

IBEW

Member Orientation

(Inside)



WELCOME

Member Orientation

Objectives

- ✓ To help our members feel welcome and comfortable as members of the local union.
- ✓ To have our members understand the value and functions of the union.
- ✓ To have our members understand their role in and responsibility to the union including their commitment to the standards set forth in the I.B.E.W. Code of Excellence.
- ✓ To help our members understand their rights as members

IBEW CODE OF EXCELLENCE



- C**ome to work on time, fit for duty and ready to work.
- O**bey recognized customer and employer work rules.
- D**emonstrate zero tolerance for alcohol and substance abuse.
- E**xercise proper safety, health and sanitation practices.

- O**wn up to “8 for 8” and be on the job unless authorized to leave.
- F**ollow safe, reasonable and legitimate management directives.

- E**ncourage respect for the customer’s rights and property, as well as that of others.
- X**ercise the skills and abilities of the trade.
- C**are for tools and equipment provided by the employer.
- E**liminate waste and other forms of property abuse including graffiti.
- L**imit lunch and break times to allocated periods, adhere to start and quit times.
- L**eave inappropriate behavior to those of lesser knowledge.
- E**mploy the proper tool for the job and maintain personal tool responsibilities.
- N**o solicitation of funds or selling merchandise without BM’s approval.
- C**urtail idle time and personal business during work hours, no cell phones.
- E**xpell all conduct that would cast the IBEW in a bad light.

In 1891 the 10 locals organized by a St. Louis lineman, Henry Miller, who packed his tools and traveled to many cities of the United States to work at the trade and to organize the electrical workers he met and worked with into local unions, met in a small room above Stolley's Dance Hall in St. Louis, adopted the name of National Brotherhood of Electrical Workers and drafted our Constitution.

Our union, which began with less than 2000 members, has grown to over 800,000 strong. Instead of 10 locals there are now over 1000 local unions, which represent members in many fields, including Construction and Maintenance, Utility, Telecommunications, Railroad, Broadcasting and Recording, Manufacturing and Government.

1891 Preamble to the Constitution

"We earnestly invite all workers belonging to our trade to come forward, join our ranks and help increase our numbers, until there shall be no one working at our trade outside of our Brotherhood..."

Seeing how difficulties could arise in the interpretation of the IBEW Constitution, our founders left the power of making final interpretations to the International President.

DUES

One of the major concerns at the beginning of our union was the need for a death benefit to help the families of members. A death benefit of \$50 for the death of a member and \$25 for spouses was created. This benefit almost led to the bankruptcy of the union because so many people were dying and dues were only 10 cents a month per member. In 1895 the wives' benefit was abolished, the per capita was increased to 25 cents and the minimum initiation fee was increased to \$5.

In 1922 the membership voted to replace the old death benefit system with the Electrical Workers Benefit Association (EWBA). This placed the IBEW on stable financial footing.

Every organization or business firm requires financial support to carry out its functions and responsibilities. Local unions need financial resources to conduct their affairs and provide services to their members.

The payment recorded on the face of this receipt has been posted to your local union membership record. The I.O. portion will be processed when the payment is reported to the International Office.

PAYMENT CODES		
I.O.	L.U.	DESCRIPTION OF PAYMENT
1	2	Initiation Fee
3	4	Difference Fee
5	6	Reinstatement Fee
7		PBF Initiation Fee (Art. X, Sec. 3)
	8	Death Benefit Fee
9	10	Dues
11	12	Difference in Dues
	13	Insurance
	14	Other
	15	Hospitalization
	16	Building Fund
	17	Death Benefits
	18	Social Fund
	19	Vacation
	20	Interest
	21	Rent
	22	Sale
	23	Retirement
	24	Optional Benefits
	25	Working Dues

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS SERIES LP-08

OFFICIAL RECEIPT

MEMBERS COPY 456001

I.O. PORTION		LOCAL UNION PORTION				PAID	
AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	DATE	TOTAL
Date Paid Through						LU NO	MEMB. TYPE
							CARD NO.
REC'D OF						TRADE CLASSIFICATION	
						FINANCIAL SECRETARY	

Reasons for Dues

- ✓ **Contract Negotiations**
- ✓ **Grievance and Arbitration Handling**
- ✓ **Representing interests of members before various levels of government**
- ✓ **Organizing unrepresented workers**
- ✓ **Office expenses Salaries of full-time staff**

As members of the IBEW, we have a voice in determining the amount of dues we pay. The international portion of the dues is established by a vote of the delegates to the international convention. The local union portion of the dues is voted on by a meeting of the local union.

A portion of your monthly dues is sent to the International. This portion includes:

— Pension Benefit Fund - \$23.00/month effective 1/1/25 (“A” members only).

— General Fund - \$23/month, effective 7/1/24. Money from the General Fund is used to pay for the day-to-day operations and expenses of the international office, dues to the AFL-CIO, payment to the national building trades, the monthly publication of the *IBEW Journal*, and International Convention costs.

Local union dues are retained by the local union to finance all of its operations and services.

— In local 443 each member pays an additional \$10/month for Journeyman and CE’s and \$5/month for apprentice’s and CW’s. This money goes to the local union’s general fund.

— Dues payments are required whether the member is working or not, unless a withdrawal card is issued to the member by the local union.

--- Working Assessments are 4% of gross wages and are paid only when working in the local union jurisdiction

Local Union Dues

Basic dues - \$10.00 per month*
C.O.P.E. (voluntary .02 per hour) **
Working dues - 4% of gross***

*The Local Union portion of your monthly dues goes to the local union to pay for all of its day to day operations and expenses.

**COPE (Committee on Political Education) money is used to educate politicians and members about labor issues.

*****The total dollar amount the members pay to the local union is deducted monthly or weekly from your pay check and sent in by your employer and is paid only on hours worked in the local union. If you are working in another local's jurisdiction, the assessment is deducted and paid to the local union where you are working.**

Negotiated Wage Rates

Inside Journeyman Wireman

09/01/24 Through 08/31/25 **\$31.10/hr.**

Local Union Pension

Southern Electrical Retirement Fund (S.E.R.F.)

\$6.00 per hour worked for Inside Journeyman Wireman.

(Defined Contribution* paid by employer)

Years	Amount Contributed	Interest Gained *	Accrued Benefits*
5	\$60,000.00	\$11,195.86	\$71,195.86
10	\$120,000.00	\$51,051.73	\$171,051.73
15	\$180,000.00	\$131,104.76	\$311,104.76
20	\$240,000.00	\$267,536.38	\$507,536.38
25	\$300,000.00	\$483,041.88	\$783,041.88
30	\$360,000.00	\$809,452.60	\$1,169,452.60
35	\$420,000.00	\$1,291,413.63	\$1,711,413.63
40	\$480,000.00	\$1,991,542.01	\$2,471,542.01

*Basis for accrued benefit:

- 2000 hours worked per year
- 7% average return on investment per year
- Based on current contribution rate for Inside Wiremen.

**Defined Contribution is a cash value pension plan.



**SOUTHERN ELECTRICAL
RETIREMENT FUND**
3928 VOLUNTEER DRIVE, CHATTANOOGA, TN 37416-3817
Phone: (423) 899-2593
EIN-62-6125711



STATEMENT OF YOUR INDIVIDUAL ACCOUNT
PLAN YEAR ENDED 12/31/2003

JAMES B. CARDWELL

SOCIAL SECURITY NO:
[REDACTED]

CONTRIBUTIONS REPORTED IN YOUR BEHALF

EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED	EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED	
SPIGENER ELECTRIC COMPANY	09/2003	160.00	240.00					
SPIGENER ELECTRIC COMPANY	09/2003	152.00	228.00					
SPIGENER ELECTRIC COMPANY	10/2003	200.00	300.00					
SPIGENER ELECTRIC COMPANY	11/2003	160.00	240.00					
SPIGENER ELECTRIC COMPANY	12/2003	150.00	225.00					
							822.00 \$	1233.00
								TOTAL HOURS WORKED AND EMPLOYER CONTRIBUTIONS FOR THIS PLAN YEAR

ACCOUNT BALANCE UPDATE

BEGINNING BALANCE	\$.00
PLUS		
CURRENT EMPLOYER CONTRIBUTIONS		1,233.00
EQUAL		
ADJUSTED BALANCE		1,233.00
PLUS		
INVESTMENT GAIN(LOSS)		34.81
MINUS		
ADMINISTRATIVE COST	(28.99)
ENDING BALANCE	\$	1,238.82

Beneficiary
NONE ON FILE



Prepared by: Southern Benefit Administrators, Incorporated



SOUTHERN ELECTRICAL
RETIREMENT FUND

3923 VOLUNTEER DRIVE, CHATTANOOGA, TN 37416-3817
Phone: (423) 899-2593
EIN-62-6125711



STATEMENT OF YOUR INDIVIDUAL ACCOUNT
PLAN YEAR ENDED 12/31/2004

JAMES B. CARDWELL



SOCIAL SECURITY NO



CONTRIBUTIONS REPORTED IN YOUR BEHALF

EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED	EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED	
SPIGENER ELECTRIC COMPANY	01/2004	140.00	210.00					
SPIGENER ELECTRIC COMPANY	02/2004	160.00	240.00					
SPIGENER ELECTRIC COMPANY	03/2004	210.00	315.00					
SPIGENER ELECTRIC COMPANY	04/2004	151.00	225.50					
SPIGENER ELECTRIC COMPANY	05/2004	132.00	198.00					
SPIGENER ELECTRIC COMPANY	05/2004	145.00	217.50					
SPIGENER ELECTRIC COMPANY	07/2004	140.00	210.00					
SPIGENER ELECTRIC COMPANY	08/2004	172.00	258.00					
SPIGENER ELECTRIC COMPANY	09/2004	157.00	235.50					
							1517.00 \$	2275.50
TOTAL HOURS WORKED AND EMPLOYER CONTRIBUTIONS FOR THIS PLAN YEAR								

ACCOUNT BALANCE UPDATE

BEGINNING BALANCE	\$	1,238.82
PLUS		
CURRENT EMPLOYER CONTRIBUTIONS		2,275.50
EQUAL		
ADJUSTED BALANCE		3,514.32
PLUS		
INVESTMENT GAIN (LOSS)		210.13
MINUS		
ADMINISTRATIVE COST	(17.68)
ENDING BALANCE	\$	3,706.77

Beneficiary



Prepared by: Southern Benefit Administrators, Incorporated



SOUTHERN ELECTRICAL
 RETIREMENT FUND
 3928 VOLUNTEER DRIVE, CHATTANOOGA, TN 37416-3817
 Phone: (423) 899-2593
 EIN-62-6125711



STATEMENT OF YOUR INDIVIDUAL ACCOUNT
 PLAN YEAR ENDED 12/31/2011

JAMES B. CARDWELL



SOCIAL SECURITY NO:



CONTRIBUTIONS REPORTED IN YOUR BEHALF

EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED	EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED
LOCAL #443	01/2011	160.00	512.00				
LOCAL #443	02/2011	160.00	512.00				
LOCAL #443	03/2011	160.00	512.00				
LOCAL #443	04/2011	200.00	640.00				
LOCAL #443	05/2011	160.00	512.00				
LOCAL #443	06/2011	160.00	512.00				
LOCAL #443	07/2011	160.00	512.00				
LOCAL #443	08/2011	160.00	512.00				
LOCAL #443	09/2011	200.00	640.00				
LOCAL #443	10/2011	160.00	512.00				
LOCAL #443	11/2011	160.00	512.00				
LOCAL #443	12/2011	200.00	640.00				
						2040.00 \$	6528.00
TOTAL HOURS WORKED AND EMPLOYER CONTRIBUTIONS FOR THIS PLAN YEAR							

ACCOUNT BALANCE UPDATE

BEGINNING BALANCE	\$ 41,133.25
PLUS	
CURRENT EMPLOYER CONTRIBUTIONS	6,528.00
EQUAL	
ADJUSTED BALANCE	47,661.25
PLUS	
INVESTMENT GAIN (LOSS)	1,969.06
MINUS	
ADMINISTRATIVE COST	(37.70)
ENDING BALANCE	\$ 49,592.61

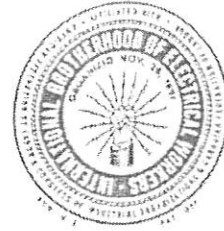
Beneficiary



Prepared by: Southern Benefit Administrators, Incorporated



SOUTHERN ELECTRICAL
 RETIREMENT FUND
 3928 VOLUNTEER DRIVE, CHATTANOOGA, TN 37416-3817
 Phone: (423) 899-2593
 EIN-62-6125711



STATEMENT OF YOUR INDIVIDUAL ACCOUNT
 PLAN YEAR ENDED 12/31/2013

JAMES B. CARDWELL



SOCIAL SECURITY NO:

CONTRIBUTIONS REPORTED IN YOUR BEHALF

EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED	EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED
LOCAL #443	01/2013	160.00	512.00				
LOCAL #443	02/2013	160.00	512.00				
LOCAL #443	03/2013	200.00	640.00				
LOCAL #443	04/2013	160.00	512.00				
LOCAL #443	05/2013	160.00	512.00				
LOCAL #443	06/2013	160.00	512.00				
LOCAL #443	07/2013	160.00	512.00				
LOCAL #443	08/2013	160.00	512.00				
LOCAL #443	09/2013	160.00	528.00				
LOCAL #443	10/2013	160.00	528.00				
LOCAL #443	11/2013	160.00	528.00				
LOCAL #443	12/2013	160.00	528.00				
				1960.00 \$ 6336.00			
				TOTAL HOURS WORKED AND EMPLOYER CONTRIBUTIONS FOR THIS PLAN YEAR			

ACCOUNT BALANCE UPDATE

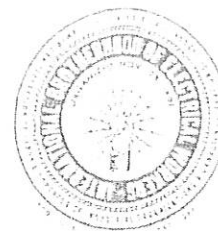
BEGINNING BALANCE	\$ 61,696.91
PLUS	
CURRENT EMPLOYER CONTRIBUTIONS	6,336.00
EQUAL	
ADJUSTED BALANCE	68,032.91
PLUS	
INVESTMENT GAIN (LOSS)	10,536.86
MINUS	
ADMINISTRATIVE COST	(46.13)
ENDING BALANCE	\$ 78,523.64

Beneficiary



SOUTHERN ELECTRICAL
RETIREMENT FUND

3923 VOLUNTEER DRIVE, CHATTANOOGA, TN 37416-3317
Phone: (423) 899-2593
EIN-62-6125711



STATEMENT OF YOUR INDIVIDUAL ACCOUNT
PLAN YEAR ENDED 12/31/2015

JAMES B. CARDWELL



SOCIAL SECURITY NO:



CONTRIBUTIONS REPORTED IN YOUR BEHALF

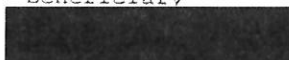
EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED	EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED
LOCAL #443	01/2015	200.00	680.00				
LOCAL #443	02/2015	160.00	544.00				
LOCAL #443	03/2015	160.00	544.00				
LOCAL #443	04/2015	160.00	544.00				
LOCAL #443	05/2015	200.00	680.00				
LOCAL #443	06/2015	160.00	544.00				
LOCAL #443	07/2015	200.00	680.00				
LOCAL #443	08/2015	160.00	544.00				
LOCAL #443	09/2015	160.00	544.00				
LOCAL #443	10/2015	200.00	680.00				
LOCAL #443	11/2015	160.00	544.00				
LOCAL #443	12/2015	160.00	544.00				

TOTAL HOURS WORKED AND EMPLOYER CONTRIBUTIONS FOR THIS PLAN YEAR 2080.00 \$ 7072.00

ACCOUNT BALANCE UPDATE

BEGINNING BALANCE	\$ 92,659.91
PLUS	
CURRENT EMPLOYER CONTRIBUTIONS	7,072.00
EQUAL	
ADJUSTED BALANCE	99,731.91
PLUS	
INVESTMENT GAIN(LOSS)	1,944.20
MINUS	
ADMINISTRATIVE COST	(43.55)
ENDING BALANCE	\$ 101,632.55

Beneficiary





**SOUTHERN ELECTRICAL
RETIREMENT FUND**
3928 VOLUNTEER DRIVE, CHATTANOOGA, TN 37416-3817
Phone: (423) 899-2593
EIN-62-6125711



STATEMENT OF YOUR INDIVIDUAL ACCOUNT
PLAN YEAR ENDED 12/31/2016

JAMES B. CARDWELL



SOCIAL SECURITY NO:

