

**IBEW LOCAL 915  
HEALTH AND WELFARE FUND**

SUMMARY PLAN DESCRIPTION  
AMENDED  
AUGUST 1, 2006

**IBEW LOCAL 915  
HEALTH AND WELFARE FUND**

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	(800) 950-9582
BLUE CROSS/BLUE SHIELD	
PPO PROVIDERS.....	(800) 810-2583
CLAIMS/INQUIRIES.....	(800) 830-1501
HOSPITAL PRE-CERTIFICATION.....	(888) 376-6544

**TABLE OF CONTENTS**

	<b>PAGE</b>
Letter from Trustees.....	4
Important Information.....	5
Frequently Asked Questions.....	6
How to Use the Plan.....	7-8
<b>Blue Card Program</b> .....	<b>9-10</b>
More Important Information.....	11-12
<b>SECTION I - ELIGIBILITY RULES</b>	
New Eligibility.....	13-15
Continuation of Eligibility.....	16-17
Disability Credits.....	17
Contribution Bank.....	17
Termination of Eligibility.....	18
Uniformed Services.....	18-19
Self-Contributions/ Regular.....	19-20
COBRA.....	20-24
Reinstatement.....	21
Non-Bargaining Unit Employees.....	25-26
Retirees.....	26
Voluntary Refusal of Coverage.....	27
Employees Under Florida Small Works Addendum.....	27-28
<b>SECTION II - BENEFITS</b>	
Schedule of Benefits.....	29-31
Major Medical Benefits.....	32-44
Prescription Drug Card Service Program.....	36
Coverage of Pregnancy.....	37
Nervous/Mental Disorders and Substance Abuse.....	37
Child Health Supervision Services.....	37
Annual Physical Exam Benefit.....	38
Organ and Tissue Transplant Benefits.....	38-39
Exclusions, Exceptions and Limitations.....	40-43
Pre-Existing Condition Limitation.....	44
<b>SECTION III - GENERAL PROVISIONS</b>	<b>45-53</b>

Limitation of Benefits To Plan Assets.....	46
Right of Refund or Subrogation .....	47-48
Regular and Customary Charges.....	48
Coordination of Benefits.....	49-52
Coordination of Benefits and Medicare.....	52-53
	<b>PAGE</b>
<b>SECTION IV - CLAIM PROCEDURES</b>	
General Information.....	54-55
Notification Requirements.....	55-56
Benefit Determinations.....	56-58
Definitions .....	59
Certain Employee Rights Under ERISA.....	60-61
<b>SECTION V - ADDITIONAL PLAN PROVISIONS</b>	
Type of Funding.....	62
Plan Identification Number .....	62
Agent For Service of Legal Process.....	62
Trustees.....	62
Plan Termination .....	62
<b>SECTION VI - DEFINITIONS</b> .....	65-69
<b>SECTION VII - PROVISIONS &amp; RESPONSIBILITIES FOR PLAN ADMINISTRATION</b>	
Plan Administrator.....	70
Funding the Plan and Payment of Benefits .....	71
Recovery of Overpayments .....	71-72
Physical Examination and Autopsy.....	72
Amending and Terminating the Plan.....	73
Important Information Regarding <b>COBRA</b> .....	74-77
Compliance with <b>HIPAA Privacy Requirements</b> .....	78-84

## **IMPORTANT MESSAGE**

### **IBEW LOCAL 915 HEALTH AND WELFARE FUND**

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 - NECA and other signatory employers. You may obtain copies of the Collective Bargaining Agreement upon written request from the Local Union or the Fund Office. The Administrative Manager may make a reasonable charge for the copies.

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.

Benefit Services, Inc. has been retained by the Board of Trustees to handle the routine administrative duties necessary for the efficient operation of the Fund. Blue Cross and Blue Shield has been engaged by the Board of Trustees and is authorized to process and pay all eligible claims submitted. Blue Cross and Blue Shield does not provide any insurance, but simply acts as a claims administrator.

There have been many changes since the last Summary Plan Description. It is very important that you review this booklet carefully to understand the benefits available to you and the manner in which you become eligible for coverage. We urge you to keep this booklet in a safe place for future reference.

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, Benefit Services, 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

## 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.

You should also contact the Fund Office if you do not have a directory of PPO providers. This directory is available to you at no cost.

The Fund Office address is:

Benefit Services, Inc.  
5621 Harney Road  
Tampa, Fl. 33610

Phone: (813) 740-1484  
(800) 950-9582 TOLL FREE  
(813) 740-1518 FAX

Blue Cross and Blue Shield

Customer Service: (800) 830-1501  
Pre-certification: (888) 376-6544  
PPO Providers: (800) 810-2583  
Website: [www.myinsurancemanager.com/fl](http://www.myinsurancemanager.com/fl)

Rx Mail Order Program – Sav-Rx

Phone Number: (866) 233-4239

## 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. 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. PPO 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 unmarried children to 19 years of age, and to age 25 if a full-time student and dependent on you for principal support and maintenance.

**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 spouse is eligible for a group insurance plan where she works, but they want her to pay a portion of the cost. Does she have to enroll in that plan?**

A. Yes. If your spouse is eligible for other group coverage he/she is required to enroll in that plan.

**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.

## **HOW TO USE THE PLAN**

Our Plan is 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 the Blue Cross and Blue Shield Preferred Provider Organization. BC/BS 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 BC/BS by using their toll-free number, (800) 810-2583 or their website at [www.myinsurancemanager.com/fl](http://www.myinsurancemanager.com/fl). You should contact the Network to identify a medical provider in your area, or to be sure your doctor is still in the network.

1. 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 PPO. 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.
2. 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 BC/BS PPO he will most likely be able to make any referrals to other network providers.
3. If you are scheduled to be admitted to the hospital, or for outpatient surgery, be sure to contact the pre-certification at BC/BS at (888) 376-6544.
4. 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 pre-certification and utilization review department. For emergency admissions this contact must be done within 48-hours of your admission.

