# IBEW LOCAL 915
## HEALTH AND WELFARE FUND

# SUMMARY PLAN DESCRIPTION

**AMENDED**
**January 1, 2022**

# IBEW LOCAL 915
# HEALTH AND WELFARE FUND

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HOSPITAL PRECERTIFICATION: (800) 764-6810
PROVIDER DIRECTORY: http://welcometouhc.com/uhss
NURSELINE: (877) 543-3811
SAV-RX: (866) 233-IBEW (4239)
DENTAL BENEFIT PLAN: (800) 831-4914
VISION BENEFITS: Vision Service Plan (800) 877-7195

**You can find information on the Health and Welfare Plan by accessing IBEW 915's website at:**
www.ibew915.org

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# IMPORTANT MESSAGE

To: ALL ELIGIBLE PARTICIPANTS

This booklet and Summary Plan Description describe the Comprehensive Benefit Program available to you and your qualified dependents under the IBEW LOCAL 915 HEALTH AND WELFARE FUND. The Trust Fund is maintained pursuant to a Collective Bargaining Agreement between Local Union 915 and Florida West Coast Chapter of NECA and other signatory employers. You may obtain copies of the Collective Bargaining Agreement upon written request from the Local Union.

The cost of the benefits provided by your Health and Welfare Fund is being borne by your employers through contributions made on your behalf to the IBEW Local 915 Health and Welfare Fund as required by the Collective Bargaining Agreement and the Agreement and Declaration of Trust.

The Fund's primary purpose is to provide Health and Welfare benefits to you and your qualified dependents. These benefits will be provided promptly upon submission of a properly completed claim form and all other necessary information required for the processing of the claim.

Southern Benefit Administrators, Inc. has been retained by the Board of Trustees to handle the routine administrative duties necessary for the efficient operation of the Fund. Southern Benefit Administrators is responsible for processing and paying all eligible medical and dental claims submitted. You can contact Southern Benefit Administrators by calling 1-800-831-4914.

The Plan uses UnitedHealthcare as the Preferred Provider Organization Network (PPO). Please be sure your providers know this is the PPO our Plan uses. If your ID Card does not show this please contact Southern Benefit Administrators for a new ID Card. Please remember that although the Plan uses the UnitedHealthcare PPO Network, UHC does not provide any insurance. Medical and Dental Benefits are fully self-funded.

Vision benefits are provided by Vision Service Plan (VSP). These benefits are fully insured by VSP. Please contact VSP when you are ready to use these benefits. You can call them at (800) 877-7195 or you may visit vsp.com. You will have to identify yourself as a participant of the IBEW Local 915 Health and Welfare Fund.

**The Plan of Benefits has been impacted by the Patient Protection and Affordable Care Act, commonly referred to as the Affordable Care Act (ACA). The Plan complies with ACA and maintains "grandfathered" status. The Plan has increased the calendar year maximum to unlimited, as required by the Department of Health and Human Services. Because of the requirement that medical benefits be unlimited the Trustees have purchased "stop-loss" insurance to protect the Fund from catastrophic claims.**

Life Insurance and Accidental Death and Dismemberment benefits are provided under a fully insured arrangement with 5 Star Life Insurance Company. You should provide the Fund Office with

a signed beneficiary card. If you have not completed one, or don't recall who you named as beneficiary, please contact the Fund Office for a beneficiary designation form.

It is important that you provide Southern Benefit Administrators with enrollment information. This will make it easier for you to use the Plan when necessary. In addition to beneficiary designation you should contact Southern Benefit Administrators to update their records when you change addresses, get married, divorced, retire, become disabled, or have a dependent reaching the limiting age. You should also contact Southern Benefit Administrators when your coverage is terminated. You will be provided with a Certificate of Creditable Coverage which may help when you become covered under another group insurance program.

This booklet has been written in everyday language to summarize the benefits, rights and obligations you have under your Plan. We hope you will find this information helpful and will discuss it with your family. If you have any questions, or if you would like to discuss the details further, Southern Benefit Administrators, Inc., or the Board of Trustees, will be glad to help you. You can be assured that the Board of Trustees will do everything possible to maintain the Health and Welfare Fund on a sound and effective basis, so that the best benefits available can be provided for you and your qualified dependents.

Sincerely,

THE BOARD OF TRUSTEES

# GRANDFATHERED STATUS

The Trustees believe that our 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 the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. 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 Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Finally, if you have any questions regarding eligibility, benefits, or claim status, please contact the Fund Office toll-free at 1-800-831-4914.

# IMPORTANT INFORMATION

It is extremely important that you contact the Fund Office when you satisfy the Initial Eligibility requirements. You will be required to complete an enrollment form and a beneficiary designation. You should advise the Fund Office whenever you change your address, add a dependent, become married or divorced, retire, or have a dependent reach the limiting age.

If you do not have internet access you can contact the Fund Office for a directory of participating providers. This directory is available to you at no cost.

Fund Office

Address: Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN 37070-1449

Phone: (615) 859-0131
(800) 831-4914 TOLL FREE
(615) 859-4699 FAX

UnitedHealthcare's Choice Plus PPO

Precertification: (800) 764-6810
Nurseline: (877) 543-3811
Provider Directory: http://welcometouhc.com/uhss

Rx Mail Order Program – Sav-Rx
Phone: (866) 233-4239
Website: www.savrx.com

Vision Service Plan: (800) 877-7195
Fax: (976) 851-4652

Life and Accidental Death and Dismemberment benefits are insured by 5 Star Life Insurance Company. Please be sure that a current beneficiary designation is on file in the Fund's Office. The Policy Number for this coverage is D0116. The Schedule of Benefits in this booklet contains the benefits provided under this coverage. There are provisions of this Policy including Premium Waiver, Conversion rights, etc. which are described in a Certificate of Insurance prepared by 5 Star Life. You can obtain a copy of this summary from the Fund Office.

# FREQUENTLY ASKED QUESTIONS

The following are questions and answers relating to your Health and Welfare Plan. If you familiarize yourself with these answers, it may clarify the purpose of coverage of the program.

**Q. How can I make sure that I am eligible for benefits under the Health & Welfare Fund?**

A. If you have any question concerning your eligibility, it is your responsibility to check with the Administrator's Office to see whether your name is included as eligible for receiving benefits.

**Q. Must I register with the Health and Welfare Fund?**

A. Yes. When you become eligible for benefits you will receive a Health and Welfare Fund Enrollment Card. On this card you will list your dependents and designate your beneficiary and other pertinent data. Please keep the Fund Office advised when you change your address or change your marital status.

**Q. Are all employees covered?**

A. Federal laws and the financial requirements of maintaining this Fund do not allow coverage of all employees. Those employees who satisfy eligibility rules are automatically covered. It would be financially impossible to cover all employees.

**Q. If I lose coverage, or if one of my dependents reaches the limiting age, what are my alternatives?**

A. Contact the Fund Office. They can advise you if you are eligible to make self-contributions, or COBRA payments. If your dependent children reach the limiting age, you need to advise the Fund Office. When your eligibility is terminated you should contact the Fund Office and ask for a Certificate of Creditable Coverage. This may help you in obtaining benefits under future health insurance coverage.

**Q. Will the Plan reimburse me for whatever my physician charges me?**

A. No. Benefits are based upon reimbursing you for a percentage of the usual, reasonable and customary charges for covered services. A suggested procedure to follow before an operation or receiving medical treatment is to have your physician explain the total fee he will charge for your medical treatment or operation. You may then contact the Fund office claims department for advice as to whether or not the entire charge will be considered a covered expense under the Plan's reasonable and customary guidelines. This will help eliminate misunderstandings on what is covered by the Plan and thus enable you to find out in advance how much you may owe the physician. UHC providers have previously agreed to discounted fees. You will not be responsible for the discounted amounts.

**Q. What is the deductible?**

A. The deductible is the dollar amount of expenses which must be satisfied by you and each of your dependents within each calendar year before Major Medical Benefits are payable. The deductible is applied only once in a calendar year.

**Q. I support my mother. Can she become covered as my dependent?**

A. No. Dependents include the spouse of the member and his children to 26 years of age.

**Q. Does the Plan cover me on the job?**

A. No. Workers' Compensation insurance carried by your employer covers you on the job. The Health and Welfare Fund covers you for non-occupational illness or injuries.

**Q. My wife is employed and has Group Insurance with her employer. Can I collect under her Plan and this Plan?**

A. Payment would be subject to the Coordination of Benefits provisions under either Plan. For more information contact the Administrative office.

**Q. If a medical claim is denied can I appeal the denial?**

A. If you feel a claim has been denied improperly you should submit a letter of appeal addressed to the Board of Trustees and send it to the Fund Office. A sample appeal letter is shown at the end of this booklet.

# HOW TO USE THE PLAN

Medical benefits are entirely self-funded. Every dollar paid out in benefits comes directly from employer contributions made on behalf of participants working under the terms of a collective bargaining agreement, or through self-contributions. It is important that you understand the Plan and use the benefits wisely.

Our Plan utilizes UnitedHealthcare's Choice Plus Preferred Provider Organization Network. UHC has negotiated discounts with doctors, hospitals and other medical providers. These discounts reduce the dollars spent by the Plan as well as your out-of-pocket expenses. Please be sure you have a current PPO directory to help in locating a participating medical provider. You can contact UHC at (800) 764-6810 to find a PPO provider. You can also find a UHC provider by using UHC's website at http://welcometouhc.com/uhss.

If you need to make an appointment with a doctor, or if you do not have a doctor, you should call the PPO's toll-free number to locate a doctor in your area. If you find a doctor in the directory, you should call the toll-free number to be sure the provider is still in the network. Once you have located a doctor, call him for an appointment. When you arrive they will likely ask for a copy of your insurance I.D. card. If you do not have one please contact the Fund Office.

If your doctor needs to refer you to a specialist, admit you to a hospital, or send out lab work or x-rays, ask your doctor to make referrals to PPO providers whenever possible. If the doctor knows you are in the UHC PPO he will most likely be able to make any referrals to other network providers.

If you are scheduled to be admitted to the hospital, or for outpatient surgery, be sure to contact the precertification at (800) 764-6810.

If you are scheduled to be admitted to the hospital, or for out-patient surgery, or if you are admitted to the hospital on an emergency basis, you or your doctor must contact the precertification and utilization review department. For emergency admissions this contact must be done within 48-hours of your admission.

PPO providers will likely submit claims on your behalf. To submit medical bills for reimbursement you should obtain a claim form from the Fund Office. Complete the claim form and send it along with copies of all itemized bills to Southern Benefit Administrators. Please be sure each bill shows the patient's name, date of each treatment, charge for each treatment, nature of illness (diagnosis), and the type of service rendered.

**It is your responsibility to be sure precertification is obtained and to confirm your provider is in the PPO network when services are rendered.**

# MORE IMPORTANT INFORMATION

## PREFERRED PROVIDER

Throughout this booklet you will find many references to the Preferred Provider Organization Network provided by UnitedHealthcare. The Trustees have entered into an agreement with UHC to use their Preferred Provider Organization Network, PPO for short. The discounts available through the PPO reduce your out-of-pocket expenses and enable the Fund to provide a higher level of reimbursement. The discounts obtained enable the Fund to provide this Plan of Benefits.

## HOSPITAL AND SURGICAL PRECERTIFICATION PROGRAM

This provision applies to all admissions to any hospital, unless the admission is done on an emergency basis. The Plan requires that all suggested non-emergency hospital admissions be called into the Precertification Office by both yourself and your doctor before the admission takes place. Precertification is required for outpatient septoplasties and lithotripsies. Precertification is also required for durable medical equipment with a cost greater than $500.

You are responsible for having your doctor call whether the hospital admission is about to occur in Florida, in Georgia or wherever. The company your doctor must call is United Healthcare's Utilization Management Review Team, and the phone number is: 1-800-764-6810.

UHC will provide its necessary pre-admission certification for any needed hospital stay. If there is any doubt about the need for hospitalization, the doctor will be consulted by the medical staff of UHC. Examples of hospital admissions that will be questioned are: admissions on a Friday or Saturday, unless for an emergency or unless surgery is performed within 24 hours of admission; admissions for a procedure which could be performed on an outpatient basis and still not lower the quality of care needed to treat the patient.

## WHAT IS THE PURPOSE OF PRECERTIFICATION?

By discussing your non-emergency admission with your doctor before he admits you, the Precertification Manager can sometimes suggest preferable alternatives and provide you with better care. The precertification department will advise you as to whether or not it is in your best interest to be treated as an outpatient or as an inpatient. This determination should be made by the Precertification Manager and your doctor. Therefore, it is important that you have your doctor call before you are admitted.

## WHAT ABOUT EMERGENCIES?

Naturally, in an emergency there is no need to call before the admission. Do whatever is medically necessary. However, notification is required within 48 hours after admission.

### DOES THIS PROGRAM ONLY APPLY TO HOSPITAL ADMISSIONS?

No. Surgical procedures done as an outpatient should also be precertified. Septoplasties and lithotripsies done on an outpatient basis must be precertified. Once again, your doctor should call the Precertification Office before scheduling your surgery.

### WHAT ABOUT SECOND SURGICAL OPINIONS? ARE THEY REQUIRED AND WHEN?

Since there are no fixed rules for determining when a second opinion is required, the Precertification Manager can only determine the need after consulting with your doctor.

### HOW SOON SHOULD MY DOCTOR CALL FOR A MATERNITY ADMISSION?

Your doctor should call 2-3 weeks before your scheduled delivery date.

### ARE THERE SPECIAL FORMS TO COMPLETE?

No. There are no complicated forms for you or your doctor. All you need to do is remind your doctor to call, and everything is done by telephone.

### ARE THERE PENALTIES IF I DON'T FOLLOW THESE RULES?

Certification is the responsibility of the employee. For failure to precertify a penalty of an additional $300.00 deductible will be imposed against non-PPO hospital charges, surgical charges and medical service charges related to that hospital stay. If a PPO hospital confinement is not precertified the room and board expenses will not be considered a covered expense. Expenses for outpatient surgery which is not certified will be paid at 50%, or subject to a $300 penalty, whichever is less.

### HOSPITAL AND SURGICAL PRECERTIFICATION PROGRAM SUMMARY

All hospital admissions (except emergencies) must be precertified before admission.

All outpatient surgical procedures must be precertified before surgery.

All emergency hospital admissions require notification within 48 hours of admission.

A second opinion may be required for surgery (in-hospital and outpatient)

Have your doctor call for precertification

***<u>FAILURE TO COMPLY WILL RESULT IN REDUCTION OF BENEFITS.</u>***

# SECTION I

## ELIGIBILITY RULES

A. **NEW ELIGIBILITY**

1. <u>**Initial Eligibility**</u> (Regular Rules of Eligibility)

An Employee of a contributing Employer for whom contributions are required to be made shall become eligible for benefits on the first day of the calendar month following the date on which he has worked either: a minimum of one thousand (1000) hours in twelve consecutive months or less, or 600 hours in six consecutive months or less, and contributions have been made in his name by participating employers. He shall remain eligible until the following January 1, April 1, July 1, or October 1, whichever comes first. However, in no case will an individual have less than three months of coverage after satisfying the New Eligibility requirement. Further eligibility will be in accordance with the provisions below. Neither disability credits nor self-payments may be utilized to become eligible under this provision.

First-year apprentices will have non-spousal coverage. Coverage will be provided to the Apprentice and his covered children under age 26. Spousal coverage will be provided on an elective basis at a cost of $200 per month. Election and payment must be made within 30 days of attaining initial eligibility.

<u>**Expedited Eligibility**</u>

The following paragraph applies to Employees (hereafter also referred to collectively as "first time Unit Employees") who are working under the terms of the Collective Bargaining Agreement and are either:

Unit employees of Newly Organized Employers, provided they have never been covered under this Plan; or

Newly Participating Employees (resulting from a merger or group transfer from another IBEW local union).

In order for these Expedited Eligibility rules to apply the Employee must be eligible for benefits under the group insurance Plan provided by his employer or eligible for benefits under the former IBEW Local Union's Welfare Plan. Evidence of eligibility for benefits may be provided by a HIPAA certification of creditable coverage or by the Administrative Manager of the Welfare Plan.

Under Expedited Eligibility the initial minimum of 1,000 hours in 12 months or 600 hours in six months, required under the Initial Eligibility provisions set forth in the preceding paragraph one (1) of this section "A" may be waived in the sole and exclusive discretion of the Trustees. In that event, these first-time Unit Employees of a contributing Employer shall become initially eligible for plan benefits on the first day of the calendar month following a month during which at least 130 hours have been worked, and contributions are required to be paid by a contributing Employer, in a calendar month. For example an employee who has 130 hours or more for work during January will become eligible for benefits on February 1.

Employees working in the CE and CW classifications who satisfy the 130 hour requirement will be eligible for employee only coverage. They will have thirty days after their eligibility date to elect and pay for family coverage. The monthly payment for family coverage is $200. If the employee does not elect family coverage during this thirty day period, he will be allowed to elect family coverage each following January 1. If he elects and pays for family coverage but later stops making payments his family coverage will be terminated. Again, he will be entitled to elect family coverage in December of each year for a January 1 effective date of family coverage.