CONTRIBUTIONS REPORTED IN YOUR BEHALF

EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED	EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED
LOCAL #443	01/2016	200.00	680.00				
LOCAL #443	02/2016	160.00	544.00				
LOCAL #443	03/2016	160.00	544.00				
LOCAL #443	04/2016	200.00	680.00				
LOCAL #443	05/2016	160.00	544.00				
LOCAL #443	06/2016	160.00	544.00				
LOCAL #443	07/2016	200.00	680.00				
LOCAL #443	08/2016	160.00	544.00				
LOCAL #443	09/2016	200.00	700.00				
LOCAL #443	10/2016	160.00	560.00				
LOCAL #443	11/2016	160.00	560.00				
LOCAL #443	12/2016	200.00	700.00				

2120.00 \$ 7280.00
TOTAL HOURS WORKED AND EMPLOYER CONTRIBUTIONS FOR THIS PLAN YEAR

ACCOUNT BALANCE UPDATE

BEGINNING BALANCE	\$ 101,632.55
PLUS	
CURRENT EMPLOYER CONTRIBUTIONS	7,280.00
EQUAL	
ADJUSTED BALANCE	108,912.55
PLUS	
INVESTMENT GAIN (LOSS)	6,757.99
MINUS	
ADMINISTRATIVE COST	(48.67)
ENDING BALANCE	\$ 115,621.87

Beneficiary





**SOUTHERN ELECTRICAL
RETIREMENT FUND**
3928 VOLUNTEER DRIVE, CHATTANOOGA, TN 37416-3817
Phone: (423) 899-2593
EIN-62-6125711



STATEMENT OF YOUR INDIVIDUAL ACCOUNT
PLAN YEAR ENDED 12/31/2019

JAMES B. CARDWELL



SOCIAL SECURITY NO:



CONTRIBUTIONS REPORTED IN YOUR BEHALF

EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED	EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED
LOCAL #443	01/2019	173.00	640.10				
LOCAL #443	02/2019	173.00	640.10				
LOCAL #443	03/2019	173.00	640.10				
LOCAL #443	04/2019	173.00	640.10				
LOCAL #443	05/2019	173.00	640.10				
LOCAL #443	06/2019	173.00	640.10				
LOCAL #443	07/2019	173.00	640.10				
LOCAL #443	08/2019	173.00	640.10				
LOCAL #443	09/2019	173.00	683.35				
LOCAL #443	10/2019	173.00	683.35				
LOCAL #443	11/2019	173.00	683.35				
LOCAL #443	12/2019	173.00	683.35				
				2076.00 \$ 7854.20			
				TOTAL HOURS WORKED AND EMPLOYER CONTRIBUTIONS FOR THIS PLAN YEAR			

ACCOUNT BALANCE UPDATE

BEGINNING BALANCE	\$ 144,544.89
PLUS	
CURRENT EMPLOYER CONTRIBUTIONS	7,854.20
EQUAL	
ADJUSTED BALANCE	152,399.09
PLUS	
INVESTMENT GAIN (LOSS)	20,677.58
MINUS	
ADMINISTRATIVE COST	(44.65)
ENDING BALANCE	\$ 173,032.02

Beneficiary





**SOUTHERN ELECTRICAL
RETIREMENT FUND**
3928 VOLUNTEER DRIVE, CHATTANOOGA, TN 37416-3817
Phone: (423) 899-2593
EIN-62-6125711



STATEMENT OF YOUR INDIVIDUAL ACCOUNT
PLAN YEAR ENDED 12/31/2020

JAMES B. CARDWELL



SOCIAL SECURITY NO:

CONTRIBUTIONS REPORTED IN YOUR BEHALF

EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED	EMPLOYER	WORK MONTH	HOURS	CONTRIB RECEIVED
LOCAL #443	01/2020	173.00	683.35				
LOCAL #443	02/2020	173.00	683.35				
LOCAL #443	03/2020	173.00	683.35				
LOCAL #443	04/2020	173.00	683.35				
LOCAL #443	05/2020	173.00	683.35				
LOCAL #443	06/2020	173.00	683.35				
LOCAL #443	07/2020	173.00	683.35				
LOCAL #443	08/2020	173.00	683.35				
LOCAL #443	09/2020	173.00	726.60				
LOCAL #443	10/2020	173.00	726.60				
LOCAL #443	11/2020	173.00	726.60				
LOCAL #443	12/2020	173.00	726.60				
				2076.00 \$ 8373.20			
				TOTAL HOURS WORKED AND EMPLOYER CONTRIBUTIONS FOR THIS PLAN YEAR			

ACCOUNT BALANCE UPDATE

BEGINNING BALANCE	\$ 173,032.02
PLUS	
CURRENT EMPLOYER CONTRIBUTIONS	8,373.20
EQUAL	
ADJUSTED BALANCE	181,405.22
PLUS	
INVESTMENT GAIN (LOSS)	16,616.58
MINUS	
ADMINISTRATIVE COST	(36.36)
ENDING BALANCE	\$ 197,985.44

Beneficiary



Southern Electrical Retirement Fund



my retirement summary

1. [Home](#)
2. View Retirement Summary

Year	Beginning Balance	Contributions	Investment Gain/Loss	Operating Expense	Ending Balance	Beneficiary	Work History
2021	\$197,985.44	\$8,892.20	\$29,695.67	(\$36.54)	\$236,536.77	ELISABET CARDWELL	View Detail
2020	\$173,032.02	\$8,373.20	\$16,616.58	(\$36.36)	\$197,985.44	ELISABET CARDWELL	View Detail
2019	\$144,544.89	\$7,854.20	\$20,677.58	(\$44.65)	\$173,032.02	ELISABET CARDWELL	View Detail
2018	\$137,943.73	\$7,542.80	(\$899.85)	(\$41.79)	\$144,544.89	ELISABET CARDWELL	View Detail
2017	\$115,621.87	\$7,335.20	\$15,034.37	(\$47.71)	\$137,943.73	ELISABET CARDWELL	View Detail
2016	\$101,632.55	\$7,280.00	\$6,757.99	(\$48.67)	\$115,621.87	ELISABET CARDWELL	View Detail
2015	\$92,659.91	\$7,072.00	\$1,944.20	(\$43.56)	\$101,632.55	ELISABET CARDWELL	View Detail

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Southern Electrical Retirement Fund



my retirement summary

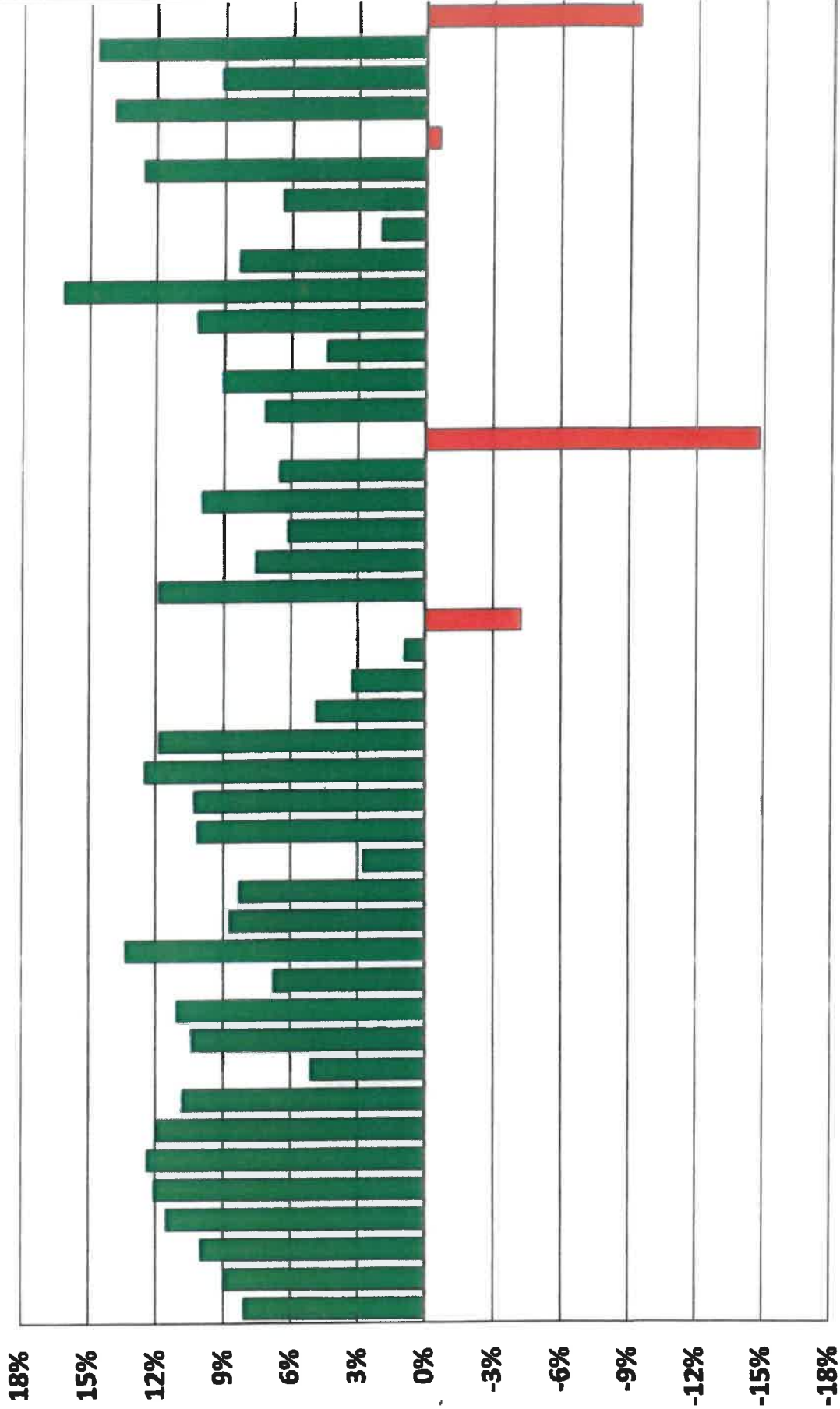
1. [Home](#)
2. View Retirement Summary

Year	Beginning Balance	Contributions	Investment Gain/Loss	Operating Expense	Ending Balance	Beneficiary	Work History
2022	\$236,536.77	\$8,727.85	(\$22,751.19)	(\$33.00)	\$222,480.43	ELISABET CARDWELL	View Detail
2021	\$197,985.44	\$8,892.20	\$29,695.67	(\$36.54)	\$236,536.77	ELISABET CARDWELL	View Detail
2020	\$173,032.02	\$8,373.20	\$16,616.58	(\$36.36)	\$197,985.44	ELISABET CARDWELL	View Detail
2019	\$144,544.89	\$7,854.20	\$20,677.58	(\$44.65)	\$173,032.02	ELISABET CARDWELL	View Detail
2018	\$137,943.73	\$7,542.80	(\$899.85)	(\$41.79)	\$144,544.89	ELISABET CARDWELL	View Detail
2017	\$115,621.87	\$7,335.20	\$15,034.37	(\$47.71)	\$137,943.73	ELISABET CARDWELL	View Detail
2016	\$101,632.55	\$7,280.00	\$6,757.99	(\$48.67)	\$115,621.87	ELISABET CARDWELL	View Detail
2015	\$92,659.91	\$7,072.00	\$1,944.20	(\$43.56)	\$101,632.55	ELISABET CARDWELL	View Detail

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SOUTHERN ELECTRICAL RETIREMENT FUND

Annual Rates Of Return Credited To Participants 1979 Through 2022



79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 00 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22

SOUTHERN ELECTRICAL RETIREMENT FUND

Table Of Historical Rates Of Return (Net Of Investment Expenses)

YEAR	RATE OF RETURN
1977	6.64%
1978	7.30%
1979	8.08%
1980	8.98%
1981	10.00%
1982	11.53%
1983	12.06%
1984	12.37%
1985	11.99%
1986	10.79%
1987	5.08%
1988	10.38%
1989	11.05%
1990	6.76%
1991	13.36%
1992	8.72%
1993	8.29%
1994	2.76%
1995	16.13%
1996	10.28%
1997	12.48%
1998	11.85%
1999	4.87%
2000	3.26%
2001	0.92%
2002	-4.24%
2003	11.88%

2004	7.56%
2005	6.14%
2006	9.94%
2007	6.53%
2008	-14.82%
2009	7.18%
2010	9.05%
2011	4.41%
2012	10.18%
2013	16.13%
2014	8.31%
2015	2.01%
2016	6.40%
2017	12.56%
2018	-0.63%
2019	13.88%
2020	9.35%
2021	14.63%
2022	-9.42%

AVERAGE RATES OF RETURN

FOR SELECT PERIODS:

Latest 5 Years	5.56%
Latest 10 Years	7.32%
Since 01/01/1979 ¹⁾	7.71%

¹⁾This is the date SBAI became the Fund's Consultant.

Pension

National Electrical Benefit Fund (NEBF)

\$33.00 PER MONTH PER YEAR OF SERVICE

(Defined Benefit* paid by Employer)

<u>Years</u>	<u>Monthly Benefits</u>
5	\$165.00
10	\$330.00
15	\$495.00
20	\$660.00
25	\$825.00
30	\$990.00
35	\$1,155.00
40	\$1,320.00

Requirements:

- Five years vesting.
- Average 1,000 hours worked per year.
- Work no less than 300 hours per year.

*Defined benefit provides a lifetime monthly income.

NEBF

National Electrical
Benefit Fund

SUMMARY PLAN
DESCRIPTION



2016

INTRODUCTION

The National Electrical Benefit Fund (NEBF) was established as a result of an agreement between the International Brotherhood of Electrical Workers (IBEW) and the National Electrical Contractors Association (NECA) in 1946 to provide workers in the electrical construction industry with a retirement plan.

This booklet is a "Summary Plan Description" (SPD) and contains a summary of the Plan of Benefits for the NEBF (the Plan) in effect as of January 1, 2016. As a summary, this SPD cannot cover all of the details of the Plan; it is an overview. The Plan governs all questions concerning benefits, rights, and responsibilities under the Plan. In the event of a conflict between the SPD and the Plan, the Plan will govern.

There have been many changes to the Plan since it was established. Your benefit is generally based on the rules of the NEBF at the time you begin receiving a benefit. Therefore, before making any decision that could affect your rights or responsibilities under the Plan — such as a decision to retire — you should contact the NEBF office and ask about how the Plan applies to your situation. If you have any questions about the NEBF, you should contact the NEBF office.

CONTACTING NEBF

We invite you to visit NEBF's website at www.nebf.com where you can find all of the basic forms and documents used by NEBF and the latest information concerning NEBF.

You may also contact NEBF by writing to the address shown below. If you would like to speak to a Pension Services Representative, you may call between the hours of 8:00 a.m. and 5:00 p.m. (EST), Monday through Friday.

National Electrical Benefit Fund
2400 Research Boulevard, Suite 500
Rockville, MD 20850-3266
Telephone: 301-556-4300
Fax: 301-556-0100
www.nebf.com

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Section 1 – What Is NEBF?

The National Electrical Benefit Fund (NEBF) is a Taft-Hartley, multiemployer, defined benefit pension plan that provides retirement benefits and related benefits to employees in the electrical industry.

Participants accumulate credit in NEBF based upon their years of Covered Employment. Qualifications for benefits and the amount of those benefits are based upon a Participant's years of service with Covered Employers, age at retirement, type of benefit selected, and the pension rate at time of retirement.

How Are Contributions Made?

Contributions are made each month by Covered Employers on behalf of employees who are covered by either:

- A collective bargaining agreement with the International Brotherhood of Electrical Workers (IBEW) or one of its Local Unions, *or*
- A signed participation agreement with NEBF.

How Much Does My Employer Contribute to NEBF?

Covered Employers contribute 3% of their covered employees' gross labor payroll each month to NEBF.

Can I Contribute to NEBF?

No. All contributions to NEBF are made by Covered Employers. Covered employees do not themselves make contributions to NEBF and do not have individual accounts in NEBF.

Section 2 – Participating in NEBF

You become a Participant in NEBF on your first day of Covered Employment. Your hours in Covered Employment will count toward your eligibility for a benefit from NEBF. You shall no longer be a Participant upon the loss of your Vesting Service Credits.

Once you become Vested, you have a right to a benefit from NEBF, and you cannot lose that right. If you stop working in Covered Employment before you are Vested, you remain a Participant until your Vesting Service Credits are lost.

Section 3 – Becoming Vested

Effective January 1, 1988, you are considered Vested when you have accumulated five Vesting Service Credits or reach age 65 with earned Pension Credits. Different rules apply to becoming Vested prior to January 1, 1988.