5. 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 BC/BS. 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 pre-certification is obtained and to confirm your provider is in the PPO network when services are rendered.**

## THE BLUECARD PROGRAM

All Blue Cross and/or Blue Shield Plans participate in a national program called "The BlueCard Program". Whenever a Covered Member accesses health care services outside the geographic area the Corporation serves, the Covered Member's claims for those services may be processed through the BlueCard Program and presented to the Corporation for payment in conformity with network access rules of the BlueCard Program policies then in effect. Under the BlueCard Program, when a Covered Member receives covered health care services within the geographic area served by a Blue Cross and/or Blue Shield licensee, the Corporation will remain responsible to the Employer for fulfilling its contract obligations. However, the host Blue Cross and/or Blue Shield licensee will only be responsible, in accordance with applicable BlueCard Program policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of the BlueCard Program are described generally below.

When the Covered Member obtains health care services through BlueCard outside of the state in which they reside, the amount they pay for covered services is calculated on the lower of:

- The billed charges for covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Plan") passes on to the Corporation.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Plan. But sometimes it is an estimated price that factors into the actual price such as: expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be Billed Charges reduced to reflect an average expected savings with the Covered Member's health care provider or with a specified group of providers.

The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be prospectively adjusted in the future to correct for over- or underestimation of past prices. However, the amount the Covered Member pays is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating the covered plan participant's liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim, or to add a surcharge. Should any state statutes mandate liability calculation methods for the covered plan participant that differ from the usual BlueCard method or require a surcharge, Blue Cross Blue Shield would then calculate the Covered

Member's liability for any covered health care services in accordance with the applicable state statute in effect at the time the Covered Member received care.

Under the BlueCard Program, recoveries from a host Blue Cross and/or Blue Shield licensee or from participating providers of a host Blue Cross and/or Blue Shield licensee can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the host Blue Cross and/or Blue Shield licensee will engage third parties to assist in discovery or collection of recovery amounts. The fees of such third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Program policies, which generally require correction on a claim-by-claim or prospective basis.

For information on the BlueCard participation status of providers, call the customer service number on the ID card.

## **MORE IMPORTANT INFORMATION**

### **PREFERRED PROVIDER ORGANIZATION (PPO)**

Throughout this booklet you will find many references to the Preferred Provider Organization, or the Preferred Provider Network. The Trustees have entered into an agreement with Blue Cross and Blue Shield to use their Preferred Provider 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 maintain its ability to provide this Plan of Benefits.

### **HOSPITAL AND SURGICAL PRE-CERTIFICATION 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 Pre-certification Office by both yourself and your doctor **before** the admission takes place. Pre-certification is required for outpatient septoplasties and lithotripsies. Pre-certification 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 BC/BS, and the phone number is:

**1-888-376-6544**

BC/BS 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 BC/BS. 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 out-patient basis and still not lower the quality of care needed to treat the patient.

### **WHAT IS THE PURPOSE OF PRE-CERTIFICATION?**

By discussing your non-emergency admission with your doctor **before** he admits you, the Pre-certification Manager can sometimes suggest preferable alternatives and provide you with better care. The pre-certification 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 Pre-certification 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 pre-certified. Septoplasties and lithotripsies done on an outpatient basis must be pre-certified. Once again, your doctor should call the Pre-certification 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 Pre-certification 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 pre-certify 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 pre-certified the room and board expenses will not be considered a covered expense. Expenses for out-patient surgery which is not certified will be paid at 50%, or subject to a \$300 penalty, whichever is less.

### **HOSPITAL AND SURGICAL PRE-CERTIFICATION PROGRAM SUMMARY**

- All hospital admissions (except emergencies) must be pre-certified **before** admission.
- All outpatient surgical procedures **must** be pre-certified **before** surgery.
- All emergency hospital admissions require notification within 48 hours of admission.
- A second opinion may be required for surgery (in-hospital and out-patient)
- Have your doctor call for pre-certification

- FAILURE TO COMPLY WILL RESULT IN REDUCTION OF BENEFITS.

## SECTION I ELIGIBILITY RULES

### A. NEW ELIGIBILITY

1. Initial Eligibility (Regular Rules of Eligibility) Effective October 1, 2006

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.

2. Expedited Eligibility:

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;

- a. Unit employees of Newly Organized Employers, provided they have never been covered under this Plan; or
- b. 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 \$350 in contributions are required to be paid by a contributing Employer. This is reduced to \$210 for employees working in either a Construction Electrician (CE) or Construction Wireman (CW) classification. For example an employee who has \$350 or more in employer contributions for work during January will become eligible for benefits on February 1.

Employees working in the CE and CW classifications who satisfy the \$210 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 \$140. 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 three hundred and fifty dollars (\$350) in Employer contributions are paid for each successive month without interruption by a contributing Employer. This amount is reduced to two hundred and ten dollars (\$210.) for CE and CW employees who are eligible for employee only coverage. However, no such first-time Unit Employee shall be entitled to accumulate any contributions in his individual "Contribution 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 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 three hundred and fifty dollars (\$350) in employer contributions in any month before that minimum contribution threshold 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. This amount is reduced to two hundred and ten dollars (\$210) for CE and CW employees who are eligible for employee only coverage. Eligibility may only be continued under the COBRA provisions in section “G” of these Eligibility Rules.

3. 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 \$350 in employer contributions are required for work performed for a contributing employer. This amount is reduced to \$210 for employees working as a Construction Electrician (CE) or as a Construction Wireman (CW). 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 \$210 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 \$140. 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.

Newly Organized Employees who attain eligibility, as well as eligible family members, will be subject to the Plan’s pre-existing limitations. However if a HIPAA certification of prior coverage is provided the pre-existing limitations may be reduced, or eliminated.

Thereafter, eligibility for plan benefits shall continue from month-to-month for each such Newly Organized Employee if at least three hundred and fifty dollars (\$350) in Employer contributions are paid for each successive month without interruption by a contributing Employer. This requirement is \$210 for employees working under the under either a CE or CW classification. However, no such Newly Organized Employee shall be entitled to accumulate any contributions in his individual “Contribution 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 the "Reinstatement of Eligibility" provisions in section "H", of these Eligibility Rules.