Thereafter, eligibility for plan benefits shall continue from month-to-month for each such first-time Unit Employee if at least one hundred and thirty (130) hours are worked during each successive month without interruption for a contributing Employer. However, no such first-time Unit Employee shall be entitled to accumulate any contributions in his individual Hour Bank as set forth in section "D" of these Eligibility Rules.

Once a first time Unit Employee satisfies these Expedited Eligibility requirements and subsequently meets the requirements for Initial Eligibility (Paragraph 1) requirement of 1,000 hours in 12 consecutive months, or 600 hours in 6 consecutive months of employment, eligibility will be maintained on a quarterly basis. Until the Continuation of Eligibility (Section B) requirements are met the first time Unit Employee will not be entitled to (a) eligibility during a disability period pursuant to the "Disability Credits" section "C" or (b) reinstatement of eligibility pursuant to the "Reinstatement of Eligibility" provisions in section "H" of these Eligibility Rules.

Further, if the first-time Unit Employee fails to have a minimum of one hundred thirty (130) hours of employment in any month before that minimum requirement is met, his eligibility for plan benefits shall terminate on the last day of the eligibility month (or "period") for which the minimum contribution hours have been reported. Eligibility may only be continued under the COBRA provisions in section "G" of these Eligibility Rules.

**Expedited Eligibility for Newly Organized Employees**

Newly Organized Employees, who can provide evidence of prior coverage under another group insurance plan, will become eligible for benefits on the first day of the month following a month during which at least 130 hours of work are performed for a contributing employer. Newly Organized Employees not working under either a CE or CW designation will be eligible for family coverage.

Employees working in the CE and CW classifications who satisfy the 130 hour requirement will be eligible for employee only coverage. They will have thirty days after their eligibility date to elect and pay for family coverage. The monthly payment for family coverage is $200. If the employee does not elect family coverage during this thirty day period, he will be allowed to elect family coverage each following January 1. If he elects and pays for family coverage but later stops making payments his family coverage will be terminated. Again, he will be entitled to commence family coverage each subsequent January 1.

Thereafter, eligibility for plan benefits shall continue from month-to-month for each such Newly Organized Employee if at least 130 hours are worked in covered employment without interruption by a contributing Employer. However, no such Newly Organized Employee shall be entitled to accumulate any contributions in his individual "Hour Bank" as set forth in section "D" of these Eligibility Rules.

Once a Newly Organized Employee satisfies these Expedited Eligibility requirements and subsequently meets the Initial Eligibility requirements of the regular rules of eligibility (Paragraph 1 above) of 1,000 hours in 12 consecutive months, or 600 hours in 6 consecutive months of employment, eligibility will be maintained on a quarterly basis under the regular rules of eligibility. Until the Continuation of Eligibility (Section B) requirements are met the Newly Organized Employee will not be entitled to (a) eligibility during a disability period pursuant to the "Disability Credits" section "C" or (b) reinstatement of eligibility pursuant to the "Reinstatement of Eligibility" provisions in section "H" of these Eligibility Rules.

Further, if the Newly Organized Employee fails to work a minimum of 130 hours in covered employment in any month before that minimum requirement is met, his eligibility for plan benefits shall terminate on the last day of the eligibility month (or "period") for which the minimum hours have been reported. Eligibility may only be continued under the COBRA provisions in section "G" of these Eligibility Rules.

Newly Organized Employees may only take advantage of these expedited rules one time.

Employees who work under the CE or CW classification and enter the apprentice program will be entitled to family coverage during the Eligibility Period immediately

following the Qualifying Period during which they begin working in the apprentice classification. Continuing eligibility for the next Eligibility Period will be in accordance with the Continuation of Eligibility requirements.

## B. CONTINUATION OF ELIGIBILITY

For continuing eligibility purposes, a year is divided into four three month Eligibility Periods commencing January 1, April 1, July 1, and October 1. Each has a "Qualifying Period" preceding the "Eligibility Period" as shown below. The Qualifying Periods and corresponding Eligibility Periods are:

| Period | Qualifying Period | Eligibility Period |
|---|---|---|
| No. 1 | July 1 through September 30 | January 1 through March 31 |
| No. 2 | October 1 through December 31 | April 1 through June 30 |
| No. 3 | January 1 through March 31 | July 1 through September 30 |
| No. 4 | April 1 through June 30 | October 1 through December 31 |

An Employee must be credited with a minimum of three hundred ninety (390) hours of work performed in each Qualifying Period thereafter to continue coverage for the corresponding Eligibility Period. This hour requirement may be satisfied in any of the following ways, or combination of ways:

1. Contributions for hours worked with participating Employers
2. Disability credits (130 hours per month) for a maximum of three months
3. Withdrawals from Hour Bank

The minimum requirement for employees working under the agreement with Busch Gardens is 390 hours per quarter.

The minimum hour requirement is 345 hours for Employees working in Apprentice classifications.

**These hour requirements may change from time to time. When the hour requirements change, corresponding changes will be made in other provisions of these Eligibility Rules.**

## C. DISABILITY CREDITS

For continuing eligibility purposes, a month of proven disability will be credited toward Continuing Eligibility. A month of proven disability is defined as any calendar month in which an Eligible Employee can medically substantiate that he has been unable to perform the duties of his trade for a minimum of 20 consecutive days. An Eligible Employee will be credited with 130 hours for each consecutive month commencing with the month in which proven disability has been furnished to the Fund Office. The maximum credit for disability will be limited to three consecutive calendar months. Successive periods of disability must be separated by return to active employment for at least one month. Disability credits may not be used to establish new eligibility or to reinstate an Employee who was previously terminated.

## D. HOUR BANK

All hours reported in a Qualifying Period by participating Employers on the employee's behalf that are in excess of 480 hours will be credited to his individual Hour Bank. These hours will be withdrawn as necessary to continue his eligibility as set forth in section "B."

The maximum a participant can maintain in the Hour Bank is limited to an amount which could maintain eligibility for no more than eighteen months.

## E. TERMINATION OF ELIGIBILITY

1. A review of the hours for each employee will be made prior to January 1, April 1, July 1, and October 1 of each year. Eligibility for benefits will terminate as of the last day of each Eligibility Period if the employee has not accumulated the required hours (including Disability Credits and Hour Bank credit), during the preceding Qualifying Period described in section "B," unless the self-pay privilege is exercised in accordance with section "G."

2. The eligibility of an employee shall also terminate on the date the Plan of Benefits is terminated.

3. There is no conversion option available under the Plan.

4. Furthermore, no person shall be eligible to participate in this Plan and to obtain Health and Welfare benefits hereunder unless such person is working for, or is available for work with, a contributing employer to this Plan in a category of work covered by the Collective Bargaining Agreement; provided, however, that this provision shall not be applicable to disabled employees, retired employees, employees working in salted employment, or employees who are working for, or available for work with a contributing employer of a reciprocating local union; and further provided that such termination will be immediate upon receipt of written notification of such person's status in the Administrative Office. If an employee is working at the trade for a non-contributing employer, he is deemed to be unavailable for work with a contributing employer. An employee terminated under this provision shall not be eligible for Self-Contributions as set forth in section "G."

5. Employees who continue to work for an employer who is seriously delinquent in making contributions to the Fund will have their eligibility terminated. The termination date of coverage will be determined by the Trustees but will generally be the last day of the month during which contributions for the second delinquent month are due. If an employee continues to work for the seriously delinquent employer his eligibility will be terminated and any hours in his "bank" will be forfeited.

## F. UNIFORMED SERVICES

An Employee who is inducted or enlists or is otherwise called to active duty in the Uniformed Services of the United States of America shall be entitled to credit or the right to make self-contributions for continued coverage as set forth herein:

1. For ***active uniformed service of 31 days or less*** - The Employee will be credited with hours of contributions equal to 8 hours per day for each day (Monday-Friday) of active uniformed service provided that the Employee reports to work no later than the first regularly scheduled working period one week after termination of active duty.

2. For ***active uniformed service of more than 31 days***, - all benefits for an Employee and his dependents will be terminated on the date the Employee enters active uniformed service in excess of 31 days. However, an Employee shall have the right to continue coverage for the period of the active service, not to exceed 24 months, by making self-contributions in the amount and under the terms set forth in these eligibility rules for making self-contributions for continued coverage. In order to be entitled to make self-contributions, the employee must notify the Trustees in writing within 60 days of his entry into active uniformed service.

   Employees who are discharged from active uniformed service of 60 months or less shall be reinstated for benefits provided the Employee submits an application for reemployment or seeks reemployment through the Union within 14 days (if the active uniformed service is for 31 to 181 days) or 90 days (if the active uniformed service is more than 181 days). The time for reemployment application shall be extended in the event of injury or hospitalization as further provided in the Uniformed Services Employment and Reemployment Rights Act of 1994.

   The term active uniformed service shall include active duty with the Armed Forces, the Army National Guard and the Air National Guard (when engaged in active duty training, inactive duty training or full time National Guard duty), the commissioned corps of the Public Health Service and any category of persons designated by the President of the United States in the time of war or emergency.

## G. SELF-CONTRIBUTIONS FOR CONTINUED COVERAGE

If you fail to have the minimum hour requirement during a Qualifying Period, you can make self-contributions to continue your coverage. There are two types of self-contributions. “Regular” self-contributions and “COBRA” self-contributions.

## REGULAR SELF-CONTRIBUTIONS

In the event an Employee's eligibility is terminated in accordance with Section E. of these Rules, self-contributions will be accepted in order to provide continuing eligibility. Self-contributions will not be accepted for New Eligibility or Reinstatement of Coverage. Self-contributions can be made for a maximum of eight (8) consecutive Eligibility Periods. The amounts and manner of Regular Self-Contributions is determined by the Board of Trustees. Once an Employee has exhausted the eight (8) Eligibility Period limit, coverage can only be continued by making COBRA self-contributions, satisfying the Reinstatement of Coverage Provision or satisfying the New Employee Provision.

An employee who has had no hours of employment reported on his behalf for two (2) consecutive Qualifying Periods will not be permitted to make regular self-contributions. He will be eligible to make COBRA contributions.

The Employee will be notified shortly before the end of the current Eligibility Period of the amount he must pay to satisfy the Minimum Hour Requirement to continue coverage during the next Eligibility Period. He must make the required self-payment, and any subsequent self-payments, by the due date.

In the event a participant does not make his Regular Self Contribution by the due date the Trustees may grant an exception on a one-time basis. For this one-time exception to be made payment must be remitted within ninety (90) days of the due date.

# IMPORTANT INFORMATION REGARDING COBRA

This section contains important information about your right to COBRA continuation coverage, which is temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you, and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should request a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is:

Board of Trustees
c/o Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN 37070-1449
(800) 831-4914 TOLL FREE

The Board of Trustees has engaged Southern Benefit Administrators, Inc. to perform the day to day administrative functions of the Plan, including administration of COBRA continuation coverage.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

**COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;

2. Your spouse's hours of employment are reduced;

3. Your spouse's employment ends for any reason other than his or her gross misconduct; or

4. You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;

2. The parent-employee's hours of employment are reduced;

3. The parent-employee's employment ends for any reason other than his or her gross misconduct;

4. The parents become divorced; or

5. The child stops being eligible for coverage under the Plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the employee, the employer must notify the Fund office of the qualifying event.

For the other qualifying events (divorce or a dependent child's losing eligibility as a dependent child), **you** must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to:

Board of Trustees
c/o Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN 37070-1449
(800) 831-4914 TOLL FREE

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, divorce or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified benefiticiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended, as explained below:

**Maximum Period of 24 months for Service in the Armed Services**

If you enter active duty in the Uniformed Services of the United States of America for a period of more than 30 days, the maximum period of COBRA coverage which you may elect is 24 months, provided you notify the Fund Office in writing within 60 days of your entry into active uniformed service.

**Disability Extension of 18 month Period of Continuation Coverage**

If you or anyone in your family covered under the Plan are determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be able to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18 month period of COBRA continuation coverage. This notice should be sent to:

Board of Trustees
c/o Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN 37070-1449
(800) 831-4914 TOLL FREE

**Second Qualifying Event Extension of 18 Month Period of Continuation Coverage**

If your family experiences another qualifying period while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension may be available to the spouse and dependent children if the former employee dies or gets divorced. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases you must make sure the Plan Administrator is notified of the second qualifying event. This notice must be sent to:

Board of Trustees
c/o Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN 37070-1449
(800) 831-4914 TOLL FREE

## PROCEDURE FOR OBTAINING CONTINUATION COVERAGE

Once the Fund office knows that an event which qualifies you or a dependent for continuation coverage has occurred, the Fund office will send an election notice to your last known address or to the address of your dependent, as applicable. You will have sixty days after the date on the election notice in which you or your dependent must notify the Fund office of an election to continue coverage.

If you or your dependent do not elect coverage within the sixty day time period, the right to continue group health coverage will end. A period of forty-five days will be allowed from the date of an election of continued coverage in which to make any retroactive payment due under this provision. Each employee, or each covered dependent if electing separately, will be required to make monthly payments in an amount and manner which will be determined by the Trustees in accordance with applicable law. The monthly amount of each payment will be established no more often than once a year.

**TYPE OF COVERAGE EXTENDED**

The benefits extended under COBRA will be the same as those provided to active employees and their dependents the day before the qualifying event.

**CANCELLATION OF COBRA COVERAGE**

Continued coverage will be cancelled by the Fund upon the occurrence of any of the following events:

1. You do not make the required monthly payment by the due date, including the allowable 30 day grace period;

2. The Plan terminates;

3. You become covered under any other group health care plan; or

4. You become covered by Medicare.

**ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Children's Health Insurance Program (CHIP), Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of those options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment[1] to sign up for Medicare Part A or B, beginning on the earlier of:

1. The month after your employment ends; or

2. The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1]https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

## IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund office at the address listed below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA office are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

## KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Fund 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 Fund office.

## PLAN CONTACT INFORMATION

Information about the Plan and about your rights and obligations under COBRA can be obtained at the Fund office by writing or calling:

IBEW Local 915 Health and Welfare Fund
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Phone: (615) 859-0131
Toll-Free: (800) 831-4914
Fax: (615) 859-0818

## H. REINSTATEMENT OF ELIGIBILITY

An employee whose eligibility has been terminated less than twelve (12) months will be reinstated to eligible status on the first day of the corresponding Eligibility Period following a Qualifying Period in which he is credited with at least the current hours requirement. Further eligibility will be in accordance with section "B."

An employee whose eligibility has been terminated twelve (12) months or more will be considered a new employee and will qualify only in accordance with the requirements of section "A," New Eligibility.

## I. ELIGIBILITY RULES FOR NON-BARGAINING UNIT EMPLOYEES

A. The following Rules and Regulations and Rules of Participation are for Non-Bargaining Unit Employees who are employed by Local Union 915 or the Local 915 Apprenticeship Program.

1. Contributions shall be made at a rate established by the Board of Trustees on the basis of 173 hours per month. This rate may be higher for employees of the Local Union and its Apprenticeship Program who were formerly working under the Collective Bargaining Agreement (Alumni).

2. Contributions shall be made at least monthly on a separate report form for the employees covered by the Collective Bargaining Agreement.

3. Contributions must be continuous and without interruption. In the event that contributions are discontinued for more than thirty one (31) days, the Trustees may refuse to accept any future contributions.

4. Eligibility for benefits shall become effective in accordance with the Eligibility Rules as outlined for all other participants, provided, however, for non-Alumni staff, eligibility shall commence the first of the month following the date of employment.

5. All benefits to which a covered employee is entitled shall be determined in accordance with the Plan Document Eligibility Rules.

6. The agreement to remit contributions shall terminate if and when the Collective Bargaining Agreement terminates.

7. The aforementioned Rules and Regulations may be modified, altered or changed by the Trustees. The Trustees shall have the power and authority to make additional Rules and Regulations as may be required.

8. NBUs who are employed after February 1, 2021 and are not Alumni will not have an Hour Bank. NBUs who are Alumni will retain any hour bank in existence at the time the Alumni became an NBU and shall continue to have additions to their Hour Bank during their employment by the Union as an NBU.

B. **The following Rules and Regulations and Rules of Participation are for Non-Bargaining Unit Employees who are owners or partners, directors, officers, stockholders, or other persons whether hourly or salaried employees of employers who have applied, been accepted by the Board of Trustees, have agreed to contribute on behalf of such employees, and agree to abide by the Rules of Participation. The Board of Trustees may, from time to time, offer existing employers the ability to participate under this provision.**

1. Participation in the IBEW LOCAL 915 HEALTH & WELFARE FUND (hereafter "Trust Fund", "Fund" or "Plan") and eligibility for Plan benefits for non-bargaining unit Employees (hereafter also referred to as "NBU" or "non-unit Employees") of participating contributing Employers shall be governed by the following identified "Plan Documents" which have been made available to such Employers and their affected NBU (non-unit) Employees and are incorporated herein by reference as such:

   (a) the Trust Fund's current Restated Agreement and Declaration of Trust and as from time-to-time amended and/or restated;

   (b) the Trust Fund's current Summary Plan Description and as from time-to-time amended; and,

   (c) the Trust Fund's current Eligibility Rules as set forth in the Plan and as from time-to-time amended.

2. By submitting an "Application for Participation on Behalf of Non-Bargaining Employees" for acceptance by the Trust Fund's Board of Trustees (Trustees), each contributing Employer expressly agrees on behalf of itself and each of its participating non-bargaining unit employees to be bound by all of the terms and conditions of such Plan Documents and all future amendments and modifications thereto.