Why Is It Important to Be Vested?

There are three reasons why it is important to be Vested.

NORMAL
RETIREMENT BENEFIT

EARLY
RETIREMENT BENEFIT

REDUCED EARLY
RETIREMENT BENEFIT

DISABILITY BENEFIT

PRE-RETIREMENT
SPOUSE BENEFIT

1. You have a right to a benefit from NEBF, and you cannot lose that right.
2. You will not lose any Vesting Service Credits or Pension Credits that you have already earned should you incur a Break in Service.
3. You may earn additional Pension Credits if you return to Covered Employment without having to become Vested again.

What Happens If I Do Not Become Vested?

If you are not Vested and incur a Break in Service, you lose all Vesting Service Credits and Pension Credits that you have accumulated. However, if you retire at age 65 or older and have not lost your Pension Credits, you may be eligible for a benefit even if you are not Vested.

Section 4 — Earning Credits Toward a Benefit

Your eligibility for a benefit and the amount of that benefit depend on the number of credits you earn. Generally, credits are earned for hours worked in Covered Employment. There are two types of credits you can earn: Vesting Service Credits and Pension Credits.

Section 4.1 — Vesting Service Credits

Vesting Service Credits determine your right to a benefit. To be Vested means that you have a non-forfeitable right to a benefit from NEBF.

How Do I Earn Vesting Service Credits?

Generally, you earn Vesting Service Credits by accumulating hours worked in Covered Employment in Good Years. There is a 1,000 hour requirement for each Vesting Service Credit.

You generally earn one Vesting Service Credit for each year you work 1,000 hours or more. The hours in excess of 1,000 can be used to meet the 1,000 hour requirement for other Good Years in which you worked less than 1,000 hours.

For hours to count toward the 1,000 hour requirement, you must have a Good Year. A Good Year is generally a year in which you work 300 or more hours in Covered Employment. You can earn only one Vesting Service Credit in any calendar year.

In the event you believe you are entitled to Vesting Service Credits for time not reflected in NEBF's records, it will be your responsibility to produce records proving your entitlement to such Vesting Service Credits.

Can I Earn Vesting Service Credits for Time When I Was in Non-Covered Employment?

Yes, you can earn Vesting Service Credits for time when you were in Non-Covered Employment if you meet either of the requirements in A or B below:

A	<ul style="list-style-type: none">• You have previously worked in Covered Employment, and• You work 300 hours or more in Non-Covered Employment for a Covered Employer.
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OR

B

- You earn a Past Service Credit (see Section 4.2.2).

Can I Earn Vesting Service Credits for My Time While on Maternity or Paternity Leave?

If you leave and return to Covered Employment for maternity or paternity leave, you may be granted hours that count toward the 1,000 hour requirement for a Vesting Service Credit. It is your responsibility to provide NEBF with timely information to determine your right to these hours.

Can I Earn Vesting Service Credits for My Time in Military Service?

You may receive $83\frac{1}{3}$ hours for each month during the term of your military service plus the length of time taken to return to Covered Employment or Non-Covered Employment for a Covered Employer that count toward the 1,000 hour requirement for a Vesting Service Credit, if you meet the following requirements:

- You previously worked in Covered Employment, **and**
- You leave Covered Employment or Non-Covered Employment with a Covered Employer to enter military service, **and**
- You enter military service for the first time or because you are recalled, **and**
- You leave military service after your first term of service or the period of recall, **and**
- You return to Covered Employment or Non-Covered Employment with a Covered Employer within three months of leaving military service.

It is important that you notify NEBF when you leave employment to enter the military and when you are discharged and return to employment. NEBF also complies with USERRA, if that law provides greater benefits.

Section 4.2 – Pension Credits

Pension credits are generally earned while working in Covered Employment. They are used to determine your benefit amount. You cannot earn Pension Credits for hours worked in Non-Covered Employment. Pension Credits are not based on union membership.

There are two types of Pension Credits: Benefit Service Credits and Past Service Credits. These are added together to give the total number of Pension Credits that are used to determine your benefit amount.

Section 4.2.1 – Benefit Service Credits

Benefit Service Credits are earned based upon the number of hours you work in Covered Employment.

How Do I Earn Benefit Service Credits?

Generally, you earn Benefit Service Credits by accumulating hours worked in Covered Employment in Good Years. There is a 1,000 hour requirement for each Benefit Service Credit.

You generally earn one Benefit Service Credit for each year you work 1,000 hours or more. The hours in excess of 1,000 can be used to meet the 1,000 hour requirement for other Good Years in which you worked less than 1,000 hours.

For hours to count toward the 1,000 hour requirement, you must have a Good Year. A Good Year is generally a year in which you work 300 or more hours in Covered Employment. You can earn only one Benefit Service Credit in any calendar year.

In the event you believe you are entitled to Benefit Service Credits for time not reflected in NEBF's records, it will be your responsibility to produce records proving your entitlement to such Benefit Service Credits.

Can I Earn Benefit Service Credits for Time When I Was in Non-Covered Employment?

No, you cannot earn Benefit Service Credits for working in Non-Covered Employment. Benefit Service Credits are only earned for working in Covered Employment.

Can I Earn Benefit Service Credits for My Time While on Maternity or Paternity Leave?

No, you cannot earn Benefit Service Credits for time while on maternity or paternity leave.

Can I Earn Benefit Service Credits for My Time in Military Service?

You may receive $83\frac{1}{3}$ hours for each month during the term of your military service plus the length of time taken to return to Covered Employment or Non-Covered Employment for a Covered Employer that count toward the 1,000 hour requirement for a Benefit Service Credit, if you meet the following requirements:

- You previously worked in Covered Employment, **and**
- You leave Covered Employment or Non-Covered Employment with a Covered Employer to enter military service, **and**
- You enter military service for the first time or because you are recalled, **and**
- You leave military service after your first term of service or the period of recall, **and**
- You return to Covered Employment or Non-Covered Employment with a Covered Employer within three months of leaving military service.

It is important that you notify NEBF when you leave employment to enter the military and when you are discharged and return to employment. NEBF also complies with USERRA, if that law provides greater benefits.

Section 4.2.2 – Past Service Credits

Past service credits are credits that recognize the years you worked in a job classification that was not Covered Employment but later becomes Covered Employment for that employer.

How Do I Earn Past Service Credits?

You may earn a maximum of five Past Service Credits. These credits are earned on a one-for-one basis (one Past Service Credit for one Benefit Service Credit). Past Service Credits also count toward earning a Vesting Service Credit.

You earn one Past Service Credit *in any year* you meet the following requirements:

- You earn a Benefit Service Credit while in Covered Employment with your current employer, *and*
- Your past employer becomes or remains a Covered Employer, *and*
- Your past job classification is Covered Employment with that past employer.

In the event you believe you are entitled to Past Service Credits for time not reflected in NEBF's records, it will be your responsibility to produce records proving your entitlement to such Past Service Credits.

Section 5 – Losing Vesting Service Credits and Pension Credits

Once you are Vested, you do not lose the Vesting Service Credits or the Pension Credits you have earned. If you are not Vested and incur a Break in Service, all Vesting Service Credits and Pension Credits will be lost.

What Is a Break in Service?

After January 1, 1985, a Break in Service is a period of five consecutive calendar years when you do not have a Good Year in Covered Employment. Different rules apply to a Break in Service prior to January 1, 1985.

What Does a Break in Service Mean to Me?

The effect of a Break in Service depends on your vesting status. If you are Vested, you do not lose any previously accumulated Vesting Service Credits or Pension Credits. However, a Break in Service may affect your benefit amount.

If you are not Vested, you lose any previously accumulated Vesting Service Credits and Pension Credits.

Are There Circumstances Not Considered a Break in Service?

There are circumstances that are not considered a Break in Service because:

- You are unable to work in your job classification as a result of serious injury, illness, or disease, **or**
- You are receiving or entitled to receive accident and/or sickness benefits or workmen's compensation, **or**
- You are on strike or locked out for a maximum period of six months, **or**
- You are on maternity or paternity leave, **or**
- You are on military leave, **or**
- You are working in Non-Covered Employment for a Covered Employer, **or**
- You are working for an employer, under an IBEW contract, that does not make contributions to NEBF, **or**
- You are working as an instructor in an IBEW/NECA apprenticeship program where such instructors are not covered by NEBF, **or**
- You are working as an electrical inspector for a governmental authority, where such inspectors are not covered by NEBF, **or**
- You are working as a full time employee of a State or National Labor Federation or a similar organization in which the IBEW or NECA is a member.

It is your responsibility to prove that one of the above circumstances applies.

Section 6 — Determining Your Benefit Amount

For each Benefit Service Period, the number of Pension Credits you have earned is multiplied by the pension rate, and the results are added together. The total is your benefit amount for that Benefit Service Period.

What Is a Benefit Service Period?

A Benefit Service Period is a period of time to which a particular pension rate applies. A Participant may have multiple Benefit Service Periods due to a gap in employment.

If you leave Covered Employment or are out of Covered Employment for a specific period of time, the Pension Credits you previously earned will be added together and a specific pension rate will be applied to them. Some Participants may have multiple pension rates applied in determining their benefit amount, while others may have only one.

Pension Rates

The pension rates paid for Pension Credits have improved over the years. The pension rate is based on the pension rates that are in effect at your Effective Date. The pension rate that is used to determine your benefit amount depends on two factors:

- When you left Covered Employment, *and*
- How long you have been out of Covered Employment.

Over the years, there have been amendments to the Plan which have changed the rate in effect rules. The rate in effect rules are:

- If you left Covered Employment for three or more years and your last Good Year prior to leaving Covered Employment was 1989 or earlier, the pension rate applied to the Pension Credits you earned prior to that gap in employment will be the pension rate in effect three years after you left Covered Employment plus any increases which may apply to that rate.
- If you left Covered Employment for five or more years and your last Good Year prior to leaving Covered Employment was between 1990 and 1992, the pension rate applied to the Pension Credits you earned prior to that gap in employment will be the pension rate in effect five years after you left Covered Employment plus any increases which may apply to that rate.
- If you left Covered Employment for seven or more years and your last Good Year prior to leaving Covered Employment was 1993 or later, the pension rate applied to the Pension Credits you earned prior to that gap in employment will be the pension rate in effect seven years after you left Covered Employment plus any increases which may apply to that rate.
- If you have earned Pension Credits and have not left Covered Employment for the three, five, or seven year periods described above, or you have earned Pension Credits upon returning to Covered Employment following a gap, the pension rate applied to the Pension Credits you earned will be the rate in effect on the Effective Date of your benefit plus any increases which may apply to that rate.

Determining the Pension Rate

The table on the following page shows the pension rate or rates that apply to your benefit amount. There will be only one rate if you only have one Benefit Service Period. There will be more than one rate if you have more than one Benefit Service Period.

If you have a gap in Covered Employment, use the rate in effect rules discussed earlier in this section to determine if you have more than one Benefit Service Period.

Example 1

If you continuously work in Covered Employment until the date of your retirement in 2006, the pension rate applied to the Pension Credits you earned will be the rate in effect when you retire. The rate for 2006 is \$32.00 for each Pension Credit.

Example 2

If you continuously work in Covered Employment from 1999 through 2003; do not work in Covered Employment in 2004 or 2005; and return to Covered Employment and retire in 2006, your gap in Covered Employment is not long enough to create a separate Benefit Service Period. The pension rate applied to the Pension Credits you earned will be the rate in effect when you retire. The rate for 2006 is \$32.00 for each Pension Credit.

Example 3

If you left Covered Employment prior to retirement in 1987 and never returned, the 1990 pension rate will be applied to the Pension Credits you earned, giving you \$19.68 for each Pension Credit.

CURRENT NORMAL RETIREMENT RATES

DATES	AMOUNT
Prior to July 1-1977	\$8.03
July 1-1977 thru Dec 31-1980	\$12.09
Jan 1-1981 thru Dec 31-1982	\$13.42
Jan 1-1983 thru Dec 31-1984	\$15.28
Jan 1-1985 thru Feb 28-1986	\$15.99
Mar 1-1986 thru Dec 31-1986	\$17.98
Jan 1-1987 thru Dec 31-1988	\$18.63
Jan 1-1989 thru Dec 31-1989	\$19.19
Jan 1-1990 thru Dec 31-1990	\$19.68
Jan 1-1991 thru Dec 31-1991	\$21.29
Jan 1-1992 thru Dec 31-1992	\$21.82
Jan 1-1993 thru Dec 31-1993	\$22.96
Jan 1-1994 thru Nov 30-1995	\$23.64
Dec 1-1995 thru Dec 31-1996	\$25.13
Jan 1-1997 thru Dec 31-1997	\$26.22
Jan 1-1998 thru Dec 31-1998	\$27.59
Jan 1-1999 thru Dec 31-1999	\$29.13
Jan 1-2000 thru Dec 31-2000	\$30.60
Jan 1-2001 thru Jun 30-2001	\$31.00
July 1-2001 forward	\$32.00

Section 7 — Types of Benefits

NEBF provides three types of benefits:

- Retirement Benefits
- Disability Benefits
- Pre-Retirement Spouse Benefits

Benefits are available to eligible Participants who submit an application. Each of the benefit types and its eligibility requirements are discussed in this section.

You can use the chart on the next page to quickly determine the NEBF benefit type you are eligible to receive. The descriptions can be easily located using the "color coded" tabs printed along the right hand side of the page.

Pension

IBEW Pension Benefit Fund (PBF)-currently \$5.50 per month per year of service. (Defined Benefit* financed by your monthly dues.)

<u>Years</u>	<u>Monthly Benefits</u>
5	\$27.50
10	\$55.00
15	\$82.50
20	\$110.00
25	\$137.50
30	\$165.00
35	\$192.50
40	\$220.00

*Defined Benefit provides a lifetime monthly income.



IBEW Pension Benefit Fund (PBF)

Bruce Burton
Director

IBEW Pension and Reciprocity Department

Contact info:

Phone: (202) 728-6094

Fax: (202) 728-6260

PBF History

- Death Benefit (EWBA) established in 1922
- PBF authorized at 1927 Convention; began in 1928 for "A" members only
- Only Normal (age 65-older) until 1966
- Disability and Vested Pension added 1966
- Optional Spousal Benefit added 1970
- Early retirement added 1973
- EWBA and PBF merged January 1, 1992

PBF Facts

For Fiscal Year ending June 30, 2018

- PBF assets approximately 2.2 billion dollars (U.S.)
- Currently, 114,323 retirees receive a monthly pension payment from PBF
- 7,352 members retired during FY 2017
- Pension payments over \$143 million (U.S.)
- PBF paid 8,492 death claims for a total of \$19.2 million (U.S.)

PBF Documents

- IBEW Constitution Article XI
- International Executive Council's Rules and Regulations
- Summary Plan Description
- Frequently Asked Questions
- All are available on IBEW website at www.ibew.org

Article XI

Admission to Pension

- PBF is a union-dues financed plan with no employer contributions whatsoever. Thus, PBF not subject to vesting requirements of ERISA
- Current contribution rate is \$18 a month
- “A” members must maintain continuous good standing until member is placed on pension
- Retired members may not work in the Electrical Industry, except where permitted in Article XI Section 6, Subsection (d): Prohibition of Work
- IEC interprets “Electrical Industry” very broadly

Application Procedures

- Make application no more than six (6) months before retirement.
- Applications available online at LU Connections and www.ibew.org Click on the Resources Link then Other Labor Organization Sites or Departments Link and then Pension and Reciprocity
- Member must complete entire application, including direct deposit form, or application will not be processed
- LU must approve application and provide signatures including LU seal before sending application and required documents to IBEW Pension and Reciprocity Department.

Normal Pension

- Must be age 65 and have minimum 5 years service
- Pay-out rate of \$4.50 per year of continuous membership effective January 1, 2007
- **May not work in the electrical industry,** except where permitted in Article XI Sec. 6(d)
- Optional Spousal Benefit is available but is **irrevocable once placed on pension**
- Lump sum payment if monthly benefit equal or less than \$30.00 (U.S.) or Canadian equivalent.