Further, if the Newly Organized Employee fails to have a minimum of \$350, or \$210 for employees working in either a CE or CW classification, in employer contributions in any month before that minimum contribution threshold 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.

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:

<u>Period</u>	<u>Qualifying Period</u>	<u>Eligibility Period</u>
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

**This contribution requirement may change from time to time. When the contribution requirement changes, corresponding changes will be made in other provisions of these Eligibility Rules.**

An Employee must be credited with a minimum of one thousand and fifty dollars (\$1,050) of contributions for work performed in each Qualifying Period thereafter to continue coverage for the corresponding Eligibility Period. This contribution requirement may be satisfied in any of the following ways, or combination of ways:

1. Contributions from participating Employers
2. Disability credits (\$350 per month for a maximum of three months)
3. Withdrawals from Contribution Bank

Employees who are having contributions made at the first-year apprentice rate will be required to have a minimum of \$850 in employer contributions during a Qualifying Period to maintain eligibility. Employees working at the second-year apprentice rate will be required to have a minimum of \$925 in employer contributions in a Qualifying Period to maintain eligibility.

#### **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 \$350 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.

Disability credits during the Qualifying Periods beginning on and after July 1, 2004 will be at the \$350 per month level.

#### **D. CONTRIBUTION BANK**

In a Qualifying Period, all contributions reported by participating Employers on the employee's behalf that are in excess of one thousand two hundred dollars (\$1,200) will be credited to his individual Contribution Bank. For employees working under the Construction Electrician (CE) and Construction Wireman (CW) classifications this threshold is reduced to \$780 in a Qualifying Period. These contributions will be withdrawn as necessary to continue his eligibility as set forth in Section B.

Credit for all hours in an employee's hour bank as of July 1, 2004 will be valued at \$2.80 per hour. This amount will then be credited to his Contribution Bank.

#### **E. TERMINATION OF ELIGIBILITY**

1. A review of the contributions 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 a minimum of one thousand and fifty dollars (\$1,050) in contributions (including Disability Credits and Contribution 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.

#### **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. Effective with all elections for Continued Coverage made on or after December 10, 2004, 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. (18 months for such elections made prior to December 10, 2004)

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 contribution requirement during an 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 employer contributions made 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 Contribution 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.

### **CONTINUATION OF COVERAGE AS REQUIRED (SELF-PAY) BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)**

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives you and your dependents the right to be offered an opportunity to make self-payments for continued health coverage if coverage is lost for certain reasons (called "qualifying events").

#### **QUALIFYING EVENTS**

- Your termination of employment (other than due to gross misconduct) or reduction in your hours. Retirement is considered a qualifying event due to termination of employment.
- Your death.
- Your divorce or legal separation from your spouse.
- A child failing to meet the Plan's definition of a dependent.

#### **MAXIMUM COVERAGE PERIODS**

1. **18 month maximum coverage period** – You and/or your eligible (covered) dependents are entitled to elect COBRA coverage and to make self-payments for the coverage for a maximum period of up to 18 months after your coverage would otherwise terminate due to a reduction in your hours or termination of your employment.
  - a. 11-month extension rule – If you, or one of your covered dependents, is disabled (as defined by Social Security for the purpose of Social Security disability benefits) on the date of your termination of employment or reduction in hours, or if you or a covered dependent become so disabled within 60 days after the 18 month COBRA period starts due to such an event, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. The monthly self-payment for the extra 11 months of coverage for the family may be increased. You or the disabled dependent must notify the Fund Office within 60 days of the Social Security disability determination and before the end of the initial 18 month period, and also within 30 days of the date Social Security determines that you or the dependent is no longer disabled. (This 11 month extension does not apply to dependents during a 36 month maximum coverage period as explained below.)
  - b. Cobra coverage during Military Service – Effective with all elections for Continued Coverage made on or after December 10, 2004 those employees electing continued coverage in accordance with the provisions of Article G of this SECTION shall be entitled to continue coverage hereunder for a maximum period of twenty-four months. (18 months for such elections made prior to December 10, 2004) You or the dependent are entitled to elect COBRA Coverage and to make COBRA self-payments for the coverage, regardless of any coverage provided by the military or government (subject to all applicable rules governing COBRA Coverage).
2. **36-Month Maximum Coverage Period** – Your eligible dependents may elect COBRA Coverage and make self-payments for the coverage for up to 36 months after coverage would otherwise terminate because of your death, your divorce or legal separation from your spouse, or a child's failure to meet the definition of a dependent (loses dependent status).
3. **Special COBRA Extension for Dependents due to Employee Medicare Enrollment** –
  - a. If you become enrolled in Medicare while you are an active employee and then you or your dependents' coverage would end due to termination of your employment or a reduction in hours, COBRA Coverage enrollment for yourself and/or your dependents is as follows:

>**Employee** – You are entitled to up to 18 months of COBRA Coverage as noted in No. 1 above.

>**Dependents** – Your dependents are entitled to 36 months of COBRA Coverage measured from the date of your Medicare enrollment or 18 months measured from the date their coverage would end due to your termination of employment or reduction in hours, whichever period is longer.

b. The above special extension for dependents applies only if dependent coverage is going to end (due to your termination of employment or reduction in hours) within 18 months after the date of your Medicare enrollment. If your dependents' coverage will end more than 18 months after your Medicare enrollment, they will have 18 months of coverage the same as you do.

4. **Multiple Qualifying Events** – If your dependents are covered under an 18 month maximum coverage period due to your termination of employment or reduced hours and a second qualifying event occurs, their COBRA Coverage may be extended as follows:

- If you die, or if you are divorced or legally separated, or if a child loses dependent status, your spouse or the child are entitled to COBRA Coverage for up to a maximum of 36 months minus the number of months of COBRA Coverage already received under the 18 month continuation.
- Only a person (spouse or child) who was your dependent on the day before the first qualifying event (your employment termination or reduction in hours) is entitled to make an election for this extended coverage when a second qualifying event occurs except as follows: if a child is born to you (employee) or placed with you for adoption during the first 18 month continuation period, that child will have the same “qualified beneficiary” status as that of individuals who were your dependents on the day before the first qualifying event.

