="list-style-type: none"> • Generic Prescription • Brand Name Prescription 	\$25 \$35 ²

Specialty Medications³	10% Coinsurance, up to a maximum of \$125 per prescription fill for a 34-day supply ⁴
<p>¹ For maintenance medications, only the original prescription and first two refills of maintenance medication may be purchased from the Retail Network. The third refill and all subsequent refills must be filled by the Mail-Order Program.</p> <p>² Plus difference in cost between the generic and brand name prescriptions when a generic is available.</p> <p>³ Specialty medications that are included on the Select Drugs and Products List and are administered by a health care provider in a hospital, clinic, or facility, and those self-administered, are subject to Pre-certification for Medical Necessity and participation in the Select Drugs and Products Program. All Covered Persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to Prior Authorization, step therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain Medical Necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.</p> <p>⁴ Covered Persons who were receiving specialty medications prior to January 1, 2013 will continue to pay the Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable.</p>	
DENTAL BENEFITS*	
Maximum Benefit per Person age 19 and older	\$1,500 per Calendar Year
Maximum Benefit per Person under age 19	Unlimited
Coinsurance <ul style="list-style-type: none"> • Type I • Type II • Type III • Orthodontia 	90% of Allowable Charges 85% of Allowable Charges 50% of Allowable Charges 50% of Allowable Charges up to a lifetime maximum orthodontia benefit of \$2,000
VISION BENEFITS*	
Coverage for each Covered Person age 19 and older includes:	Calendar year eye exam, lenses, frames, and contact lenses
Maximum Benefit per Calendar Year for each Covered Person age 19 and older	\$400 maximum
Coverage for each Covered Person under age 19 includes:	Eye exams and materials related to vision correction, including any one of the following options: <ul style="list-style-type: none"> a. Frames and lenses b. Contact lenses c. One set of frames and a one-year supply of contact lenses
Maximum Benefit per Calendar Year for each Covered Person under age 19	No dollar maximum
EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

* If you wish, you may elect to cease coverage for dental benefits and/or vision benefits under the Plan for yourself or your Dependents. If you previously elected to cease coverage for dental and/or vision benefits under the Plan, you may reinstate coverage. If you wish to cease or reinstate coverage, you must notify the Fund Office in writing. See your SPD/Plan Document for more information.

Alternative Plan for Active Employees

Schedule of Benefits for Active Employees and Their Eligible Dependents with Alternative Plan Coverage

Effective June 1, 2022

NOTE: This Schedule of Benefits also reflects the benefits for the Employee and Dependent Children Only coverage tier, which does not cover Spouses.

DEATH BENEFITS – EMPLOYEE ONLY	
Active Employees' Death Benefit	\$10,000
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – EMPLOYEE ONLY	
Active Employees' Accidental Death and Dismemberment Benefit	\$10,000
WEEKLY INCOME BENEFIT	
Weekly Benefits <ul style="list-style-type: none"> • First 6 Weeks • 7th through 12th Week • 13th through 26th Week 	\$390 \$520 \$650
Maximum Number of Weeks Payable	26 Weeks
Benefits begin: <ul style="list-style-type: none"> • Disability due to Injury • Disability due to Sickness 	1st day of Disability 8th day of Disability
<ul style="list-style-type: none"> • If Disability due to Sickness lasts more than 8 weeks, the Plan will retroactively pay benefits for the first week of Disability. • Treatment resulting from an Accident must occur within 14 days of the Accident. • Disabilities lasting longer than 13 weeks are subject to large case management review. 	
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Benefits are payable for the Allowable Charges for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after the individual meets the Calendar Year Deductible.	
Calendar Year Maximum (applies to Covered Expenses)	Unlimited
Calendar Year Deductible <ul style="list-style-type: none"> • Individual Deductible • Family Maximum Deductible 	\$1,000 \$3,000
Coinsurance <ul style="list-style-type: none"> • PPO Provider • Non-PPO Provider 	70% of first \$10,000 of Individual Allowable Charges, 100% thereafter 60% of first \$7,500 of Individual Allowable Charges, 100% thereafter
Calendar Year Out-of-Pocket Maximum, after Deductible <ul style="list-style-type: none"> • Individual • Family Maximum 	\$3,000 \$6,000

