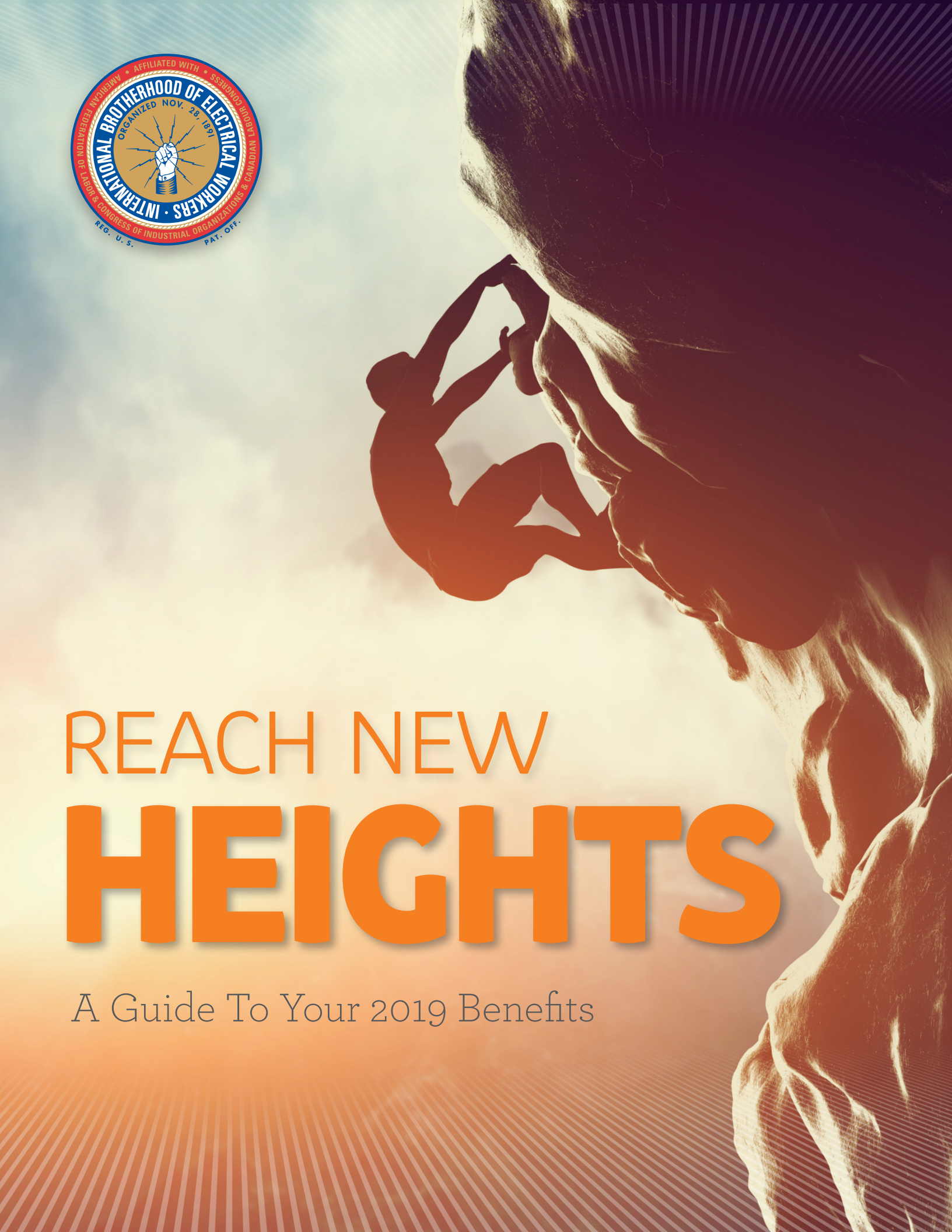

REACH NEW HEIGHTS

A Guide To Your 2019 Benefits

WELCOME

We are committed to providing you with a competitive, comprehensive benefits program that provides the care you and your family need to lead healthy, productive lives. Please review this guide carefully for highlights of our benefits and discuss your options with your family.

Eligibility

- You are eligible for benefits if you have worked 475 hours of service per quarter or 1,900 hours of service in the current period and the three previous contribution periods, made proper application, and paid any applicable assessments to the fund.
- Benefits are effective on the first day of the fourth month after your date of hire.

Qualified Life Events

Elections you make at this time will remain in effect until our next Open Enrollment period. In addition, if you decline coverage for yourself and/or your dependent(s) when first becoming eligible, you must wait until the next Open Enrollment period to enroll. However, if you experience a qualified life event during the year, you may make changes to your elections at that time.