3. The Trustees of the Trust Fund shall have the power, in its sole and exclusive discretion: (i) to amend these "Rules of Participation for Non-Bargaining Unit Employees," as well as the Plan Documents referred to in paragraph one (¶1) above; and, (ii) to determine, interpret and resolve all questions or controversies in connection with the Fund, these Rules and related documents in connection with an Employer's or an NBU Employee's eligibility to participate, or continue to participate, as an NBU participant including, without

limitation, determining and resolving conflicting or disputed facts, and interpretations and application of facts, in connection with all such matters, without prior notice to or consent by any contributing Employers or any of its or their participating non-bargaining unit Employees.

4. Contributing Employers and their participating non-unit Employees may examine the Plan Documents and any amendments or modifications thereto during normal business hours at the office of the Trust Fund's Administrative Manager which is currently:

   Southern Benefit Administrators, Inc.
   P.O. Box 1449
   Goodlettsville, TN 37070-1449

5. By participating, contributing Employers ratify the appointment of all Employer Trustees to the Trust Fund heretofore made and those Employer Trustees which may be appointed hereafter.

6. Employer contributions shall be made continuously and without interruption, month-after-month, on the basis of the contribution rate or rates established by the Trustees from time-to-time in their sole and exclusive discretion. Employer contributions should be remitted to the Fund's receiving agent by the fifteenth (15th) of the month preceding the coverage month.

7. Contributing Employers shall identify and report on behalf of each of their full-time non-unit Employees to the Trust Fund, monthly, on a reporting form separate from that used to report the Employer's "unit" employees. In addition, each such Employer:

   (a) shall identify and contribute on behalf of each of its full-time (employed thirty (30) or more hours per week) non-unit or NBU Employees timely prior to the commencement of NBU participation on its "Application for Participation On Behalf of Non-Bargaining Unit Employees"; and,

   (b) shall identify and contribute on behalf of each full-time NBU Employee subsequently employed on a separate "Application for Participation On Behalf of Non-Bargaining Unit Employees" within thirty (30) days of his or her commencement of such employment; and,

   (c) shall acknowledge that participation in and eligibility for benefits from the Trust Fund by each such NBU Employee is subject to advance approval by the Trustees and must be proposed for such participation, in writing, on forms approved by the Trustees within thirty (30) days of commencement of such non-unit employment with the employer or the

Employer and each of its NBU Employees shall thereafter be prohibited from any NBU participation in the Fund.

8. For each enrolled NBU Employee, the Employer further expressly acknowledges and agrees:

    (a) that all such contribution remittances must be post-marked, delivery-dated or received by the Fund's designated receiving agent no later than the 15th day of the month preceding the month for which Fund coverage and eligibility will be applicable e.g., the contributions must be mailed or delivered to or received by April 15th for participation and coverage in the month of May or will be considered delinquent and, in that event, a One Percent (1%) liquidated damage assessment of all NBU contributions owed for the coverage month shall also be due and payable with the delinquent NBU contributions for each day late until the first (1st) day of the coverage month; and,

    (b) that if all delinquent NBU contributions and liquidated damage assessments are not mailed or delivered to or received by the Fund's designated receiving agent by the first (1st) day of the coverage month, the Employer's NBU participation entitlement and each NBU Employee's coverage shall be terminated effective that day.

9. Employer contributions shall continue to be made without interruption, on a monthly basis, and payment must be post-marked, delivery-dated or received in advance of the coverage month.

10. The Employer agrees to pay the Trust Fund's reasonable attorney's fees and costs if it is determined that the Employer has breached any of the provisions of its Participation Agreement or these "Rules of Participation for Non-Bargaining Unit Employees."

11. Such Employer contributions on behalf of its non-unit Employees must be continuous and without interruption. Further, under no circumstances will the Trust Fund accept an Employer's contributions for participation by its NBU Employees if the Employer's "unit" employees' contributions are then delinquent.

12. These "Rules of Participation for Non-Bargaining Unit Employees" apply to all Employers that are signatory to or otherwise bound by the terms of one or more Collective Bargaining Agreements or Other Written Agreements entered into by and between the I.B.E.W. Local Union No. 915 and the Florida West Coast Chapter of N.E.C.A. as of the date of the Trustees' adoption hereof and/or the effective date of the Trust Fund's approval of the Employer's

"Application for Participation On Behalf of Non-Bargaining Unit Employees."

13. An Employer's entitlement to continued participation in the Trust Fund on behalf of its NBU Employees shall terminate immediately upon the occurrence of any of the following conditions:

    (a) If the Employer is no longer signatory to the then-current Collective Bargaining Agreement which provides for participation in the Trust Fund for its "unit" or bargaining unit employees; or,

    (b) If the Employer fails to comply with any provisions of these "Rules of Participation for Non-Bargaining Unit Employees" as from time-to-time amended and/or restated by the Trustees.

14. Each Employer, and each NBU Employee enrolled for NBU participation in the Fund, acknowledges and agrees:

    (a) Effective May 1, 2007 and continuing thereafter, no NBU Employee shall be entitled to disability credits nor to any accumulation in the Hour Bank but until that date, if a NBU Employee previously participating had established an hour bank credit, that credit will be frozen and, except for these exclusions, each NBU Employee will be entitled to all other provisions of the Fund's Health and Welfare Plan; and,

    (b) the NBU Employer shall notify the Fund, on a form provided by it, within three (3) business days of an NBU Employee's separation of employment or else it shall remit such additional contributions for such periods and in such amounts as the Fund's Trustees, in their sole and exclusive discretion, deem appropriate; and,

    (c) that no partial or pro rata refund of any NBU contributions remitted to the Fund on behalf of any NBU Employee shall be due or payable to such Employer or Employee by the Fund for any period of a month following the separation of Employment of any NBU Employee(s); and,

    (d) that NBU participation and coverage for each NBU Employee who has separated from employment shall terminate as of midnight: (i) before May 1, 2007, on the last date of the month during which the last hours were reported; and, (ii) effective May 1, 2007 and continuing thereafter, the last day of the month of the NBU Employee's separation of employment, unless the NBU Employee timely elects COBRA continuation coverage.

15. The payment of fringe benefit contributions by an Employer does not constitute participation in the Trust Fund unless an "Application for Participation On Behalf of Non-Bargaining Unit Employees" and related documents are submitted by the Employer and approved by the Fund Trustees, in writing, and further provided the Employer's participation (and/or entitlement to continued participation) in the Trust Fund has not been terminated as provided in the Plan Documents or these Rules.

16. This Participation Agreement and any resulting rights or obligations arising therefrom may be canceled and terminated at any time by either party, the Board of Trustees of the Trust Fund or any contributing Employer, effective prospectively only upon the receipt of written notice of such termination by the other party.

17. Coverage for individuals under this provision will commence on the first day of the calendar month following receipt of employer contributions, and terminate at the end of the month during which the last contributions were made. Examples; If contributions for May are received by April 15, coverage is effective May 1. If an individual is last reported in the month of May his eligibility will terminate as of midnight May 31.

## J. **RETIREES**

Upon termination of employment as an Active Employee who is eligible for retirement as set forth below, such Employee shall automatically be deemed, and classified, to be a Retiree for all purposes of the Plan. Thereafter, when such a Retiree may lose eligibility for benefits provided by the Fund, he or she may apply to the Fund Office for continuation of eligibility for themselves and their eligible dependents by self-paying timely to the Fund a monthly rate established by the Board of Trustees.

In order for self-payments to be considered "timely" they must be received in the Fund Office, or post marked, no later than the 20th day of the month preceding the month for which payment is required. Self-payments received after the 20th will not be accepted. Self-payments must be made by authorized automatic deductions from the Retiree's account at the PowerNet Credit Union.

While the Trustees hope to allow Retirees this privilege as long as possible into the foreseeable future, it is important for all Retirees to understand that they have no permanent or vested right to the self-payment privilege or to any benefits provided by the Fund. The self-payment, benefit levels and other coverage provisions for retired employees and their dependents may be augmented, revised, or entirely eliminated at any time. The current requirements, all of which must be satisfied for self-payment as a Retiree, include:

1. Previously an Eligible Employee of the Plan and maintaining continuous coverage from active participant to retired participant; and

2. Attained at least age 60 or are totally disabled (as defined by the Federal Social Security Act) and receiving Social Security benefits; and

3. No longer employed in the electrical industry.

A Retiree returning to employment as an Active Employee will continue to be considered a Retiree until he satisfies the New Eligibility (Section A) or Reinstatement (Section H) provisions of these Eligibility Rules.

## K. DEPENDENTS OF DECEASED EMPLOYEES

Benefits for dependents of an Eligible Employee who dies will be continued for such period of time as the Eligibility Rules in effect at the time would have continued coverage of the Employee had he lived, excluding the self contributions provisions.

## L. AMOUNT OF COVERAGE

The amounts for which an eligible person is covered under the Plan shall be those amounts specified in the Plan of Benefits and may be changed by the Trustees as deemed necessary.

An employee who performs services for more than one participating employer shall not be entitled to benefits greater than those which would apply if his services were performed for only one participating employer.

## M. VOLUNTARY REFUSAL OF COVERAGE

A Covered Employee may voluntarily elect to opt out of coverage for his Covered Dependents for all benefits provided under this Plan of Benefits. The Covered Employee may opt out of coverage for all his Covered Dependents, as a group, or may choose to opt out of coverage individually, but only with regard to any of his Covered Dependent children who are legally married. This election must be on an "Acknowledgment of Coverage Refusal" form available in the Fund office. Upon receipt of the signed and notarized form in the Fund office, coverage for the dependent(s), will be terminated immediately. Coverage may be reinstated immediately upon receipt in the Fund office of an express and unequivocal written notice signed by the employee and spouse confirming the decision to revoke the "Acknowledgment of Coverage Refusal." Any expenses incurred during the period of time coverage was refused will not be credited toward deductibles or payable under the Plan.

## N. EMPLOYEES WORKING UNDER THE IBEW FIFTH DISTRICT RECOVERY ADDENDUM

Employees who are working under the terms of the IBEW FIFTH DISTRICT RECOVERY ADDENDUM to the INSIDE AGREEMENT will become eligible under the same New Eligibility requirements as other employees. They will be eligible for single coverage only (no dependents

covered) unless they elect to make self-contributions for this coverage. This election, and payment, must be made within thirty (30) days of obtaining eligibility.

If an employee does not make this election at the time eligibility is established he can make this election during the month of December each year. If he elects and pays for dependent coverage his eligible dependents will be covered effective January 1. Contributions for dependent coverage must be remitted prior to the 20th day of the month in order for coverage to be in effect the following month. For example, contributions for March coverage must be made by February 20.

If an employee working under this agreement has contributions in a quarter sufficient to meet the minimum contribution requirement for continuing eligibility, his eligible dependents will be covered without the need to make self-contributions.

## O. **POWER OF TRUSTEES**

These Rules and Regulations, in whole or in part, may be modified, altered or augmented by majority vote of the Trustees at any regular or special meeting. The Trustees have the power and authority to make additional rules as may be required.

## P. **ENSURING CONTINUITY OF CARE**

If a provider goes from being an in-network provider to an out-of-network provider, you may have the option to continue to see the out-of-network provider and still have your benefits paid at the in-network level of benefit. These protections extend to participants defined as a "continuing care patient" and include participants who are undergoing a course of treatment for a serious and complex condition, undergoing institutional or inpatient care, scheduled to undergo non-elective surgery including post-operative care, pregnant and undergoing treatment, or terminally ill and receiving services. If you qualify for continuity of care services, you will have up to 90 days of such care at the in-network benefit level to allow for a transition of care to an in-network provider. When a provider goes from in-network to out-of-network status, the fund office will notify you and give you the opportunity to elect to continue such care if you qualify for such treatment.

# SECTION II

## SCHEDULE OF BENEFITS

| Life Insurance | Active Employees | $10,000 Life and $10,000 AD&D |
|---|---|---|
| | Retirees | $5,000 Life |

*Life and AD&D benefits are underwritten by 5 STAR Life Insurance Company.*

Major Medical Benefits for each covered person:

| | **In-Network PROVIDER** | **Out-of-Network PROVIDER** |
|---|---|---|
| Calendar Year Deductible | $350 per individual<br>$1,050 per family | $350 per individual<br>$1,400 per family |
| Calendar year Maximum | UNLIMITED | UNLIMITED |

Percentages Payable after satisfaction of Calendar Year Deductible

| | | |
|---|---|---|
| Hospital Services | 85% | 50% |

Hospital admissions must be precertified through United Healthcare - Failure to comply will result in a denial of room and board expenses for PPO hospitals and a $300 penalty for non-ppo hospitals.

| | | |
|---|---|---|
| Supplemental Accident Benefit<br>(ER Excluded) | 100% of first $300 | No first dollar coverage |
| Physicians | 85% | 50% |
| Surgery<br>(Outpatient septoplasty and lithotripsy procedures require precertification) | 85% | 50% |
| Inpatient Mental & Nervous Treatment | 85% | 50% |
| Outpatient Mental & Nervous Treatment | 85% | 50% |
| Ambulance Service | 85% | 85% |
| Hospice Care -<br>Limited to 30-days or per six-month benefit period | 85% | 50% |
| Skilled Nursing Facility | 85% | 50% |

| | | |
|---|---|---|
| Home Health Care in Lieu of hospital<br>Inpatient treatment – Maximum of 1 visit per day | 85% | 50% |
| Outpatient physical, occupational & speech Therapy | 85% | 50% |
| Durable Medical Equipment<br>(expenses Above $500 require precertification) | 85% | 50% |

**Although the Plan encourages use of in-network providers there are times when the participant has no control over providers who render service. If a participant is admitted to an in-network hospital and finds an "in-house" anesthesiologist, radiologist, pathologist, hospitalist, or emergency room physician are not in the network, expenses from these providers will be paid at the in-network level of reimbursement. If an in-network doctor refers a participant to an out-of-network therapist or medical equipment provider, these expenses will be paid at the in-network level of reimbursement. If there is not an in-network provider (within the required specialty) within 40 miles, the in-network level of benefits will be paid.**

All Emergency services benefits, that are subject to the No Surprises Act, will be paid at the in-network provider level of benefit, whether incurred with an in-network or out-of-network provider.

Generally speaking, non-emergency services claims subject to the No Surprises Act performed by out-of-network providers at in-network facilities will be covered at the in-network provider level of benefit, unless proper notice and consent has been satisfied.

Out-of-network air ambulance services will be paid at the in-network level of benefit.

Once an employee has satisfied the Calendar Year Deductible and paid $4,000 in in-network co-insurance, any additional covered in-network expenses incurred in that same calendar year will be reimbursed at 100%.

**ROUTINE PHYSICAL EXAM BENEFIT**

Routine Physical Exams with an in-network provider are reimbursed at 100%. This benefit is available for the employee, spouse and dependent child(en). This benefit is not subject to the Calendar Year Deductible. Employees and spouses who have a Routine Physical Exam will be entitled to a $350 refund of expenses applied to the Calendar Year Deductible in that same year.

**SLEEP DISORDERS**

Eligible expenses will be covered for treatment of sleep related disorders including sleep apnea. These expenses will be subject to the Plan's deductibles and coinsurance provisions. Covered expenses will include sleep studies and CPAP machines.

## CHIROPRACTIC TREATMENT

Expenses incurred for chiropractic care will be limited to 12 visits each calendar year. These expenses include diagnostic services and treatment ordered or rendered by a licensed chiropractor.

## FACILITIES NOT COVERED

There are several medical facilities that offer spine surgery but do not participate in the Plan's Preferred Provider Organization (PPO), United Healthcare's Choice Plus network. Charges for services provided by these providers incurred will not be considered "eligible expenses" under this Plan.

The providers who currently fall under this exclusion are:

- American Medical Care, Incorporated
- BioSpine Institute
- Bonati Spine Institute
- Gulf Coast Orthopedic Center
- Laser Spine Institute
- Medical Development Corporation of Pasco County

The services not covered will include all services provided at these facilities or related facilities including but not limited to facilities charges, physician charges, etc.

## PREVENTIVE HEALTH SERVICES

The Patient Protection and Affordable Care Act requires coverage for many preventive health services for plans that have lost grandfathered status. Although your plan has not lost grandfathered status, the trustees have determined to allow you access to have these services provided in accordance with the Act. Charges incurred for the following preventive services provided by a PPO provider will be paid without application of co-pays, coinsurance or deductibles. If the provider bills for an office visit separately from the wellness services, the office visit billing will be subject to applicable co-pays, deductible, and coinsurance.

1. Evidence - based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

3. With respect to infants, children and adolescents, evidence - informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, such additional preventive care and screenings not described in 1. herein as provided in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of Section 2713(a) as listed on the website below of the Patient Protection and Affordable Care Act.

Preventive Health Services as listed on the website below are available to you and your Dependents. **All services must be provided by PPO providers**. This list is provided by the United States Government. There may also be additions or deletions to this list at any time. You should access the following website for additional information:

www.healthcare.gov/coverage/preventive-care-benefits

**PRESCRIPTION DRUG CARD SERVICE PROGRAM (SAV-RX)**

| CO-PAYS | RETAIL (30 DAYS) | MAIL-ORDER (90 DAYS) |
|---|---|---|
| Generics | $5 | $10 |
| Formulary Brand | 20% | 20% |
| Non-Formulary Brand | 20% | 20% |

Note: If a brand name drug is dispensed when a generic alternative is available the employee will pay the brand co-pay plus the difference in the cost between the brand name drug and the generic alternative.