**NOTIFICATION RESPONSIBILITIES** – You, your spouse or the child must notify the Fund Office if you get divorced or legally separated or if the child loses dependent status. The Fund Office must be notified within 60 days of the date of the qualifying event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later.

Your employer must notify the Fund Office of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent an election notice as soon as possible, you should also notify the Fund Office any time any type of qualifying event occurs.

**BENEFITS UNDER COBRA COVERAGE** – A person electing COBRA Coverage is entitled to the same class of health care benefits that he was eligible for on the day before the qualifying event.

### **ELECTING COBRA COVERAGE**

1. When the Fund Office is notified of a qualifying event, you and/or your dependents will be sent an election notice that explains when your coverage will terminate, your right to elect COBRA Coverage, the due dates, the amount of the self-payments, etc. An election form will be sent along with the election notice. This is the form you or a dependent fill in and send back to the Fund Office if you want to elect COBRA Coverage.
2. A person has 60 days after he is sent the election notice or 60 days after his coverage would terminate, whichever is later, to return the completed election form. An election of COBRA Coverage is considered to be made on the date the election form is personally sent to the Fund Office or on the date of the postmark on the returned election form. If the election form is not sent to the Fund Office within the allowable time period, you and/or your dependents will not be entitled to elect COBRA Coverage.
3. Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA Coverage. If you elect COBRA Coverage for yourself and or your dependents, your election is binding on your dependents. You do not have to show that you or your dependents are insurable to elect COBRA Coverage.
  - ◆ If you do not elect COBRA Coverage for your dependents when they are entitled to COBRA Coverage, your dependent spouse has the right to elect COBRA Coverage for herself and any children for up to 18 months within the time period that you could have elected the coverage for them.

### **COBRA COVERAGE SELF-PAYMENT RULES**

COBRA self-payments must be made monthly. The amount of the monthly self-payment is determined by the Trustees based on Federal regulations. The amount is subject to change, but not more than once a year.

A person has 45 days after the date of the election to make the initial payment for coverage provided between the date coverage would have terminated and the date the payment is made. (If you wait 45 days to make the initial payment, your first monthly payment may also fall due within that period.) The due date for

each following monthly payment is the 1st day of the month for which coverage is desired. A payment is considered on time if it is mailed within 30 days of the due date.

**Summary of Dates for Monthly Installment Payments:**

<b>Monthly Installment Coverage</b>	<b>Due Date</b>	<b>Grace Period Ends</b>
January	January 1	January 31
February	February 1	March 3
March	March 1	March 31
April	April 1	May 1
May	May 1	May 31
June	June 1	July 1
July	July 1	July 31
August	August 1	August 31
September	September 1	October 1
October	October 1	October 31
November	November 1	December 1
December	December 1	December 31

TERMINATION OF COBRA COVERAGE – COBRA Coverage for a person will terminate before the end of the applicable maximum coverage period when the first of the following events occurs:

A correct and on-time payment is not made to the Fund.

The Fund no longer provides group health coverage for any employees.

The person has been receiving extended COBRA Coverage for up to an additional 11 months due to his or another family member’s disability. And Social Security has determined that he or the other family member is no longer disabled; or

After an election of COBRA Coverage, the person becomes covered under another group health plan, including Medicare, as an employee or otherwise. This termination rule will not apply if the person has a pre-existing medical condition that would cause benefits to be excluded or limited under the other Plan.

**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 contribution 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**

The following Rules and Regulations and Rules of Participation for Non-Bargaining Unit Employees, shall apply to partners, directors, officers, stockholders, and 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 employers; and agree to abide by the Rules of Participation.

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.
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.
5. All benefits to which a covered employee is entitled shall be determined in accordance with the Plan Document Eligibility Rules (provided however COBRA self-contributions may be made only by an employee whose coverage terminates as a result of loss of employment, retirement or reduction of hours worked).
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. Any hours in an NBU's Hour Bank as of July 1, 2004 will be valued at \$2.80 per hour. NBU's who are employees of IBEW Local 915 and the Apprentice Program, will not have their Contribution Bank frozen.

## **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 20<sup>th</sup> day of the month preceding the month for which payment is required. Self-payments received after the 20<sup>th</sup> 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 contribution privilege or to any benefits provided by the Fund. The self-contribution, 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 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**

An Employee may voluntarily elect to opt out of coverage, for any or all of his eligible dependents, for all benefits provided under this Plan of Benefits. 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 FLORIDA SMALL WORKS ADDENDUM**

Employees who are working under the terms of the FLORIDA SMALL WORKS 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 20<sup>th</sup> 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.

**SECTION II**  
**SCHEDULE OF BENEFITS**  
 Effective August 1, 2006

Life Insurance Benefits for active employees and retirees only:

.....	<u>Active Employees</u>	<u>Retirees</u>
Death Benefit	\$10,000	\$5,000
AD&D	\$10,000	n/a

Major Medical Benefits for each covered person:

	<u>PPO PROVIDER</u>	<u>NON-PPO PROVIDER</u>
Calendar Year Deductible	\$400 per individual \$1,200 per family	\$400 per individual \$1,200 per family
Calendar year Maximum	\$100,000	\$100,000
Lifetime Maximum	\$250,000	\$250,000

Percentages Payable after satisfaction of Calendar Year Deductible:

Hospital Services	80%	50%
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Hospital admissions must be pre-certified through Blue Cross and Blue Shield - Failure to comply will result in a denial of room and board expenses for PPO hospitals and a \$300 penalty for non-ppo hospitals.

Hospital Emergency Room      There will be a separate \$100 deductible applied to emergency room expenses unless the patient is admitted as an inpatient directly from the emergency Room. Applies to PPO and NON-PPO.