Early Retirement

- Age 62-64 with minimum 20 years service
- Pay-out rate of \$4.50 per year of continuous service effective 1/1/07 reduced by 6.66% for each year under age 65
- **May not work in the electrical industry,** except where permitted in Article XI Sec. 6(d)
- Optional Spousal Benefit is available and is **irrevocable once placed on pension**
- Early retirement, once selected, is **irrevocable**
- Lump sum payment if monthly benefit equal or less than \$30.00 (U.S.) or Canadian equivalent

Total Disability Pension

- Must have minimum 20 years service
- Pay-out rate of \$4.50 per year of continuous service effective 1/1/07
- Must be totally disabled; **may not work whatsoever** (unlike Social Security)
- SSD or CPP award or equivalent is preferred. In lieu of award, medical information may be submitted and reviewed by IBEW physician
- Optional Spousal Benefit available and is **irrevocable once placed on pension**
- Apply for total disability pension if you have filed for SSD, CPP, or equivalent

Vested Pension

- Must have minimum of 20 years service
- PBF does not have automatic vesting – if you are eligible and wish to leave “A” membership, you must apply or lose pension benefit.
- **Will not qualify unless leaving the electrical industry**
- Pay-out rate of \$4.50 per year of continuous service reduced by \$4.50 for each year member is under age 65 at time of application
- Vested pension available first month following 65th birthday. Retiree must contact PBF
- **No Disability Pension, Death Benefit or Optional Spousal Benefit**
- Lump sum payment made if monthly benefit equal to or less than \$30.00 (U.S.) or Canadian equivalent
- Instead of vested pension, I.O. encourages members leaving electrical industry to take a Participating Withdrawal - \$37 monthly dues: \$18 PBF, \$19 per capita

Optional Spousal Benefit (OSB)

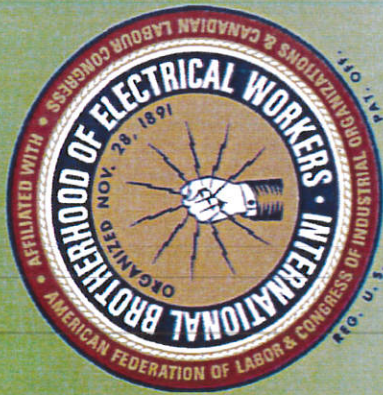
- Normal, early and disability applicants can elect OSB
- **Election cannot be changed once member is placed on pension**
- OSB reduces monthly benefit to 86.5%, plus or minus .5%, based on calculations using member's and spouse's birth dates
- Upon member's death spouse receives one half of member's monthly benefit
- Lump sum payment made if monthly benefit equal or less than \$30.00 (U.S.) or Canadian equivalent
- Member's pension will "pop-up" if spouse predeceases or divorces member

Death Benefit (DB)

- Average age at time of passing: 81.3 years
- Normal DB \$6,250.00
- Accidental DB only for active "A" members: \$12,500
- Retiree DB is reduced from \$6,250 by amount of pension payments received, but no lower than \$3,000
- Member must have minimum six months continuous good standing to be eligible for DB
- Per Article XI, member who is more than 2 months in arrears is ineligible, unless arrearage was no fault of the member

Death Benefit (Continued)

- Only active “A” members and normal, early, total disability pensioners eligible for DB. **Those on vested pension are ineligible.**
- Per Article XI, Section 4, Subsection (b), all members have the right to name a beneficiary
- However, in absence of named beneficiary DB will be paid in descending order: members spouse, children, parents, estate
- Contact Pension and Reciprocity Department to initiate a claim



Questions?

Pension Department Contact
Information:

Phone 202-728-6206

Fax 202-728-6138

Email Pension@ibew.org

NECA- IBEW FAMILY MEDICAL CARE PLAN

(FMCP - Inside Wiremen)

Major Medical Benefits

\$8.85 per hour worked (paid by employer)

- Family Coverage
- 85% coverage after \$350.00 deductible
- \$100.00 deductible for Emergency Room
- 100% coverage after out-of-pocket expense
- Prescription Coverage – Generic \$0 co-pay / Brand Name 20% co-pay up to \$1,00.00 out of pocket max
- \$1,900 maximum out-of-pocket per person per year
- \$3,800 maximum out-of-pocket per family per year
- \$0.15 per hour into Health Savings Account

Dental Benefits

- Maximum Benefit \$1,500 per person per calendar year.
- 80% preventative & basic care
- 50% major restorative care
- Orthodontia 50% with \$1,000 lifetime max

Vision Benefits

- Provided through Vision Service Plan (VSP)
- Examination once per year paid in full
- Frames every 12 months \$180.00
- Lenses every 12 months paid in full
- Contacts every 12 months \$150.00
- Safety Glasses every 12 Months \$65 (Frames)

IMPORTANT CONTACT INFORMATION

<p>NECA/IBEW Family Medical Care Plan Benefit Office 410 Chickamauga Avenue, Suite 301 Rossville, GA 30741</p> <p>Phone: 1-877-937-9602 or 1-706-841-7000 Fax: 1-706-841-7020</p> <p>Contact the FMCP Benefit Office if you have:</p> <ul style="list-style-type: none"> • Questions regarding claims or eligibility; • Need a new medical I.D. card; • If you or a dependent moves, if your family/ dependent status changes, if anyone in your family acquires other coverage, or if you retire or enter active military service. 	<p style="text-align: center;">Anthem Blue Cross <i>Blue Card through Anthem/BSBSGA</i></p> <p>Members - To find a PPO Provider:</p> <ul style="list-style-type: none"> • www.anthem.com • Call 1-800 810-BLUE (2583) <p>Providers - To verify eligibility / benefits:</p> <ul style="list-style-type: none"> • Call 1-844-594-0393 • Providers should file claims through their local Blue Cross affiliate. <p>Utilization review, care management & pre-certification</p> <ul style="list-style-type: none"> • Call 1-855-343-4852 <p>Important:</p> <ul style="list-style-type: none"> • If you use a Blue Card PPO provider, covered services will be paid at the high in-network benefit level. • Your group identification number is on your ID card.
<p style="text-align: center;"><i>Vision Benefits - if applicable</i></p> <p style="text-align: center;">VSP PO Box 385018 Birmingham, AL 35238-5018</p> <p>For customer service or to find a PPO provider:</p> <ul style="list-style-type: none"> • www.vsp.com • Call 1-800-877-7195 <p>Important:</p> <ul style="list-style-type: none"> • Vision claims should NOT be sent to the Benefits Office or Anthem BCBS. 	<p style="text-align: center;"><i>Dental Benefits - if applicable</i></p> <p style="text-align: center;">MetLife® PO Box 981282 El Paso, TX 79998-1282</p> <p>For customer service or to find a PPO Provider:</p> <ul style="list-style-type: none"> • www.metlife.com/mybenefits • Call 1-800-942-0854 <p>Important:</p> <ul style="list-style-type: none"> • Your group account number is 304133. • MetLife handles all dental claims.
<p style="text-align: center;"><i>Treatment Plan Review</i></p> <p style="text-align: center;">Best Doctors 60 State Street, Suite 600 Boston, MA 02109</p> <p>For customer service:</p> <ul style="list-style-type: none"> • Phone: 1-800-497-1634 • https://members.bestdoctors.com/ 	<p style="text-align: center;"><i>Prescription Drug Benefits</i></p> <p style="text-align: center;">Sav-Rx</p> <p>For customer service:</p> <ul style="list-style-type: none"> • www.savrx.com • Call 1-866-233-IBEW (4239) <p>Important:</p> <ul style="list-style-type: none"> • Contact Sav-Rx if you have questions about your prescription drug benefits.
<p style="text-align: center;"><i>24/7 Virtual Doctor Visits</i></p> <p style="text-align: center;">LiveHealth Online</p> <p>To access this service:</p> <ul style="list-style-type: none"> • Visit livehealthonline.com or download the free LiveHealth Online app to your mobile device. 	

INTRODUCTORY INFORMATION

About This Booklet

This booklet outlines the health care benefits provided to participants in Plan 15 provided by the NECA/IBEW Family Medical Care Plan (referred to as “the Plan” in this booklet).

Wherever the term “you” or “your” is used in this booklet, it means an eligible employee or, where applicable, an eligible retiree.

If you are a Plan 15 participant who meets the Plan’s eligibility requirements, you and your family members who meet the Plan’s definition of a *dependent* (on page 68 of this booklet) will be eligible for the benefits described herein.

The following benefits that are discussed in this booklet are considered ancillary benefits, and you will only be entitled to these coverages if they are included in your employer’s contract with the Plan:

Dental	Vision
Weekly Disability	Life insurance
AD&D insurance	Individual Special Fund Account

If you are not sure which benefits you are entitled to you, call the Benefit Office at 1-877-937-9602.

Other Benefit Plans Provided by the Fund

The NECA/IBEW Family Medical Care Trust Fund (referred to as the “Fund” in this booklet) provides benefit schedules that differ from the benefit plan described in this booklet. Because the benefits differ, those plans are described in separate booklets. (The plan of benefits that applies to a specific Plan participant is determined by the participant’s employer’s agreement with the Trustees of this Plan.)

Be Sure to Carry and Use Your I.D. Cards

You and your spouse should both carry an Anthem Blue Cross Blue Shield I.D. card or a United Healthcare (UHC) Medicare Advantage I.D. card if you are a Medicare-eligible retiree or the dependent of a Medicare-eligible retiree covered under the UHC Medicare Advantage Plan. Show your card whenever you or a family member receives medical care at a hospital, doctor’s office or other medical facility. Call the Benefit Office if you need another medical I.D. card.

If you are on the UHC Medicare Advantage Plan, be sure to carry both your UHC I.D. card and Sav-Rx prescription drug card, as your prescription drug benefits are administered jointly by UHC and Sav-Rx. Call the Sav-Rx customer service line if you need prescription cards.

Does the Benefit Office Have Your Current Address?

When the Benefit Office is informed that your or a dependent’s coverage is going to terminate, it is required by law to send you information about your right to make self-payments. Therefore, the Benefit Office should always have the current mailing address for you and all your eligible dependents so that you can be sent this information as well as other important notices which are mailed to Fund participants from time to time.

Be sure to inform the Benefit Office if you or any of your eligible dependents have a change of address.

SPECIAL PLAN FEATURES

Your Blue Card PPO Network

Your Preferred Provider (PPO) network is the national Blue Card PPO network through Anthem/Blue Cross Blue Shield of Georgia (your “home plan”), an independent licensee of the Blue Cross and Blue Shield Association. The Blue Card network links individual Blue Cross Blue Shield (BCBS) PPO networks to provide you with access to the largest health care network in America.

If you use BCBS PPO network providers, you will receive the PPO (in-network) benefits shown on the *Schedule of Benefits*.

Most hospitals and physicians participate in the national Blue Card network.

**To locate a BCBS PPO provider:
Call 1-800-810-BLUE (2583) or go to www.anthem.com.**

The phone number and website address are also on the back of your I.D. card.

Your Anthem I.D. Card

Your Anthem/BCBS I.D. card gives you access to BCBS network providers throughout the United States. The three-letter alpha prefix that precedes your subscriber number on your I.D. card identifies Anthem/Blue Cross and Blue Shield of Georgia (BCBSGA) as your home plan.

Preferred and Participating Providers

There are two types of health care professionals in the Blue Card program:

- **Preferred Providers (PPO Providers)** are part of the regular PPO network. They file claims for you, and your benefits are generally higher when you use their facilities and services.
- **Participating Providers** are non-PPO providers who have agreed to perform services at discounted rates for Blue Card PPO members. Typically, you would go to a participating provider if there are no PPO health care professionals in your area who can provide the medical care you need. Participating providers will also file your claims for you.

Pre-Certification Requirements

Call 1-855-343-4852 for pre-certification.

The number to call for pre-certification is also on your I.D. card.

- **Inpatient Confinements** - You and your dependents are required to pre-certify each inpatient hospitalization by calling Anthem prior to admission. A \$250 benefit reduction will apply to each hospitalization that is not pre-certified.
- **Home Health Care and Durable Medical Equipment** - You should also call for pre-certification prior to receiving home health care, and durable medical equipment that costs at least \$500.
- **Diagnostic Imaging – AIM Specialty Health** - You must also obtain pre-certification for imaging procedures and specialized cardiovascular treatments in order for these benefits to be covered by the Plan. Pre-certification for these services is done by AIM Specialty Health, an Anthem affiliate, but you can access AIM through the same telephone number (1-855-343-4852). AIM Specialty Health will pre-certify services such as:

- Computed tomography (CT)
- Magnetic resonance imaging and angiogram (MRI/MRA)
- Positron emission tomography (PET)
- Heart/cardio procedures such as myocardial perfusion imaging (MPI), stress echocardiography, transthoracic echocardiography, transesophageal echocardiography, arterial ultrasound, cardiac catheterization and percutaneous coronary intervention (PCI)

Pre-certification is NOT a guarantee of payment.

Services are approved based on medical necessity and appropriateness. Actual payment is dependent upon that person meeting the Plan's eligibility rules and other provisions. See page 35 for more information about the *Utilization Review Program*.

Your Dental PPO Network (if applicable)

MetLife® administers the Plan's dental benefits. In addition to handling your dental claims, MetLife has a network of dentists – called the MetLife® Preferred Dentist Program (PDP) – who have agreed to accept MetLife's maximum allowed charge as payment in full. However, you do NOT have to use MetLife dentists to receive dental benefits. The same benefit levels will be provided for both in-network and out-of-network dental services. But you will save money using PDP dentists because of lower fees.

**For customer service or to find a PPO provider:
Call MetLife at 1-800-942-0854 or go to www.metlife/mybenefits.
Refer to group account number 304133.**

You do not need any authorization from MetLife or the Benefit Office to choose a dentist. See page 46 for more information about Your Dental PPO Network.

Your Vision Plan (if applicable)

Vision Service Plan (VSP) administers the Plan's vision benefits and provides a network of VSP doctors who will provide basic vision services to you at no charge and with no claims to file. See the *Vision Benefits* section starting on page 50 for more information.

Your Medicare Advantage Plan (if applicable)

United Healthcare (UHC) administers the Plan's Medicare Advantage Plan for Medicare eligible retirees and their dependents. For a summary of benefits provided by UHC, please review your UHC Medicare Advantage Plan information packet or call UHC at 1-800-457-8506.

Your Prescription Drug Program

The Plan provides its prescription drug benefits through a program administered by Sav-Rx. You can use your medical I.D. card to purchase short-term or acute prescription drugs (such as antibiotics or pain relievers) from any participating retail pharmacy. There is also a mail-order feature allowing you to save even more money on your long-term and maintenance prescription drugs. See page 43 for more information about your prescription drug program.

If you are on the UHC Medicare Advantage Plan, your prescription drug coverage is administered jointly by UHC and Sav-Rx. UHC is the primary prescription drug plan and Sav-Rx is secondary, but your benefits will not change if both prescription drug programs are used.

**You can contact Sav-Rx for customer service at 1-866-233-IBEW (4239)
or at www.savrx.com.**

Note: If your spouse has coverage under another health plan, he or she must follow the rules of her prescription drug plan first and then file a claim with Sav-Rx for consideration of the remaining charge. The same applies to

prescription drugs for any children for whom your spouse's plan pays primary benefits.

**Wal-Mart and Sam's Club are NOT part of your network.
The Plan will not cover drugs purchased from their pharmacies.**

LiveHealth Online

LiveHealth Online is a new benefit that uses two-way video to connect you with board-certified physicians that can help diagnose minor illnesses or injuries. Doctors using LiveHealth Online can answer your questions, assess your condition and even provide certain prescriptions if needed.

You can utilize this service with your smartphone, tablet or computer with a webcam. To begin using this program, visit www.livehealthonline.com and sign up for an account using your Plan information. Once your account is set up and your insurance information is entered correctly, you can begin connecting with doctors immediately.

LiveHealth Online is a great tool to use when you don't have time to get to your primary care physician or you want to avoid an unnecessary trip to the emergency room.

For more information, please contact the Benefit Office or go to www.livehealthonline.com.

Best Doctors

Best Doctors helps ensure you are receiving the best medical care from all of your providers. At your request, Best Doctors can review your medical records and provide helpful information and advice from a world-renowned medical expert in the appropriate field when you or your dependent are facing a critical medical decision that involves a serious diagnosis like cancer or surgery. It's a great tool to ensure that your physician is treating whatever illness or injury you have using the best possible treatments available.

For more information or to discuss your medical case with a Best Doctors' representative, call 1-800-497-1634 or visit <https://members.bestdoctors.com/>.

The Working Spouse Rule

Basic Rule

If your spouse works and is eligible for coverage through his or her employer, then your spouse is REQUIRED to enroll in the employer's health plan. If your spouse fails to enroll in the employer's plan, this Plan will only pay 20% of covered medical and prescription drug expenses your spouse incurs.

If your spouse has already declined his/her employer's plan at the time you become eligible, the penalty reduction will not apply to your spouse's claims as long as he/she opts into his/her employer's plan during the next open enrollment period.