Non-Accident Emergency Room Deductible (does not apply to Deductible or Out-of-Pocket Maximum)	\$50 per visit after first two visits per Calendar Year
Physician Office Visits Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	\$20 per visit
Specialist Office Visits Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	\$40 per visit
Chiropractic Treatment <ul style="list-style-type: none"> • Coinsurance paid by Plan • Calendar Year Maximum • Calendar Year Out-of-Pocket Maximum 	50% 48 visits None
Temporomandibular Joint Dysfunction (TMJ) <ul style="list-style-type: none"> • Coinsurance Plan Pays • Lifetime Maximum (The TMJ lifetime maximum applies to appliances, manipulation, and other non-surgical, non-diagnostic charges for Participants and Dependents age 18 and older. There is no lifetime maximum for Dependent children up to age 18.) 	75% \$3,500
Testosterone Replacement Therapy Calendar Year Maximum (requires verification of Medical Necessity and lab results showing deficiency)	\$2,500
Growth Hormone Therapy <ul style="list-style-type: none"> • Lifetime Maximum (subject to Medical Necessity) • Lifetime Maximum for Dependent Child (subject to Medical Necessity) 	No maximum No maximum
Physical/Massage/Speech/Occupational/Acupuncture Therapy <ul style="list-style-type: none"> • Physical/Massage/Acupuncture Therapy Calendar Year Maximum • Speech Therapy Calendar Year Maximum • Occupational Therapy Calendar Year Maximum (Limits are for Eligible individuals age six and older; benefits for Dependents younger than age six are unlimited as long as the Dependent is making ongoing therapeutic progress.)	48 visits 48 visits 48 visits
Hearing Aid Benefit <ul style="list-style-type: none"> • For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) • EPIC Hearing Service Plan 	\$1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020) Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries
ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	

<p>Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.</p>	
<p>Organ Transplant Calendar Year Deductible Individual Deductible</p>	Major Medical Deductible of \$1,000
<p>Organ Transplant Coinsurance</p> <ul style="list-style-type: none"> • COE Facility • Non-COE Facility 	<p>70% of first \$19,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges</p>
<p>Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible</p> <ul style="list-style-type: none"> • COE Facility • Non-COE Facility 	<p>Major Medical Out-of-Pocket Maximum of \$3,000 No Out-of-Pocket Maximum</p>
<p>Organ Transplant Immunosuppressive Medications</p>	See "Specialty Medications"
<p>Organ Procurement Benefit</p>	<p>\$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities (effective October 1, 2020) Not subject to Deductible</p>
<p>Organ Transplant Transportation/Lodging</p>	\$10,000 (effective October 1, 2020)
<p>BEHAVIORAL HEALTH BENEFITS</p>	
<p>Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).</p>	
<p>EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM</p>	
<p>3 EAP Counseling Sessions</p>	Plan pays 100%
<p>PRESCRIPTION DRUG BENEFITS</p>	
<p>Prescription Drug Deductible per Calendar Year per Person</p>	None
<p>Participating Retail Pharmacy Copayment up to a 34-day supply:¹</p> <ul style="list-style-type: none"> • Generic Prescription • Preferred Brand Name Prescription • Non-Preferred Brand Name Prescription 	<p>\$25 \$40² \$50²</p>
<p>Non-Participating Retail Pharmacy Coinsurance</p>	50%
<p>Mail-Order Program Copayment up to a 90-day supply:</p> <ul style="list-style-type: none"> • Generic Prescription • Preferred Brand Name Prescription • Non-Preferred Brand Name Prescription 	<p>\$50 \$80² \$100²</p>

Specialty Medications³	10% Coinsurance, up to a maximum of \$125 per prescription fill for a 34-day supply ⁴
<p>¹ For maintenance medications, only the original prescription and first two refills of maintenance medication may be purchased from the Retail Network. The third refill and all subsequent refills must be filled by the Mail-Order Program.</p> <p>² Plus difference in cost between the generic and brand name prescriptions when a generic is available.</p> <p>³ Specialty medications that are included on the Select Drugs and Products List and are administered by a health care provider in a hospital, clinic, or facility, and those self-administered, are subject to Pre-certification for Medical Necessity and participation in the Select Drugs and Products Program. All Covered Persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to Prior Authorization, step therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain Medical Necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.</p> <p>⁴ Covered Persons who were receiving specialty medications prior to January 1, 2013 will continue to pay the Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable.</p>	
EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

Base Plan for Retired Employees Under Age 65

Schedule of Benefits for Retired Employees and Eligible Dependents Under Age 65 with Base Plan Coverage

Effective June 1, 2022

DEATH BENEFITS – RETIRED EMPLOYEE ONLY	
Retired Employees' Death Benefit	\$5,000
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Benefits are payable for the Allowable Charges for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after the individual meets the Calendar Year Deductible.	
Calendar Year Maximum (applies to Covered Expenses)	Unlimited
Calendar Year Deductible	
<ul style="list-style-type: none"> Individual Deductible Family Maximum Deductible 	\$600 \$1,800
Coinsurance	
<ul style="list-style-type: none"> PPO Provider Non-PPO Provider 	90% of first \$19,000 of Individual Allowable Charges, 100% thereafter 75% of first \$7,600 of Individual Allowable Charges, 100% thereafter
Calendar Year Out-of-Pocket Maximum, after Deductible	
<ul style="list-style-type: none"> Individual Family Maximum 	\$1,900 \$3,800
Non-Accident Emergency Room Deductible (does not apply to Deductible or Out-of-Pocket Maximum)	\$60 per visit after first two visits per Calendar Year
Physician Office Visits	
Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	\$15 per visit
Specialist Office Visits	
Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	\$15 per visit
Chiropractic Treatment	
<ul style="list-style-type: none"> Coinsurance paid by Plan Calendar Year Maximum Calendar Year Out-of-Pocket Maximum 	50% 48 visits None