Supplemental Accident Benefit	100% of first \$300 (ER Excluded)	No first dollar coverage
Physicians	80%	50%
Surgery	80%	50%
(Outpatient septoplasty and lithotripsy procedures require pre-certification)		

Hospital based Anesthesiologists, Radiologists, Pathologists & ER Physicians	80%	50%
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Diagnostic Laboratory and x-rays outside Dr's.	80%	50%
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office

	<u>PPO PROVIDER</u>	<u>NON-PPO PROVIDER</u>
Inpatient Mental & Nervous Treatment (30 day lifetime limit)	80%	50%
Outpatient Mental & Nervous treatment (Limit of 30 visits)	80%	50%
Ambulance Service	80%	80%
Hospice Care- Limited to 30-days or \$5,000 per six-month benefit period	80%	50%
Skilled Nursing Facility (limited to \$50,000)	80%	50%
Home Health Care in Lieu of hospital Inpatient treatment – Maximum of 1 visit per Day	80%	50%
Outpatient physical, occupational & speech therapy (limit of \$10,000)	80%	50%
Durable Medical Equipment (expenses above \$500 require pre-certification)	80%	50%

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

#### ROUTINE PHYSICAL EXAM BENEFIT

Routine Physical Exams with a PPO provider are reimbursed at 100% up to \$350. This benefit is available for the employee and spouse. This benefit is not subject to the Calendar Year Deductible.

Individuals who have a Routine Physical Exam will be entitled to a \$200 refund of expenses applied to the Calendar Year Deductible in that same year.

Screening colonoscopies are covered as any other illness.  
**PRESCRIPTION DRUG PROGRAM (SAV-RX)**  
(Effective December 1, 2005)

CO-PAYS*	RETAIL	MAIL-ORDER
	<u>(30 DAYS)</u>	<u>(90 DAYS)</u>
Generics	\$10	\$20
Formulary Brand	\$20	\$40
Non-Formulary Brand	\$35	\$70

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

Calendar Year Maximum is \$5,000 per individual

The Prescription Drug Program will not cover drugs for weight loss, cosmetic purposes, fertility, erectile dysfunction, vitamins, smoking cessation, over the counter medications and injectables (except insulin).

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

**DENTAL PROGRAM**  
(Effective December 1, 2005)

When you use the Assurant program you will be responsible for the discounted cost of most dental procedures. Here are several examples;

Office Visit Co-Pay – You pay \$10.  
Routine Cleaning – adult or child – you pay \$5.  
Complete x-ray series – you pay \$5.  
One surface silver filling – you pay \$20  
Anterior root canal – you pay \$155  
Single tooth extraction – you pay \$30

Assurant's toll free number is (800) 380-6347. You can also access their website at [www.assurantemployeebenefits.com](http://www.assurantemployeebenefits.com) To locate a dentist click "find a dentist" then enter Heritage Series.

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.

**Routine Physical Exam Benefit** – A maximum benefit of \$350 (100% up to \$350) will be paid for a routine physical examination. This benefit is available for the employee and spouse only. The physical exam must be provided by a PPO provider. Expenses under this provision are not subject to the Deductible. Expenses over and above the \$350 benefit cannot be applied to the Deductible.

If you have a Routine Physical Exam and have satisfied at least \$200 of your Calendar Year Deductible you will be entitled to a \$200 refund. Proof of both your exam and your deductible must be submitted to the Fund Office.

**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 non-PPO 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 Maximum Benefit Amount or the “Benefit Limits” of the Plan.

**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 assignees.

**Maximum benefit amount** - The maximum benefit amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all covered charges incurred in a person's lifetime, while covered.

### **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:

- A. 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;
- B. Surgical Expenses for the performance of necessary surgical procedures, only when performed due to medical necessity (including necessary related post-operative care), by physicians.
- C. Additional Expenses, if not included under Subsection A. and B. above for:
  - (1) Treatment by a legally qualified physician and surgeon (excluding expenses which are related to surgical procedures); however, covered charges of a legally qualified physician, for out-patient treatment of mental, psychoneurotic or personality disorders shall be limited to a maximum of 30 visits per calendar year.
  - (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 while covered under this Plan. 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. 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 deductible and applicable coinsurance rates for:
- a. one baseline mammogram for women ages 35 through 39

- b. one mammogram for women 40 through 49 every two years
  - c. one mammogram every year for women age 50 and older
- (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) Benefits will be provided for usual and customary expenses incurred for medical, surgical and hospital expenses incurred 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.
- (16) Diabetic strips and supplies, but not insulin. Insulin is available under the Prescription Drug Program.

## **PRESCRIPTION DRUG CARD SERVICE PROGRAM**

### **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

### **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, contraceptives, 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.

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

## **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 minimum of 48 hours of inpatient confinement of a covered person following normal delivery of a newborn will be covered. If a newborn is delivered by caesarean section a minimum of 96 hours of inpatient confinement will be covered. However, the Plan may pay for a shorter stay, if the attending provider (the physician, midwife, nurse, or physician's assistant) after consultation with the mother, discharges the mother or newborn earlier.

## **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 as follows:

- A. Covered Hospital charges, charges for convulsive or shock treatment and surgical charges are payable in the same manner and subject to the same limitations and conditions as any other sickness subject to the maximum stated in the Schedule of Benefits.
- B. For all other covered charges incurred as a result of nervous or mental disorder or combination thereof, benefits are payable provided that the maximum payable for professional psychiatric treatment by a physician at home, the office or the hospital shall not exceed the amount shown under Eligible 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 16 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 until the child's sixteenth birthday.

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, 80% for PPO providers and 50% for non-PPO providers.

### **ANNUAL PHYSICAL EXAM BENEFIT**

A maximum benefit of \$350 per calendar year will be paid for a routine physical examination. This benefit is available to the employee and spouse only. The physical exam must be performed by a PPO provider. This benefit is also available for eligible participants residing outside the state of Florida. Any charge over \$350 is not reimbursable under this Plan.

### **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:

#### **I. 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

#### **II. Provisions**

1. 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.
2. 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.

