Amendment No. 3

to the

IBEW Local 347 Electrical Workers Health and Welfare Fund
Combination Plan Document and Summary Plan Description

WHEREAS, Section 13.10 of the IBEW Local 347 Electrical Workers Health and Welfare Fund Combination Plan Document and Summary Plan Description ("Plan"), restated effective September 1, 2012 provides that the Board of Trustees has complete power and discretion to amend the Plan, in whole or in part, at any time;

WHEREAS, it is the desire of the Board of Trustees to amend the provisions of the Plan;

NOW, THEREFORE, BE IT RESOLVED that the Plan shall be amended as follows:

SUMMARY OF BENEFITS

The Summary of Benefits shall be clarified at the Section, "PRESCRIPTION DRUG BENEFITS (ARTICLE III)" by deleting the Section in its entirety and inserting in its place the following, "PRESCRIPTION DRUG BENEFITS (ARTICLE III)":

PRESCRIPTION DRUG BENEFITS (ARTICLE III)		
PRESCRIPTION DRUG TYPE	**WALK-IN RETAIL PHARMACY** (Up to a 34 Day Supply)	**MAIL ORDER PHARMACY** (Up to a 90 Day Supply)
GENERIC	100% after the greater of: 20% or $7 Copay	100% after $10 Copay
PREFERRED BRAND	100% after the greater of: 20% or $15 Copay *	100% after $10 Copay *
* If a generic equivalent is available, and you purchase a preferred brand drug you will be required to pay the applicable Copay plus the price difference between the generic drug and the preferred brand name drug unless your Physician has indicated, "Dispense as Written" on your prescription. If your Physician has indicated, "Dispense as Written" on your prescription, you will only be required to pay the Copay.		
NON-PREFERRED BRAND	100% after the greater of: 25% or $30 Copay*	100% after $70 Copay *
* If a generic equivalent is available, and you purchase a non-preferred brand drug, you will be required to pay the applicable Copay plus the price difference between the generic drug and the non-preferred brand name drug unless your Physician has indicated, "Dispense as Written" on your prescription. If your Physician has indicated, "Dispense as Written" on your prescription, you will only be required to pay the Copay.		
SPECIALTY	100% after a $50 Copay *	100% after $50 Copay *
* Specialty drugs are limited to a 30 day supply.		

ARTICLE I – ELIGIBILITY

Effective January 1, 2014, Article I shall be amended at Section 1.17 by deleting subsection (b) and inserting in its place the following subsection (b):

(b) Child

The child of a Covered Employee or Retiree will be covered under this Plan as a Dependent of the Covered Employee or Retiree if the child meets the criteria of (1) and (2) below.

(1) He has one of the following relationships to the Covered Employee or Retiree:

i. Is a son, daughter, stepson or stepdaughter;

ii. Is an eligible foster child*;

iii. Is legally adopted or lawfully placed with the Covered Employee or Retiree for legal adoption so long as the child is adopted or placed with the Covered Employee or Retiree for legal adoption prior to his 18th birthday; or

iv. Is a child for whom the Covered Employee or Retiree has legal responsibility by virtue of a court order for custody and support or maintenance (including a legal guardianship), or who is the subject of a Qualified Medical Child Support Order (QMCSO)**.

(2) He meets one of the following conditions:

i. Is under the age of 26; or

ii. Is permanently and totally disabled and the disability began before the child would have lost coverage under the Plan if not for this provision.

* A foster child means an individual who is placed with the Covered Employee or Retiree by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction. In order for a foster child to be covered under the Plan, no parent can claim the child as a "qualifying child" under the tax code and the non-parent Covered Employee or Retiree must have a higher adjusted gross income (AGI) than any parent of the child.