<p>Temporomandibular Joint Dysfunction (TMJ)</p> <ul style="list-style-type: none"> • Coinsurance Plan Pays • Lifetime Maximum (The TMJ lifetime maximum applies to appliances, manipulation, and other non-surgical, non-diagnostic charges for Participants and Dependents age 18 and older. There is no lifetime maximum for Dependent children up to age 18.) 	<p>75% \$3,500</p>
<p>Testosterone Replacement Therapy Calendar Year Maximum (requires verification of Medical Necessity and lab results showing deficiency)</p>	<p>\$2,500</p>
<p>Growth Hormone Therapy</p> <ul style="list-style-type: none"> • Lifetime Maximum (subject to Medical Necessity) • Lifetime Maximum for Dependent Child (subject to Medical Necessity) 	<p>No maximum No maximum</p>
<p>Physical/Massage/Speech/Occupational Therapy</p> <ul style="list-style-type: none"> • Physical/Massage/Acupuncture Therapy Calendar Year Maximum • Speech Therapy Calendar Year Maximum • Occupational Therapy Calendar Year Maximum <p>(Limits are for Eligible individuals age six and older; benefits for Dependents younger than age six are unlimited as long as the Dependent is making ongoing therapeutic progress.)</p>	<p>48 visits 48 visits 48 visits</p>
<p>Hearing Aid Benefit</p> <ul style="list-style-type: none"> • For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) • EPIC Hearing Service Plan 	<p>\$1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020) Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries</p>
<p>ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)</p>	
<p>Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.</p>	
<p>Organ Transplant Calendar Year Deductible Individual Deductible</p>	<p>Major Medical Deductible of \$600</p>

Organ Transplant Coinsurance	
<ul style="list-style-type: none"> • COE Facility • Non-COE Facility 	<p>90% of first \$19,000 of Allowable Charges, 100% thereafter</p> <p>50% of Allowable Charges</p>
Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible	
<ul style="list-style-type: none"> • COE Facility • Non-COE Facility 	<p>Major Medical Out-of-Pocket Maximum of \$1,900</p> <p>No Out-of-Pocket Maximum</p>
Organ Transplant Immunosuppressive Medications	See “Specialty Medications”
Organ Procurement Benefit	<p>\$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities (effective October 1, 2020)</p> <p>Not subject to Deductible</p>
Organ Transplant Transportation/Lodging	\$10,000 (effective October 1, 2020)
BEHAVIORAL HEALTH BENEFITS	
Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).	
EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 EAP Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Prescription Drug Deductible per Calendar Year per Person	\$60
Participating Retail Pharmacy Copayment up to a 34-day supply:¹	
<ul style="list-style-type: none"> • Generic Prescription • Brand Name Prescription 	<p>\$15</p> <p>\$20²</p>
Non-Participating Retail Pharmacy Coinsurance	50%
Mail-Order Program Copayment up to a 90-day supply:	
<ul style="list-style-type: none"> • Generic Prescription • Brand Name Prescription 	<p>\$25</p> <p>\$35²</p>

Specialty Medications³	10% Coinsurance, up to a maximum of \$125 per prescription fill for a 34-day supply ⁴
<p>¹ For maintenance medications, only the original prescription and first two refills of maintenance medication may be purchased from the Retail Network. The third refill and all subsequent refills must be filled by the Mail-Order Program.</p> <p>² Plus difference in cost between the generic and brand name prescriptions when a generic is available.</p> <p>³ Specialty medications that are included on the Select Drugs and Products List and are administered by a health care provider in a hospital, clinic, or facility, and those self-administered, are subject to Pre-certification for Medical Necessity and participation in the Select Drugs and Products Program. All Covered Persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to Prior Authorization, step therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain Medical Necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.</p> <p>⁴ Covered Persons who were receiving specialty medications prior to January 1, 2013 will continue to pay the Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable.</p>	
DENTAL BENEFITS*	
Maximum Benefit per Person age 19 and older	\$1,500 per Calendar Year
Maximum Benefit per Person under age 19	Unlimited
Coinsurance <ul style="list-style-type: none"> • Type I • Type II • Type III • Orthodontia 	90% of Allowable Charges 85% of Allowable Charges 50% of Allowable Charges 50% of Allowable Charges up to a lifetime maximum orthodontia benefit of \$2,000
VISION BENEFITS*	
Coverage for each Covered Person age 19 and older includes:	Calendar year eye exam, lenses, frames, and contact lenses
Maximum Benefit per Calendar Year for each Covered Person age 19 and older	\$400 maximum
Coverage for each Covered Person under age 19 includes:	Eye exams and materials related to vision correction, including any one of the following options: <ul style="list-style-type: none"> a. Frames and lenses b. Contact lenses c. One set of frames and a one-year supply of contact lenses
Maximum Benefit per Calendar Year for each Covered Person under age 19	No dollar maximum
EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