Hardship Exemption

The working spouse rule will NOT apply if your spouse:

1. Has gross annual wages of less than \$23,000; or
2. Has gross annual wages greater than or equal to \$23,000 but less than \$35,000 and must pay more than \$200 per month toward the cost of the least expensive health plan offered by her employer.

You are responsible for demonstrating your entitlement to a hardship exemption by submitting a letter attesting to wages and cost of coverage from the employer on company letterhead. The Benefit Office will determine whether a spouse with variable wages qualifies for the hardship exemption by looking at the spouse's average wages over the past twelve months.

Additional Provisions and Exceptions to the 20% Plan Payment Rule

1. The Working Spouse Rule does not apply to Plan participants whose employers make multi-tiered contributions to this Fund. To determine if your employer makes multi-tiered contributions on your behalf, please contact the Benefit Office or ask your employer.
2. The working spouse rule only applies to your spouse's claims, not to claims incurred by your children.
3. The rule only applies to medical and drug expenses. Enrollment in the employer's dental and/or vision plan is not required. (However, if your spouse does enroll in the employer's dental program, this Plan will coordinate benefits and pay secondary to the employer's plan.)
4. The working spouse rule applies EVEN IF any of the following apply:
 - The working spouse's employer's plan does not have a single-only coverage option.
 - Medical coverage is an option under a cafeteria plan.
 - The working spouse's employer's plan is an HMO.
 - Your spouse works part-time.
 - You are a retiree, but your spouse is still actively employed.
 - The employer offers an incentive to induce employees not to enroll.
5. The working spouse rule will NOT apply in any of the following situations:
 - Your spouse's employer does not offer medical or prescription drug coverage.
 - Your spouse's employer requires your spouse to pay the full cost of the healthcare coverage.
 - Your spouse's only other option for group insurance is retiree coverage.
 - Your spouse's only other option for group insurance is COBRA coverage.
 - Your spouse's only other coverage option is an HMO and your residence is more than 25 miles outside the HMO service area.
 - Your spouse's claim would have been denied under the working spouse's employer's plan (for example, if the claim was for a preexisting condition incurred during the preexisting waiting period).
6. If this Plan pays 20% of your spouse's claims because of this rule, those coinsurance shares will not apply to the Plan's out-of-pocket limits, nor will the claim be paid at 100% if your spouse's out-of-pocket limit was previously met by other charges.
7. You are required to provide accurate and timely information to the Fund about your spouse's employment status and benefit entitlement, and the Benefit Office may require verification of this information from your spouse's employer.

Dual Coverage Saves You Money

When your spouse is covered by his or her employer's plan and this Plan at the same time, the two plans together will usually pay 100% of your spouse's covered claims under the coordination of benefits rules. If your spouse requires a hospitalization or surgery, you will generally come out ahead financially from the dual coverage, even after the cost of the premiums are taken into account.

PLAN 15 SCHEDULE OF BENEFITS

Life/Accidental Death & Dismemberment Insurance (if applicable)

Employee life insurance	\$10,000
Retiree life insurance	\$7,500
Accidental death & dismemberment (AD&D) insurance principal sum (active employees only)	\$10,000

Weekly Disability Benefit (employees only – if applicable)

Weekly Benefit Amount	
Non-occupational disability	\$250
Occupational disability	\$125
Maximum period payable per disability	26 weeks
Benefits start on the following day of disability: Accident - 1st day; Illness - 8th day. If a disability due to sickness lasts more than 8 weeks, benefits will be retroactively paid for the first 7 days of disability.	

Major Medical Benefit

Benefits are payable only for covered expenses. Covered expenses do not include amounts in excess of allowable charges, or charges for treatment that is not medically necessary. All benefits are subject to the maximum benefits and limitations stated below and to all Plan conditions and exclusions. All benefits and limitations shown are per covered person unless specifically stated otherwise.

Your spouse is required to enroll in her employer's health plan. See the *Working Spouse Rule* on page 4.

Deductibles & reductions

Calendar year deductibles

Per person	\$350
Per family (aggregate)	\$1,050
Emergency room deductible, per occurrence (in addition to above)	\$100
Benefit reduction for failure to pre-certify an inpatient hospitalization	\$250

Coinsurance (payment percentages) per calendar year after satisfaction of the calendar year deductible

BCBS PPO expenses	85%
Emergency room treatment at an out-of-network hospital for an emergency medical condition, including professional fees	85%
Professional charges by an out-of-network radiologist, pathologist or anesthesiologist for services provided at a BCBS PPO hospital	85%
Out-of-network expenses (except as stated above)	75%

Out-of-pocket limits per calendar year

PPO	
Per person	\$1,900
Per family (aggregate)	\$3,800
Non-PPO	no limit

All deductibles, co-payments and coinsurance payments made for covered PPO expenses count toward an individual's out-of-pocket limit. Once a person's out-of-pocket limit is met, most covered PPO expenses are paid at 100% during the remainder of the year.

Special Benefits and Limitations

Normal deductible and coinsurance percentage apply unless otherwise stated.

Preventive care

Preventive care provided by PPO providers

Payable at 100% – no deductible applies

- The Plan covers a wide range of preventive and wellness services designed to keep participants and dependents healthy. These types of expenses are covered by the Plan at 100% with no deductible or co-pay only when the services are rendered by a PPO provider. No benefits are payable for preventive services provided by non-PPO providers.
- Preventive and wellness services covered by the Plan are subject to change pursuant to applicable laws and regulations.
- *For a list of preventive and wellness services covered by the Plan, please see the Appendix starting on page 86.*

Benefit Limitations

Non-PPO ambulatory surgical centers

Excluded

Chiropractic care - maximum allowable visits per calendar year. (Chiropractic visits are subject to the deductible and coinsurance.)

15 visits per year

Hearing aids - maximum allowable hearing aids, including fitting

One standard hearing aid per ear per lifetime

Speech therapy - maximum allowable visits per calendar year for speech therapy to restore abilities lost due to stroke or trauma. Speech therapy for the treatment of developmental delays is not covered by the Plan.

35 visits per year

Skilled nursing facility - maximum allowable days per calendar year

30 days per year

Home health care - maximum allowable visits per calendar year

120 visits per year

Orthotics - Custom molded foot orthotics when prescribed or performed by in-network PPO providers only

1 pair every two years when prescribed or performed by in-network provider

Orthoptics (vision therapy) - maximum allowable visits

20 visits per lifetime

Prescription Drug Program (Sav-Rx)

Sav-Rx administers the Plan's Prescription Drug Program. You pay the following co-pays directly to the participating retail or mail-order pharmacy.

Co-Pays (what you pay)

Generics

0%

Formulary brands

20%

Non-formulary brands

30%
minimum \$40 for 30-day supply,
\$80 for 90-day supply

Out-of-Pocket Limits per Calendar Year

Individual out of pocket limit

\$1,000

Family out of pocket limit (aggregate)

\$2,000

Co-payment after out-of-pocket limit of \$1,000 per calendar year per person has been met

0%

- Wal-Mart and Sam's Club are NOT in your network.
- If you decline a generic substitution, you must pay the cost difference between the brand and generic. The difference does not apply to your out-of-pocket limit and must be paid even after your out-of-pocket limit has been met.
- "Generic drugs" are those with multiple manufacturers. You will have to pay the 20% or 30% co-pay for a generic drug sold by only one or two companies.

Dental Benefits (MetLife®) (if applicable)

Dental Benefits are provided for active employees and their eligible dependents only. These benefits are not provided for retirees or dependents of retirees. You are only entitled to these benefits if they are included in your employer's contract with the Plan. For more information, contact your employer or the Benefit Office.

Maximum

Maximum payable per person per calendar year <i>Maximum does not apply to children under age 19.</i>	\$1,000
Orthodontia lifetime maximum per person <i>(covered for children under age 19 only)</i>	\$1,000

Payment percentages for covered expenses

Preventive care	80%
Basic restorative care	80%
Major restorative care (crowns and prosthetics)	80%
Orthodontia (children under age 19 only)	50%

Vision Benefits (Vision Service Plan) (if applicable)

The Plan's Vision Benefit is administered by Vision Service Plan (VSP). Vision Benefits are provided for active employees and their eligible dependents only. These benefits are not provided for retirees or dependents of retirees. You are only entitled to these benefits if they are included in your employer's contract with the Plan. For more information, contact your employer or the Benefit Office.

Vision Care Services (one per calendar year)	VSP Doctor	Non-Network Provider
Vision exam	Provided in full	\$35
Lenses (per pair):		
Single	Provided in full	\$30
Lined bifocal	Provided in full	\$40
Lined trifocal	Provided in full	\$55
Lined lenticular	Provided in full	\$55
Contacts (elective)	Provided up to \$150 allowance	\$120
Frame	Provided up to \$180 allowance	\$35
Safety glasses:*		
Frame	Provided up to \$65 allowance	\$25
Lenses (per pair)		
Single vision	Provided in full	\$30
Bifocal	Provided in full	\$35
Trifocal	Provided in full	\$45
Lenticular	Provided in full	\$60

* The safety glasses benefit is for employees only. One pair is provided per calendar year in addition to regular eyeglasses.

Preventive Care Coverage

The Plan covers a wide range of preventive and wellness services designed to keep participants and dependents healthy. The types of expenses covered are listed below. The Plan covers these services and supplies for eligible individuals at 100% of the **allowable charge** with no deductible or co-pay when rendered by a PPO or Non-PPO provider. If these services are performed or provided by a Non-PPO provider, however, you may be subject to balance billing for amounts over the allowable charge.

This list is subject to **reasonable medical management techniques and guidelines** and may be revised in accordance with applicable law and regulatory guidance.

ADULT PREVENTIVE SERVICES

- Abdominal Aortic Aneurysm: Ultrasound Screening.
- Alcohol Use: Screening and Brief Behavioral Counseling.
- Anxiety Disorders: Screening.
- Low-dose Aspirin for Prevention of Cardiovascular Disease (CVD) and Colorectal Cancer (CRC) (generic only).
- Chlamydia, Gonorrhea, and Syphilis: Screening.
- Colorectal Cancer: Screening for Adults **starting at age 45.**
 - ***Please Note:** Frequency of coverage dependent upon reasonable medical management techniques, including the type of screening/testing utilized. The Plan will only cover generic bowel preps and bowel prep brands with no generic equivalent, subject to reasonable medical management techniques.*
- Depression and Suicide Risk: Screening.
- Diabetes, Pre-diabetes, and Type 2 Diabetes: Screening.
- Unhealthy Drug Use: Screening.
- Healthy Diet and Physical Activity for Cardiovascular Disease (CVD) Prevention.
- Hepatitis B Virus: Screening.
- Hepatitis C Virus: Screening.
- Human Immunodeficiency Virus (HIV): Screening.
- HIV - Preexposure prophylaxis (PrEP) with effective antiretroviral therapy for those at high risk of HIV infection.
- Hypertension: Screening.

- Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening.
- Lung Cancer: Screening with Low-Dose CT Screening.*
- Sexually Transmitted Infections: Behavioral Counseling.
- Skin Cancer Prevention: Behavioral Counseling.
- Statin Prevention Medication (subject to the Plan's Step Therapy Program).
- Tobacco Smoking Cessation in Adults:
 - Coverage for two (2) tobacco cessation attempts per calendar year & four (4) cessation counseling sessions per calendar year.
 - 90 days of treatment using FDA-approved medications if indicated (1 cycle per calendar year).
- Tuberculosis: Screening (at-risk populations).
- Weight loss to Prevent Obesity-Related Morbidity and Mortality in Adults with BMI of 30 or Higher, including:
 - 26 face-to-face 15-minute behavioral therapy sessions per calendar year with a PPO provider; and
 - One (1) dietary assessment by a licensed nutritionist.
 - *Please Note: Referrals for additional obesity-related services or intensive, multicomponent behavioral interventions are not covered, including exercise or diet programs.*
- Annual Preventive Health Exam ("Well Visit").

WOMEN'S PREVENTIVE SERVICES

- Bacteriuria Urinary Tract or Other infections: Screening.
- BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing (women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer, or an ancestry associated with BRCA 1/2 gene mutation).*
- Breast Cancer: Counseling Related to Chemoprevention Use to Reduce Risk For Women at Increased Risk over age 35.
- Breast Cancer: Mammography Screenings (Women ages 40-74 years old).
- Breastfeeding Support Prenatal and Postnatal: Supplies & Counseling.
- Cervical Cancer: Screening.

****Prior Authorization Required.***

- Contraception: All FDA-approved Contraceptive Methods, including contraceptive counseling, initiation of contraceptive use, and services related to follow-up and management for women as prescribed by a provider. Abortifacient drugs are not covered.
 - ***Please Note:*** The plan will only cover 1) generics; and 2) brands that are medically necessary for the individual, subject to reasonable medical management techniques.
- Folic Acid Supplements for Pregnancy.
- Gestational Diabetes: Screening (asymptomatic pregnant persons at 24 weeks of gestation or after).
- Healthy Weight and Weight Gain in Pregnancy: Behavioral Counseling – Interventions.
- Osteoporosis: Screening (Women over age 65 or women age 64 and younger that have gone through menopause)
- Preeclampsia: Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication.
- Prenatal Care, meaning Routine Doctor Visits ONLY.
 - ***Please Note:*** Delivery, prenatal lab work, ultrasounds, and high-risk pregnancy care services are covered under the Plan’s regular major medical benefit and are covered for employees, retirees, and spouses ONLY and are not covered for Dependent children.
- Rh Incompatibility Screening for Pregnant Women at First Prenatal Visit, and Repeated Testing at 24-28 Weeks of Gestation as Necessary.
- Annual Women’s Preventive Health Exam (“Well Visit”).

CHILDREN PREVENTIVE SERVICES

- Anxiety Disorders: Screening.
- Depression and Suicide Risk: Screening.
- Human Immunodeficiency Virus (HIV): Screening.
- Obesity in Children and Adolescents: Screening.
- Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication (newborns).
- Dental Health (Children Younger than 5 years): Screening and Interventions, Including Oral Fluoride.

- Sexually Transmitted Infections: Behavioral Counseling.
- Skin Cancer Prevention: Behavioral Counseling.
- Tobacco Use in Children and Adolescents: Primary Care Interventions.
- Vision Screening for amblyopia in Children for children ages 3-5 years.
- Newborn screenings for Hemoglobinopathies, Hearing loss, Hypothyroidism, Phenylketonuria (PKU), and Heritable Disorders.
- Iron Supplements (Children ages 6 to 12 months).
- Annual Preventive Health Exam (“Well Visit”).

IMMUNIZATIONS

- Immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and those that have been adopted by the Centers for Disease Control and Prevention (CDC), including but not limited to:
 - Hepatitis B (HepB)
 - Rotavirus (RV)
 - Diphtheria, Tetanus, and Pertussis DTaP)
 - Influenza Type B (Hib)
 - Pneumococcal (PCV/PPSV)
 - Polio (IPV)
 - Influenza (Seasonal)
 - Measles, Mumps & Rubella (MMR)
 - Varicella
 - Hepatitis A (HepA)
 - Meningococcal (MCV)
 - Human Papillomavirus (HPV)
 - Zoster (Shingles)

IMPORTANT NOTICE ABOUT YOUR BENEFIT PLAN

July 2024

To Plan Participants:

This notice summarizes important changes to the NECA/IBEW Family Medical Care Plan. If you have any questions regarding the changes summarized in this Summary of Material Modifications (“SMM”), you should contact the Benefits Office. Please keep a copy of this SMM with your Summary Plan Description for future reference.

Identity Protection Through LifeLock™

Effective August 1, 2024, the Plan will offer family identity protection coverage to all eligible participants. To enroll in this benefit, please review the attached LifeLock information document to access the QR code and custom URL or visit www.nifmcp.com to access a digital copy of the LifeLock information document. Please note that the LifeLock coverage will be active only for the months in which you are enrolled as an active participant or retiree in the Plan.

Human Growth Hormone Therapy

Effective September 1, 2024, the Plan’s exclusion for Human Growth Hormone (“HGH”) therapy will no longer apply. HGH therapy will be covered in accordance with the Plan’s applicable deductibles, copayments and coinsurance rates. Please note that HGH therapy is subject to utilization review and medical necessity. Coverage of this benefit is subject to all other provisions of the Plan.

Weekly Disability Benefit Certification

Effective September 1, 2024, the Fund will no longer accept certification for weekly disability benefits from a chiropractor. Please remember that you may also be required to submit additional medical information to be reviewed by an independent medical provider to verify you are eligible for Weekly Disability Benefits. Contact the Benefit Office for more information.

* * *

Please keep this notice with your Summary Plan Description booklet for future reference.