3. Pre-certification is required for all services and expenses anticipated under this benefit.

### III. Limitations

1. The only transplant procedures covered under this Plan are those noted in Section I above.
2. The replacement of natural organs with artificial or mechanical devices is not covered. Replacement by animal organs is also not covered.
3. If the transplant recipient and the donor are both covered persons, benefits will be provided for each in accordance with his respective Covered Expenses.
4. 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.
5. The maximum benefit payable for expenses incurred by a donor shall not exceed \$10,000 during the lifetime of the covered person.
6. The maximum benefit for organ and tissue procurement is \$10,000 per transplant.
7. The maximum benefit for transportation, lodging and meals is \$10,000 per transplant.
8. The maximum benefit for outpatient private duty nursing care by a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.) is \$10,000 per transplant.
9. 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.
10. 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.
11. All benefits described in this section are included in, and are not in addition to, calendar year and lifetime 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 worker's 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 worker's 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 person 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) 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 if both the husband and wife are charged with felonies.
- (8) Any loss that is due to a declared or undeclared act of war.
- (9) 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.
- (10) 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. Benefits payable for this treatment will be limited to a lifetime maximum of \$1500.
- (11) Professional services performed by a person who ordinarily resides in the covered persons 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.
- (12) Care and treatment provided for cosmetic reasons, whether or not recommended for psychological reasons. This exclusion will not apply if the care and treatment:
  - (a) is for repair of damage from an accident that occurred no more than five (5) years prior to the date expenses are incurred;
  - (b) is due solely to surgical removal of all or part of the breast tissue of an injury or sickness to the breast or;
  - (c) is for correction of an abnormal congenital condition in a child born within five (5) years of the date expenses are incurred.
- (13) 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.
- (14) Audiology tests, hearing aids, or the fitting of such items.
- (15) 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.
- (16) 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.
- (17) 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.

- (18) Spare items of the nature of: braces of the leg, arm, back or neck; artificial arms, legs or eyes; or lenses for the eye.
- (19) Services that are of the nature of stress management, family planning, marital counseling, social counseling, educational or vocations testing or training and treatment of learning disabilities, behavior problems and behavioral modification therapy or attention deficit disorders, biofeedback and other forms of self-care or self-help training.
- (20) 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.
- (21) 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, wigs, devices for simulating natural female body contours (except for post-mastectomy surgery), first-aid supplies and non-hospital adjustable beds.
- (22) 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.
- (23) 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.
- (24) Care and treatment for reversal of surgical sterilization.
- (25) 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.
- (26) Pre-natal testing, including amniocentesis, when done for the purpose of determining the sex of the child or without medical diagnosis.
- (27) Care and treatment for hair loss.
- (28) Exercise programs, travel and lodging for treatment of any condition, whether or not recommended by a Physician.

- (29) 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.
- (30) Care and treatment of pregnancy, childbirth, and miscarriage of an eligible dependent other than the covered Employee's spouse.
- (31) Acupuncture, acupressure, or hypnosis, except when performed by a Physician in lieu of anesthesia.
- (32) Charges incurred due to handling of nuclear materials.
- (33) Charges for prescription drugs are only covered under the Prescription Drug Program. Charges for any drugs or medication that can be purchased without a prescription. 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; anorexiant (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 and special diets; birth control pills or devices, whether or not prescribed or recommended by a Physician.
- (34) Care and treatment of sleep APNEA.
- (35) Charges for chelation therapy; except for treatment of acute arsenic, gold, mercury or lead poisoning.
- (36) Charges for missed appointments or for completion of claim forms.
- (37) Care and treatment for alcoholism, chemical dependency and drug abuse.
- (38) Care and treatment for sickness or injuries sustained as the result of the misuse of any controlled substance when not prescribed by a Physician.
- (39) 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.
- (40) Care or treatment of any illness or injury incurred or aggravated while in the uniformed service.
- (41) Care or treatment of any illness or injury performed by a Chiropractor.

#### **PRE-EXISTING CONDITION LIMITATION**

Medical expenses incurred for a Pre-existing condition will not be covered during the first twelve (12) months of coverage. A pre-existing condition is defined as follows:

“Pre-existing Condition” is any injury or illness for which an Eligible Employee or Dependent sought the advice of a Physician, received treatment or services, or took prescribed medication within the 90 day period before becoming eligible under the Plan. Expenses incurred for a pre-existing condition during the first twelve months of coverage will not be covered. An Eligible Employee or Dependent will become covered for a pre-existing condition after he has been covered under the Plan for 12 consecutive months. This period may be reduced if the Eligible Employee or Dependent was covered under another group insurance program. This reduction in the pre-existing limitation period is contingent on receipt of certification of coverage and there has not been a break of more than 63 days between loss of the prior coverage and eligibility under this Plan.

Pre-existing Limitations will not apply to pregnancy nor to newborns if they are covered under the Plan within 30 days of their birth.

In the event the Eligible Employee and his Dependent lose their eligibility for more than a 12-month period and later re-qualify under the eligibility rules, Pre-existing Condition Limitations shall apply.

### **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.

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

### **ASSIGNMENT**

Benefits which are not based on expenses incurred may not be assigned; however, benefits payable for expenses incurred on account of hospital, nursing, medical, or surgical treatment resulting from a specified injury or period of sickness may be assigned in writing by the covered person to the institution or individual furnishing the respective services for which benefits are payable. The Plan assumes no responsibility for the validity of any assignment, nor will it be liable under any assignment until and unless satisfactory proof of assignment is submitted to the Plan prior to payment of the assigned benefits. Any payment made by the Plan prior to receipt of satisfactory proof of assignment will completely discharge the Plan's obligations to the extent of such payment and the Plan will not be required to see to the application of payment.

### **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 disavows any application of the "make whole" doctrine and may therefore exercise a right of subrogation 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 worker's 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 worker's 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 under-insured motorist insurance providing coverage to the covered person, any medical payments, no-fault, worker's 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 trustee 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.

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.

If an employee or dependent is eligible for benefits under another Plan Coordination of Benefits will apply, regardless of whether or not they are actually enrolled in that Plan. If benefit information is not provided it will be assumed the other Plan's benefits are identical to this Plan.