* If you wish, you may elect to cease coverage for dental benefits and/or vision benefits under the Plan for yourself or your Dependents. If you previously elected to cease coverage for dental and/or vision benefits under the Plan, you may reinstate coverage. If you wish to cease or reinstate coverage, you must notify the Fund Office in writing. See your SPD/Plan Document for more information.

Alternative Plan for Retired Employees Under Age 65

Schedule of Benefits for Retired Employees Under Age 65 and Their Eligible Dependents with Alternative Plan Coverage
Effective June 1, 2022

DEATH BENEFITS – RETIRED EMPLOYEE ONLY	
Retired Employees' Death Benefit	\$5,000
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Benefits are payable for the Allowable Charges for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after the individual meets the Calendar Year Deductible.	
Calendar Year Maximum (applies to Covered Expenses)	Unlimited
Calendar Year Deductible	
<ul style="list-style-type: none"> • Individual Deductible • Family Maximum Deductible 	\$1,000 \$3,000
Coinsurance	
<ul style="list-style-type: none"> • PPO Provider • Non-PPO Provider 	70% of first \$10,000 of Individual Allowable Charges, 100% thereafter 60% of first \$7,500 of Individual Allowable Charges, 100% thereafter
Calendar Year Out-of-Pocket Maximum, after Deductible	
<ul style="list-style-type: none"> • Individual • Family Maximum 	\$3,000 \$6,000
Non-Accident Emergency Room Deductible (does not apply to Deductible or Out-of-Pocket Maximum)	\$50 per visit after first two visits per Calendar Year
Physician Office Visits	
Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	\$20 per visit
Specialist Office Visits	
Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	\$40 per visit
Chiropractic Treatment	
<ul style="list-style-type: none"> • Coinsurance paid by Plan • Calendar Year Maximum • Calendar Year Out-of-Pocket Maximum 	50% 48 visits None

<p>Temporomandibular Joint Dysfunction (TMJ)</p> <ul style="list-style-type: none"> • Coinsurance Plan Pays • Lifetime Maximum (The TMJ lifetime maximum applies to appliances, manipulation, and other non-surgical, non-diagnostic charges for Participants and Dependents age 18 and older. There is no lifetime maximum for Dependent children up to age 18.) 	<p>75% \$3,500</p>
<p>Testosterone Replacement Therapy Calendar Year Maximum (requires verification of Medical Necessity and lab results showing deficiency)</p>	<p>\$2,500</p>
<p>Growth Hormone Therapy</p> <ul style="list-style-type: none"> • Lifetime Maximum (subject to Medical Necessity) • Lifetime Maximum for Dependent Child (subject to Medical Necessity) 	<p>No maximum No maximum</p>
<p>Physical/Massage/Speech/Occupational/Acupuncture Therapy</p> <ul style="list-style-type: none"> • Physical/Massage/Acupuncture Therapy Calendar Year Maximum • Speech Therapy Calendar Year Maximum • Occupational Therapy Calendar Year Maximum <p>(Limits are for Eligible individuals age six and older; benefits for Dependents younger than age six are unlimited as long as the Dependent is making ongoing therapeutic progress.)</p>	<p>48 visits 48 visits 48 visits</p>
<p>Hearing Aid Benefit</p> <ul style="list-style-type: none"> • For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) • EPIC Hearing Service Plan 	<p>\$1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020)</p> <p>Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries</p>
ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
<p>Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.</p>	
<p>Organ Transplant Calendar Year Deductible Individual Deductible</p>	<p>Major Medical Deductible of \$1,000</p>
<p>Organ Transplant Coinsurance</p> <ul style="list-style-type: none"> • COE Facility • Non-COE Facility 	<p>70% of first \$19,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges</p>

Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible	
<ul style="list-style-type: none"> • COE Facility • Non-COE Facility 	<p>Major Medical Out-of-Pocket Maximum of \$3,000</p> <p>No Out-of-Pocket Maximum</p>
Organ Transplant Immunosuppressive Medications	See “Specialty Medications”
Organ Procurement Benefit	\$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities (effective October 1, 2020) Not subject to Deductible
Organ Transplant Transportation/Lodging	\$10,000 (effective October 1, 2020)
BEHAVIORAL HEALTH BENEFITS	
Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).	
EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 EAP Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Prescription Drug Deductible per Calendar Year per Person	None
Participating Retail Pharmacy Copayment up to a 34-day supply:¹	
<ul style="list-style-type: none"> • Generic Prescription • Preferred Brand Name Prescription • Non-Preferred Brand Name Prescription 	<p>\$25</p> <p>\$40²</p> <p>\$50²</p>
Non-Participating Retail Pharmacy Coinsurance	50%
Mail-Order Program Copayment up to a 90-day supply:	
<ul style="list-style-type: none"> • Generic Prescription • Preferred Brand Name Prescription • Non-Preferred Brand Name Prescription 	<p>\$50</p> <p>\$80²</p> <p>\$100²</p>

Specialty Medications³	10% Coinsurance, up to a maximum of \$125 per prescription fill for a 34-day supply ⁴
<p>¹ For maintenance medications, only the original prescription and first two refills of maintenance medication may be purchased from the Retail Network. The third refill and all subsequent refills must be filled by the Mail-Order Program.</p> <p>² Plus difference in cost between the generic and brand name prescriptions when a generic is available.</p> <p>³ Specialty medications that are included on the Select Drugs and Products List and are administered by a health care provider in a hospital, clinic, or facility, and those self-administered, are subject to Pre-certification for Medical Necessity and participation in the Select Drugs and Products Program. All Covered Persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to Prior Authorization, step therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain Medical Necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.</p> <p>⁴ Covered Persons who were receiving specialty medications prior to January 1, 2013 will continue to pay the Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable.</p>	
EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

Base Plan for Retired Employees Over Age 65 and Eligible for Medicare

Schedule of Benefits for Retired Employees and Eligible Dependents Over Age 65 and Eligible for Medicare with Base Plan Coverage

Effective January 1, 2023

DEATH BENEFITS – RETIRED EMPLOYEE ONLY	
Retired Employees' Death Benefit	\$5,000
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Retirees and Eligible Dependents over age 65 that are Eligible for Medicare are covered under a Medicare Advantage Plan, which has its own Schedule of Benefits (see page 25).	
Hearing Aid Benefit <ul style="list-style-type: none"> For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) EPIC Hearing Service Plan 	\$1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020) Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries
ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.	
Organ Transplant Calendar Year Deductible Individual Deductible	Major Medical Deductible of \$600
Organ Transplant Coinsurance <ul style="list-style-type: none"> COE Facility Non-COE Facility 	90% of first \$19,000 of Individual Allowable Charges, 100% thereafter 50% of Allowable Charges
Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible <ul style="list-style-type: none"> COE Facility Non-COE Facility 	Major Medical Out-of-Pocket Maximum of \$1,900 No Out-of-Pocket Maximum
Organ Transplant Immunosuppressive Medications	See "Specialty Medications"
Organ Procurement Benefit	\$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities (effective October 1, 2020) Not subject to Deductible
Organ Transplant Transportation/Lodging	\$10,000 (effective October 1, 2020)

BEHAVIORAL HEALTH BENEFITS	
Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).	
EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 EAP Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Retirees and Eligible Dependents who are age 65 or over and Eligible for Medicare Parts A and B have a choice when electing Prescription Drug Benefits to complement the Medical Benefits provided through the Medicare Advantage Plan .	
Retirees and Eligible Dependents can choose the Base Plan’s Prescription Drug Benefits or the Alternative Plan’s Prescription Drug Benefits. The Alternative Plan’s Prescription Drug Benefits provide a lower level of coverage at a reduced cost. Retirees who select the Alternative Plan’s Prescription Drug Benefits will not have the option, at any time, of re-enrolling in the higher level of coverage under the Base Plan’s Prescription Drug Benefits.	
Prescription drug coverage for both the Base Plan and Alternative Plan is provided through the SilverScript Employer PDP sponsored by NECA-IBEW (SilverScript), a group Medicare Part D prescription drug plan with additional coverage provided by NECA-IBEW. Please refer to the <i>Evidence of Coverage</i> from SilverScript for details about the Medicare Part D portion of your coverage.	
This chart shows the Base Plan’s Prescription Drug Benefits.	
Prescription Drug Deductible per Calendar Year per Person	\$60
Copayment per prescription for up to a 34-day supply at a preferred network retail pharmacy:	
• Generic Drug	\$15
• Brand Name Drug	
– Preferred Brand Name Drug	\$20
– Non-Preferred Brand Name Drug	\$20
Copayment per prescription for up to a 60-day supply at a preferred network retail pharmacy:¹	
• Generic Drug	\$30
• Brand Name Drug	
– Preferred Brand Name Drug	\$40
– Non-Preferred Brand Name Drug	\$40
Copayment per prescription for up to a 90-day supply at a preferred network retail pharmacy:¹	
• Generic Drug	\$45
• Brand Name Drug	
– Preferred Brand Name Drug	\$40
– Non-Preferred Brand Name Drug	\$60