The Prescription Drug Program will not cover drugs for weight loss, cosmetic purposes, fertility, erectile dysfunction, vitamins, smoking cessation, over the counter medications and any other drugs or categories of drugs listed elsewhere herein.

These co-pays cannot be used toward satisfying the Calendar Year Deductible nor for the out-of-pocket limitation.

**PRESCRIPTION DRUG CARD BENEFITS**

The Prescription Drug Card Service Program will provide you and your eligible dependents with a card to purchase prescription drugs at a Participating Pharmacy. Employees and their eligible dependents will not be eligible under this Plan until records have been received and updated with the Fund Office.

**PARTICIPATING PHARMACIES**

Most of the large major chains participate in the Program - See Participating Pharmacy Directory or contact the Fund Office for others. Walmart and Sam's are not participating pharmacies.

## ELIGIBLE PRESCRIPTIONS

a. State and Federal legend drugs including compounded prescriptions with at least one legend drug;

b. Insulin and disposable insulin;

c. Maintenance drugs, when written by a duly authorized Physician; and

d. Contraceptives approved by the Federal Drug Adminstration (FDA) and requiring a prescription. Contraceptives covered include hormonal birth control, such as oral contraceptives, shot/injections, implants, Intrauterine Devices (IUD), patches and vaginal rings. Types of contraceptives not covered include those not FDA approved, those not requiring a prescription, barrier methods of birth control or any form of Emergency Contraceptive (morning after pills).

## DISPENSING LIMITATIONS

a. 30 day supply;

b. Non steroid anti-inflammatory medication and H2 receptor medication are limited to a 30 day supply only.

## EARLY REFILL POLICY

Refills will not be allowed unless at least 75% of the prescription is used, according to the Physician's directions.

## LIMITATIONS ON PRESCRIPTION CARD PROGRAM

The prescription drug card will not be applicable toward the purchase of:

a. All medication for which cost is recoverable under any Workers' Compensation, occupational disease law, or governmental agency or medication furnished by any other drug or medical service for which no charge is made to the patient;

b. Any drug labeled "Caution: limited by law to investigational use" or "experimental drug";

c. Medical supplies or devices;

d. Fertility agents, fluoride preparations, anti-obesity drugs, antacids, smoking deterrents, laxatives, cosmetic drugs (such as Retin A and Rogaine), vitamins, and reusable needles; and

e. Over-the-counter medications.

f. Any drugs or services rendered in connection with gene therapy, regardless of its intended use or stated purpose.

g. Drugs used for the prophylactic treatment or management of hemophilia Type A or Type B, or their administration.

h. Any pre-exposure prophylaxis drugs or medications, or their administration.

**Prescriptions purchased outside Prescription Drug Program – There is no provision for coverage of prescription drugs purchased outside the Prescription Drug Program.**

**DENTAL BENEFITS**

Deductible . . . . . . . . . . None
Percentage Payable:
Class I Preventive Services . . . . . . . . . . 100%
Class II Major Services . . . . . . . . . . 80%
Maximum Benefit per Covered*
Person per Calendar Year . . . . . . . . . . $1,000

*The maximum does not apply to reasonable preventive services rendered to Covered Persons under age 19 through the end of the calendar month in which the Covered Person attains age 19.

**DENTAL BENEFITS**

This benefit provides for the payment of the Usual, Reasonable and Customary expenses incurred for dental care provided by, or under the supervision of, a Doctor of Dental Surgery (D.D.S.) or a Doctor of Dental Medicine (D.M.D.) when rendered for the care and treatment of the teeth and gums and when not otherwise covered under the Plan.

Benefits are subject to the maximum payment amount and co-payment percentages listed in the Schedule of Benefits, as well as the Exclusions and Limitations listed below.

Covered Persons may choose to voluntarily waive this coverage (opt-out) by filing a written, signed request with the Fund office.

**BENEFITS**

The maximum benefit payable per person is shown in the Schedule of Benefits. The following describes covered dental benefits.

**Class I - Preventive Services**

1. Two routine oral examinations per calendar year

2. Prophylaxis (cleaning, scaling and polishing of teeth), two times per calendar year

3. Topical application of fluoride in conjunction with prophylaxis for covered Dependent children under 18 years of age, two times per calendar year

4. Bitewing x-rays once per calendar year, complete mouth x-rays or panoramic x-rays once in any 36 consecutive month period (a panoramic x-ray will be considered a complete mouth x-ray and subject to the same limit), and periapical (root area) x-rays as required

**Class II - Major Services**

1. Emergency treatment for relief of pain

2. Restorative services (fillings)

3. Oral surgery which provides for extractions and other oral surgery, including pre- and post-operative care

4. Endodontics, including pulpotomy, pulp capping and root canal treatment

5. Periodontics (treatment for diseases of the gums)

6. Space maintainers

7. Crowns

8. Bridges

9. Full and partial dentures

10. Relining, repair or duplication of full and partial dentures

**EXCLUSIONS AND LIMITATIONS**

No payment will be made under this section for any of the following:

1. Orthodontics

2. Expenses which are otherwise payable under other provisions of the Plan

3. Expenses incurred for any treatment required because of congenital malformations or treatment required for cosmetic or aesthetic reasons

4. Expenses incurred for the treatment required to correct a temporomandibular joint dysfunction

## VISION BENEFITS

Vision benefits are provided by Vision Service Plan on a fully insured basis. The following is a schedule of benefits provided by Vision Service Plan:

### Coverage from a VSP Doctor

Exam every 12 months – covered in full after a $10 co-pay

Prescription Glasses after a $15 co-pay;
Lenses – every 12 months
Single vision, lined bifocal and lined trifocal,
    Polycarbonate lens for dependent children
Frame – every 24 months
    Frame of your choice up to $130

Contact Lens Care – every 12 months

When you choose contacts instead of glasses, your $120 allowance applies to the cost of your contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.

Safety Glasses for Employees only after a $15 co-pay;
    Lenses – every 12 months
        Single vision, lined bifocal and lined trifocal lenses
    Frames – every 24 months
        Frame of your choice up to $65.

The lenses and frames provided under this plan are certified as safe for the work environment by meeting the necessary requirements set forth by ANSI (American National Standards Institute).

### Out-of-Network Reimbursement Amounts

Exam . . . . . . . . . . . . . . . . . . . . . . . . . . . . Up to $35
Lenses:
    Single Vision . . . . . . . . . . . . . . . . . . Up to $25
    Bifocal. . . . . . . . . . . . . . . . . . . . . . . Up to $40
    Trifocal . . . . . . . . . . . . . . . . . . . . . . Up to $55
    Frame . . . . . . . . . . . . . . . . . . . . . . . Up to $45
    Contact Lenses . . . . . . . . . . . . . . . . Up to $105

If you decide not to see a VSP doctor, co-pays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the VSP network, call VSP first at (800) 877-7195.

## COST MANAGEMENT SERVICES

### PRE-ADMISSION REVIEW SERVICE

**(1)** **Payment of Covered Hospital Charges.** Participating hospital are responsible for pre-admission certification. For out-of-network hospitals you are responsible for precertification. Failure to obtain the precertification will result in a 25% reduction in the allowable expense from the hospital.

**(2)** **Pre-admission Review.** This review will determine the number of days of hospital confinement authorized for payment of the scheduled benefit. The Employee is responsible for calling for precertification and obtaining pre-authorization of an out-of-network hospital confinement.

**(3)** **Non-emergency Confinement.** Before a Covered Person is confined in a non-participating hospital, a request for Pre-admission Review must be submitted. The request must be made by phone, in advance, by calling toll-free (800) 764-6810.

**(4)** **Emergency Confinement.** This is a hospital confinement for a covered Injury or Sickness that, unless treated at once on an inpatient basis, would either be a threat to life or seriously impair bodily functions. Precertification must be contacted within 48-hours after the start of an emergency admission.

**(5)** **Extra Confinement Days.** If extra days of confinement are necessary, UHC must be notified. This request must be made before the extra days are used.

### PRE-SURGICAL REVIEW SERVICE

**(1)** **Payment of Covered Surgical Charges.** This service applies to covered charges for surgery and anesthesia billed by a Physician for surgical procedures being performed on an outpatient basis. UHC will advise if the procedure is approved, whether it may be done as an inpatient or outpatient, or if a second opinion is necessary. The Plan's scheduled benefits will be paid for covered charges when UHC is contacted, otherwise, the related charges will be paid at 50%.

**(2)** **Pre-surgical Review.** Prior to performing an outpatient surgical procedure, UHC must be contacted. This is done by calling toll-free to (800)-764-6810. UHC may suggest that the procedure be performed as a hospital inpatient, or require a second opinion to confirm the need for surgery.

The second opinion must be performed by a Physician who is:

(a) a Board Certified Specialist in the area in which the operation is concerned; and

(b) not financially associated with the surgeon originally recommending surgery.

If the second opinion does not confirm the need for surgery a third opinion is required to obtain the scheduled benefits for the surgery. Even if the third opinion does not confirm the need for surgery, full Plan benefits will be paid if the Covered Person desires the procedure. All such consultations will be paid at the rate of 100% of the Usual and Reasonable Charge. Charges for second opinions and, if necessary, third opinions are not subject to the calendar year deductible.

Pre-Admission Review Services and Pre-Surgical Review Services shall include preadmission reviews, length of stay reviews, utilization reviews, retrospective reviews, audits and managed care to such an extent as is appropriate to insure that neither persons covered under the Plan nor the Plan incur avoidable hospitalization or other costs in obtaining quality appropriate medical care covered by the Plan.

## INDIVIDUAL CASE MANAGEMENT

Under the Individual Case Management Program, hospital admissions in large claim risk categories are reviewed to determine if an alternate (and more efficient) site for medical care is indicated.

## PLAN ADMINISTRATOR'S SOLE DISCRETION

The Plan Administrator or its designated agent may, at its sole discretion, pay benefits in an individual case or more generally for services and supplies not specifically covered by this Plan. This applies only if the Plan Administrator or its designated agent determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be covered under the Plan and are required for the care and treatment of a Covered Person.

## MAJOR MEDICAL EXPENSES BENEFITS

When accidental bodily injury or sickness causes a covered person to incur Hospital-Surgical-Medical expense, the Plan will pay the applicable percentage of the Eligible Expenses actually incurred as a result of said injury or sickness. Said benefits will be payable only after application of the applicable Deductible Amount and up to the Maximum Amount payable, as stated in the Schedule of Benefits.

**Supplemental Accident Benefit** - In the event of an accidental bodily injury the first $300 of Surgical or Medical expenses will be reimbursed at 100%. Eligible expenses must be incurred within fourteen (14) days of the accident. This benefit is not subject to the Deductible. This benefit is not applicable to out-of-network expenses nor to expenses incurred in the emergency room of a hospital.

The **"Deductible Amount"** shall be the total of the cash amount specified in the Schedule of Benefits. Such Deductible Amount must first be satisfied each Calendar Year by the application of expenses incurred as listed below before any such expenses incurred will be payable as benefits under the Plan.

In the event more than one Covered Person in the same family is injured by reason of any one accident or in the event a Covered Person contracts a contagious disease which is otherwise covered hereunder, and any other Covered Person or Persons in the same family contracts the same disease within 30 days thereafter, only one deductible will be applied to all such Covered Persons as the result of such accident or such contagious disease.

**BENEFIT PAYMENT** - Each Calendar Year, benefits will be paid for the covered charges of a Covered Person that are in excess of Deductibles and any amounts paid under Basic Benefits for the same services. Payment will be made at the rate shown under Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the "Benefit Limits" of the Plan.

**DISCRETIONARY PAYMENT OF CLAIMS TO MEDICAL PROVIDERS** - At the sole discretion of the trustees of the Plan, health benefits payable hereunder may be paid directly to a health provider. Any direct payment to a medical provider is in lieu of payment to the participant or beneficiary.

**ALLOCATION AND APPORTIONMENT OF BENEFITS** - The Plan reserves the right to allocate deductible amounts to any eligible charges and to apportion the benefits to the covered person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the covered person and all medical providers.

**MAXIMUM BENEFIT AMOUNT** - The maximum benefit amount effective January 1, 2014 is unlimited.

## ELIGIBLE EXPENSES

"Eligible Expenses" means the following charges, not in excess of the reasonable and customary charges, made by the person, group or other entity for the services rendered, or the supplies furnished, when actually made to, or on account of, a Covered Person for services or supplies which are necessary for the care and treatment of accidental bodily injury or sickness and are ordered by a physician:

**Hospital Expenses** for daily room and board limited to the maximums noted in the Schedule of Benefits and the following miscellaneous hospital expenses: Operating room, medicines, drugs, un-replaced blood and blood plasma (including administration thereof), anesthetic (including administration thereof in a hospital by a physician and surgeon), x-ray examinations, radiation treatments, physiotherapy, laboratory tests, surgical dressings and medical supplies, and hospital ambulance service;

**Surgical Expenses** for the performance of necessary surgical procedures, only when performed due to medical necessity (including necessary related post-operative care), by physicians.

**Post Mastectomy Expenses** for medical, surgical and hospital care in connection with breast reconstruction surgery required as the result of a mastectomy in a manner consistent with benefits provided for other medically necessary expenses including:

a. reconstruction of the breast on which the mastectomy was performed;

b. surgery and reconstruction of the other breast to produce symmetrical appearance; and

c. prostheses and physical complications of all stages of a mastectomy, including lymphedemas

**Additional Expenses**, if not included above for:

1. Treatment by a legally qualified physician and surgeon (excluding expenses which are related to surgical procedures);

2. Services of a licensed registered graduate nurse or of a licensed practical nurse rendered in or out of a hospital and also the services of a licensed undergraduate nurse provided such service is rendered in a hospital, other than by a person who ordinarily resides in the Covered Person's home or is a member of the Covered Person's immediate family (consisting of the Covered Person's spouse, children, brothers, sisters and parents);

3. Anesthetic and its administration (other than local infiltration or digital block anesthesia);

4. Treatment for physical, speech and occupational therapy as provided by a licensed therapist (other than a member of the Covered Person's immediate family defined above) for rehabilitation of an injury or sickness;

5. Dental treatment by a physician, dentist or dental surgeon for:

    a. a fractured jaw as a result of an accident or for injury to sound natural teeth, including replacement of such teeth. Treatment must commence within three months of the accident and be completed within twelve months after the date of the accident;

    b. surgical and non-surgical treatment of the temporomandibular joints up to a maximum of $1,500 per calendar year. These expenses will not include kinesiography, electromyography, muscle testing, occlusal analysis, orthodontic treatment, crowns, inlays, onlays and other prosthodontic treatment;

    c. excision of impacted wisdom teeth.

6. X-ray or radium treatment;

7. Home Health care services and supplies-the following home health care services and supplies will be covered, subject to the calendar year deductible and the appropriate coinsurance, when received in lieu of hospital confinement;

a. part time or intermittent nursing care by, or under the supervision of, a registered nurse (RN).

b. part time or intermittent home health aide services provided through a Home Health Care Agency. This does not include general housekeeping services.

c. physical, occupational and speech therapy.

d. medical supplies

e. laboratory services by or on behalf of the Hospital. These services are limited to one visit per day and 100 visits per year.

8. X-ray and laboratory examinations, excluding dental x-rays unless rendered for dental treatment of a fractured jaw or of injury to sound natural teeth within twelve months after the date of the accident;

9. Ambulance charges - for necessary local transportation of a Covered Person by professional ambulance service to the nearest hospital for In-Patient care, or to the nearest hospital for emergency accident care where the necessary treatment is available, or, if medically necessary from a hospital to another hospital or rehab facility for further inpatient care. In cases of life threatening sickness or injury, air ambulance or regularly scheduled commercial airplane or train services for the patient(s) will be permitted only to the nearest hospital providing the necessary facilities and not to exceed the cost of one round-trip fare for any one accident or sickness;

10. Medical Supplies - drugs and medicines obtainable only by prescription and dispensed by a licensed pharmacist; blood and blood plasma; artificial limbs and eyes; surgical dressings; casts; splints, trusses; braces; crutches; rental of wheel chairs, hospital bed, iron lung, and the rental of equipment for its administration to the extent such total rental costs do not exceed a reasonable purchase price, as determined by the Plan. **Coverage for prescription drugs is provided under the Prescription drug program only.**

11. Mammography charges- benefits will be paid subject to the Patient Protection and Affordable Care Act:

12. The initial corneal lens following cataract surgery performed while covered under the Plan;

13. Skilled Nursing Facility Charges for room and board and other necessary services and supplies, except fees for professional services, incurred while under the continuous care of an attending physician and during Inpatient confinement commencing within 14 days following hospital confinement as an inpatient for 3 or more consecutive days that was covered by this plan and due to the same or related causes. However, charges that are after the first 90 days of (a) any one continuous period of confinement, or (b) successive periods of confinement

separated by less than 3 consecutive months and due to the same or related causes, will not be Covered Medical Charges.

