

ELECTRICAL WORKERS BENEFIT TRUST FUND
NOTICE TO PLAN PARTICIPANTS

Summary of Material Modifications

The Plan document provides that the Board of Trustees have the right to amend the Plan. The Trustees have made the following changes, effective as noted.

1. The Trustees have added a new “wellness” benefit for Participants and Eligible Dependents, as appropriate, effective January 1, 2008, as follows:

Wellness Benefits

Wellness benefits are paid at 100% and must be obtained through an in-network provider

- Mammogram - once every two years age 40-49 and once per year over age 50.
- Pap Smear - once per year in conjunction with a routine physical examination.
- Sigmoidoscopy - once every five years over age 50.
- Colonoscopy - once every ten years over age 50.
- PSA test - one routine test every year in conjunction with a routine physical examination.
- Physical examination - once per year over age 2 with a \$300 limitation. Any amount over \$300 will be paid under the Major Medical portion of the Plan.
- Well-child visits and immunizations up to age 24 months.

If these services are performed by an out of network provider, the benefit will be paid under the major medical benefit at the applicable deductibles and co-payments.

2. The Trustees added enrollment as an apprentice in the Indianapolis Electrical Joint Apprenticeship and Training Program (IEJATP) as a type of vocational training to the definition of Eligible Dependent effective August 16, 2007. This means that unmarried children 19 years of age or over but under 24 years of age who are enrolled as apprentices in the IEJATP will be covered as Eligible Dependents, subject to verification of such status.
3. Effective January 1, 2008, the annual **chiropractic** benefit limit was increased from \$500 to \$750 per year.
4. Effective July 1, 2007, the podiatry benefit of \$4,000 per lifetime was modified to exclude surgeries. Any necessary surgeries will be paid under the plan’s major medical benefit. The podiatry benefit will cover non-surgical services performed by a podiatrist.
5. Effective January 1, 2008 the **Medical Review provider** has been changed from Care Allies to Individualized Care Management (**ICM**). In addition to notifying

the medical review partner of in-patient stays, the Trustees are recommending you also work with this partner for the following additional medical services:

- Durable Medical Equipment
- Home Health Care
- Hospice
- Outpatient Surgery
- Physical Therapy
- Skilled Nursing Facility

While there is no penalty for not calling the medical review partner, we encourage you to take advantage of this service provided to you. The ICM team will work with you to make sure you receive the appropriate care and answer all your questions.

ICM Contact Information: 1-(800) 728-0327, option #4.

6. Effective May 15, 2008 the alternative death benefit option under the Retiree Pre-Funding program was eliminated in order to comply with IRS regulations. The Retiree Pre-Funding program is available to defray the cost of the monthly self-payment amount for medical coverage under the Senior Retiree Program.
7. Effective July 1, 2008 all Retirees that elect coverage under the Senior (Retired) Employee Program will be required to remit self-payments to maintain continued coverage. All Non-Bargaining Unit Employees who are retired from covered employment and eligible for benefits through the Senior Employee Program shall not be eligible for benefits as an employee under any Non-Bargaining Unit Agreement.

The rules for retirees working in bargained employment remain unchanged. If you work enough hours under the terms of a Collective Bargaining Agreement to satisfy the eligibility requirements, you will gain active eligibility and may discontinue your retiree self-payments until your active eligibility terminates.

8. Effective June 1, 2008, the Plan was amended to require pre-certification for Durable Medical Equipment which costs over \$1,000. The Fund's chosen medical review firm for such pre-certification is ICM. You may contact ICM at: (800) 728-0327, option #4. The medical review firm will help you find the equipment and negotiate the best price with the provider.
9. Effective January 28, 2008 the Plan was amended to include information regarding the right of a participant to take up to 26 weeks of Family Medical Leave to care for a spouse, son, daughter, parent, or next of kin who is a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. If you have any questions about the FMLA, you should contact your Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under the U.S. Government, Department of Labor, Employment Standards Administration. You can also visit the Department of Labor's FMLA webpage at: www.dol.gov/esa/whd/fmla.