<p>Copayment per prescription for up to a 34-day supply at a standard network retail pharmacy:¹</p> <ul style="list-style-type: none"> • Generic Drug • Brand Name Drug <ul style="list-style-type: none"> – Preferred Brand Name Drug – Non-Preferred Brand Name Drug 	<p>\$15</p> <p>\$20</p> <p>\$20</p>
<p>Copayment per prescription for up to a 60-day supply at a standard network retail pharmacy:¹</p> <ul style="list-style-type: none"> • Generic Drug • Brand Name Drug <ul style="list-style-type: none"> – Preferred Brand Name Drug – Non-Preferred Brand Name Drug 	<p>\$30</p> <p>\$40</p> <p>\$40</p>
<p>Copayment per prescription for up to a 90-day supply at a standard network retail pharmacy:¹</p> <ul style="list-style-type: none"> • Generic Drug • Brand Name Drug <ul style="list-style-type: none"> – Preferred Brand Name Drug – Non-Preferred Brand Name Drug 	<p>\$45</p> <p>\$60</p> <p>\$60</p>
<p>Copayment per prescription for up to a 34-day supply at a long-term care facility:</p> <ul style="list-style-type: none"> • Generic Drug • Brand Name Drug <ul style="list-style-type: none"> – Preferred Brand Name Drug – Non-Preferred Brand Name Drug 	<p>\$15</p> <p>\$20</p> <p>\$20</p>
<p>Copayment per prescription for up to a 90-day supply through the network mail-order pharmacy:</p> <ul style="list-style-type: none"> • Generic Drug • Brand Name Drug <ul style="list-style-type: none"> – Preferred Brand Name Drug – Non-Preferred Brand Name Drug 	<p>\$25</p> <p>\$35</p> <p>\$35</p>
<p>High Cost or Specialty Medications</p>	<p>10% Coinsurance, up to a maximum of \$125 per prescription fill for a 34- or 90-day supply¹</p>
<p>¹ If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable. You may also prepay for your specialty medications and send proof of payment listing the prescription to the Fund Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.</p>	
<p>DENTAL BENEFITS*</p>	
<p>Maximum Benefit per Person age 19 and older</p>	<p>\$1,500 per Calendar Year</p>
<p>Maximum Benefit per Person under age 19</p>	<p>Unlimited</p>
<p>Coinsurance</p> <ul style="list-style-type: none"> • Type I • Type II • Type III • Orthodontia 	<p>90% of Allowable Charges</p> <p>85% of Allowable Charges</p> <p>50% of Allowable Charges</p> <p>50% of Allowable Charges up to a lifetime maximum orthodontia benefit of \$2,000</p>

VISION BENEFITS*	
Coverage for each Covered Person age 19 and older includes:	Calendar year eye exam, lenses, frames, and contact lenses
Maximum Benefit per Calendar Year for each Covered Person age 19 and older	\$400 maximum
Coverage for each Covered Person under age 19 includes:	Eye exams and materials related to vision correction, including any one of the following options: a. Frames and lenses b. Contact lenses c. One set of frames and a one-year supply of contact lenses
Maximum Benefit per Calendar Year for each Covered Person under age 19	No dollar maximum
EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

* If you wish, you may elect to cease coverage for dental benefits and/or vision benefits under the Plan for yourself or your Dependents. If you previously elected to cease coverage for dental and/or vision benefits under the Plan, you may reinstate coverage. If you wish to cease or reinstate coverage, you must notify the Fund Office in writing. See your SPD/Plan Document for more information.

Alternative Plan for Retired Employees Over Age 65 and Eligible for Medicare

Schedule of Benefits for Retired Employees and Eligible Dependents Over Age 65 and Eligible for Medicare with Alternative Plan Coverage