14. Nursery charges for newborns will be considered eligible expenses when care is made necessary due to a medical condition of the mother, and the continued stay of the mother has been certified as medically necessary.

15. Diabetic strips and supplies, but not insulin. Insulin is available under the Prescription Drug Program.

16. Expenses incurred with Pain Management physicians or clinics must be with PPO providers. This includes drug screenings. Any referrals made by Pain Management clinics or physicians, as well as drug screenings, must be made to PPO providers.

17. Expenses incurred for a prescribed Cologuard test.

18. Wigs required due to hair loss as the result of radiation or chemotherapy due to cancer treatment. Lifetime benefit of $1,000, subject to the calendar year deductible and plan coinsurance.

19. Effective with all charges incurred during the period commencing March 18, 2020 and ending on the date the COVID-19 National Public Health Emergency ceases to exist, the following items and services are subject to a Fund payment percentage of 100% without application of a deductible:

    a. In vitro diagnostic tests as defined in section 809.3 of title 21, Code of Federal Regulations, for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that:

        - is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act;

        - for which the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

        - is developed in and authorized by a State that has notified the Secretary of Health and Human Services (HHS) of its intention to review tests intended to diagnose COVID-19; or

        - other tests that the Secretary of HHS determines appropriate in guidance.

b. items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph a., but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

**COVERAGE OF PREGNANCY**

Coverage of the Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any Sickness for a covered employee or spouse of a covered employee. A federal law requires that a covered person and her newborn infant are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarean section. Further, a Plan cannot require the provider (hospital or doctor) to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. (The attending provider may however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Cesarean section.) The Plan will provide benefits for the covered medical expenses incurred by an eligible female employee or dependent spouse (or an eligible female retiree or spouse) during the prescribed time periods, subject to the applicable exclusions, deductibles, co-payment percentages payable and maximum benefits and limitations shown on the applicable Schedule of Benefits. The reduction in benefits when the Hospital Review Program rules are not followed will not apply to maternity admissions that do not exceed 48 hours for vaginal deliveries or 96 hours for Caesarean deliveries.

**NERVOUS OR MENTAL DISORDERS**

If a Covered Person incurs expense for covered charges as a result of a nervous or mental disorder, benefits are payable in exactly the same manner as other medical expenses.

**CHILD HEALTH SUPERVISION SERVICES**

These benefits are payable for covered dependent children of a covered person eligible for family coverage from the moment of birth to age 26 years.

Such services shall consist of physician delivered or physician supervised services at approximately the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months and 2 years. After the second birthday, benefits will be provided for one visit per calendar year.

Services to be considered as eligible expenses at each visit include a history, physical examination, developmental assessment, appropriate immunizations and laboratory tests in keeping with prevailing medical standards and are limited to one (1) visit payable to one (1) provider for all services at each visit.

Each visit is not subject to the deductible, and the co-insurance percentage will be the Plan's standard percentage, 85% for in-network providers and 50% for out-of-network providers.

## ROUTINE PHYSICAL EXAM BENEFIT

The physical exam must be performed by a PPO provider. This benefit is also available for eligible participants residing outside the state of Florida. Employees and spouses who have an Annual Physical Exam will receive a credit of $350 toward their Calendar Year Deductible during the same year as the Exam.

Routine Physical Exams with a PPO provider for dependent children will be paid at 100%. This benefit is not subject to the Calendar Year Deductible. Exams for dependent children do not provide credit toward the Calendar Year Deductible.

## ORGAN AND TISSUE TRANSPLANT BENEFITS

Benefits are provided to a Covered Person for services and expenses in connection with the following listed human organ and tissue transplant procedures. Benefits are subject to the following limitations, in addition to other limitations cited in other provisions of the Plan:

### Procedures Covered

Heart
Heart/Lung
Liver
Kidney
Pancreas
Cornea
Skin
Bone Marrow, only for the following conditions:
Acute Lymphocytic Leukemia
Acute Non-Lymphocytic Leukemia
    Hodgkin's Disease
    Non-Hodgkin's Lymphoma
    Stage II, III, and IV Breast Cancer

### Provisions

Benefits are provided only when the hospital and physician(s) customarily charge a transplant recipient for such care and services. No benefits are payable for expenses the covered person would not be legally obligated to pay if there were no coverage under this Plan.

The covered person who is the organ or tissue recipient must provide two written medical opinions verifying the need for transplant surgery. The medical opinions must be from Board Certified

specialists in the involved field of surgery. The opinions must verify that conventional treatment would be unsatisfactory, unavailable and/or more hazardous than a transplant.

Precertification is required for all services and expenses anticipated under this benefit.

**Limitations**

The only transplant procedures covered under this Plan are those noted herein.

The replacement of natural organs with artificial or mechanical devices is not covered. Replacement by animal organs is also not covered.

If the transplant recipient and the donor are both Covered Persons, benefits will be provided for each in accordance with his respective Covered Expenses.

If the recipient is not covered by this Plan and the donor is covered, expenses will not be covered for either the recipient or the donor.

The maximum benefit payable for expenses incurred by a donor shall not exceed $10,000 per transplant.

The maximum benefit for organ and tissue procurement is $10,000 per transplant.

The maximum benefit for transportation, lodging and meals is $10,000 per transplant.

No benefits are provided for any financial consideration to the donor other than for Covered Medical Expenses incurred in the performance of/or in relation to transplant surgery.

Immunosuppressant drugs may be covered, but only for those transplants covered under the Plan and only when taken in conjunction with a transplant performed while covered under the Plan.

All benefits described in this section are included in, and are not in addition to, calendar year maximum benefits outlined in the Plan's Schedule of Benefits.

**EXCLUSIONS, EXCEPTIONS AND LIMITATIONS**

Any charges incurred for services or supplies not specifically covered by the Plan are excluded. For all basic and Major Medical Expense Benefits shown in the Schedule of Benefits, examples of charges not covered include, but are not limited to, the following:

1. Care and treatment of any occupational injury or sickness. The term "occupational injury or sickness" shall include any injury or sickness related to any injury, sickness, illness or disease arising out of or sustained in the course of any employment (or self-employment) for compensation or profit.

Any injury or sickness shall be deemed to have arisen out of or be related or sustained in the course of employment if an employment related cause is a substantial contributing cause of the injury or sickness being treated.

The following presumptions shall apply to this exclusion:

a. The filing of a Notice of Injury or Claim for workers' compensation benefits shall give rise to a presumption that an occupational injury or sickness exists.

b. The filing of suit or bankruptcy claim contending that an injury or sickness arises from one's occupation shall give rise to a presumption that an occupational injury or sickness exists.

c. The receipt of any benefit under a workers' compensation or similar law or the receipt of any recovery through settlement or otherwise as a result of filing of a suit or bankruptcy claim under the preceding paragraph shall give rise to a conclusive presumption that the sickness or illness for which such payments are received is an occupational injury or sickness.

2. Care, treatment or supplies for which there would not have been a charge if no coverage had been in force (subject to the right, if any, of the United States government to recover reasonable and customary charges for care provided in a military or veterans' hospital).

3. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or where otherwise prohibited by law.

4. Care and treatment that is either medically unnecessary or experimental in nature.

5. Supplies or equipment for personal hygiene, comfort or convenience including but not limited to telephone, television, cosmetics, guest trays, magazines, beds or cots for family members or other guests.

6. The part of an expense for care and treatment of an injury or sickness that is in excess of the usual and reasonable charge.

7. Any loss that is due to a declared or undeclared act of war.

8. Any loss due to an intentionally self-inflicted injury, unless the self-inflicted injury is proven to be the result of a medical condition, including depression.

9. Care, treatment, services and supplies directly or indirectly provided for realignment of teeth or jaws, including but not limited to atrophy of the lower jaw, occlusion, maxillofacial surgery and retrognathia. Expenses incurred for treatment of temporomandibular joint

dysfunction (TMJ) will be covered provided treatment is for medical conditions caused by the temporomandibular joint dysfunction.

10. Professional services performed by a person who ordinarily resides in the covered person's home or is related to the covered person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

11. Care and treatment provided for cosmetic reasons, whether or not recommended for psychological reasons. This exclusion will not apply if the care and treatment:

    is for repair of damage from an accidental bodily injury;
    is due solely to surgical removal of all or part of the breast tissue of an injury or sickness to the breast or;
    is for correction of an abnormal congenital condition in a newborn child.

12. Radial and hexagonal keratotomy or other eye surgery to correct near and far sightedness, astigmatism, or other refractive errors. Also, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

13. Audiology tests, hearing aids, or the fitting of such items.

14. Routine physical exams, lab tests, and routine chest x-rays beyond any such coverage specifically allowed by the Plan except mammograms and pap smears at medically recommended intervals.

15. Services or supplies provided mainly as a rest cure, maintenance or custodial care, or which are palliative in nature. This exclusion also applies to any services or treatment that cannot reasonably be expected to lessen the patient's disability enough to enable the patient to live outside of an institution.

16. The following care, treatment or supplies for the feet:

    Orthopedic shoes; orthotics or orthopedic appliances including orthopedic prescription devices to be attached to or placed in shoes; treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations; and treatment of corns, calluses or toenails, except the surgical removal of nail roots or treatment required in connection with metabolic or peripheral-vascular disease.

17. Spare items of the nature of: braces of the leg, arm, back or neck; artificial arms, legs or eyes; or lenses for the eye.

18. Unless required by law, services that are of the nature of stress management, family planning, marital counseling, social counseling, educational or vocational testing or training and

treatment of behavior problems and behavioral modification therapy, biofeedback and other forms of self-care or self-help training.

19. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

20. Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, hot water bottles, rubber gloves, home enema equipment, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, devices for simulating natural female body contours (except for post-mastectomy surgery), first-aid supplies and non-hospital adjustable beds.

21. Care and treatment of obesity, weight loss, or dietary control including but not limited to weight loss programs, liposuction and gastric stapling, whether or not it is, in any case, a part of the treatment plan for another sickness.

22. Care, treatment and counseling for gender identification, sex transformations, sexual impotency, and sexual dysfunction including any complications arising therefrom. This exclusion will not apply to expenses incurred for the surgical implant of a penile prosthesis, if medically necessary.

23. Care, treatment and counseling for sexual impotency and sexual dysfunction including any complications arising therefrom. This exclusion will not apply to expenses incurred for the surgical implant of a penile prosthesis, if medically necessary.

24. Care and treatment for infertility, artificial insemination or in-vitro fertilization and any charges for a surrogate mother to bear a child, for inseminating a surrogate mother with a covered person's sperm, and any complications thereof.

25. Pre-natal testing, including amniocentesis, when done for the purpose of determining the sex of the child or without medical diagnosis.

26. Care and treatment for hair loss, except as identified in item 17. of Additional Expenses as listed under the MAJOR MEDICAL EXPENSES BENEFITS OF SECTION II - SCHEDULE OF BENEFITS.

27. Exercise programs, travel and lodging for treatment of any condition, whether or not recommended by a Physician.

28. Abortion, except that a legal abortion performed on any covered person, including a dependent daughter, will be covered if the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of incest or rape.

29. Care and treatment of pregnancy, childbirth, and miscarriage of an eligible dependent other than the covered Employee's spouse.

30. Acupuncture, acupressure, or hypnosis, except when performed by a Physician in lieu of anesthesia.

31. Charges incurred due to handling of nuclear materials.

32. Charges for prescription drugs are only covered under the Prescription Drug Program. Items specifically excluded include Yohimbine preparations or similar products for treating sexual impotency; Clomid, Serophene or similar products for treating infertility; Sandimmune or similar products for immuno-suppressants; Antabuse or similar products for treating alcoholism or substance abuse; anorexiants (diet pills), Nicorette or similar smoking deterrents, minoxidil preparations (Rogaine) or similar products; Retin-A or similar products when used primarily for cosmetic purposes after the age of 26; enzymes, herbs, vitamins, minerals, nutritional supplements, special diets and other items as denoted in the Prescription Drug Service Program.

33. For injuries sustained while committing a felony, while participating in a riot or civil insurrection, or if caused during a covered person's violation of local, state, or federal law. This exclusion will not apply to acts of domestic violence.

34. Charges for chelation therapy; except for treatment of acute arsenic, gold, mercury or lead poisoning.

35. Charges for missed appointments or for completion of claim forms.

36. Care and treatment for alcoholism, chemical dependency and drug abuse.

37. Care and treatment for sickness or injuries sustained as the result of the misuse of any controlled substance when not prescribed by a Physician.

38. Care and treatment for senile deterioration, Alzheimer's Syndrome or organic mental and nervous disorders, except as specifically set forth in the Schedule of Benefits.

39. Care or treatment of any illness or injury incurred or aggravated while in the uniformed service.

40. Expenses incurred outside the United States, unless the participant or dependent is a U.S. resident and the charges are incurred while traveling on business or for pleasure.

41. Coverage for laser spine surgery or any treatment at The Bonati Spine Institute, Laser Spine Institute, Gulf Coast Orthopaedic Center, Inc., Medical Development Corp of Pasco County, Inc., American Medical Care, Inc., BioSpine Institute or any related entity. The services that

are not covered include <u>all</u> services rendered at such facilities or related facilities, including but not limited to facilities charges, physician charges, anesthesiologist charges and radiological charges.

42. Charges incurred due to injuries sustained while participating in a riot or civil insurrection, or if caused during a Covered Person's violation of local, state, or federal criminal law, including either felonies or misdemeanors for which the person is charged. In the event the person is found not guilty or all criminal charges are dismissed, the person may re-apply for payment of benefits and provide proof of the not guilty determination or of all charges being dismissed. This exclusion will not apply to acts of domestic violence.

43. Charges incurred in connection with gene therapy, regardless of its intended use or stated purpose.

44. Charges incurred for the purchase or administration of drugs used for the prophylactic treatment or management of hemophilia Type A or Type B.

45. Charges incurred for the purchase or administration of any pre-exposure prophylaxis drugs or medications.

## VISION BENEFITS

You and your eligible dependents will be eligible for Vision Care Benefits. Vision care benefits are provided through a contract between the Board of Trustees and Vision Service Plan (VSP).

### <u>DUAL CHOICE BENEFITS</u>

**VSP gives you a choice of the way you and your family receive vision care:**

**You can use the VSP Network Doctors:**

VSP has arranged for a number of doctors in your area (VSP doctors) who will provide professional vision care for you and your dependents. VSP guarantees quality and cost control. Except for a small co-payment for examinations and lenses and/or frames, VSP doctors provide examinations, professional services, lenses and frames at no additional cost to you, provided you stay within the limits of the Plan. Please refer to the Schedule of Benefits. VSP pays the VSP doctors for the rest of the covered services and supplies provided to you. Any additional vision care, services and/or materials not covered by VSP can be arranged between you and the VSP doctor, based on the wholesale cost difference and a modest service fee.

**You can use your own non-network doctor:**

You can go to any optometrist, opthalmologist and/or dispensing optician who does not participate in VSP for your vision care.

You must pay the doctor his full fee and then file a claim with VSP for reimbursement. You will be reimbursed according to the “Out Of Network” reimbursement amounts in the Schedule of Benefits.

## COVERED VISION CARE SERVICES AND SUPPLIES

Below are the vision care services and supplies that you will receive from a VSP doctor at no cost except for your small co-payments. If you use a non-VSP doctor, the services and supplies for which VSP will reimburse you are according to the Out-Of-Network Reimbursement Amounts in the Schedule of Benefits.

**Vision Examination** – Allowable once per 12-month period. This includes a complete analysis of the eyes and related structure to determine the presence of vision problems or other abnormalities.

**Lenses** – Allowable once per 12-month period.

**Frames** – Allowable once per 24-month period.

**Contact Lenses** – Elective contact lens services are covered instead of frames and lenses. The allowance (up to $120) applies to the contact lens exam (fitting and evaluation) and lenses. Additionally, VSP doctors provide an exclusive 15 percent discount off their contact lens professional services. Any costs exceeding this amount are the patient’s responsibility.

Medically necessary contact lenses are covered in full from a VSP doctor with pre-approval from VSP if a medical condition prevents the member from wearing eyeglasses. Co-payments may apply.

**Safety Glasses** - Safety glasses are available for the employee only. Lenses are covered after the $15 co-payment every 12 months and frames every 24 months.

Remember: This benefit is designed to cover your visual needs. If you select any of the supplies that are listed in the “Exclusions and Limitations” section, VSP will not reimburse any of the cost of the non-covered supplies received from a non-VSP doctor, and there will be an extra charge by a VSP doctor if he does not receive prior authorization from VSP to provide them.

## HOW TO GET VISION CARE BENEFITS

Using VSP Doctors – Choose the VSP doctor you want to use and make an appointment for an examination. You can call VSP at 1(800) 877-7195 to request a list of VSP doctors or visit their website at www.vsp.com to find a VSP doctor.

The VSP doctor will need your (employee’s) name, date of birth and Social Security number. Be sure to tell the VSP doctor that you are a participant in the IBEW Local 915 Health and Welfare Fund.

You will need to pay the VSP doctor any co-payments or other costs not covered by VSP. The VSP doctor will file a claim with VSP for the balance of the cost.