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IMPORTANT NOTICE ABOUT YOUR BENEFIT PLAN

May 2024

To Participants in Plan:

This notice summarizes important changes to the NECA/IBEW Family Medical Care Plan. If you have any questions regarding the changes summarized in this Summary of Material Modifications (“SMM”), you should contact the Benefits Office. Please keep a copy of this SMM with your Summary Plan Description for future reference.

Diagnostic Imaging

Effective June 1, 2024, the Plan will no longer require pre-certification for most imaging procedures (such as computed tomography (CT) scans, magnetic resonance imaging and angiogram (MRI/MRA) scans, and positron emission tomography (PET) scans) in order for these benefits to be covered by the Plan.

Pre-certification by Anthem (1-855-343-4851) is still required for specialized cardiovascular procedures, including but not limited to stress echocardiography, transthoracic echocardiography, transesophageal echocardiography, arterial ultrasound, cardiac catheterization and percutaneous coronary intervention (PCI).

Fertility Services Through Progyny

Effective June 1, 2024, the Plan will cover a variety of fertility services for members and their dependent spouses (dependent children excluded) through Progyny. This benefit will include up to two (2) Smart Cycles per lifetime. A Smart Cycle bundles individual services, tests, and treatments together to create a comprehensive family building benefit that is flexible and allows a provider to customize the most appropriate treatment plan for each participant, which may include:

- Artificial Insemination (IUI)
- FDA Bloodwork and Testing
- Fresh In Vitro Fertilization (IVF) Cycle
- Frozen Embryo Transfer (FET)
- Patient Care Advocate (PCA) Concierge Support
- Fertility Medications (via Progyny Rx)
- Pre-implantation Genetic Screening
- Pre-implantation Genetic Diagnosis
- Tissue Transportation
- Donor Tissue Purchase

Please note that fertility services provided outside of the Plan's Progyny benefit are excluded from coverage by the Plan. Benefits through Progyny are subject to other Plan limitations and exclusions provisions, including but not limited to eligibility and medical necessity. Dependent children are not eligible for the pregnancy services.

Progyny's Patient Care Advocates are available to speak via phone regarding this new benefit at (833) 233-0981 or go online to www.Progyny.com for more information.

Fund Trustees

Below is a list of the Plan's current Trustees as of May 1, 2024.

Kenneth Cooper
International Brotherhood of Electrical Workers
900 7th Street NW
Washington, DC 20001

David Long
National Electrical Contractors Association
1201 Pennsylvania Avenue NW, Suite 1200
Washington, DC 20004

Paul Noble
International Brotherhood of Electrical Workers
900 7th Street NW
Washington, DC 20001

Ryan Courtney
National Electrical Contractors Association
1201 Pennsylvania Avenue NW, Suite 1200
Washington, DC 20004

Edward Allen
IBEW Local 66
4345 Allen Genoa Road
Pasadena, TX 77504

Gregory Bowman
Nabco Electric
P.O. Box 9397
Chattanooga, TN 37412-0397

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Please keep this notice with your Summary Plan Description booklet for future reference.

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IMPORTANT NOTICE ABOUT YOUR BENEFIT PLAN

November 2023

To Participants in Plan:

This notice summarizes important changes to the NECA/IBEW Family Medical Care Plan. If you have any questions regarding the changes summarized in this Summary of Material Modifications (“SMM”), you should contact the Benefits Office. Please keep a copy of this SMM with your Summary Plan Description for future reference.

Weekly Disability Benefits

(If applicable)

Effective January 1, 2024, if your Plan includes Weekly Disability Benefits as a provided benefit, the weekly disability benefit amounts shall increase to the following:

- 1) \$600 per week for non-occupational injuries, up to twenty-six (26) weeks; or
- 2) \$300 per week for occupational injuries, up to twenty-six (26) weeks.

Coverage of these benefits is subject to all other provisions in the Plan.

Life Insurance Benefits

(If applicable)

Effective January 1, 2024, if your Plan provides a Life Insurance Benefit to you, the life insurance benefit amount shall increase as stated below:

- | | |
|-------------------------------|------------------------|
| 1) Current Benefit: \$5,000 | New Benefit: \$10,000 |
| 2) Current Benefit \$7,500 | New Benefit: \$15,000 |
| 3) Current Benefit : \$10,000 | New Benefit: \$20,000 |
| 4) Current Benefit: \$20,000 | New Benefit: No Change |

Coverage of these benefits is subject to all other provisions in the Plan.

Working Spouse Rule – Hardship Exemption

Under the Plan’s Working Spouse Rule, if your spouse works and is eligible for coverage through his or her employer, then your spouse is required to enroll in the employer’s health plan. If your spouse fails to enroll in the employer’s plan, this Plan will only pay 20% of covered medical and prescription drug expenses your spouse incurs. If your spouse has already declined his/her employer’s plan at the time you become eligible, the penalty reduction will not apply to your spouse’s claims as long as he/she opts into his/her employer’s plan during the next open enrollment period. For more information on the Working Spouse Rule, please see your Summary Plan Description.

Effective January 1, 2024, the Working Spouse Rule's **Hardship Exemption** is modified so that the Working Spouse Rule will NOT apply if your spouse:

1. Has gross annual wages of less than \$29,000; or
2. Has gross annual wages greater than \$29,000 but less than \$44,000 and must pay more than \$200 per month toward the cost of the least expensive health plan offered by his/her employer.

Virtual Physical Therapy Services

Effective January 1, 2024, the Fund will now offer coverage of virtual physical therapy services through its new vendor, SWORD. SWORD offers telehealth-based physical therapy services provided by licensed professionals around the country using innovative telehealth technology and training. Coverage of these benefits is subject to all other provisions in the Plan.

If you have any questions or are interested in finding out more about this new benefit, please contact the Benefits Office.

Preventive Services Coverage

An updated list of preventive services can be found at www.nifmcp.com under "Plan Notices." These services are covered by the Plan at 100% of the allowable charge with no cost-sharing to you. The Plan may revise its list of covered preventive services pending additional guidance from the federal government from time to time, but any changes will apply prospectively. You may also request a paper copy free of charge by contacting the Benefit Office at 877-937-9602.

Fund Trustees

Below is a list of the Plan's current Trustees as of November 1, 2023.

Kenneth Cooper

International Brotherhood of Electrical Workers
900 7th Street NW
Washington, DC 20001

David Long, CEO

National Electrical Contractors Association
1201 Pennsylvania Avenue NW, Suite 1200
Washington, DC 20004

Paul Noble

International Brotherhood of Electrical Workers
900 7th Street NW
Washington, DC 20001

Ryan Courtney

National Electrical Contractors Association
1201 Pennsylvania Avenue NW, Suite 1200
Washington, DC 20004

Paul Shaffer

IBEW Local 474
1870 Madison Avenue
Memphis, TN 38104

Gregory Bowman

Nabco Electric
P.O. Box 9397
Chattanooga, TN 37412-0397

* * *

Please keep this notice with your Summary Plan Description booklet for future reference.

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IMPORTANT NOTICE ABOUT YOUR BENEFIT PLAN

October 2024

To Plan 15 Participants:

This notice summarizes important changes to the NECA/IBEW Family Medical Care Plan. If you have any questions regarding the changes summarized in this Summary of Material Modifications (“SMM”), you should contact the Benefits Office. Please keep a copy of this SMM with your Summary Plan Description for future reference.

Dental Benefits Through Delta Dental

Effective January 1, 2025, the Plan will provide dental benefits for eligible members and dependents through Delta Dental. Should you have any questions regarding this benefit, please contact Delta Dental at (855) 277-4526 or visit <https://www1.deltadentalins.com/fmcp>. This change to the plan offers enhanced dental benefits. Below is a description of the new dental services:

DENTAL BENEFIT	
Maximum Benefit Payable by the Plan Per Individual Per Calendar Year <i>(Does Not Apply to Children Under Age 19)</i>	\$1,500
Orthodontic Maximum Benefit Payable by the Plan Per Individual Per Lifetime <i>(Children Under Age 19 only)</i>	\$1,000
Deductible per Year	
Per Person	\$0
Per Family	\$0
Percentage Payable by Plan	
Preventive	100%
Minor Restorative	80%
Major Restorative	50%
Orthodontia <i>(Children Under Age 19 only)</i>	100%

Please note that dental benefits may not be available for retirees and their dependents. Please contact your Employer for more information or the Benefit Office at the number listed above.

Please keep this notice with your Summary Plan Description booklet for future reference.

ELIGIBILITY FOR HOURLY BARGAINING UNIT EMPLOYEES

This section describes the eligibility rules that apply to active hourly bargaining unit employees whose employers contribute to the Fund based on hours worked. The eligibility rules for non-bargaining unit employees are on page 20. The retiree eligibility section starts on page 21.

Definitions Applicable to Eligibility

Benefit Month

A period of one calendar month during which a person is eligible for Plan benefits because he or she has met the applicable eligibility requirements during the corresponding eligibility (work) month.

Eligibility (Work) Month

A period of one calendar month during which a person meets the applicable eligibility requirements necessary to provide benefit coverage during the corresponding benefit month.

Credited Hour

Any hour: 1) worked by an employee for which an employer contribution is made to the Fund under the terms of a written plan of benefits; 2) worked by a non-bargaining unit employee for which an employer contribution is made under the terms of the employer's participation agreement with the Trustees; 3) credited under the Plan's eligibility during disability provisions; or 4) received or due from another welfare fund having a reciprocity agreement with this Fund.

Initial Eligibility Requirements

Initial Eligibility Date

You will become initially eligible on the first day of the benefit month corresponding to the eligibility (work) month in which you first accumulate at least 140 credited hours of employment for which an employer is required to make and actually makes a contribution to the Fund on your behalf. The date on which you become initially eligible is called your *initial eligibility date*.

Initial Eligibility Rule for New Employees - Individuals who were never covered under the Plan in the past can earn initial eligibility if they have 200 hours during a two-consecutive month period. The lag month still applies. For example, 100 hours in January and 100 hours in February earn initial eligibility effective April 1. The normal 140-hour rule described in the paragraph above also applies—new employees will become initially eligible by satisfying either rule.

When Benefits Start (Effective Date of Benefits)

Your benefit coverage will start on your initial eligibility date. For example, if your employer makes contributions for you for at least 140 credited hours for work performed in January, your coverage will start on March 1.

If you have dependents on the date your coverage starts, their coverage will start on that same date. If you later acquire a dependent while you are eligible, coverage will start on the date the person became your dependent. Your dependents' eligibility is contingent upon your eligibility.

The Plan's definition of a "dependent" starts on page 68.

Legal documentation (such as an original registered marriage certificate, certified government-issued birth certificate or divorce decree) is required by the Benefit Office before any benefits can be paid. The Benefit Office reserves the right to request additional documentation to determine eligibility status as necessary.

Continuing Eligibility

Once you become eligible, you and your dependents will continue to be covered during each benefit month if you meet the continuing eligibility rules during the corresponding eligibility (work) month. The minimum credited hour requirement for continuing eligibility is 140 hours per eligibility month. The table below shows how eligibility months correspond to benefit months.

Eligibility (Work) Month	→	Benefit Month	Eligibility (Work) Month	→	Benefit Month
November		January	May		July
December		February	June		August
January		March	July		September
February		April	August		October
March		May	September		November
April		June	October		December

Your Hour Bank

After you have satisfied the initial eligibility rules, your credited hours in excess of 140 in an eligibility (work) month will be credited to your hour bank.

The maximum you can accumulate in your hour bank is 840 hours (140 hours times six months = 840 hours).

If you fail to have 140 credited hours in an eligibility month, the number of credited hours necessary to make up the difference will be deducted from your hour bank.

If your combined hours from work and your hour bank are less than 140, you may make a self-payment for the hours you are short (see the following section for more information). If you don't make the self-payment but return to work within six (6) months, the hours remaining in your hour bank can be used to help you re-establish eligibility. If you do not return to work within the 6-month window, any remaining amounts in your hour bank will be forfeited.

Your hour bank is not a vested benefit. The hours in your hour bank may, at any time, be limited, changed or extinguished through Trustee action. Your hour bank also has no monetary value.

Self-Payments for Short Hours

If you do not have 140 credited hours in an eligibility (work) month even with your banked hours, you can make up to six (6) consecutive monthly self-payments to cover the difference between your credited hours and the number of hours needed to satisfy the 140-hour rule.

An additional 6-month self-pay period will be allowed if you return to covered employment and have at least 100 credited hours during an eligibility (work) month that corresponds with, or immediately follows, a benefit month during which you were eligible because of a self-payment for short hours. Additional 6-month self-pay periods will be allowed without limit as long as you continue to meet the 100-hour requirement.

You are only entitled to a self-pay period if you are an active employee who is already covered under the Plan when your hours shortage occurs.

Self-payment amounts will be determined by multiplying the hours you are short of 140 times the current hourly contribution rate. The due date for short hours self-payments is the last day of the benefit month for which the payment is being made.

Eligibility During Disability (if applicable)

You are only entitled to this benefit if your employer's contract with the Plan includes this benefit. Please contact your employer for more information.

Protection During Short-Term Disabilities

If you become totally disabled, and your employer's contract with the Plan includes disability benefits, your eligibility will continue for **up to twelve (12) months** provided that you meet ALL three of the following requirements:

1. You must be an eligible active employee on the date your disability starts; AND
2. You must be eligible for the benefit month which next follows the benefit month in which you became disabled; AND
3. You must have worked enough hours and have been credited with sufficient disability hours in the eligibility (work) month in which you became disabled to satisfy the Plan's continuing eligibility rules. This means that the number of any disability hours to which you might be entitled, together with your regular credited hours, must equal or exceed 140 (160 for non-bargaining unit employees who qualify for disability hours) in the month your disability starts.

If you meet the above qualifications, you will be credited with eight disability hours each day of the work week, Monday through Friday, during your period of disability. Your disability credit hours will stop accumulating, however, once you reach 140 hours (160 for non-bargaining unit employees who qualify for disability hours) and no credit will accumulate to your hour bank.

You are NOT entitled to eligibility protection during disability if you are a COBRA continuee or retiree.

Additional Rules Governing Eligibility During Disability

1. If you do not qualify for eligibility during disability as explained above, no credit for disability will be granted to you for future use.
2. You can receive disability credit for non-work-related disabilities and work-related disabilities.
3. You cannot receive disability credit if you are retired or making COBRA self-payments.
4. To receive disability credit for an occupational disability you must have become disabled on the job while you were working for an employer who was making contributions to the Fund on your behalf under a collective bargaining agreement or participation agreement. If you became disabled on the job while working for an employer who was not signatory to a collective bargaining agreement or participation agreement, you will NOT be eligible for disability credit.
5. The maximum period that your eligibility will be continued is 12 benefit months. However, if your eligibility is continued under this provision and you return to employment for a contributing employer before the expiration of 12 benefit months, your eligibility will be continued for the rest of the benefit month in which you return to work on a continuous full-time basis and for the next two succeeding benefit months. This permits your eligibility to be continued without interruption while you are working to earn future eligibility.
6. If you qualify for disability credit and you recover in the same month in which your total disability began, you will be eligible in the benefit month related to the eligibility month in which you were totally disabled, provided you would have been eligible if you had worked full-time for a contributing employer during your period of total disability.
7. If you are covered under this provision for the allowed 12 months and are still disabled and unable to go back to work, or if you recover from your total disability but there is no work available in your jurisdiction, you may be entitled to continue coverage by making COBRA self-payments.
8. If you recover after receiving disability credit and you do not go to work for an employer contributing to the Fund, your coverage will terminate on the date you are no longer disabled or the date your coverage terminates under the Plan's continuing eligibility rules unless you make correct and on-time COBRA self-payments.

If you die while you are covered under this provision and you have not accumulated any further eligibility, your dependents will be covered for three (3) more months starting with the first day of the month following the

month in which you die. After the 3-month period, your dependents may be entitled to continue coverage by making COBRA self-payments.

Special Circumstances

Below is a description of special circumstances that may affect your eligibility and coverage under the Plan. However, your employer may have additional or different requirements for Plan coverage under these circumstances. Please contact your employer for more information.

Reciprocity

The Fund is signatory to the Electrical Industry Health and Welfare Reciprocal Agreement. The purpose of the reciprocity agreement is to permit you to retain eligibility when contributions are made for you to another IBEW welfare fund.

If you want this Fund to be your home fund when you travel outside of its jurisdiction, you should register with the Electronic Reciprocal Transfer System (ERTS) at any IBEW Local Union office.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) requires certain employers (but not all) to grant unpaid leave for specific reasons, such as the birth of a child or a serious family illness. Eligibility for this unpaid leave is determined by the employer, not by the Trustees of this Fund.