** A child who does not meet the eligibility criteria under this Plan may still be covered as a Dependent if the Plan receives a Qualified Medical Child Support Order (QMCSO) from the court ordering the Plan to provide coverage to the child as the Alternate Recipient under the QMCSO. A National Medical Support Notice received by the Plan by a state agency regarding coverage for a child will also be treated as a QMCSO. The Plan will review the QMCSO and determine whether it is qualified in accordance with the Plan's written procedures for handling medical child support orders. The Plan's procedures for handling medical child support orders will be provided to a Participant or Beneficiary upon request and free of charge.

Effective January 1, 2014, Article I shall be amended at Section 1.21 by deleting the Section in its entirety and inserting in its place the following Section 1.21:

Section 1.21 – Termination of Dependent Child Eligibility and Coverage

A Dependent child's eligibility and coverage will terminate when the Covered Employee or Retiree's coverage terminates for any reason, except as provided in Sections 1.22 and 1.23 as applicable. A Dependent child's eligibility and coverage will also terminate in accordance with Sections 1.21(a) and (b) below.

(a) A Dependent child will automatically remain covered through the end of the month containing his 26th birthday. A Dependent child's coverage will terminate at 12:01 a.m. on the first day of the month following his 26th birthday unless the Dependent child is eligible under Section 1.17(b)(2)(ii) above.

(b) Notwithstanding the age limit above, a permanently and totally disabled Dependent child may remain eligible for coverage despite his age, provided the other criteria are met. A Dependent child will be considered permanently and totally disabled for purposes of receiving continued eligibility for benefits under the Plan if he is unable (because of a physical or mental condition) to support himself financially, as long as the disability began before the child's coverage would have otherwise terminated. The Plan may require proof of the disability in order to continue coverage past the age of 25, and may continue to require this proof from time to time. The Covered Employee, Retiree or Dependent must inform the Plan Administrator if a disabled Dependent child is entitled to Medicare. For the rules regarding the Plan's coordination of benefits with Medicare, see Section 10.04.

All Covered Persons are responsible for promptly notifying the Plan Administrator when a Dependent child no longer meets the Plan's definition of Dependent. This means a Covered Person must notify the Plan Administrator immediately if a Dependent child is no longer permanently and totally disabled. Failure to notify the Fund Office that a child is no longer permanently and totally disabled will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If a Covered Employee or Retiree does not notify the Plan Administrator that a child is no longer permanently and totally disabled, the Plan may recover any payments made for claims incurred by the child after the date of such event (i.e. after the child was no longer eligible for coverage from the Plan as a Dependent child) in accordance with Section 13.18.

ARTICLE III – PRESCRIPTION DRUG BENEFITS

Article III shall be clarified at the beginning of the Section by deleting the chart and inserting in its place the following chart:

PRESCRIPTION DRUG BENEFITS (ARTICLE III)		
PRESCRIPTION DRUG TYPE	**WALK-IN RETAIL PHARMACY** (Up to a 34 Day Supply)	**MAIL ORDER PHARMACY** (Up to a 90 Day Supply)
GENERIC	100% after the greater of: 20% or $7 Copay	100% after $10 Copay
PREFERRED BRAND	100% after the greater of: 20% or $15 Copay *	100% after $10 Copay *
* If a generic equivalent is available, and you purchase a preferred brand drug you will be required to pay the applicable Copay plus the price difference between the generic drug and the preferred brand name drug unless your Physician has indicated, "Dispense as Written" on your prescription. If your Physician has indicated, "Dispense as Written" on your prescription, you will only be required to pay the Copay.		
NON-PREFERRED BRAND	100% after the greater of: 25% or $30 Copay*	100% after $70 Copay *
* If a generic equivalent is available, and you purchase a non-preferred brand drug, you will be required to pay the applicable Copay plus the price difference between the generic drug and the non-preferred brand name drug unless your Physician has indicated, "Dispense as Written" on your prescription. If your Physician has indicated, "Dispense as Written" on your prescription, you will only be required to pay the Copay.		

SPECIALTY	100% after a $50 Copay *	100% after $50 Copay *
* Specialty drugs are limited to a 30 day supply.		