Using Non-VSP doctors – If you use a non-VSP doctor, you must pay the doctor his full fee and get an itemized paid receipt – you cannot assign these benefits. Then you must file a claim with VSP by sending in the paid receipt. VSP will reimburse you for the reasonable and customary amount of the charges up to but not to exceed the amounts shown on the Out-of-Network Reimbursement Amounts shown in the Schedule of Benefits minus your co-payment amounts.

There is no assurance that the amounts shown in the Schedule of Benefits will be sufficient to reimburse you for the amount you paid the non-VSP doctor for the examination and the materials.

You should obtain a claim form from VSP and then fax it, along with the paid receipt, to (976) 851-4652. Instead of sending it by fax you can mail the claim to

VSP
P.O. Box 997105
Sacramento, CA. 95899-7105

**SERVICES AND MATERIALS NOT COVERED**

The following materials and services are not covered under the Vision Benefits:

Orthoptics or vision training and any associated supplemental training

Non-prescription glasses and contact lenses

Two pairs of glasses instead of bifocals

Complete replacement of glasses for those that are lost or broken (except at the normal intervals when services are otherwise available)

Medical or surgical treatment of the eyes outside of discounts provided for laser vision correction

Experimental vision services, treatments, and materials

Vision care expenses which may be excluded under the Plan's Limitations and Exclusions.

**EXTENSION OF VISION CARE BENEFITS**

If a person has a covered examination and a prescription is ordered while the person is eligible for the Vision Care Benefit, benefits will be payable even if the covered supplies are provided to the person after his eligibility terminates.

# SECTION III

## GENERAL PROVISIONS

Plan Year - For purposes of this Document the plan year will run from January 1st through December 31st.

Clerical Error - Clerical Error by the Fund shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Workers' Compensation Not Affected - This Plan is not in lieu of, and does not affect any requirement for coverage by Workers' Compensation Insurance.

Time Effective - The effective time with respect to any dates used in the plan or any Amendment thereto shall be 12:01 A.M. Standard Time at the address of the Board of Trustees.

Pronouns - Masculine Pronouns, or other gender based pronouns used herein shall apply to both sexes.

Payment of Claims - Subject to any written direction of the Covered Person in an application or otherwise, all or a portion of any Medical Expense Benefits provided by the Plan on account of hospital, nursing, medical or surgical service may be paid directly to the hospital or person rendering such services, but is not required that the service be rendered by a particular hospital or person.

Written proof of loss, including sufficient information to identify the Covered Person, must be furnished to the Plan within twelve (12) months of the Date of Loss. Failure to provide such notice will invalidate any claim unless it shall be proven to the satisfaction of the Trustees that it was not reasonably possible to furnish such notice or proof within the time limits provided.

Any accrued indemnities unpaid at the Covered Person's death may, at the option of the Plan, be paid either to the provider of medical services or to the estate of the Covered Person. All other indemnities will be payable to the Covered Person.

Physical Examination and Autopsy - The Plan, at its own expense, shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Legal Actions - No action at law or in equity shall be brought to recover on the Plan prior to the expiration of 90 days after written proof of loss has been furnished. No such action shall be brought after the expiration of two years after the time written proof of loss is required to be furnished, nor before completing the requirements of the Claim Review and Appeal Procedures established by the Board of Trustees.

Invalidity of Certain Provisions Does Not Invalidate All - If any provisions of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision hereof and this Plan shall be construed and enforced as if such provisions had not been included.

Termination of the Plan - The Plan may be terminated at any time by action of the Board of Trustees. Notice of such termination shall be given in writing to the United States Department of Labor, and to all persons who have an interest in the Plan, or to any other person or entity required by law. All claims which have not been submitted at the date of termination but which would have been paid had the Plan continued, will be paid in accordance with all the provisions of the Plan at the time of termination, except that there is no liability on the Board of Trustees or any individual or entity to provide payments over and beyond the amounts available in the Trust for such purposes.

## EXERCISE OF TRUSTEE DISCRETION

The joint Board of Trustees, in its sole and exclusive discretion, has the right to interpret and resolve all questions or controversies of whatever character or nature in connection with the Restated Agreement and Declaration of Trust, the Plan Documents and the Fund's rules and regulations, including the Summary Plan Description, and any amendments or modifications to any such documents (hereafter all collectively referred to as "the Plan Documents"), in the administration and operation of the Fund and its plan of benefits and in connection with coverage and eligibility and in acting on claims for benefits and claim reviews and appeals therefrom. Such discretion includes but is not limited to resolving conflicting or disputed facts, and interpretations and application of facts, in connection with the Plan Documents and acting on and processing claims for benefits and claim reviews and appeals. All decisions of the Board of Trustees in such matters shall be uniform and final and binding on all persons and parties involved in connection with any such matters and no decision shall discriminate in favor of or against any such persons or parties or otherwise be arbitrary or capricious.

## LIMITATION OF BENEFITS TO PLAN ASSETS

Any provisions of this Summary Plan Description notwithstanding, all benefits payable are limited to the assets of the Trust Fund and no benefit shall be payable to the extent that such benefit exceeds the assets in the Trust Fund as of the date of submission of a completed claim for benefits hereunder.

## NON-ASSIGNMENT OF CLAIMS, ERISA RIGHTS OR OTHER RIGHTS OF PARTICIPANT OR BENEFICIARY –

No assignment by a participant or beneficiary of claims, ERISA rights or other assignment of rights shall be valid against the Fund, the Plan, the Trustees or their service providers, except as specifically approved by the Board of Trustees in writing. Assignments pursuant to a Qualified Medical Child Support Order shall be allowed.

A medical provider may represent a participant or beneficiary in the filing of an appeal to the extent provided by regulations issued by the Department of Labor, but may not file an appeal on behalf of a participant or beneficiary, except in accordance with the representative rules set forth herein.

## STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under federal law, group health plans and insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall at a minimum provide for: (1) reconstruction of the breast on which the mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions such as deductibles and payment percentages.

## QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Fund will honor the provisions of a Qualified Medical Child Support Order. The Fund office has established procedures for determining whether such an order meets all of the legal requirements. A copy of these procedures will be furnished to you, without charge, upon written request filed with the Fund office.

## NO THIRD PARTY BENEFICIARY

The terms and provisions of this plan inure solely to the benefit of participants and beneficiaries and no other persons shall have any rights, interest or claims hereunder or under this plan of benefits, or be entitled to sue for breach thereof as a third party beneficiary or otherwise. Health care providers shall not be third party beneficiaries under this plan.

## RIGHT OF REFUND OR SUBROGATION

If the negligence or wrongful act of a third-party causes the death or injury of a covered person, and benefits are paid or payable by the Plan for such death or injury, the Plan and/or the Trustees will be subrogated to the rights of the covered person and those entitled by law to proceed against such third party, its insurance carrier or in the case of an automobile accident, any uninsured or under-insured motorist coverage available to the covered person to the extent of the benefits paid or payable under the Plan. In addition, in the event that benefits are paid by a third party, its insurance carrier, or in the case of an automobile accident, any uninsured or under-insured motorist, the Plan shall be paid out of the proceeds of such payment any and all benefits paid by the Plan.

The Plan specifically acknowledges the application of the "equitable lien by agreement" doctrine and disavows any application of the "make whole" doctrine or "common fund" doctrine and may therefore exercise a right of subrogation or reimbursement against any and all such proceeds without regard to the nature and characterization of such proceeds or the expenses incurred by the covered person to procure such proceeds (including attorney's fees), without regard to any comparative

or contributory negligence on the part of the covered person, and without regard to any ability or inability of the injured person to recover due to limited insurance.

In the event that benefits are paid as a result of any occupational injury or sickness, the Plan and/or Trustees will be subrogated to the rights of the covered person and those entitled by law to proceed against any workers' compensation carrier, covered persons or any person claiming for him, or through him or for his benefit, may be required to execute documents to protect the interest of the Plan as a condition to receiving benefits under this Plan.

The Plan and/or Trustees at its or their option, may:

a. recover from the covered person or any person claiming for him, through him or for his benefit, any and all benefits paid by the Plan out of the proceeds of any settlement, judgment, or other award, and/or

b. proceed directly against the third-party causing the death or injury in its own name or under the name of the covered person or those entitled to use as plaintiff or in the name of the plaintiff for the benefit of the Plan and/or the Trustees, and/or

c. proceed directly against the workers' compensation carrier in its own name or under the name of the covered person or those entitled to make claim for the person or in the name of the claimant for the benefit of the Plan and/or the Trustees, and/or

d. the Plan's subrogation rights of full recovery may be from the third party, any liability or other insurance covering the third party, any uninsured motorist coverage or underinsured motorist insurance providing coverage to the covered person, any medical payments, no-fault, workers' compensation, or school insurance coverages which are paid or payable.

**REGULAR AND CUSTOMARY CHARGES**

The purpose of the Plan is to pay covered medical expenses which are medically necessary and reasonable in amount. Excessive hospital charges and excessive physicians' fees will not be fully paid by the Plan.

Charges made for medical services or supplies essential to the care of the covered person will be considered "regular and customary" if they are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received. In determining whether charges are "regular and customary" due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or experience. Prior to receiving treatment, except emergency treatment, you should have a clear understanding with your treating physician as to what his fees will be.

## COORDINATION OF BENEFITS

A. Benefits subject to this provision. All Medical Expense Benefits provided under the IBEW Local 915 Health and Welfare Fund.

B. Definitions (for Coordination of Benefits Section only)

(1) Plan. The term "Plan" as used in this section shall mean any plan which a covered person is eligible for, regardless of whether they are enrolled or not, providing benefits or services for or by reason of medical care or treatment which are provided by: (1) Blanket Group Coverage, including all group or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the Covered Person's membership in or connection with a particular group or organization; (2) any governmental programs or coverage required or provided by any statute, including Medicare; (3) coverage provided under hospital or medical service plans or other prepayment coverage, provided on a group basis; (4) group labor-management trusteed plans, union plans, group association plans, employer organization plans, employee benefit organization plans; or (5) individual liability policies or contracts including "No-Fault" automobile insurance, as used herein, refers to that coverage as required by the Florida Automobile Reparations Reform Act under which Personal Injury Protection benefits are paid or payable irrespective of whether such coverage was in effect at the time of loss.

(2) This Plan. The term "this Plan" means that portion of the IBEW Local 915 Health and Welfare Fund which provides Medical Benefits.

(3) Allowable Expense. The term "Allowable Expense" means any necessary, reasonable, and customary item of medical expense incurred, a portion of which is covered under one of the Plans covering the person for whom claim is made. Charges which are in excess of previously agreed upon discounted billings, under either Plan, will not be considered Allowable Expenses.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

This Plan shall not be required to determine the existence of any other Plan, or the amount of benefits payable under any Plan other than this Plan. The payment of benefits under this Plan shall be affected by the benefits payable under other Plans only if this Plan is furnished with information concerning the existence of such other Plans by the employer, any insurance company, organization or covered person.

(4) Claim Determination Period means a period commencing with any January 1, and ending at 12 o'clock midnight on the following December 31st or that portion of

such period during which the person on whose behalf the claim is based has been covered under this Plan.

(5) Coordination with PIP and/or "No-Fault". In the State of Florida and in many other states, owners of private motor vehicles (excluding motorcycles) are required to obtain "No-Fault" insurance and personal injury protection (PIP) Benefits as required by law, without regard to any deductible which may be in effect and without regard to the purchase of such insurance by, or on behalf of, the Covered Person. Accordingly, if a Covered Person fails, for any reason whatsoever, to obtain and maintain "No-Fault" and/or PIP insurance as required by law, or if a deductible is included under such insurance, the Plan shall pay Benefits as if the Covered Person had such insurance in effect with no deductible.

C. Effect on Benefits

(1) This provision shall apply in determining the benefits due a covered person under this Plan for any Claim Determination Period if the sum of the benefits that would be payable under this Plan in the absence of C.O.B., and the benefits that would normally be payable under all other Plans would exceed 100% of the expenses actually incurred.

(2) As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under this Plan in the absence of C.O.B. for the Allowable Expenses incurred shall be reduced to the extent necessary so that the sum of (a) such reduced benefits and (b) all benefits paid or payable under all other Plans shall not exceed the Allowable Expenses.

(3) The Plan which covers the person as an employee will be primary. Any other Plan will be secondary

(4) If another Plan insuring or covering the person under this Plan contains a similar non-duplication of medical expense benefits provision, or has an "always secondary" provision, the following rules approved by the National Association of Insurance Commissioners will apply in determining the order of benefit determination.

(5) For the purposes of this Section, the rules establishing the order of benefit determination are:

(a) The benefits of a Plan which covers the person on whose behalf claim is based other than as a dependent, shall be determined before the benefits of a Plan which covers such person as a dependent;

(b) For children's expenses where both the mother and father have dependent coverage the Plan of the parent whose birthday is earlier in the calendar year

is primary. For children where parents are separated or divorced, if there is a court decree that establishes responsibility for medical benefits then that determines who is primary. Otherwise, the Plan covering the parent with custody of the children would be primary. If the parent with custody remarries and the children are covered under the group Plan of the parent and the step-parent, the Plan covering the parent would be primary and that of the step-parent would be secondary. If the children are also covered by the parent who does not have custody, then that would be in the third position;

(3) when rules (1) and (2) do not clearly establish an order of benefit determination, the benefits of a Plan which has covered the person on whose behalf claim is based for the longer period of time shall be determined first. Neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring or the sponsor of the Plan, nor a change from one type of Plan to another, would constitute the start of a new Plan for purposes of this Section.

(6) If any Plan lacks a coordination of benefits provision, it is the primary Plan.

Right to Receive and Release Necessary Information. For the purposes of enforcing, or determining the applicability of, the terms of this provision of this Plan or any similar provision of any other Plan, the Trustees may, without the consent of the Covered Person, release to, or obtain from, any insurance company, organization or person any information, with respect to the covered person, which the Trustees deem to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Trustees such information as may be necessary to enforce this provision.

D. Facility of Payment. Whenever payments which should have been made under this Plan are made under any other Plan, this Plan shall have the right in its sole discretion to pay to any organization making such payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

E. Right of Recovery. Whenever payments have been made by this Plan in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, this Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Trustees shall determine in their sole discretion: (a) any persons to or for or with respect to whom such payments were made, or (b) any Insurance Companies, or ( c ) any organizations which owe benefits due to such Allowable Expense under any other Plan.

# COORDINATION OF BENEFITS AND MEDICARE

## MEDICARE BENEFITS AT AGE 65

If an eligible employee is entitled to benefits under Medicare because he is 65, the following rules will determine which Plan is primary under the Coordination of Benefits (COB) provision.

### For Active Employees

This Plan will be the Primary Plan to Medicare for a person who is age 65 or older and an active employee. Even though a person may have accrued eligibility as a result of hours worked, he will be considered a Retired Employee as soon as he ceases active employment. Likewise a Retired Employee who returns to work will not be considered an Active Employee until he has satisfied the Initial or Reinstatement requirements of the Eligibility Rules.

**For both Retired Employees (if covered under this Plan) and eligible dependents**, this Plan will be a secondary Plan to Medicare for a person who is age 65 or older and a retired person. To determine the amount of reduction for purposes of C.O.B., the Plan will include all benefits for which the person is eligible under Medicare Parts A and B. Such benefits will be considered payable under Medicare, whether or not the person has registered for Part A benefits, or enrolled for Part B benefits.

## MEDICARE BENEFITS DUE TO TOTAL DISABILITY

A person may become entitled to Medicare benefits prior to age 65 if he is totally disabled or has end stage renal disease. The following rules apply with respect to COB with Medicare due to total disability or end stage renal disease prior to age 65. Upon attainment of age 65, the rules for COB with Medicare at age 65 will apply.

### During the Medicare Waiting Period

This Plan will be a Primary Plan to Medicare during any waiting period for Medicare benefits due to total disability or end stage renal disease.

### After the Medicare Waiting Period

After the Medicare waiting period has been met, the person is entitled to Medicare benefits, this Plan will be:

1. a primary Plan to Medicare for a person who is an active employee and entitled to Medicare benefits due to total disability other than end stage renal disease; and

2. a secondary Plan to Medicare for a person who is:

    a. an active person who is entitled to Medicare benefits due to end stage renal disease; or

    b. a retired person who is entitled to Medicare benefits due to total disability or end stage renal disease.

# SECTION IV

## CLAIM PROCEDURES

1. Claims Filing Requirements:

Claims must be filed with the Plan within 12 months of the date charges are incurred. Claims filed later than that date may be declined or reduced unless:

(a) It is not reasonably possible to submit the claim in that time; and

(b) The claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Plan will determine whether enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

2. Requests for Pre-Approval of a Claim (Pre-Service Claims):

Covered Persons may request a determination as to whether any proposed services or treatments will be covered under the Plan prior to the receipt of such services or treatments. The Plan or its agent shall respond to all requests for precertification or pre-approval in a timely manner, as follows:

(a) Urgent Care Claims - If proposed treatment is determined to be urgent in nature, as defined below and as determined by the Covered Person's attending provider, a decision on a request for pre-approval will be made and communicated to the Covered Person within 72 hours of receipt of such request. If it is determined that additional information is necessary to make a decision on the claim, the Covered Person will be notified of such as soon as possible but in no instance more than 24 hours after receipt of the request. The Covered Person will then be given not less than 48 hours to provide the required information.

An Urgent Claim is a claim which, if treated as a claim for non-urgent care:

(1) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(2) In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without care or treatment that is the subject of the claim.