Effective January 1, 2023

DEATH BENEFITS – RETIRED EMPLOYEE ONLY	
Retired Employees' Death Benefit	\$5,000
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Retirees and Eligible Dependents over age 65 that are Eligible for Medicare are covered under a Medicare Advantage Plan, which has its own Schedule of Benefits (see page 25).	
Hearing Aid Benefit <ul style="list-style-type: none"> For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) EPIC Hearing Service Plan 	\$1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020) Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries
ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.	
Organ Transplant Calendar Year Deductible Individual Deductible	Major Medical Deductible of \$600
Organ Transplant Coinsurance <ul style="list-style-type: none"> COE Facility Non-COE Facility 	90% of first \$19,000 of Individual Allowable Charges, 100% thereafter 50% of Allowable Charges
Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible <ul style="list-style-type: none"> COE Facility Non-COE Facility 	Major Medical Out-of-Pocket Maximum of \$1,900 No Out-of-Pocket Maximum
Organ Transplant Immunosuppressive Medications	See "Specialty Medications"
Organ Procurement Benefit	\$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities (effective October 1, 2020) Not subject to Deductible

Organ Transplant Transportation/Lodging	\$10,000 (effective October 1, 2020)
BEHAVIORAL HEALTH BENEFITS	
Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).	
EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Retirees and Eligible Dependents who are age 65 or over and Eligible for Medicare Parts A and B have a choice when electing Prescription Drug Benefits to complement the Medical Benefits provided through the Medicare Advantage Plan .	
Retirees and Eligible Dependents can choose the Base Plan’s Prescription Drug Benefits or the Alternative Plan’s Prescription Drug Benefits. The Alternative Plan’s Prescription Drug Benefits provide a lower level of coverage at a reduced cost. Retirees who select the Alternative Plan’s Prescription Drug Benefits will not have the option, at any time, of re-enrolling in the higher level of coverage under the Base Plan’s Prescription Drug Benefits.	
Prescription drug coverage for both the Base Plan and Alternative Plan is provided through the SilverScript Employer PDP sponsored by NECA-IBEW (SilverScript), a group Medicare Part D prescription drug plan with additional coverage provided by NECA-IBEW. Please refer to the <i>Evidence of Coverage</i> from SilverScript for details about the Medicare Part D portion of your coverage.	
This chart shows the Alternative Plan’s Prescription Drug Benefits.	
Prescription Drug Deductible per Calendar Year per Person	None
Copayment per prescription for up to a 34-day supply at a preferred network retail pharmacy:¹	
• Generic Drug	\$25
• Brand Name Drug	
– Preferred Brand Name Drug	\$40
– Non-Preferred Brand Name Drug	\$50
Copayment per prescription for up to a 60-day supply at a preferred network retail pharmacy:¹	
• Generic Drug	\$50
• Brand Name Drug	
– Preferred Brand Name Drug	\$80
– Non-Preferred Brand Name Drug	\$100
Copayment per prescription for up to a 90-day supply at a preferred network retail pharmacy:	
• Generic Drug	\$75
• Brand Name Drug	
– Preferred Brand Name Drug	\$120
– Non-Preferred Brand Name Drug	\$150

<p>Copayment per prescription for up to a 34-day supply at a standard network retail pharmacy:¹</p> <ul style="list-style-type: none"> • Generic Drug \$25 • Brand Name Drug <ul style="list-style-type: none"> – Preferred Brand Name Drug \$40 – Non-Preferred Brand Name Drug \$50 	
<p>Copayment per prescription for up to a 60-day supply at a standard network retail pharmacy:¹</p> <ul style="list-style-type: none"> • Generic Drug \$50 • Brand Name Drug <ul style="list-style-type: none"> – Preferred Brand Name Drug \$80 – Non-Preferred Brand Name Drug \$100 	
<p>Copayment per prescription for up to a 90-day supply at a standard network retail pharmacy:¹</p> <ul style="list-style-type: none"> • Generic Drug \$75 • Brand Name Drug <ul style="list-style-type: none"> – Preferred Brand Name Drug \$120 – Non-Preferred Brand Name Drug \$150 	
<p>Copayment per prescription for up to a 34-day supply at a long-term care facility:</p> <ul style="list-style-type: none"> • Generic Drug \$25 • Brand Name Drug <ul style="list-style-type: none"> – Preferred Brand Name Drug \$40 – Non-Preferred Brand Name Drug \$50 	
<p>Copayment per prescription for up to a 90-day supply through the network mail-order pharmacy:</p> <ul style="list-style-type: none"> • Generic Drug \$50 • Brand Name Drug <ul style="list-style-type: none"> – Preferred Brand Name Drug \$80 – Non-Preferred Brand Name Drug \$100 	
<p>High Cost or Specialty Medications</p>	<p>10% Coinsurance, up to a maximum of \$125 per prescription fill for a 34- or 90-day supply¹</p>
<p>¹ If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable. You may also prepay for your specialty medications and send proof of payment listing the prescription to the Fund Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.</p>	
<p>EXCLUDED PROVIDERS</p>	
<p>The Fund will not pay claims from the following out-of-network providers:</p>	<p>Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida</p>

Medicare Advantage Plan

Effective January 1, 2023, Covered Medical Expenses for Medicare-eligible retired Participants and their Medicare-eligible spouses and Dependents, who are enrolled in Medicare Parts A and B, are administered under a group Medicare Advantage Plan with Humana through Retiree First (formerly known as Labor First). The general limitations, exclusions, claims and appeals procedures applicable to Medicare-Eligible retirees' and their Medicare-eligible spouses and Dependents' comprehensive major medical benefits incurred on and after January 1, 2023, will be governed by the Humana group Medicare Advantage Plan. The Fund's Medicare Advantage benefits and coverage will not affect the Plan's Medicare-Retiree prescription drug coverage or other ancillary benefits, such as dental, vision, hearing aid, and death benefits.