Article III shall be clarified at Section 3.01 by deleting the Section in its entirety and inserting in its place the following Section 3.01:

LDI is the pharmacy benefit manager that administers the prescription drug benefits. LDI provides a network of participating retail pharmacies and the mail order and specialty pharmacy program.

When a non-occupational Injury or Sickness causes a Covered Person to need prescription drugs, the Plan will pay benefits according to the above chart. Prescription drugs can be legally obtained only by the written prescription of a Physician. The Plan does not cover prescriptions filled at Wal-Mart and Sam's Club pharmacies.

If you purchase a preferred or non-preferred brand name drug when a generic equivalent is available, you will be required to pay the applicable Copay plus the price difference between the generic drug and the preferred or non-preferred brand name drug unless your Physician has indicated, "Dispense as Written" on your prescription. If your Physician has indicated, "Dispense as Written" on your prescription, you will only be required to pay the applicable Copay.

Article III shall be clarified at Section 3.04 by deleting the Section in its entirety and inserting in its place the following Section 3.04:

Section 3.04 – Specialty Drugs

Specialty Drugs are, in general, more expensive than non-specialty medications due to the cost of the ingredients to develop them. They are dispensed in 30-day (or less) quantities depending on FDA guidelines and are often not carried in stock at retail pharmacies.

Specialty Drugs include oral, injectable, infused or inhaled medications that are either self-administered or administered by a healthcare provider, and used or obtained in either an outpatient or home setting.

Injectable drugs including specialty oral medications shall encompass all medications, and biological, human or animal derived products or biosynthetic agents, including preparations that are sterile and pyrogen-free including, inhalation or implantation.

Specialty Drugs have the following key characteristics:

- More expensive than non-specialty medications;
- Need frequent dosage adjustments;
- Cause more severe side effects than traditional drugs;
- Need special storage, handling and/or administration;
- Have a narrow therapeutic range; and
- Require periodic laboratory or diagnostic testing.

Specialty Drugs are limited to a 30-day supply due to the nature of the drug and the need for dosage adjustments.

- The Plan will not cover Specialty Drugs unless they are filled at the LDI Specialty Pharmacy or meet one of the following criteria: the Specialty Drug is a limited distribution drug and it is not available at the LDI Specialty Pharmacy (e.g. if you have asthma, your doctor prescribes you Xolair, and the Xolair is not available at the LDI Specialty Pharmacy, the Plan will cover the Xolair even if it is not purchased at the LDI Specialty Pharmacy); or

- The Specialty Drug is an immediate need drug (e.g., if you have surgery and your doctor prescribes you Enoxaparin in order to prevent you from getting blood clots after your surgery, the Plan will cover seven doses of Enoxaparin even if it is not purchased at the LDI Specialty Pharmacy).

LDI provides a list of Specialty Drugs on their website. If you have questions regarding Specialty Drugs you can call LDI at (866) 516-4121 or visit www.LDIRx.com.

The Trustees encourage you to seek prior authorization before you purchase a Specialty Drug (other than Specialty Drugs used to prevent blood clots immediately after surgery). To request prior authorization, either you or your provider should contact LDI at (866) 516-3121. It is important to remember that prior authorization is not a prerequisite for receiving a Specialty Drug. It is a service provided by the Plan to enable you to obtain an evaluation of whether a particular Specialty Drug will be covered by the Plan. If you or your provider requests prior authorization and is informed that the Plan will not pay for the Specialty Drug, you are still free to obtain the Specialty Drug and submit a claim which will be evaluated based on the actual information submitted in support of the claim and not the information submitted in your (or your provider's) request for prior authorization.