(b) Non-Urgent Care Claims - If proposed treatment is determined to be of a non-urgent nature, a decision on a request for pre-approval will be made and communicated to

the Covered Person within 15 days of receipt of the request. If it is determined that additional information is necessary to make a decision on the claim, the Plan may require up to an additional 15 days to make a decision on the request. If such an extension is required, the Covered Person will be notified within 15 days of receipt of the request regarding the extension and a decision will be made as soon as possible. If the extension is required because it is necessary for the Covered Person to provide additional information, the Covered Person will be given at least 45 days to provide the requested information.

It shall to be the practice of the Trustees, as the Plan adminstrator, along with the Fund office staff and any other designated agents, to timely process all requests for pre-approval and to respond to all such requests immediately where possible, but always within the time periods described above.

3. Payment of Claims by Plan:

All claims received by the Plan will be processed for payment as soon as possible. However, no claim will be paid until all information necessary to process the claim has been received.

Once the information required to make a determination as to whether a claim is payable has been received, a decision will be made promptly and the Covered Employee will be notified regarding any benefit payments. However, in no event will the decision regarding payment be made more than 30 days after the claim has been fully and properly filed.

If it is determined that additional information is required from an Covered Person or in his behalf, the Covered Person will be given 45 days in which to provide any missing information necessary to process the claim.

4. Notice of Adverse Benefit Determination:

Upon determination that a claim submitted by or on behalf of an Covered Person is not covered under the Plan, the Covered Employee will be notified in writing within the time frame outlined above regarding the adverse benefit determination. This notice will set forth, in a manner calculated to be understood by the claimant, all of the following information:

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action

under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review;

(e) If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, practice or procedure will be provided free of charge to the claimant upon request;

(f) If the adverse benefit determination is based on medical necessity or expermental treatment or similar exclusion or limit, a statement that the claimant will be provided free of charge upon request an explanation of the scientific or clinical judgment applied to the terms of the Plan with respect to the claimant's medical circumstances used in making the determination;

(g) If the claim involves urgent care, a description of the expedited review process applicable to such claims. If an adverse benefit determination involves an urgent claim, the contents of the notice may be provided orally to the claimant. However, in such instances a written notification will be furnished to the claimant not later than three days after the oral notification; and

(h) Information sufficient to identify the claim involved, including:

(1) The date of service,

(2) The health care provider,

(3) The claim amount (if applicable), and

(4) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

(i) If the claim is denied because the claimant has failed to establish proof of disability:

(1) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

A. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

B. The view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

C. A disability determination presented by the claimant to the Plan made by the Social Security Administration;

(2) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(3) A statement that the claimant is entitled to received, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

The notification will be provided in a culturally and linguistically appropriate manner.

5. Claimant's Right to Review of an Adverse Benefit Determination:

A claimant whose claim for benefits has been denied under the terms of the Plan and to whom a notice of adverse benefit determination has been issued in accordance with paragraph 3. above will have the right to appeal the adverse benefit determination and will be entitled to a full and fair review of the decision by the Board of Trustees, or by a committee appointed by them. The procedures by which the claimant may appeal the adverse benefit determination and receive a full and fair review of the claim are as described below.

(a) Review Procedure

The procedure hereunder will:

(1) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination in which to appeal the determination;

(2) Provide for an independent review by the Board of Trustees, or their committee. The review will not be conducted by the individual who made the adverse benefit determination that is the subject of the appeal, nor by the subordinate of such individual;

(3) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees or their committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(4) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse

benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(5) Provide that the health care professional engaged for purposes of this appeal is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(6) Provide, in the case of a claim involving urgent care, for an expedited review process under which –

A. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant, and

B. All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

(7) In the event a claim is denied due to failure to establish proof of disability, the Trustees, or a committee appointed by them, will:

A. Provide that before the Plan can issue an adverse benefit determination on review, the Plan will provide to the claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. The evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant reasonable opportunity to respond prior to that date, and

B. Provide that, before the Plan can issue an adverse benefit determination on review based on a new or additional rationale, the Plan will provide the claimant, free of charge, the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant reasonable opportunity to respond prior to that date,

(b) <u>Notice of Trustees' Decision</u>

The Board of Trustees, or their committee, will review all appeals in accordance with the following and will notify the claimant as indicated:

(1) <u>Urgent Care Claims</u> - When the appeal of a claim involving urgent care, as that term is defined in these procedures, is received as provided herein, a

decision on the appeal will be made and will be communicated in writing (and otherwise as appropriate) within 72 hours of receipt of the claimant's request for review of an adverse benefit determination. Appeals of adverse benefit determinations involving urgent care will be addressed promptly by the Trustees, or their committee, taking into account the urgent nature of the claim, but in no instance will the decision be made later than 72 hours after receipt of the claimant's request.

(2) Non-Urgent Care Claims - Appeals of adverse benefit determinations received from claimants which are of a non-urgent care nature shall be reviewed by the Trustees, or their committee, in accordance with the following guidelines, and notification of the decision shall be communicated in writing to the claimant within the time period prescribed:

A. Pre-Service Claims - If the appeal involves a request for review of an adverse benefit determination for medical services which have not yet been provided, the Trustees or their committee will make a decision on the appeal and the decision will be communicated in writing to the claimant not later than 30 days after receipt of the claimant's request for review.

B. Post-Service Claims - If the claimant's request for review of an adverse benefit determination involves a claim for medical services which have already been provided, a decision on the claimant's appeal will be made by the Trustees or their committee and communicated in writing to the claimant within five days of the decision. The appeal will be reviewed at the meeting of the Trustees or the committee which immediately follows the Plan's receipt of a request for a review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of the request for review, but in no instance more than 120 days following receipt of the appeal.

(3) Notwithstanding the statements set forth above, notice of every appeals determination will be given to the Covered Employee within 5 days of the determination.

(c) Access to Plan Documents

At any time during the course of these appeal proceedings a claimant will be granted access to, and copies of, documents, records and other information relied upon by the Trustees or their committee in making their decision, as requested by the claimant.

(d) Notification of Decision on Appeal

Each claimant whose adverse benefit determination has been appealed to the Trustees will receive notification in writing, within the time period outlined above, of the Trustees' or the committee's decision. Such notification will set forth, in a manner calculated to be understodd by the claimant:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

(4) A statment describing any additional voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures, should the Board of Trustees adopt such procedures, and a statement of the claimant's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended; and

(5) The following information where applicable –

A. If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that such rule, guideline, practice or procedure was relied upon in making the adverse determination and that a copy of the rule, guideline, practice or procedure will be provided free of charge to the claimant upon request;

B. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge to the claimant upon request; and

C. A statement that the claimant and the Plan may have other voluntary alternative dispute resolution options, although the Plan is not required to offer such options, and that the claimant may contact the local U.S. Department of Labor office or his state insurance regulatory agency to determine what options might be available to the Plan.

(6) If the claim was denied because the claimant failed to establish satisfactory proof of disability:

A. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination presented by the claimant to the Plan made by the Social Security Administration;

B. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do no exist; and

C. The statement required under (4) above will also describe any contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the limitations period expires.

6. <u>Claimant's Right to External Review of an Adverse Benefit Determination</u>:

(a) <u>Claims Subject to Review</u>

Those claims involving Medical Judgment which have either been denied or otherwise not acted upon, as outlined herein, shall be eligible for external review, including only:

(1) Claims subject to "Surprise" billing and cost sharing protections under the "No Surprises Act"; for which the internal review process (including Trustee review) has been exhausted.

(b) <u>Claims Not Subject to Review</u>

Claims not eligible for external review shall include:

(1) Claims relating to an individual's failure to meet the requirements for eligibility (e.g. insufficient hours worked, failure to self-pay, classification of employment, failure to meet the definition of Eligible Dependent, etc.)

(2) Claims incurred while the individual is not eligible for benefits.

(3) Claims incurred for health care service that is not a covered service under the Plan.

(4) Claims for which the internal review process has not been exhausted, except as outlined under (a) above.

(5) Claims incurred for other than medical expenses.

(6) Claims denials not involving Medical Judgment.

(7) Claims for urgent care that have not been acted upon within 72 hours of receipt of the claim/request.

(8) Other claims for which the Plan fails to act within the time limits applicable to other pre-service and post-service claims, or where the the claims procedure has not been followed by the Plan.

(c) Standard External Review

This paragraph sets forth procedures for standard external reviews. Standard external review is external review that is not considered expedited as described in paragraph (d) hereof.

(1) Request for external review. The Plan will allow a claimant to file a request for an external review if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request msut be filed by the first day of the fifth month following the receipt of notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

(2) Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

A. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

B. The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

C. The claimant has exhausted the Plan's internal appeal process in accordance with subsection 5.(a)(3) hereof; and

D. The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following receipt of the notification, whichever is later.

(3) Referral to Independent Review Organization. The Plan will refer the review to an Independent Review Organization (IRO) approved by URAC (formerly the Utilization Review Accreditation Commission). To insure against bias, the Plan will rotate claim assignments among at least three such IROs.

A. Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final adverse benefit determination. Failure to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

B. Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to

the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final adverse benefit determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

C. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

(4) Reversal of Plan's Decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

(d) Expedited External Review

(1) Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review at the time the claimant receives:

A. An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of an expedited internal appeal would seriously jeorpardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

B. A final adverse benefit determination, if the claimant has a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

(2) Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph 5.(c)(2) hereof for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph 5.(c)(2) hereof for standard external review to the claimant of it eligibility determination.

(3) Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph 5.(c)(2) hereof for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final adverse benefit detrmination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

(4) Notice of final external review decision. The IRO must provide notice of the final external review decision, in accordance with the requirements set forth in 5.(c)(3) hereof, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

(e) Definitions

(1) "Adverse benefit determination" means any claims denial, or partial denial, as determined by the Plan.

(2) "Final adverse benefit determination" means any claims denial, or partial denial, upheld by the Trustees, or by their claims review committee, upon appeal.

(3) A claim denial involving "Medical Judgment" is a claim that involves medical judgment as determined by the external reviewer, including, but not limited to, those claims denials based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational.

7. Appointment of Authorized Representative:

Pursuant to Department of Labor Regulations, an authorized representative of a claimant is not precluded from acting on behalf of a claimant in pursuing a benefit claim or appeal of an adverse benefit determination. In order to assure that the person purporting to be an

authorized representative has been and continues to be authorized to act on behalf of the claimant, with respect to the particular benefit claim or appeal, any written benefit claim or appeal of an adverse benefit determination must bear the notarized signature of the claimant. (A general appointment is insufficient; the specific claim or appeal must bear the notarized signature of the claimant.) If evidence is presented that the claimant is disabled and/or incompetent to the extent that the signature of the claimant cannot be obtained, then such benefit claim or appeal shall bear the notarized signature of the spouse of the claimant, a health care surrogate of the claimant or a person holding a plenary power of attorney for the claimant. A copy of the documents establishing the health care surrogate or power of attorney shall be furnished.

A general appointment of a health care provider, as representative, prior to the rendering of services that are the subject of the benefit claim or appeal of an adverse benefit determination will not be considered as a satisfactory appointment of an authorized representative in pursuing a benefit claim or appeal of an adverse benefit determination.

Nothing in the foregoing provision would limit the ability of a health care professional, with knowledge of the claimant's medical condition, from acting as the authorized representative of the claimant in the case of a claim involving urgent care without such a notarized signature.

8. Right Granted Hereunder Are Limited to One Appeal.

In appealing an adverse benefit determination under these procedures, the claimant may choose to make a written appeal, in which event the Plan's adminstrative manager will present all documents in the claimant's behalf, or the claimant may choose to personally appear before the Trustees for the purpose of presenting an appeal, or designate a representative to appear in his behalf. Claimant appeals rights are limited to one written or personal appeal per denied claim.

9. Compliance with Appeal Procedures.

The claimant may at his own expense have legal representation at any stage of these appeal procedures. The Trustees will interpret Plan provisions in a consistent and equitable manner. The claimant will be required to exhaust these appeals procedures before proceeding to litigation.

10. Limitation of Actions:

No legal action may be commenced or maintained against the Plan (or its Trustees) by any claimant prior to the claimant exhausting the adminstrative procedures set forth herein (generally 60 days following receipt by the Trustees of a request for review or 120 days if the Trustees have extended the period within which a decision on review may be made and written notice has been provided to claimant).

No legal action may be commenced or maintained unless such action is filed in the appropriate court no more than 180 days following the exhaustion of the administrative procedures set forth herein (generally the earlier of:

(a) The date a decision on review was mailed or otherwise furnished to the claimant; and

(b) The date that is 120 days following receipt of the request for review by the Trustees.)

# CERTAIN EMPLOYEE RIGHTS UNDER ERISA

As a participant in the IBEW Local 915 Health and Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

**RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS**

Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

**CONTINUE GROUP HEALTH PLAN COVERAGE**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

**PRUDENT ACTIONS BY PLAN FIDUCIARIES**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**ENFORCE YOUR RIGHTS**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**ASSISTANCE WITH YOUR QUESTIONS**

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# SECTION V

## INFORMATION OF INTEREST AS REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

You most likely have heard about ERISA. ERISA stands for the Employee Retirement Income Security Act which was signed into law in 1974.

This federal law establishes certain minimum standards for the operation of employee benefit plans including the IBEW Local 915 Health and Welfare Fund. The Trustees of your Plan, in consultation with their professional advisors, have reviewed these standards carefully and have taken whatever steps are necessary to assure full compliance with ERISA.

ERISA requires that plan participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits and the procedure to follow when filing a claim for benefits. This information is presented to you in this booklet.

ERISA also requires that participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan. This information follows:

**TYPE OF PLAN**

This plan provides life and accidental death and dismemberment insurance and medical, drug, vision and dental benefits.

For specific coverage, see the Schedule of Benefits outlined in this booklet.

**NAME AND ADDRESS OF PLAN ADMINISTRATOR AS DEFINED BY ERISA**

Your Plan is maintained and administered by a Board of Trustees on which labor and management are equally represented. A list of all the Trustees as of the date this booklet was prepared is contained in this booklet.

This Board has the primary responsibility for decisions regarding eligibility rules, types of benefits, administrative policies, management of Plan assets and interpretation of Plan provisions.

Any correspondence with the Board of Trustees should be addressed to:

Board of Trustees<br>IBEW Local 915<br>Health and Welfare Fund<br>P.O. Box 1449<br>Goodlettsville, Tennessee 37070-1449

## TYPE OF ADMINISTRATION

Although the Trustees are legally designated as the plan administrator, they have delegated the performance of the day-to-day administrative duties to a professional administrative manager, Southern Benefit Administrators, Incorporated.

The Fund office staff, maintained by Southern Benefit Administrators, Incorporated, keeps the eligibility records, accounts for employer contributions, processes claims, informs participants of Plan changes and performs other routine administrative functions in accordance with Trustee decisions.

## COLLECTIVE BARGAINING AGREEMENTS

This Plan is established under the terms of various Collective Bargaining Agreements negotiated by and between Local Union No. 915 of the International Brotherhood of Electrical Workers and various employers and employer associations. These Collective Bargaining Agreements obligate the employers who sign the Agreement, or otherwise become bound by it, to contribute a fixed hourly rate to your Health Plan.

You may examine the Agreements at the Fund Office or at other specified locations upon written request. Or you may have a copy reproduced for a reasonable charge. The “Rights of Plan Participants” section of this booklet will explain the procedure to follow in making such a request.

## PLAN SPONSORS

This plan is maintained under the terms of various collective bargaining agreements negotiated by the Union with participating employers.

Employers who sign such an agreement are obligated to contribute to the Plan and are considered “Plan Sponsors.” If any employer is not a party to a collective bargaining agreement, then he has no legal obligation to contribute on your behalf. Consequently, in order to obtain benefits under this Plan, you must be working for a “Plan Sponsor.”

In most cases, your Union can tell you whether your employer is a Plan Sponsor. But if there is any uncertainty, check with the Fund office.

Specify the name of your employer (or potential employer) and the name of his company or firm. The Fund office will tell you whether the employer is a Plan Sponsor and if he is, will furnish you with the employer’s address as well as advise you if the employer is making timely contributions to the Fund on your behalf.

## SOURCE OF CONTRIBUTIONS

The primary source of financing for the benefits provided under the Plan is employer contributions. The rate of contribution is spelled out in the collective bargaining agreement negotiated by the Union with the participating employers.

No money is ever deducted from your paycheck to pay for Plan benefits. However, under the terms of this Plan, a participant may make self-contributions in order to retain his eligibility if he does not work sufficient hours.

A portion of the plan assets are invested and this produces additional fund income.

**FUNDING MEDIUM FOR THE ACCUMULATION OF PLAN ASSETS**

All contributions and investment earnings are accumulated in a Trust Fund. Benefits are provided in part direct from the Trust Fund and in part through insurance policies.

**CIRCUMSTANCES THAT MAY RESULT IN LOSS OF ELIGIBILITY OR BENEFITS**

Throughout this booklet those circumstances that might lead to a loss of your eligibility and a description of the limitations, exclusions or restrictions applicable to specific benefits are explained to you.