For questions or assistance related to the Humana Medicare Advantage Plan, please contact a Retiree First Advocate toll-free at 1-855-433-1668.

Schedule of Benefits for the Medicare Advantage Plan



MEDICAL	MEMBER PAYS
Deductible	\$0
Medical Maximum Out-of-Pocket	\$0
Primary Care Visit	\$0 copay
Specialist Visit	\$0 copay
Inpatient Services	\$0 per admit
Outpatient Services	\$0 copay
Inpatient Mental Health and Substance Abuse	\$0 per admit
Outpatient Mental Health and Substance Abuse	\$0 copay
Skilled Nursing Facility	\$0, Days 1-365

Urgent Care	\$0 copay
Emergency Care	\$0 copay
Ambulance Services	\$0
Durable Medical Equipment	\$0
Routine Podiatry	\$0 copay, 6 visits per year
Hearing	\$0, Routine Hearing Exam- 1 per year \$1,250 Allowance for each Hearing Aid – all types- up to 2 every 5 years. \$2,500 total benefit.
Vision	\$0, Routine Vision Exam- 1 per year
Fitness Benefit	Silver Sneakers Included
Foreign Travel Coverage	Members pay \$100 deductible, 20% coinsurance, \$25,000 Maximum Annual Benefit or 60 consecutive days, whichever is reached first. Limited to emergency Medicare covered services.

Prescription Drugs and certain other medical expenses (such as Organ Transplants) are covered under the Welfare Trust Fund, as shown in the applicable Schedule of Benefits.

The Fund also offers a discount program on hearing aids through EPIC Hearing. For questions regarding EPIC Hearing, please contact EPIC at (866) 956-5400. **Please note that the Humana Hearing benefit and the EPIC Hearing Healthcare program do not coordinate.** More information regarding the EPIC hearing benefit program can be found on the Fund’s website, or by calling the Fund Office at 1-800-765-4239.

The Fund Office encourages Medicare eligible participants and/or eligible spouses to utilize the covered eye exam under the Humana Medicare Advantage Plan, then use the EyeMed or standard Fund vision benefit second. This process will afford you more benefit dollars to use for vision materials, such as frames and lenses.

EXCLUDED PROVIDERS

The Fund will not pay claims from the following out-of-network providers: Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida.

Service Providers

Effective January 1, 2023

SERVICE PROVIDER NAME	DESCRIPTION OF SERVICES PROVIDED	CONTACT INFORMATION	WEBSITE
IBEW-NECA Benefits Administration Association	Fund Office administrative services	800-765-4239	www.neca-ibew.org
BlueCross BlueShield of Illinois	Medical PPO network administration services	800-571-1043	www.bcbsil.com
CVS Caremark	Prescription Benefit Management (PBM) services	844-345-3233	www.caremark.com
EPIC Hearing	Hearing aid discount administration services	866-956-5400	www.epichearing.com
Guardian	PPDO (dental) network administration services	888-600-9200	www.guardiananytime.com
Humana	Medicare Advantage Plan	800-733-9064	www.humana.com
Optum Health	Centers of Excellence (COE) network administration services for transplants	800-847-2050	*Please contact the Fund Office for more information about COE services.
PaydHealth, LLC	Specialty drug program services	877-869-7772	www.paydhealth.com
RetireeFirst	Retiree benefit management service provider	855-433-1668 (TTY 711)	www.retireefirst.com
SilverScript Insurance Co.	Prescription Benefit Management (PBM) services for Medicare-Eligible retirees	866-235-5660	www.silverscript.com
Telligen, Inc.	Wellness and disease management services effective January 1, 2020	833-226-7276	https://necaibew.totalwellbeinglife.com
TELUS Health	Employee Assistance Program (EAP) services	888-456-1324 888-732-9020 (en español) 800-999-3004 (TTY)	www.lifeworks.com
Valenz	Utilization review and case management services; Pre-certification, Prior Authorization, and pre-determination services	217-875-2947	www.valenzhealth.com
Wex Health	Health Reimbursement Account (HRA) administration and system services	800-765-4239	https://necaibew.lh1ondemand.com