Effective February 8, 2013, Article I shall be amended at Section 3.05 by deleting the Section in its entirety and inserting in its place the following Section 3.05:

Section 3.05 – Prescription Drug Benefit Exclusions and Limitations

Prescription Drug Benefits will not be payable for:

(a) Drugs, medicines and quantity limits that are not in compliance with the Federal Food and Drug Administration (FDA) guidelines;
(b) Drugs purchased at a Wal-Mart or Sam's Club pharmacy;
(c) Drugs or medicines covered under Article II – Comprehensive Medical Benefits;
(d) Contraceptive devices (i.e. non-oral contraceptives) except as specifically provided for in this Article;
(e) Infertility drugs, immunization agents biological and allergy sera, blood or blood plasma;
(f) Administration of any drug or medicine;
(g) Any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date;
(h) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances except as specifically provided for in this Article;
(i) Growth hormones, except when prescribed in connection with pediatric growth hormone deficiency;
(j) Levonorgestrel (Norplant);
(k) Dermatologicals and hair growth stimulants;
(l) Anorectics (any drug used for the purpose of weight loss), except for the following drugs that will be covered specifically for the treatment of Attention Deficit Disorder (ADD): Amphetamine/ Dextroamphetamine (Adderall), Dextroamphetamine (Dexedrine) and Methamphetamine HCL (Desoxyn);
(m) Topical dental products;

(n) Vitamins, singly or in combination, mineral and nutritional supplements, food supplements or substitutes except as specifically provided for in this Article;
(o) Non-legend drugs (i.e. over the counter drugs) other than insulin;
(p) Prescriptions for a Covered Person who enrolls in Medicare Part D for prescription coverage;
(q) Marijuana, even if prescribed for medicinal purposes;
(r) Specialty Drugs that are not purchased at the LDI Specialty Pharmacy except as specifically provided for in this Article; and
(s) Services and treatment excluded under Article VIII – Benefit Exclusions and Limitations.

ARTICLE IV – DENTAL BENEFITS

Article IV shall be clarified at Section 4.03 by deleting subsection (a)(3) and inserting in its place the following subsection (a)(3):

(3) Other Services

- Prophylaxis (standard cleaning of teeth) – Two cleanings per calendar year
- Topical application of fluoride – Applicable only to Dependent children. Only one application will be covered each 12 month period
- Space maintainers – Applicable to Dependent children under age 14
- Topical application of sealants – Applicable only to Dependent children under age 14; covered once each quadrant in each four year period
- Biopsy of oral tissue
- Palliative treatment – Covered as a separate procedure only if no other treatment (except x-rays) is provided during the visit
- Bacteriologic culture
- Histopathologic examination
- Pulp vitality test
- Diagnostic cast – Covered once each two year period

Article IV shall be clarified at Section 4.03 by deleting subsection (b)(3) and inserting in its place the following subsection (b)(3):

(3) Periodontic Services

- Surgical procedures – Only one of the listed periodontic surgical procedures is covered for each quadrant in a 12 month period:
  - Gingivectomy
  - Osseous surgery
  - Gingival curettage
  - Osseous graft
- Scaling and root planing (each quadrant) – Once each quadrant each six month period
- Periodontal appliance – One appliance each three year period
- Periodontal prophylaxis – Four cleanings per calendar year. This benefit coordinates with the prophylaxis described in Section 4.03(a)(3) above. This means that the Plan will only cover four cleanings (including any combination of prophylaxis described in Section 4.03(a)(3) and periodontal prophylaxis described in this Section) per calendar year.

ARTICLE XIII – MISCELLANEOUS PROVISIONS

Effective July 12, 2013, Article XIII shall be amended at Section 13.08 by deleting the Section in its entirety and inserting in its place the following Section 13.08:

Section 13.08 – Names, Titles and Addresses of the Trustees

Union Trustees	Employer Trustees
Mr. Patrick H. Wells IBEW Local 347 850 18th Street Des Moines, IA 50314	Ms. Angela S. Bowersox Iowa Chapter, NECA 2900 Westown Parkway, Suite D West Des Moines, IA 50266
Mr. Allen DeHeer IBEW Local 347 850 18th Street Des Moines, IA 50314	Mr. John Irving Baker Electric 111 SW Jackson Street Des Moines, IA 50315
Mr. Matt DeAngelo 7401 S.W. 16th Street Des Moines, IA 50314	Mr. Jim Davis The Waldinger Corporation 2601 Bell Avenue Des Moines, IA 50321
Mr. Doug Wolf 4550 Highway 14 North Newton, IA 50208	Mr. Michael Price Commonwealth Electric of the Midwest 1530 Second Ave Des Moines, IA 50314
	Mr. Don Bridgeman (alternate) Wolin Mechanical & Electrical 1720 Fuller Road West Des Moines, IA 50265