- (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 for such Allowable Expenses under all other Plans shall not exceed the benefits normally paid by this Plan.

- (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: (1) 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; (2) For children's expenses where both the mother and father have dependent coverage then the Plan of the parent who's 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 would determine 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 then 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.

D. 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.

- E. 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.
- F. 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.

## **ELECTING MEDICARE AS THE PRIMARY PLAN**

A person who is entitled to Medicare benefits at age 65, or as a result of total disability, may elect to have Medicare as the primary Plan by giving notice to the Trustees. If a person elects Medicare as their primary Plan, their health insurance under this Plan will cease.

## **SECTION IV CLAIM PROCEDURES**

When you, or a covered family member, need medical treatment the following procedures should be followed. Our Plan is designed to allow you access to medical providers when treatment is necessary. There are procedures you need to follow to be sure you obtain the highest level of benefits available. There are terms unique to this section that are defined at the end of this section.

If you need *urgent care* please follow these procedures:

- a. Go to the nearest physician, clinic, or hospital.
- b. Contact the Cost Management Administrator at (888) 376-6544. If you are admitted to the hospital this call must be made within 48 hours of your admission.

If you need to see a medical provider;

If you need to make an appointment with a doctor, but you are not sure the doctor is in the PPO, please contact the PPO. The PPO should be able to confirm the doctor participates in the PPO. If he does not they will be able to provide you with the names and phone numbers for other doctors in your area.

If the doctor who is treating you needs to have laboratory tests, blood work, or x-rays done, or if he needs to refer you to a specialist, you should ask him to make your referral to other PPO providers.

If the doctor wants to admit you to the hospital, ask him to admit you to a PPO hospital.

If you are going to be admitted to the hospital please be sure to contact the Cost Management Administrator at (888) 376-6544.

If you have already incurred medical expenses you should submit copies of your medical expenses along with a claim form to the Claims Administrator. Claim forms can be obtained from the Claims Administrator or through your Local Union.

***Complete and sign the Employee portion of the claim form***

***Have the doctor complete the Physician portion of the claim form  
Make sure the bills being sent show the name of the Plan, the diagnosis, the date of service, and the date services were rendered.***

Completed forms and bills should be mailed to: Blue Cross/Blue Shield.  
P.O. Box 10012  
Columbia, S.C. 29202-9982

**WHEN CLAIMS MUST BE FILED**

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

- (1) it is not reasonably possible to submit the claim in that time; and
- (2) 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 Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

An authorized representative of the claimant may act on behalf of the claimant in submitting a claim or an appeal. In the case of an urgent care claim a health care professional with knowledge of the claimant's condition may act as the claimant's representative.

The following outlines the duties of the Claims Administrator in responding to your claim for benefits:

**I. NOTIFICATION REQUIREMENTS**

The Claims Administrator will:

- A. Urgent Care
  1. Notify claimant within 24 hours of specific information needed to complete the claim. This notification can be oral with written notification provided within three days. The claimant will have 48 hours to provide the specified information.
  2. Provide notification of Plan's receipt of the specified information.
  3. If sufficient information is provided, notification of the benefit determination will be given within 72 hours of receipt of the information.
- B. Concurrent Care (Reduction/termination of course of treatment)

1. Provide notification in advance of reduction/termination to allow the claimant to appeal and obtain a determination on review.
  2. Handle requests to extend urgent care treatment beyond period of time or number of treatments within 24 hours of receipt, provided request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments.
- C. Non Urgent Care – Pre-Service Claims
1. Provide notification within 15 days after receipt of claim.
  2. 15 days may be extended if:
    - a. due to matters beyond control of the Plan
    - b. claimant is notified prior to expiration of the initial 15 day period of the circumstances requiring the extension and the date by which the Plan expects to render a determination
    - c. the claimant's failure to submit the necessary information the notice of extension must specifically describe the required information and the claimant will be afforded 45 days from the receipt of the notice to provide the specified information.
- D. Non Urgent Care – Post Service Claims
1. Notification of benefit determination will be provided no later than 30 days after receipt of claim
  2. This 30 day period can be extended if:
    - a. delay is caused by matters beyond control of the Plan
    - b. claimant is notified prior to expiration of the 30 day period of the circumstances requiring the extension and the date by which the Plan expects to render a determination
    - c. the claimant has not submitted information necessary to decide the claim. The notice of extension must specifically describe the required information and the claimant shall be afforded 45 days from the receipt of the notice to provide the specified information.

## II. **BENEFIT DETERMINATIONS**

The Claims Administrator is responsible for making a prompt determination on your completed claim. If your claim is not payable the Claims Administrator will:

- a. provide you with an explanation of their determination containing the specific reason for their determination.
- b. the explanation must reference the Plan provision on which determination is based
- c. must describe any additional information or material necessary to perfect the claim and an explanation of why such information is necessary
- d. must describe the Plan's review procedures including a statement of claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review

### **APPEAL OF ADVERSE BENEFIT DETERMINATIONS**

You have the right to appeal an adverse benefit determination. These rights should be provided to you.

- 1. Claimant must appeal within 180 days following receipt of notice of an adverse benefit determination
- 2. Claimant may submit written comments, documents, records and other information relating to the claim for benefits
- 3. Claimant may have reasonable access to copies of all documents, records, and other information relative to a claim for benefits
- 4. Review must consider all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial determination
- 5. Review must not give deference to the initial adverse determination
- 6. Review must be conducted by an appropriate named fiduciary of the Plan who is neither the individual or a subordinate of the individual who made the initial adverse benefit determination
- 7. If the appeal involves a benefit determination that is based in whole, or in part, on medical judgment, including whether services are experimental or not medically necessary, the appropriate named fiduciary shall consult with a health care professional who has appropriate training in the medical field of medicine involved in the medical judgment and who is neither an individual or subordinate of an individual who was consulted in connection with the initial adverse benefit determination
- 8. The Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse determination without regard to whether the advice was relied upon
- 9. In urgent care cases – an expedited review process that allows the claimant to request, in writing or orally, an expedited appeal provides for necessary

information to be provided by the Plan to the claimant by telephone, facsimile, or similar expeditious methods.