Qualified life events include:

- **Change in status:** Marriage, divorce, legal separation, annulment or death
- **Change in number of dependents:** Birth, death, adoption/placement for adoption or dependent reaching limiting age
- **Change in employment status** of employee, dependent or spouse that affects that individual's eligibility
- **Change in employee, spouse or dependent coverage** on spouse's plan during spouse's Open Enrollment period
- **Changes in entitlement** to Medicare, Medicaid or State Children's Health Insurance Program (CHIP)* for employee, dependent or spouse
- **Change in eligibility for group health plan premium assistance** under Medicaid or CHIP* for employee, dependent or spouse

It is your responsibility to notify Human Resources (HR) within 31 days of the event. If you fail to do so, you will not be able to enroll or make changes until the next Open Enrollment period. When you, your dependent(s) or your spouse become enrolled as a result of a qualified life event, coverage will be made effective retroactive to the date of the event. For more information, please contact HR.

*In such cases you have 60 days to notify HR of the event instead of 31.

Look Inside

How To Enroll

To enroll in or make changes to your benefits, fill out the appropriate enrollment forms and return them to Human Resources.

These forms must be submitted to Human Resources no later than **September 5, 2018**. Changes will be effective January 1, 2019.

BENEFITS

Medical Coverage: Administered by Allied Benefit Systems

We're proud to offer employees medical coverage that not only provides coverage for illness and injury, but also enables you and your family to focus on staying well. Following is a high-level overview of the coverage available. For complete coverage details, please refer to the Summary Plan Description (SPD).

Plan Feature	PPO Plan	
	In-Network	Out-of-Network
Annual Deductible		
▸ Employee only	$400	$1,000
▸ Family	$800	$2,000
Annual Out-of-Pocket Maximum*		
▸ Employee only	$1,000	$3,000
▸ Family	$2,000	$6,000
Office Visit		
▸ Primary Care Physician	$20 copay	Plan pays 65% after deductible is met
▸ Specialist	$20 copay	Plan pays 65% after deductible is met
Preventive Care	The plan will pay the first $100 in covered expenses with no deductible. Thereafter, a $20 copay is due per visit; then the plan pays 50% after the applicable in-network or out-of-network deductible is met	
Emergency Room Visit (copay waived if admitted)	$100 copay	
Urgent Care	**Physician's charges:** $20 copay, then 100% deductible waived **Facility charges:** Plan pays 85% after deductible is met	Plan pays 65% after deductible is met
Inpatient Hospital Stay**	Plan pays 85% after deductible is met	$300 copay per occurrence, then plan pays 65% after deductible is met
Prescription Drugs (Tier 1/Tier 2/Tier 3)		
▸ Retail (up to a 34-day supply)	**Generic:** Plan pays 100%, no deductible **Preferred & Non-Preferred Brand Name:** Plan pays 80% after deductible is met* **Specialty:** Plan pays 85% after deductible is met	
▸ Mail Order (up to a 91-day supply)	**Generic:** Plan pays 100%, no deductible **Preferred & Non-Preferred Brand Name:** Plan pays 80% after deductible is met* **Specialty:** Plan pays 85% after deductible is met	

NOTE: If your doctor requests a brand-name prescription when only a generic prescription is available, you will be charged the generic copay plus the cost difference between the brand name and generic medication. Your prescription drug benefit is administered by Caremark. For prescription drug questions, please call 866-885-4944 or visit **www.caremark.com**.

*Excludes deductible and medical copays. Non-compliance penalty (per-certification requirements) and non-covered services, or for services that are in excess of any plan maximum or limit.

**This plan includes a pre-certification penalty for non-compliance. Certain benefits are subject to a $200 penalty per occurrence (in addition to the deductible) for failure to follow the pre-certification program provisions. These services include inpatient hospital admissions and home health care services. The pre-certification member number is 888-351-3340.

Retirees over age 65 are not eligible for the prescription drug benefits.

Voluntary Dental Coverage: MetLife

Following is a high-level overview of your dental coverage. Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. Please refer to the certificate of insurance for all plan terms and provisions, including all exclusions and limitations. For complete coverage details, please refer to the Summary Plan Description (SPD).

Plan Feature	Dental Plan PDP Plus Network	
	In-Network	Out-of-Network
Annual Deductible (single/family)	$50/$150	
Annual Maximum Benefit	$1,000	
Preventive	Plan pays 100% of negotiated fee, no deductible	Plan pays 100% of reasonable and customary fee, no deductible
Basic	Plan pays 80% of negotiated fee after deductible	Plan pays 80% of reasonable and customary fee after deductible
Major	Plan pays 50% of negotiated fee after deductible	Plan pays 50% of reasonable and customary fee after deductible

1. "PDP" refers to the fees that MetLife PDP dentists have agreed to accept as payment in full.
2. Out-of-Network benefits are paid at the R&C (reasonable and customary) charge based on the lowest of the usual charge of most dentists in the same geographical area for the same or similar services as determined by MetLife (the "Customary Charge"). The Customary Charge is based on the 90th percentile.

Voluntary Vision Coverage: VSP

Following is a high-level overview of your vision coverage. For complete coverage details, please refer to the Summary Plan Description (SPD).