Please familiarize yourself with this information, especially as it relates to the requirements which must be met in order to maintain your eligibility for benefits. You must work the required number of hours in order to maintain your eligibility or make up the difference by timely self-payments. If at any time you are uncertain about how specific circumstances might affect your eligibility or benefit coverage, please contact the Fund office and, if possible, do so before the circumstance arises.

**AGENT FOR SERVICE OF LEGAL PROCESS**

Every effort will be made by the Trustees of this Plan to resolve any disagreements with participants promptly and equitably. It is recognized, however, that on occasion, some participants may feel that it is necessary for them to take legal action. Be advised that the following has been designated as Agent for service of legal process:

Board of Trustees
IBEW Local 915
Health and Welfare Fund
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449

Legal papers may also be served on the Trustees individually as well as the Fund office manager.

**PLAN IDENTIFICATION NUMBERS**

When filing various reports with the Department of Labor and the Internal Revenue Service, certain numbers are used to properly identify the Fund including:

Employer Identification Number (EIN)
assigned by the Internal Revenue Service . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 59-6169977

Plan Number . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 501

**FISCAL YEAR**

The accounting records of this Plan are kept on the basis of a fiscal year which ends on December 31.

**TRUSTEES**

UNION:

Randall King, Business Manager
IBEW Local 915
5621 Harney Road
Tampa, Florida 33610

Mr. Shawn McDonnell
5621 Harney Road
Tampa, Florida 33610

Mr. Roberto Rosa
P.O. Box 1734
Valrico, Florida 33595

EMPLOYER:

Mr. Vance Anderson
Project & Business Development Manager
Electro Design Engineering, Incorporated
8133 Eagle Palm Drive
Riverview, Florida 33548

Mr. Tony Grieco
MJM Electric
3225 East 4th Avenue
Tampa, Florida 33605

Mr. Richard Padilla
Executive Director
Florida West Coast Chapter NECA
2103 West Cass Street
Tampa, Florida 33677-4478

**PLAN INFORMATION**

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are briefly described in this booklet.

**PLAN TERMINATION**

The right to terminate the Plan is reserved to the Board of Trustees and to the Employers and the Union who are signatory to the Plan's Trust Agreement. Circumstances under which the Plan may be terminated include, but are not limited to:

a. when there are no longer sufficient assets to continue the benefits of the Plan. In this regard, the Board of Trustees will first attempt to amend the Plan's benefits, alter or postpone the

method of paying benefits or take other actions consistent with its obligations to maintain the maximum possible benefits within the limits of the Plan's resources;

b. when there are no longer any Employers who are required to make contributions under the appropriate Collective Bargaining Agreement;

c. when the last surviving participant or beneficiary entitled to receive benefits has died;

d. with respect to a particular Employer, when that Employer ceases to be a contributing Employer according to the Plan's Trust Agreement or when that Employer is declared by the Board of Trustees to be in default; or with respect to a particular Employee, when that Employee ceases to be an eligible Employee according to the Plan's Rules and Regulations.

# SECTION VI

## DEFINITIONS

"**Alternative Birthing Center**" means: a birthing center operating as part of a Hospital; or a free-standing facility solely engaged in providing an alternative to conventional obstetrics which: is licensed as such and operating within the scope of the license; is directed by a Physician specializing in obstetrics or gynecology; has a Physician or a Certified Nurse-Midwife present at all births and during the immediate post-partum period; is equipped and has a trained staff or has a written agreement with a Hospital to handle emergencies including the transfer of a patient or child; and maintains medical records on each patient and provides an ongoing quality assurance program.

"**Ambulatory Surgical Center**" means a facility which provides elective surgical care; to which the patient is admitted and discharged within the same working day; and is not a part of a Hospital. However, the following shall not be construed to be an Ambulatory Surgical Center: (1) a facility existing for the primary purpose of performing terminations of pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained for the practice of dentistry.

"**Calendar Year**" means that period from January 1st of each year through the next following December 31st.

"**Certified Nurse-Midwife**" means a person who is licensed as such within the scope of the license; and acting under proper medical direction furnished in affiliation with a facility licensed in accord with the public health law.

"**Complications of Pregnancy**" means any or all of the following: separate conditions made worse or caused by pregnancy, such as acute nephritis; nephrosis; cardiac decomposition; missed abortion; other medical problems of similar severity; and these conditions which occur during pregnancy: hypermesis gravidarum; ectopic pregnancy that is ended; non-elective Cesarean section; and miscarriages.

"**Complications of Pregnancy**" does not include false labor; occasional spotting; rest prescribed by a Physician; morning sickness; or similar conditions that are associated with a difficult pregnancy but not classified as a distinct Complication of Pregnancy.

"**Covered Dependent**" is any one of the following persons who is not covered as an employee of a contributing employer:

(1) An Employee's spouse. The term "spouse" shall exclude a common law spouse or spouse by civil union whose marriage cannot be evidenced by a duly constituted marriage license issued by the appropriate state or other jurisdiction where the marriage occurred.

(2) An Employee's children from birth to the end of the month during which the child attains age 26. The term "children" shall include natural children; adopted children (from the moment of placement in the home after assumption and retention of a Legal obligation for total or partial support of a child in anticipation of adoption of such child); step-children, children under legal guardianship, and an alternate recipient according to the terms of a qualified medical child support order.

(3) An Employee's dependent children who, upon attaining age 26, are mentally retarded or physically handicapped so as to be incapable of self-support provided such proof is furnished to the Plan Administrator within thirty (30) days of the date benefits would otherwise terminate. The Plan Administrator may require, at reasonable intervals during the two years following the dependent reaching the limiting age, subsequent proof of the child's disability and dependency.

These persons are excluded as dependents:

(1) a common law spouse whose marriage cannot be evidenced by a duly constituted marriage license issued by the appropriate state or other jurisdiction where the marriage occurred;

(2) the legally separated or divorced former spouse of the Employee;

(3) any person who is on active duty in any military service of any country;

(4) any person who is eligible for coverage under the Plan as an Employee.

If both the husband and wife are Employees, their children will be covered as dependents of the husband or wife, but not of both. No person can be covered simultaneously under this plan as both an employee and dependent.

"**Covered Employee**" means any Employee who is covered according to the provisions set forth under "Rules of Eligibility."

"**Covered Employment**" means work performed by a Covered Employee that is governed by the then current and applicable Collective Bargaining Agreement between the Local Union and one or more signatory Employers or associations.

**"Covered Person**" means either the Covered Employee or the Covered Dependent.

"**Doctor**" or "**Physician**" means doctor of medicine (M.D.) or doctor of osteopathy (D.O.). To the extent that benefits are provided and while practicing within the scope of his license, doctor or physician will include a dentist, podiatrist, chiropractor, optometrist or psychiatrist. Doctor will not include the Covered Person's dependents or any person who is the spouse, parent, child, brother or sister of a Covered Person.

"**During any Disability**" means all disability and complications from same cause until (1) a Covered Employee recovers, returns or is released to return to active full-time employment, or (2) for a Covered Dependent until he recovers and resumes normal activities for a period of three months.

"**Emergency**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in a condition described in EMTALA, including (1) placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, or (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

"**Expense Incurred**" means only fees charged for necessary medical services and supplies which are regularly and customarily charged for such services and supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Expense is considered to be incurred on the date the service or supply is rendered or obtained, not on the date of the bill.

When the terms "usual and customary" and "reasonable and customary" are used the Plan will recognize necessary charges that are within 300% of Medicare allowable.

"**Hospital**" means an institution which (1) has permanent, full-time facilities for bed care of five or more resident patients, (2) has a doctor in regular attendance, (3) provides 24 hours-a-day service by Registered Nurses, (4) maintains on its premises all of the facilities needed for the diagnosis and medical care and treatment of sickness or injury, and (5) is not a rest home, nursing home, convalescent home, or a place for the aged or for alcoholics or drug addicts. The term "Hospital" also includes institutions licensed and regulated by the State which primarily provide for the treatment of mental and nervous disorders. No claim for medical care or treatment will be denied to a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Hospitals; the American Osteopathic Association; or the Commission on the Accreditation of Rehabilitative Facilities.

"**Injury**" means a bodily injury sustained accidentally by external means. It includes all injuries received in any one accident.

"**Inpatient**" means a person who is a resident patient using and being charged for the room and board facilities of a hospital.

"**Intensive Care Unit**" means that part of a Hospital specifically designed and permanently equipped and staffed to provide more extensive care for critically ill or injured persons than available in other Hospital rooms; and close observation by trained and qualified personnel whose duties are primarily confined to that part of the Hospital for which an additional charge is made.

"**Medicare**" means the medical care program described in Title XVIII of the Social Security Act of 1965, as amended.

“**Miscellaneous Services**” means medically necessary services and supplies, other than Room and Board and professional services. These services or supplies must be provided by a Hospital or Convalescent Care Facility.

“**Outpatient**” means a person receiving services or treatment for care of sickness or injury in a hospital while not confined as an inpatient.

“**Qualified Medical Child Support Order**” is a court-ordered directive issued in divorce settlements which recognizes the right of a plan participant’s child to receive benefits under the Plan. The order must be furnished to the Plan Administrator and include: the name and last known mailing address of the plan participant and each alternate recipient covered by the order; a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which the type of coverage is to be determined; the period to which the order applies; and each plan to which the order applies. The order may not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan. If there is a charge for this coverage you will be notified.

“**Reasonable and Customary**” or “**Usual and Customary**” charges are limited to no more than 300% of Medicare allowable expenses.

“**Room and Board**” means the charges to in-patients by a Hospital or Convalescent Care Facility for the patient’s bed; meals; and general services essential to daily medical care.

“**Sickness**” means a non-occupational disease, disorder or condition which requires treatment by a physician. It includes childbirth and pregnancy of an eligible participant or eligible spouse.

“**Skilled Nursing Facility**” means an institution which (1) provides skilled nursing care under 24 hour supervision of a doctor or graduate Registered Nurse, (2) has available at all times the services of a doctor who is a staff member of a hospital, (3) provides 24 hours-a-day nursing service by a graduate Registered Nurse, Licensed Vocational Nurse or skilled practical nurse and has a graduate Registered Nurse on duty at least 8 hours per day, (4) maintains a daily medical record for each patient, (5) is not a place for rest, custodial care, for the aged, for drug addicts or alcoholics, nor is a hotel or similar institution.

“**Total Disability**” means that a Covered Employee is prevented by injury or sickness from engaging in any occupation for wages or profit for which he is, or becomes reasonably qualified by reason of education, training or experience. For a Covered Dependent it means they are prevented by injury or sickness from engaging in their normal activities given the dependent’s sex, age, education, training or experience.

“**Trustee**” means the Board of Trustees of the IBEW LOCAL 915 HEALTH AND WELFARE FUND.

"**Walk-in Clinics**" are licensed facilities used mainly for performing, on an unscheduled basis, outpatient diagnostic, therapeutic, and minor surgical treatment. The facility must be staffed by physicians. The facility must provide continuous care by registered nurses (RNs), and treatment rendered must be under the supervision of a Physician. The facility must not provide for overnight stays. A physician's office is not considered to be a Walk-in Clinic.

# SECTION VII

## GENERAL PROVISIONS AND RESPONSIBILITIES FOR PLAN ADMINISTRATION

**PLAN ADMINISTRATOR.** The IBEW Local 915 Health and Welfare Plan is the benefit plan of the Board of Trustees of IBEW Local 915 Health and Welfare Fund, the Plan Sponsor and Plan Administrator. It is to be administered in accordance with the provisions of ERISA. The Claims Administrator is appointed by the Board of Trustees and serves at its convenience.

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.

2. To decide disputes which may arise relative to an Employee's rights.

3. To keep and maintain the Plan documents and all other records pertaining to the Plan.

4. To appoint a Claims Administrator to pay claims.

5. To perform all necessary reporting as required by ERISA.

**PLAN ADMINISTRATOR COMPENSATION.** The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**FIDUCIARY.** A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**FIDUCIARY DUTIES.** A fiduciary must carry out his duties and responsibilities for the purpose of providing benefits to the Employees and their Dependents, and defraying reasonable expenses of administering the Plan. These are the duties which much be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. in accordance with the Plan documents to the extent that they agree with ERISA.

**THE NAMED FIDUCIARY.** A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment of the procedures; or

2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

**CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY.** A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

**FUNDING THE PLAN AND PAYMENT OF BENEFITS**

The cost of the Plan is funded as follows:

**For Employee or Dependent Coverage:** Funding is derived from Contributions required to be paid into the Trust Fund by Participating Employers.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee.

Benefits are paid directly from the Plan through the Claims Administrator. Any provision of this Plan notwithstanding, all benefits payable are limited to the assets of the Trust Fund and no benefit shall be payable to the extent that such benefit exceeds the assets in the Trust Fund as of the date of submission of a completed claim for benefits hereunder.

Self-funded plans are not regulated by State Insurance Departments and no guaranty fund exists to cover claims the Trust cannot pay due to bankruptcy or insolvency.

**Clerical error** shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

**RECOVERY OF OVERPAYMENTS**

Whenever payment has been made by this Plan in excess of the maximum amount of payment necessary under the provisions of this Plan, this Plan shall have the right to offset such overpayments against future benefits payable to the Employee or any of his Dependents whenever the overpayment was made in connection with claims from any family member; or to recover such excess

payment from any persons to or with respect to whom such payments were made; or from insurance companies or organizations which owe benefits under any other Plan.

If benefits are paid to or on behalf of any Covered Person when the basis of such claim is misrepresented or fraudulently presented by either the Covered Person or a medical provider, the Plan shall have the right to recover all benefits paid by either: 1) a direct recovery from the Covered Person and/or the medical provider(s); or 2) by reducing all subsequent benefits for such Covered Person or any other member of the family eligible for benefits until such time as the Plan has made full recovery of the misrepresented or fraudulent amounts.

Such recovery shall also include all costs incurred by the Fund as the result of such claims, including but not limited to medical investigation charges, auditor's fees and attorney's fees, as necessary.

## PHYSICAL EXAMINATION AND AUTOPSY

The Plan, at its own expense, shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim thereunder and to make an autopsy in case of death, where it is not forbidden by law.

## THE TRUST AGREEMENT AND COLLECTIVE BARGAINING AGREEMENT

This Plan is established under a Trust Agreement pursuant to collective bargaining agreements that are made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependents at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or Dependent:

1. A copy of the Trust Agreement or collective bargaining agreement, as the case may be.

2. A complete list of employers sponsoring the Plan.

3. Information as to whether a particular employer is a sponsor of the Plan. If the employer is a sponsor, then the address must be supplied.

## INTERPRETATION, MISREPRESENTATIONS AND AUTHORITY

The Plan Administrator has the sole right to interpret all provisions and procedures of the Plan. Unless such interpretation is arbitrary and capricious, it shall be binding on all persons, participants, employees, dependents, beneficiaries, service providers and institutions.

The provisions of the Plan shall supersede any contrary interpretation whether by the Plan Administrator, the Claims Administrator or any other person. Neither the Plan, nor the Plan Administrator nor the Claims Administrator shall be liable for any benefits other than those specified in the Plan.

Neither the Plan Administrator nor the Trustees nor the Claims Administrator nor any other person shall be liable for any misrepresentations made regarding the benefits available under the Plan.

## LIMITATION OF ACTIONS

No legal action may be commenced or maintained against the plan (or its Trustees) by any claimant prior to the claimant exhausting the administrative procedures set forth herein (generally 60 days following receipt by the Trustees of a Request for Review or 120 days if the Trustees have extended the period within which a decisional review may be made and written notice has been provided to the claimant).

No legal action may be commenced or maintained unless that action is filed in the appropriate court no more than 180 days following the exhaustion of the administrative procedures set forth herein, generally the earlier of:

The date a decision on review was mailed or otherwise furnished to the claimant; and

A date that is 120 days following receipt of the request for review by the Trustees.

## AMENDING AND TERMINATING THE PLAN

This Plan may, at any time, be amended, suspended or discontinued in whole or in part by the Plan Administrator. This includes amending the amount of benefits, types of coverage, eligibility rules, classes of covered participants, and/or any other provisions of the Plan or the Trust agreement.

## PROTECTED HEALTH INFORMATION

The Fund will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rules"). Under these standards, the Fund will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protect health information will be disclosed only (1) to the extent authorized by the patient; (2) as necessary for the administration of the Plan, including the review and payment of claims and the determination of appeals; or (3) as otherwise authorized or required by law. To the extent that protected health information is used or disclosed, the Fund will use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

The Fund has adopted a written Privacy Rules Compliance Policy ("Privacy Policy") setting forth the rules and procedures established to protect your personal health information as required by applicable law. This Privacy Policy is hereby incorporated as part of this Summary Plan Description and is available at your request.

# SAMPLE PARTICIPANT APPEAL

If your claim has been denied and you feel the denial is not correct, you should submit an appeal to the Board of Trustees. Below is a sample appeal letter.

Board of Trustees
IBEW Local 915 Health and Welfare Fund
c/o Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN. 37070-1449

Re: Employee Name, Name of Dependent

Gentlemen,

I am appealing a recent denial of a claim submitted on behalf of ____________________. I am providing a copy of the denial I have received.

I feel this claim should be covered under the Welfare Plan because:

I am enclosing additional information which should be reviewed by the Trustees in evaluating my appeal.

Thank you for your consideration,

Sincerely,

____________________________Sign