If you are granted FMLA leave, you are entitled to a continuation of the Plan's health care benefits if your employer makes the required contributions to the Fund on your behalf. Failure of your employer to submit contributions on a timely basis will result in loss of coverage under this Plan.

Military Leave

If you are called to active military duty in the uniformed services of the United States for *31 days or more*, your eligibility will be frozen until you return, provided you return to covered employment within the time prescribed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Alternatively, this Plan allows you to make self-payments to keep your coverage in force while you are on military leave. You will not need health coverage for yourself during a period of military leave, but you may want to make self-payments to continue coverage for your dependents. The maximum self-payment period during a military leave is 24 months. When you return, you will need to continue making self-payments until you re-establish eligibility under this Plan's eligibility rules and/or your employer's eligibility rules (subject to the 24-month maximum).

The provisions described above are merely a summary, and other rules may apply depending on your circumstances. If you are called to active military duty, you should call the Benefit Office as soon as possible so that they can explain these options to you in more detail. An eligibility freeze will automatically go into effect unless you tell the Benefit Office that you would like to make self-payments instead.

If you would like more information about your rights during a military leave, contact VETS at 1-866-4-USA-DOL or visit the government's website at www.dol.gov/vets.

In the Event of Your Death

If you die while you are an eligible employee (who is not making COBRA self-payments), Plan coverage for your surviving dependents may be continued according to the rules explained below.

1. Your surviving dependents will continue to be covered through the end of the benefit month in which your death occurs, unless you were covered under the eligibility during disability provisions at the time of your death, then your dependents will continue to be covered for three months starting with the first day of the month following the month in which you die.
2. After that, your dependents can continue their coverage by making COBRA self-payments, or by making survivor self-payments. If your spouse chooses to make COBRA self-payments, the rules governing COBRA cov-

erage will apply. Note that if your spouse elects COBRA, he/she will not be entitled to make survivor self-payments at any future date. Similarly, if your spouse chooses the survivor self-payment option, he/she will lose the right to elect COBRA coverage at any future date.

Remember, your employer may have additional or different requirements for Plan coverage for your surviving dependents in the event of your death. Please contact your employer for more information.

Rules Governing Survivor Self-Payments

If your surviving spouse is under age 62, he or she can make self-payments to continue coverage for himself/herself and any of your surviving dependent children in accordance with the following rules:

1. The amount of the monthly self-payment is determined by the Trustees and may be changed at any time.
2. By making the self-payments, your spouse will remain eligible for the same benefits he/she was eligible for when you died.
3. Your spouse must make his/her first self-payment on or before the date on which a self-payment to maintain continuous coverage is due. There must be no lapse in coverage.
4. Each subsequent payment must be postmarked no later than the 15th day of the month preceding the benefit month for which he/she is paying. Payments postmarked after the 15th will not be accepted.
5. If your spouse fails to make a self-payment on or before the date it is due, his/her eligibility and the eligibility of any of your surviving dependent children will terminate at the end of the benefit month for which he/she had already paid. He/she will not be allowed to make any future self-payments.
6. Once a self-payment has been accepted by the Benefit Office, it will not be returned.
7. Your spouse can continue to make self-payments until he/she remarries or until one of the other events specified in *Termination of Dependent Benefits* on page 14 occurs.
8. If your spouse doesn't elect to make survivor self-payments when he/she is first entitled to do so, he/she will not be permitted to make self-payments at any future date.
9. When your spouse becomes age 62, his/her coverage as a dependent of an active employee will terminate and he/she will then be able to make self-payments for the Plan's Retiree Benefits if Retiree Benefits would have been available to the active employee.

Coverage for your surviving dependent children will terminate if your surviving spouse's coverage under this provision terminates for any reason. It will also terminate the day the child no longer meets the Plan's definition of a dependent (for example, when the child hits the Plan's limiting age).

Termination of Eligibility

Termination of Employee Benefits

You will cease to be eligible for benefit coverage under the Plan on the earliest of the following dates unless you are entitled to COBRA coverage and a correct and on-time COBRA election and self-payment is made by you or on your behalf:

1. If you fail to meet the continuing eligibility requirements as outlined in your employer's collective bargaining agreement or participation agreement, unless you are terminated or retire and make correct and on-time self-payments for COBRA coverage or Retiree Benefits (if you are entitled to Retiree Benefits).
2. If your coverage is being continued under the eligibility during disability provisions, on the date you fail to meet the applicable requirements.
3. If you are making COBRA self-payments, at the end of the last day of the applicable maximum coverage period to which you were entitled and for which correct and on-time self-payments have been made or, on the

date of occurrence of any of the events stated in *Termination of COBRA Coverage* on page 18, whichever occurs first.

4. The date you enter employment in the electrical industry for an employer who is not signatory to an agreement which requires contributions either to this Plan or another IBEW-affiliated health and welfare trust fund. On this date, you shall forfeit all bank hours, the entire balance of your Special Fund Account, and no self-payments for short hours will be permitted except for COBRA coverage (if required by law). This provision does not apply to a member who is working as a SALT with the permission of an IBEW Local Union Business Manager pursuant to the provisions of an IBEW Salting Agreement.
5. The date on which the Plan discovers that you and/or your dependent(s): a) failed to make a required payment when it is due; or b) made a material misrepresentation or committed fraud against the Plan. This includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of a membership ID card. If the Plan determines that a) or b) occurred, the Plan has the right to rescind (retroactively revoke) coverage under the Plan and may demand repayment of all benefits paid on behalf of you and/or your dependents. "Rescind" means a cancellation or discontinuance of coverage under the Plan that has a retroactive effect. "Rescind" does not include a cancellation or discontinuance of coverage under the Plan if the cancellation or discontinuance of coverage has only a prospective effect. This provision is intended to comply with the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.
6. The date the Trustees terminate the benefits provided by this Plan.
7. The date of your death.

Termination of Dependent Benefits

A dependent of yours will cease to be eligible for benefits from this Plan on the earliest of the following dates unless the dependent is entitled to COBRA coverage and a correct and on-time COBRA election and self-payment is made by or on behalf of the dependent:

1. The date you cease to be eligible for benefit coverage for reasons other than your death.
2. For your spouse, the date of your divorce.
3. For a child who fails to meet this Plan's definition of a dependent child, at the end of the calendar month in which the child no longer meets the Plan's qualifications.
4. If COBRA self-payments are being made by or on behalf of the dependent, at the end of the last day of the applicable maximum coverage period to which the dependent is entitled and for which correct and on-time self-payments have been made, or on the date of occurrence of any of the events stated in *Termination of COBRA Coverage* on page 18, whichever occurs first.
5. The date the Trustees terminate dependent benefits (or all benefits) under the Plan;
6. In the event of your death:
 - a. At the end of the last day of the last benefit month for which you had earned eligibility before your death;
 - b. If your eligibility was being maintained under the eligibility during disability provisions, at the end of the last day of the third benefit month following the month in which your death occurred; or
 - c. If your surviving spouse is making survivor self-payments to continue coverage for himself/herself and any of your surviving dependent children, on the first of the following dates:
 - The date any of the events in No. 1 through 5 above occurs;
 - The last day of the last benefit month for which a correct and on-time self-payment was made by or on behalf of your surviving spouse;
 - The first day of the month following the month in which your surviving spouse attains age 62 (however, your spouse will then be offered the opportunity to make self-payments for Retiree Benefits);

- The date your surviving spouse becomes covered under another health care plan;
- For a surviving dependent child, the date the child ceases to meet this Plan's definition of a dependent child; or
- The date your surviving spouse remarries.

Your employer may have additional or different requirements for termination of benefits for you and your dependents. Please contact your employer for more information.

Termination Upon Employer Withdrawal

The following rules apply if an employer withdraws from the NECA/IBEW Family Medical Care Trust Fund. A withdrawal occurs when an employer's collective bargaining agreement or other written agreement ceases to require contributions to the Plan for active employees. The Trustees in their sole discretion may also deem that a withdrawal has occurred if an employer ceases to make required contributions to the Plan for two consecutive months. A withdrawal can also occur when a local union negotiates health benefit coverage for a substantial number of its members under a plan other than this Plan.

When a withdrawal occurs, persons having Plan coverage because of current or past employment with the employer that has withdrawn will cease to be eligible for coverage under this Plan on the date the employer withdraws from the Plan. This includes bargaining unit employees, employees making self-payments for short hours, employees on COBRA coverage (unless federal law requires the Plan to continue the person's COBRA coverage), employees maintaining coverage due to reciprocity, non-bargaining unit employees of the affected employer, and any dependents of affected employees. Termination of eligibility also cancels all of an employee's credited hours in his or her hour bank and forfeits the entire balance of his/her Special Fund Account. Therefore, no extended eligibility otherwise available under the Plan because of an employee's hour bank will be available. The Plan has no responsibility for claims incurred after the date of withdrawal from the Plan.

Termination of Eligibility Procedures

If the Plan determines that you and/or your dependent(s) are not eligible for coverage, the Plan will notify you in writing of its discovery. The ineligible individual's coverage will terminate on the date it is determined that the individual was no longer eligible for coverage through the Plan.

To appeal the Plan's determination of ineligibility, you must respond to the Plan's notice, as set forth below, within 30 days of the date of that notice. Failure to timely respond to the Plan's determination of ineligibility will terminate your right to appeal.

All claims or disputes regarding eligibility and enrollment, including disputes relating to a dependent's eligibility and/or dependents removed from coverage due to failure to provide documentation substantiating their eligibility, must be in writing and must include the following information:

1. The nature of the claim (i.e., appeal of eligibility denial);
2. The name of the individual(s) claiming eligibility and the relationship of such individual(s) to the actual Plan participant;
3. An explanation of why such individual(s) believes he/she is eligible to participate in, or become covered under, the plan(s) in question; and
4. Any documentation that supports your claim for eligibility.

All claims or disputes submitted under these procedures must be submitted in writing to the Benefits Office. Within 60 days after your claim is received, you will receive a written notice of the decision, subject to the Plan's right to request additional information from you or your dependents before it makes a determination on your eligibility. Should the Plan request additional information from you after receipt of your claim, the Plan shall have an additional 30 days to provide written notice of the decision. If the Plan is unable to make a determination on your eligibility appeal, the Benefit Office will present the appeal at the next Board of Trustees meeting and the full Board will make a determination.

If the Plan's determination of ineligibility is reversed, coverage will be reinstated retroactively to the date you or your dependents were removed from coverage. If applicable, your hour bank and the entire balance of your Special Fund Account shall be reinstated, and self-payments for short hours will be permitted. If your coverage level changed, contributions for coverage will be collected from the date coverage was reinstated.

For more information on the Plan's eligibility and claims procedures, contact the Benefit Office at 1-877-937-9602.

COBRA Coverage

Federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), gives you (the employee) and your eligible dependents the right to be offered an opportunity to make self-payments for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "continuation coverage," "COBRA continuation coverage," or "COBRA coverage." Below is an outline of the rules governing COBRA coverage. If you have any questions about COBRA, call the Benefit Office.

Qualifying Events/Maximum Coverage Periods

- 1. 18-Month Maximum Coverage Period** - You and/or your eligible dependents are entitled to elect COBRA coverage and to make self-payments for the coverage for a maximum period of up to 18 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"):
 - A reduction in your hours.
 - Termination of your employment (which includes retirement). (Refer to page 12 for information on continuation of coverage during a military leave.)
- 2. 29-Month Maximum Coverage Period** - If you or an eligible dependent is disabled (as defined by the Social Security Administration for the purpose of Social Security disability benefits) on the date of one of the qualifying events listed above, or if you or an eligible dependent becomes so disabled within 60 days after an 18-month COBRA period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. The COBRA self-payment may be higher for the extra eleven (11) months of coverage for the family. Also, you must notify the Benefit Office within 60 days of the latest of: 1) the date of the disability determination by the Social Security Administration; 2) the date on which the initial qualifying event occurs; or 3) the date on which the qualified beneficiary loses coverage under the Plan as a result of the qualifying event. You must also notify the Benefit Office within 30 days of the date Social Security Administration determines that the person is no longer disabled.
- 3. 36-Month Maximum Coverage Period** - Your dependents (spouse or children) are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 36 months after coverage would otherwise terminate due to one of the following qualifying events:
 - Your divorce from your spouse.
 - A dependent child's loss of dependent status.
 - Your death.

Special Medicare Entitlement Rule - A special rule provides that if you (the covered employee) become entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of hours, the period of coverage for your spouse and dependent children will be 36 months measured from the date of your Medicare entitlement, or 18 months from the date you lose coverage because of a reduction in hours or termination of employment, whichever is longer.

Multiple Qualifying Events - If your dependents are covered under COBRA coverage under an 18-month maximum coverage period due to termination of your employment or a reduction in your hours and then a second qualifying event occurs, their COBRA coverage may be extended as follows:

- If you die, or if you are divorced, or if a child loses dependent status while your dependents are covered under an 18-month COBRA coverage period, your dependent(s) who are affected by the second qualifying event are entitled to COBRA coverage for up to a maximum of 36 months minus the number of months of COBRA

coverage already received under the 18-month continuation.

- Only a person (spouse or child) who was your dependent on the day before the occurrence of the first qualifying event (termination of your employment or a reduction in your hours) is entitled to make an election for this extended coverage when a second qualifying event occurs. Exception: If a child is born to you (the employee), or adopted by you, or placed with you for adoption during the first 18-month COBRA period, that child will have the same election rights when a second qualifying event occurs as your other dependents who were eligible dependents on the day before the first qualifying event.

It is the affected dependent's responsibility to notify the Benefit Office within 60 days after a second qualifying event occurs. If the Benefit Office is not notified within 60 days, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.

Benefits Provided Under COBRA Coverage

When you or a dependent elect and make self-payments for COBRA coverage, you will be eligible for the same benefits you had when your qualifying event occurred. However, COBRA coverage does not include Life, AD&D insurance or Weekly Disability Benefits.

Notification Responsibilities

1. If you get divorced, or if your child loses dependent status, you, your spouse or child must notify the Benefit Office and request a COBRA election notice. The Benefit Office must be notified within 60 days of the date of the qualifying event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later.
2. For purposes of extending an 18-month maximum coverage period to 29 months, the Benefit Office must be notified of the person's determination of eligibility for Social Security disability benefits within 60 days of the Social Security notice of such determination and before the end of the initial 18-month period. The Benefit Office must also be notified within 30 days of the date Social Security determines that the person is no longer disabled.
3. It is your employer's responsibility to notify the Benefit Office of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notification of your election rights as soon as possible, you or a dependent should also notify the Benefit Office and request a COBRA election notice any time any type of qualifying event occurs.

In order to protect your family's rights, you should keep the Benefit Office 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 Benefit Office or that the Benefit Office sends to you.

Electing COBRA Coverage

When the Benefit Office is notified of a qualifying event, and you request notification about your COBRA rights, an election notice will be sent to you and/or your dependent(s) who would lose coverage due to the event. The election notice tells you about your right to elect COBRA coverage, the due dates, the amount of the self-payments, and other pertinent information.

An election form will be sent along with the election notice. This is the form you or a dependent fill in and return to the Benefit Office if you want to elect COBRA coverage.

The person electing COBRA coverage has 60 days after he or she is sent the election notice or 60 days after his or her coverage would terminate, whichever is later, to return the completed election form. An election of COBRA coverage is considered to be made on the date the election form is personally delivered or mailed back to the Benefit Office (the postmark date will govern the date of mailing).

If the election form is not returned to the Benefit Office within the allowable period, you and/or your dependents will be considered to have waived your right to COBRA coverage.

COBRA Self-Payment Rules

1. Self-payment amounts are determined by the Trustees based on federal regulations. The amounts are subject to change, but not more often than once a year unless substantial changes are made in the benefits.
2. A person electing COBRA coverage has 45 days after the signed election form is returned to the Benefit Office to make the initial (first) self-payment for coverage provided between the date coverage would have terminated and the date of the payment. (If a person waits 45 days to make the initial payment, the next monthly payment may also fall due within that period and must also be paid at that time.)
3. The due date for each following monthly self-payment is the first day of the month for which payment is made. A monthly self-payment will be accepted if it is received by the Benefit Office within a 30-day grace period after the due date. Your self-payment will be considered on time if it is personally delivered or mailed by the due date.
4. COBRA coverage self-payments must be made monthly and must be received by the Benefit Office in a timely manner. Your self-payment will be considered on time if it is personally delivered or mailed by the due date. (Postmarks affixed by the U.S. Postal Service will be considered proof of date of mailing. Postage meter imprints or any other evidence of mailing date, including date imprints by overnight courier services such as UPS or Airborne, will not be considered proof of date of mailing unless payment is actually delivered to the Benefit Office no later than the first business day immediately following the mailing date shown.)
5. If a self-payment is not made within the time allowed, COBRA coverage for all affected family members will terminate. You may not make up the payment or reinstate coverage by making future payments.