10. Effective January 1, 2007, the Plan was amended to correct inadvertent omissions by adding back:
 1. The explanation of *How Medicare Affects Medical Benefits Under the Plan*. Remember, all benefits under this Plan will be paid as if you are enrolled in Medicare parts A and B. Therefore, as it has been in the past, ***it is essential that, when your active coverage terminates, you enroll for Part B coverage as soon as possible***, and
 2. Adding back the reminder note on calculation of hours for continuing eligibility to indicate that when determining eligibility, the Fund's records are based on the monthly hours reported on each Employers' monthly remittance report. Since payroll periods may not always start on the first day of the month and end on the last day, the number of hours you work in a particular month may vary from the number of hours reported.
11. Effective September 1, 2008 the Plan was amended to document the Employer's premium while an Employee is on Family Medical Leave will be the same as the Plan's COBRA rate in effect at the time of the leave.
12. Effective January 1, 2008 the Trustees added a new feature to the Plan called the Health Reimbursement Account (HRA). Specifics regarding the new feature are as follows.

Health Reimbursement Account

Effective January 1, 2008, the Health Reimbursement Account (HRA) component of the Plan allows for a designated amount per hour from your Employer contributions to be allocated into a Health Reimbursement Account (HRA or Account) to reimburse Participants for certain expenses as allowed by law. That rate will be set by the Board of Trustees. No Employee contributions are permitted.

A. Establishment of Separate Account

The Plan's Administrator will establish and maintain a separate Account for each eligible Employee. This account will be used to receive the Employer HRA contributions and to reimburse allowable expenses. Although each Participant's Account will be separately identified, the combined assets of all Accounts will be held by the Fund and identified in the Plan's financial statements as the HRA reserves. The Account established for an Employee will merely be a record-keeping account for the purpose of keeping track of Employer HRA contributions and available reimbursement amounts from the Plan. The Accounts shall not be credited with any interest income earned on the HRA reserves. The Accounts will not be charged with any expenses for administration of the HRA, except as otherwise noted. The Accounts are not a vested benefit and are not the property of the Employee except for the purposes set forth herein.

B. Crediting of Accounts

A Participant's Account will be credited at the end of the month with contributions made for work performed by the Participant in the preceding month. For example, Employer contributions made for Participant's hours worked in March will be contributed to a

Participant's Account on April 30th. Only amounts actually received by the Plan will be credited to a Participant's Account.

C. Debiting of Accounts

A Participant's Account will be debited for the amount of monies reimbursed upon payment of the reimbursement.

Eligibility

In order to be eligible for reimbursements from the HRA, Participants must meet the following eligibility rules:

- A. For medical claim reimbursements, Participants must be eligible under the Plan on the date the claim was incurred; and,
- B. To use the HRA for self-payments (see *Expenses that Do Not Qualify* below), Participants must have been eligible the preceding month; and,
- C. Participants must have a balance in their HRA.

Medical Care Expenses Covered

Medical Care Expenses eligible for reimbursement under the HRA are all expenses incurred by the Participant, the Participant's spouse and/or the Participant's dependents for medical care as that term is defined in Section 213(d) of the Internal Revenue Code. For a complete listing of all covered expenses, refer to IRS Publication 502. The Publication can be found on the Internet at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. If you do not have Internet access, contact the Fund Office for a copy of Publication 502.

Expenses that Do Not Qualify for Reimbursement

The following are a list of expenses from IRS Publication 502 that do not qualify for reimbursement from a Participant's HRA:

- Baby Sitting, Childcare, and Nursing Services for a Normal, Healthy Baby
- Controlled Substances
- Cosmetic Surgery
(unless necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.)
- Dancing Lessons
- Diaper Service
(unless diapers are needed to relieve the effects of a particular disease.)
- Electrolysis or Hair Removal
- Flexible Spending Account
- Funeral Expenses
- Future Medical Care
- Hair Transplant
- Health Club Dues
- Health Coverage Tax Credit
- Health Savings Accounts
- Household Help
(you may be able to include certain expenses paid to a person providing nursing-type services.)