Plan Feature	Frequency	In-Network	Out-of-Network
Examination	Once every 12 months	$10 copay	Up to $45 reimbursement
Basic Lenses (single/bifocal/ trifocal/lenticular)	Once every 12 months	$25 copay	Up to $30/$50/$65/$100 reimbursement
Standard Frames	Once every 24 months	$130 allowance, then 20% off balance	Up to $70 reimbursement
***Contact Lenses** (in lieu of glasses)	Once every 12 months	$130 allowance ($60 copay for fitting and evaluation)*	Up to $105 reimbursement*
LASIK Surgery		15-20% off regular price; 5% off promotional price	N/A

*Medically necessary: $25 copay, then plan pays 100%
**Medically necessary: Up to $210 reimbursement out-of-network

Basic Life and AD&D Coverage: Trustmark Life Insurance Company

We help our eligible employees maintain financial security by providing a group life and accidental death and dismemberment (AD&D) benefit. This benefit is company paid.

Employee Life and AD&D	
Active Employees	$15,000
Retired Eligible Employees (Life only)	$5,000

Short-Term Disability Coverage: MetLife

We offer eligible employees short-term disability (STD) coverage for your financial needs should you need to take a leave from work due to a serious illness or non-work-related injury. Following is a brief summary of our STD coverage. This benefit is company paid.

STD Coverage Features	
Income Replacement	60%
Weekly Maximum Benefit	$400
When Benefit Begins	After 7 days
Maximum Benefit Period	26 weeks

BENEFITS CONTACT DIRECTORY

Topic	Contact	Phone Number	Website & Network
General Benefits and/or Enrollment	TIC International (Administrative Manager for the IBEW Health & Welfare Fund Plan)	833-336-1392	N/A
Medical Coverage	Allied Benefit Systems Inc. Anthem BCBS (PPO Network)	877-222-1131 800-810-2583	www.alliedbenefit.com www.anthem.com
Prescription Drug Coverage	CVS Caremark	866-885-4944	www.caremark.com
Dental Coverage	MetLife	800-275-4638	www.metlife.com
Vision Coverage	VSP	800-877-7195	www.vsp.com
Basic Life and Accidental Death and Dismemberment (AD&D) Coverage (Retirees are eligible for Basic Life only)	Trustmark Life Insurance Company	219-769-6944	www.trustmarklife.com
Disability Coverage	MetLife	800-275-4638	www.metlife.com

IMPORTANT NOTICES

Mental Health Parity Act

Per the Mental Health Parity Act, benefits for mental health and substance-use disorder must be treated like benefits for regular medical and surgical care. For example, if there is no limitation on the number of days for inpatient and number of visits for outpatient medical care, then there can be no limitation for mental health and substance-use disorder treatments. As always, treatments must be medically necessary to qualify for coverage. Plan participants should review their plan's certificate of coverage or benefit document for specific information about coverage, limitations and exclusions for mental health care and substance-use disorder treatments.

Women's Health and Cancer Rights Act

On January 1, 1999, a federal law, the Women's Health and Cancer Rights Act of 1998, became effective, which affects our company plan options. This law requires group health plans that provide coverage for mastectomies (ours does) and to also provide coverage for reconstructive surgery and prostheses following mastectomies. As required under the law, we have included this notice to inform you about it.

The law mandates that a participant or eligible beneficiary who is receiving benefits, on or after the law's effective date (January 1, 1999, for our Plan), for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the Plan.

If you have any questions about coverage for mastectomies and post-operative reconstructive surgery, please contact your local HR representative.

Summary of Benefits and Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. To help you make an informed choice, the company makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about our health coverage in a standard format, to help you compare across options. The SBC also includes a Glossary of Health Coverage and Medical Terms to help you better understand health care terms used in the SBC. You can obtain a copy of the SBC at no cost to you by contacting your local HR representative.

Notice of Grandfathered Plan Status

Federal law imposes numerous requirements affecting your health plan coverage regarding benefits, eligibility, and various rights and obligations. The law requires group health plans communicate information to plan participants. The information described in this packet is provided to comply with applicable federal law and to satisfy all notice-related requirements.

Grandfather Status
The International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund Employee Benefits Plan believes this program, The International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund Employee Benefits Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that coverage under The International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund Employee Benefits Plan believes may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 877-222-1131 Allied Benefit Systems Inc.

IMPORTANT NOTICES

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no later than 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have 60 days from the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event and provide the employer plan with timely notice of the event and your enrollment request.

To request special enrollment or obtain more information, contact Stewart C. Miller & Company, Administrative Manager, phone at 219-769-6944.

Newborn's and Mothers' Disclosure Notice

MATERNITY BENEFITS

Under Federal and state law you have certain rights and protections regarding your Maternity benefits under the Plan.

Under federal law known as the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the Mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain Authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Under Newborns' and Mothers' Health Protection Act of 1996, if your Plan provides benefits for obstetrical services your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and copayments that are no less favorable than for physical Illness generally.

Please note: This guide is intended to provide you with highlights of our benefits program. It is not intended to address all details. Actual benefit coverage is specified in the Summary Plan Descriptions (SPDs). In the event of any differences between this guide and the SPDs, the SPDs will govern.