Additional COBRA Coverage Rules

1. COBRA coverage may not be elected by anyone who was not eligible for Plan benefits on the day before the occurrence of a qualifying event.
2. Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage.
3. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents.
4. If coverage is going to terminate due to your termination of employment or reduction in hours and you don't elect COBRA coverage for your dependents when they are entitled to the coverage, your dependent spouse has the right to elect COBRA for up to 18 months for himself/herself and any children within the time period that you could have elected COBRA coverage.
5. A person who is already covered by another group health plan or Medicare may elect COBRA coverage. However, if a person becomes covered under another group health plan or Medicare after the date of the COBRA election, his or her COBRA coverage will terminate (unless the person has a preexisting condition that would cause the other plan to limit or exclude benefits).

Note to Medicare-Eligible Participants: You MUST have Part B coverage before your COBRA starts. Although this Plan's active coverage is primary to Medicare while you are covered as an active employee, this Plan becomes secondary to Medicare when you elect COBRA. This Plan will not pay any charges that could have been paid by Medicare – even if you haven't elected it. If you do not elect Part B, you will be responsible for most of your non-hospital medical expenses.

6. You do not have to show proof that you and/or your dependents are insurable in order to be entitled to COBRA coverage.

Termination of COBRA Coverage

Normally, COBRA coverage for a person will terminate at the end of the last month of the maximum period to which the person was entitled and for which correct and timely payments were made. However, COBRA coverage for a covered person will terminate before the end of the maximum period when the first of the following events occurs:

1. A correct and timely payment is not made to the Fund.
2. After an election of COBRA coverage, the person becomes entitled to Medicare benefits.
3. After an election of COBRA coverage, the person becomes covered under another group health care plan.
4. This Plan no longer provides group health coverage to any employees.
5. The person was receiving extended coverage for up to 29 months due to his/her or another family member's disability, and Social Security determines that he/she or the other family member is no longer disabled.

Other Coverage Options

There may be other coverage options for you and your family since you can buy coverage through the health insurance marketplace (exchange). On the exchange 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 for a tax credit. 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

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a health insurance marketplace, visit www.healthcare.gov. For specific information about the Welfare Fund or how to elect COBRA through the Welfare Fund, call the Fund Office at 1-877-937-9602.

Death and Disability Benefits

IBEW* Death Benefit-	\$6,250.00
IBEW* Accidental Death-	\$6,250.00
FMPC** Death Benefit-	\$20,000.00
FMCP** Accidental Death-	\$10,000.00
Total Death Benefit	\$26,250.00
Total if Accidental Death	\$42,500.00

Weekly Disability Benefits

FMCP:**

Non-Occupational	\$600.00
Occupational	\$300.00
26 weeks maximum for disability benefits.	

*IBEW Death Benefit payments are only payable to members in good standing.

**FMCP Death and Disability payments are payable only to members who are currently covered by the health plan.

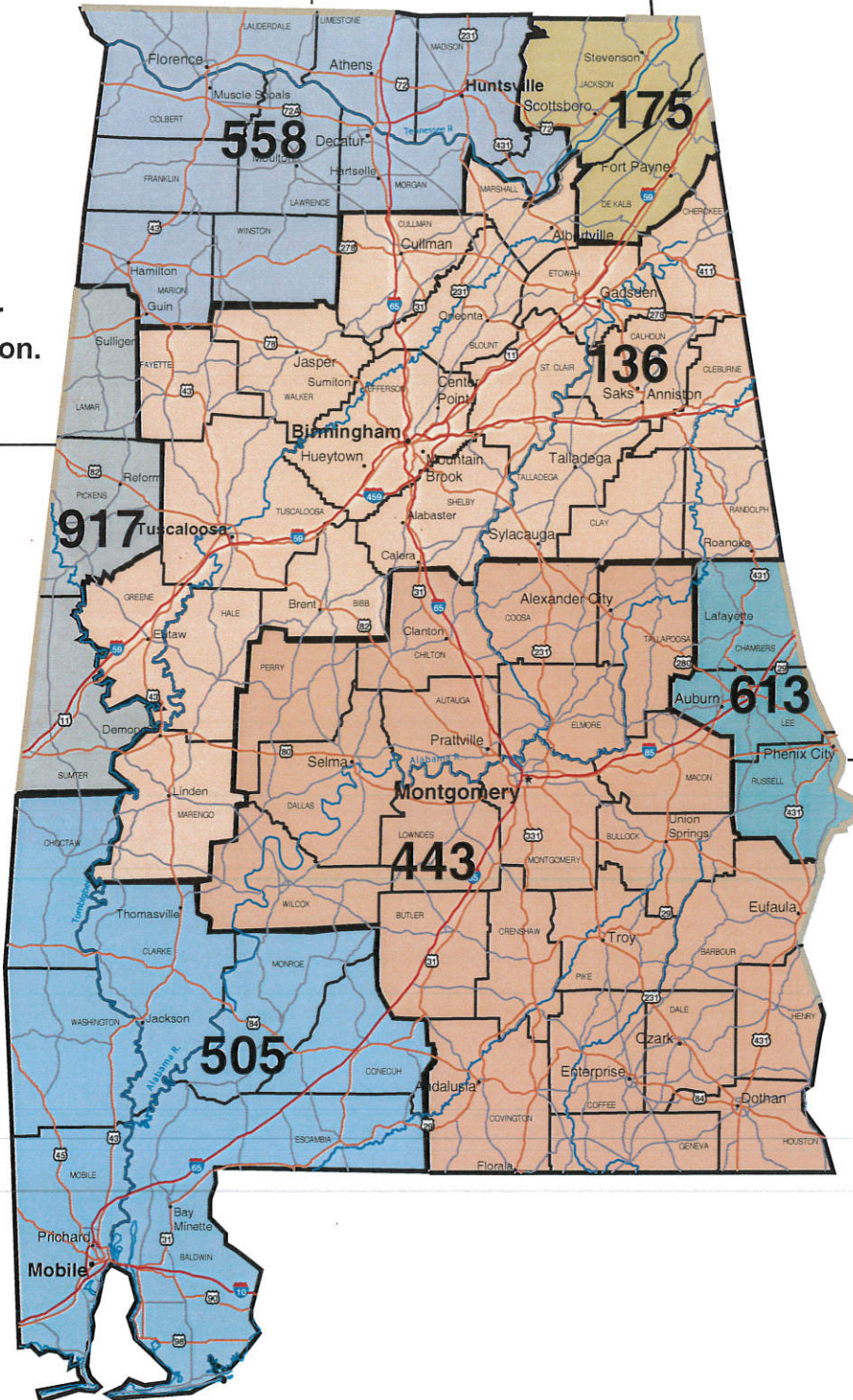
ALABAMA IBEW® Inside Jurisdiction

Revised February 2018

LU 558: See Tennessee map for additional jurisdiction.

LU 175:
See Tennessee map for additional jurisdiction.
See Georgia map for additional jurisdiction.

LU 917: See Mississippi map for additional jurisdiction.



LU 613: See Georgia map for additional jurisdiction.

Inside Wage's 1-1-2025

CLASSIFICATION	WAGE	H & W	JATC	PENSION	N.E.B.F.	LLMCC	NLMCC	Admin.	NECA	NECA	TOTAL		
												FEES	DUES
Journeyman	31.10	8.85	0.78	6.00	0.93	0.01	0.01	0.19	0.05	0.12	48.04		
Journeyman W/ OSHA 30 when reques	31.35	8.85	0.78	6.00	0.94	0.01	0.01	0.19	0.05	0.13	48.31		
General Foreman (20% above JW)	37.32	8.85	0.93	6.00	1.12	0.01	0.01	0.22	0.05	0.15	54.67		
Area Foreman (15% above JW)	35.77	8.85	0.89	6.00	1.07	0.01	0.01	0.21	0.05	0.14	53.01		
Foreman (10% above JW)	34.21	8.85	0.86	6.00	1.03	0.01	0.01	0.21	0.05	0.14	51.35		
Certified Inst. Tech. (10% above JW)	34.21	8.85	0.86	6.00	1.03	0.01	0.01	0.21	0.05	0.14	51.35		
Certified Welder (10% above JW)	34.21	8.85	0.86	6.00	1.03	0.01	0.01	0.21	0.05	0.14	51.35		
Journeyman on Nuclear Work	35.77	8.85	0.89	6.00	1.07	0.01	0.01	0.21	0.05	0.14	53.01		
<i>Apprentice</i>													
1st 6 Months (50%)	15.55	5.37	0.39	0.00	0.47	0.01	0.01	0.09	0.05	0.06	22.00		
2nd 6 Months (55%)	17.11	5.37	0.43	0.00	0.51	0.01	0.01	0.10	0.05	0.07	23.66		
2nd Year (60%)	18.66	5.37	0.47	3.00	0.56	0.01	0.01	0.11	0.05	0.07	28.31		
3rd Year (70%)	21.77	5.37	0.54	3.00	0.65	0.01	0.01	0.13	0.05	0.09	31.63		
4th Year (80%)	24.88	5.37	0.62	3.00	0.75	0.01	0.01	0.15	0.05	0.10	34.94		
5th Year (90%)	27.99	5.37	0.70	3.00	0.84	0.01	0.01	0.17	0.05	0.11	38.25		
<i>Construction Wireman</i>													
CW 1 <1000 hrs (40%)	12.44	5.37	0.31	0.00	0.37	0.01	0.01	0.07	0.05	0.05	18.69		
CW 2 1000-2000 hrs (45%)	14.00	5.37	0.35	0.50	0.42	0.01	0.01	0.08	0.05	0.06	20.84		
CW 3 2001-4000 hrs (50%)	15.55	5.37	0.39	0.50	0.47	0.01	0.01	0.09	0.05	0.06	22.50		
CW 4 4001-6000 hrs (55%)	17.11	5.37	0.43	0.50	0.51	0.01	0.01	0.10	0.05	0.07	24.16		
CW 5 6001-8000 hrs (60%)	18.66	5.37	0.47	0.50	0.56	0.01	0.01	0.11	0.05	0.07	25.81		
<i>Construction Electrician</i>													
CE 1 8001-10000 hrs (70%)	21.77	5.37	0.54	1.00	0.65	0.01	0.01	0.13	0.05	0.09	29.63		
CE 2 10001-12000 hrs (75%)	23.33	5.37	0.58	1.00	0.70	0.01	0.01	0.14	0.05	0.09	31.28		
CE 3 >12000 hrs (80%)	24.88	5.37	0.62	1.25	0.75	0.01	0.01	0.15	0.05	0.10	33.19		

Nuclear Wage Sheet 1-1-2025

CLASSIFICATION	WAGE	H & W	JATC	PENSION	N.E.B.F.	LLMCC	NLMCC	Admin.	NECA	NECA	TOTAL
								FEEES	DUES	CHARGE	Package
Journeyman	35.77	8.85	0.89	6.00	1.07	0.01	0.01	0.21	0.05	0.14	53.02
General Foreman (20% above JW)	42.92	8.85	1.07	6.00	1.29	0.01	0.01	0.26	0.05	0.17	60.63
Area Foreman (15% above JW)	41.14	8.85	1.03	6.00	1.23	0.01	0.01	0.25	0.05	0.16	58.73
Foreman (10% above JW)	39.35	8.85	0.98	6.00	1.18	0.01	0.01	0.24	0.05	0.16	56.82
Certified Inst. Tech. (10% above JW)	39.35	8.85	0.98	6.00	1.18	0.01	0.01	0.24	0.05	0.16	56.82
Certified Welder (10% above JW)	39.35	8.85	0.98	6.00	1.18	0.01	0.01	0.24	0.05	0.16	56.82
<i>Apprentice</i>											
1st 6 Months (50%)	17.89	5.37	0.45	0.00	0.54	0.01	0.01	0.11	0.05	0.07	24.49
2nd 6 Months (55%)	19.67	5.37	0.49	0.00	0.59	0.01	0.01	0.12	0.05	0.08	26.39
2nd Year (60%)	21.46	5.37	0.54	3.00	0.64	0.01	0.01	0.13	0.05	0.09	31.30
3rd Year (70%)	25.04	5.37	0.63	3.00	0.75	0.01	0.01	0.15	0.05	0.10	35.11
4th Year (80%)	28.62	5.37	0.72	3.00	0.86	0.01	0.01	0.17	0.05	0.11	38.92
5th Year (90%)	32.19	5.37	0.80	3.00	0.97	0.01	0.01	0.19	0.05	0.13	42.73
<i>Construction Wireman</i>											
CW 1 <1000 hrs (40%)	14.31	5.37	0.36	0.00	0.43	0.01	0.01	0.09	0.05	0.06	20.68
CW 2 1000-2000 hrs (45%)	16.10	5.37	0.40	0.50	0.48	0.01	0.01	0.10	0.05	0.06	23.08
CW 3 2001-4000 hrs (50%)	17.89	5.37	0.45	0.50	0.54	0.01	0.01	0.11	0.05	0.07	24.99
CW 4 4001-6000 hrs (55%)	19.67	5.37	0.49	0.50	0.59	0.01	0.01	0.12	0.05	0.08	26.89
CW 5 6001-8000 hrs (60%)	21.46	5.37	0.54	0.50	0.64	0.01	0.01	0.13	0.05	0.09	28.80
<i>Construction Electrician</i>											
CE 1 8001-10000 hrs (70%)	25.04	5.37	0.63	1.00	0.75	0.01	0.01	0.15	0.05	0.10	33.11
CE 2 10001-12000 hrs (75%)	26.83	5.37	0.67	1.00	0.80	0.01	0.01	0.16	0.05	0.11	35.01
CE 3 >12000 hrs (80%)	28.62	5.37	0.72	1.25	0.86	0.01	0.01	0.17	0.05	0.11	37.17

Local 443 Montgomery Alabama Referral Procedure and Rules of the Out of Work List Effective 6/1/2012

- 1) Referral procedure will be fairly and impartially administered.
- 2) Applicants will have dues receipt for current month.
- 3) Referral sign-in shall take place any time during normal operating hours of the business office either by fax from a local union office or in person. For initial sign-in by fax your home local must reciprocate and allow local 443 members to initial sign-in by fax. All sign-in by fax will be placed on the book at 5:00pm on the day that the sign-in takes place in the order the fax is received.
- 4) **Re-sign shall be required monthly and will be the 10th through the 16th of each month.** Re-sign may be accomplished by fax, e-mail, in person, or on the Local 443 website at www.ibew443.org. Re-sign by a registrant utilizing any of these methods will be accepted providing it is timely. Re-sign must contain the following information: Name, original sign date, card number, month dues are paid through.
- 5) All members must sign the out of work list when laid off, fired or take a voluntary quit.
- 6) Short calls – Ten (10) working days, excluding Saturday and Sunday, may remain on the out of work list if they are given a Reduction in Force. **An applicant that quits or is discharged for cause will not remain on the out of work list and must sign as a new registrant.**
- 7) All Groups 1, 2, 3 and 4 will sign the proper out of work list.
- 8) All jobs for referral will be placed on the recorder, except in emergency situations. The Business Manager is responsible for filling calls in a timely manner as needed by employers. This means in an emergency, a referral may have to be made outside normal hours using whatever means are available to fill calls and place registrants.
- 9) **If applicant accepts call but fails to show for referral or work, the applicant will be removed from the out of work list and signing will be necessary.**
- 10) Any individuals who receive two (2) discharges for cause with-in a twelve month period shall be suspended from future referral privileges until they appear before the Appeals Committee for a determination as to their continued eligibility for referral.

Job Line

Local – (334) 272-8830

Fax – (334) 272-8831

E-mail – brandon@ibew443.org

Website – www.ibew443.org

Job listings will be posted on the recorder starting at 5:00 p.m. Applicants must call the Union Office to submit their names for calling during the designated time period given on the recording. The dispatcher will then call applicants according to their place on the out of work list and inform the applicant when to sign and receive a referral. All referrals must be picked up and signed in person.

Information given to registrants regarding duration of job and hours of work is for general information only. Local 443 can not guarantee anyone how long a job may last and the overtime that may or may not be required.

J. D. Hornsby, Business Manager
Local Union 443, IBEW