The Board of Trustees may be contacted at the following Fund Office address and phone number:

Wilson-McShane Corporation
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
4200 University Avenue, Suite 320
West Des Moines, IA 50266
Telephone: (515) 224-4308
Toll-Free: (877) 224-4308

Effective January 1, 2014, Article XIII shall be amended at Section 13.11 by deleting the third paragraph and inserting in its place the following:

Benefits under this Plan are paid directly from the Fund. Benefits under this Plan are not financed or guaranteed under a contract or a policy of insurance issued by a health insurance issuer, except as provided

through a contract for stop-loss insurance. There is no liability on the Trustees or any other individual or entity to provide payment over and beyond the amount in the Fund.

Effective January 1, 2014, Article XIII shall be amended at Section 13.18 by deleting the Section in its entirety and inserting in its place the following Section 13.18:

Section 13.18 – Recovery of Overpayments

No person is entitled to any benefit under the Plan except as expressly provided under the Plan. The fact that payments have been made from the Plan in connection with any claim for benefits under the Plan does not establish the validity of the claim, or provide the right to have such benefits continue for any period of time, or prevent the Plan from recovering the benefits paid to the extent the Trustees ultimately determine that in fact, there was no right to payment of the benefits under the Plan.

The Plan shall have the right to recover, by all legal and equitable means, any amounts paid that the recipient was not rightfully entitled to under the terms of this Plan (i.e. overpayments). This right to recovery shall include, but not be limited to, the right to recoup such amounts from future benefits to be paid to or on behalf of the Participant and his Dependents and the right to recoup such amounts from any benefits to be paid to or on behalf of any survivors of the Participant or Dependent. This right to recovery shall further include the right to collect additional costs incurred by the Plan to recover the overpayment (for example, attorney's fees). For purposes of this Section 13.18, the term "overpayment" shall include payments made on behalf of an individual who was not eligible for coverage from the Plan (for example, if a Participant gets divorced and the Participant did not notify the Fund Office of the divorce, payments made for claims on behalf of the ex-spouse are considered overpayments).

The Plan's right to recovery shall include but not be limited to the following:

(a) In the event of an overpayment of benefits to or on behalf of a Participant (including an individual who ceased to meet the Plan's definition of Participant), the Plan may recover the overpayment by:

  (1) A direct recovery from the Participant;

  (2) A direct recovery from the medical provider who received the overpayment;

  (3) Reducing future benefits to or on behalf of the Participant; or

  (4) Reducing future benefits to or on behalf of the Participant's Dependents.

(b) In the event of an overpayment of benefits to or on behalf of a Dependent (including an individual who ceased to meet the Plan's definition of Dependent), the Plan may recover the overpayment by:

  (1) A direct recovery from the Dependent;

  (2) A direct recovery from the Participant whose participation in the Plan was the basis for the Dependent's eligibility in the Plan;

  (3) A direct recovery from the medical provider who received the overpayment;

  (4) Reducing future benefits to or on behalf of the Dependent;

  (5) Reducing future benefits to or on behalf of the Participant whose participation in the Plan was the basis for the Dependent's eligibility in the Plan; or

  (6) Reducing future benefits to any additional Dependent of the Participant whose participation in the Plan was the basis for the Dependent's eligibility in the Plan.

IN WITNESS WHEREOF, we have hereunto affixed our signatures and approved this Amendment this _____day of _____, 2014.

UNION TRUSTEE	EMPLOYER TRUSTEE
_____	_____
Chairman	Secretary