- Illegal Operations and Treatments
- Insurance Premiums For Other Than Health Care
- Maternity Clothes
- Medical Savings Account (MSA)
- Medicines and Drugs From Other Countries
(you can include the cost of a prescribed drug you purchase and consume in another country if the drug is legal in both the other country and the United States.)
- Nonprescription Drugs and Medicines
(except the cost of insulin is an allowable expense)
- Nutritional Supplements
(unless they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician.)
- Personal Use Items
- Swimming Lessons
- Teeth Whitening
- Veterinary Fees
- Weight-Loss Programs unless under specific terms

How to File a Claim for Reimbursement of a Medical Expense

A Participant must be eligible under the Plan for reimbursement from the HRA with the exception of self-payment premiums. The Participant must first pay the medical bill for which he or she seeks reimbursement. The claim must be filed on the appropriate claim form submitted with evidence of payment in order to request reimbursement from the HRA. Claims must total at least \$25 per person. Each claim can only be reimbursed once, either a partial reimbursement or full. If a claim is partially reimbursed, it cannot be re-submitted for the balance. If no reimbursement is made for a claim, that claim can be re-submitted within the six month filing limit. Claims will be processed in a timely manner as they are received.

Filing Time Limit

Claims for reimbursement from the HRA must be filed within 6 months of the date the expense was incurred. Late filed claims will not be eligible for reimbursement. As an initial start up exception, eligible claims incurred in 2008 may be submitted up to and including June 30, 2009.

Appeals of Denied HRA Claims

Participants have the right to appeal any denial, in whole or part, of an HRA claim in accordance with the Plan's claims and appeals procedures.

How to Apply HRA Amounts for Self-payments

Participants may use the HRA to make self-payments for continuous coverage under the Plan. When the Participant receives the monthly self-payment notice, he or she must contact the Fund Office to request any eligible HRA account balance be transferred to cover the self-payment obligation.

COBRA

Continued coverage in the HRA account is provided through COBRA continuation coverage with the Plan. COBRA cannot be purchased for the HRA alone. The HRA can be used to pay the Plan's COBRA premium.

Forfeiture of HRA

Any balance in the HRA will be forfeited upon any one of the following events:

- A. Termination of coverage from the Plan and no activity (Employer contributions or claim reimbursements) for a period of 18 months, or
- B. Termination of the Plan, or
- C. Death of the Participant with no surviving dependents

Forfeitures will be used to offset the administration expenses of the Plan.

Administration Fees

If a Participant is not eligible under the Plan and has an HRA account balance, the Trustees have the right to impose a monthly fee to each HRA account to cover the costs of administration.

Statements

Each Participant with an HRA account will receive an annual statement disclosing the activity posted to your HRA account.

Please keep this notice with your Summary Plan Description booklet, and if you have any questions regarding this notice, please contact the Fund's administrative office.

Sincerely,

Board of Trustees

Women's Health and Cancer Rights

Federal law requires that health care plans that provide medical and surgical benefits for mastectomies include medical and surgical benefits for breast reconstructive surgery which is performed as part of a mastectomy procedure.

The law provides coverage for the following:

1. Reconstruction of the breast on which the mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

Coverage of breast reconstructive surgery in connection with a mastectomy is subject to the same deductibles, co-insurance and benefit limitations and exclusions established by the Plan for other medical and surgical benefits.

According to Federal Health Information Privacy Laws, the Plan is required to notify you that a copy of the Plan's HIPAA Privacy Notice can be obtained by writing or calling the Fund Office at 1828 N. Meridian Street, Suite 103, Indianapolis, IN 46202 (317) 923-4577 or you can view the document by going to the following web address:

**Important Notice from
Electrical Workers Benefit Trust Fund
About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Electrical Workers Benefit Trust Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Electrical Workers Benefit Trust Fund has determined that the prescription drug coverage offered by the Electrical Workers Benefit Trust Fund is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage with the Electrical Workers Benefit Trust Fund will be affected. You will no longer be eligible for Prescription coverage through the Plan.

If you do decide to join a Medicare drug plan and drop your current prescription coverage with the Electrical Workers Benefit Trust Fund, be aware that you and your dependents will **NOT** be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Electrical Workers Benefit Trust Fund changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 2008
Name of Entity/Sender: Electrical Workers Benefit Trust Fund
Contact--Position/Office: Robert G. Cadwell, Administrative Manager
Address: 1828 N. Meridian Street, Suite 103
Indianapolis, IN 46202
Phone Number: (317) 923-4577