### **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 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:

1. The date a decision on review was mailed or otherwise furnished to the claimant; and
2. A date that is 120 days following receipt of the request for review by the Trustees.)

### **DEFINITIONS APPLICABLE TO THIS SECTION**

Urgent Care Claim - medical care or treatment with respect to which the application of time periods for making non-urgent care benefit determination

-

1. Could seriously jeopardize life or health of claimant, or the ability of the claimant to regain maximum function, or
2. In the opinion of a physician, with knowledge of claimant's condition, delay would subject the claimant to severe pain.
3. In the opinion of physician, with knowledge of claimant's condition, that case requires urgent care is conclusive.

Pre-Service Claim - Claim for a benefit where Plan terms condition receipt of the benefit in whole, or in part, on approval of the benefit in advance of obtaining the medical care.

Post-Service Claim - Any claim that is not a "pre-service claim".

Adverse Benefit Determination - Any denial, reduction or termination of, or failure to provide, or make payment, in whole or in part, (including those based on eligibility determinations) for a benefit under the Plan, including by application of any utilization review or rule related to experimental or not medically necessary.

Relevant - A document is relevant to a claimant's claim if such document, record, etc.:

1. Was relied upon in making the benefit determination.
2. Was submitted or generated in the course of making the benefit determination.
3. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether relied upon in making the benefit determination.

## **CERTAIN EMPLOYEE RIGHTS UNDER ERISA**

As a participant in the IBEW Local 915 Health and Welfare Plan 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you

become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### ***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 Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

## **SECTION V ADDITIONAL PLAN PROVISIONS**

### **PLAN REPLACEMENT OF PRIOR COVERAGE**

The benefits payable under the provisions of this Plan will be reduced to the extent any benefits were paid or payable to a covered person under the provisions of any previous policy of group insurance (prior coverage) issued to the Trustees.

### **MAXIMUM BENEFITS**

The maximum benefits payable by the Plan shall be limited to the lesser of those specified in the "Schedule of Benefits", or the available assets of the Plan. Any benefits provided by group insurance policies issued to the Trustees prior to this Plan, as well as any possible group insurance policies which may be issued to the Trustees at a later date, will be considered along with benefits provided by this Plan in determining maximum benefits payable.

### **TYPE OF FUNDING**

Contributory accumulation of reserve for payment of Trust Fund expenses, benefits, and the disbursement of said benefits. Life and Accidental Death and Dismemberment benefits are provided through an insured arrangement with Boston Mutual Life Insurance Company. The Fund has purchased "stop-loss" coverage. This coverage is presently underwritten by Union Labor Life Insurance Company. All other disbursements of benefits are through the Trust Fund.

### **PLAN IDENTIFICATION NUMBER**

Federal Identification Number  
59-6169977

Plan Number  
501

### **THIS PLAN ADMINISTERED BY**

The Board of Trustees  
c/o Benefit Services, Inc.

5621 Harney Road  
Tampa, Fl. 33610

**AGENT FOR SERVICE OF LEGAL PROCESS**  
THE BOARD OF TRUSTEES  
c/o Benefit Services, Inc.  
5621 Harney Road  
Tampa, Fl. 33610

**PLAN YEAR**

Each 12 month period beginning on November 1 consists of an entire Plan Year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

**TRUSTEES**

**UNION:**

William Dever, Business Manager  
IBEW Local 915  
5621 Harney Road  
Tampa, Fl. 33610

Don Canty, Jr.  
7606 Log House Rd.  
Plant City, Fl. 33565

Roberto Rosa  
2731 Pakaw Lane  
Valrico, Fl. 33594

**EMPLOYER:**

Frank Carpenter  
A & A Ekectric Services, Inc..  
4409 N. Thatcher Ave.  
Tampa, Fl. 33614

Robert R. Coppersmith,  
Chapter Manager  
Florida West Coast Chapter  
NECA  
P.O. Box 4478  
Tampa, Florida 33677-4478

Vance Anderson  
% Dale Rossman, Inc.  
P.O. Box 1021  
Mulberry, Fl. 33860

**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
- e. 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 freestanding 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: hypermeses 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 refer only to a person of the opposite sex who is a husband or wife. 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. The term "marriage" means only a legal union between one man and one woman as husband and wife.

- (2) An Employee's unmarried children from birth to the date the child attains age 19, or to the date age 25 is attained if a full-time student at an accredited school, college or university. Dependent children must be principally dependent upon the Employee for support and maintenance. 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, provided they regularly reside with the Employee; children under legal guardianship if the child depends primarily upon the Employee for support and maintenance and lives with the Employee in a regular parent-child relationship; and an alternate recipient according to the terms of a qualified medical child support order.
- (3) An Employee's unmarried dependent children who, upon attaining age 19, 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. After such two year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such dependent examined by a Physician of the Plan Administrator's choice, at the Fund's expense, to determine the existence of such incapacity.

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.

**“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.

**“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.

**“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 when the body’s organs do not function normally; when temporary alignment reduces the body’s ability to function normally; or pregnancy.

**“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 must 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 have 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:

1. The date a decision on review was mailed or otherwise furnished to the claimant; and
2. 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.

## **IMPORTANT INFORMATION REGARDING COBRA**

This notice 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 either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is:

Board of Trustees  
% Benefit Services, Inc.  
5621 Harney Road  
Tampa, Florida 33610  
(800) 950-9582 TOLL FREE

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

### **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;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated 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 parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) 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, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), NEBA will provide you and/or your qualified beneficiaries with a COBRA continuation offer.

For the other qualifying events (divorce, or legal separation of the employee and spouse, 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  
% Benefit Services, Inc.  
5621 Harney Road  
Tampa, Florida 33610  
(800) 950-9582 TOLL FREE

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. For each qualified beneficiary who elects COBRA continuation coverage, COBRA

continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways this 18 month period of COBRA continuation coverage may be extended:

**Disability extension of 18 month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can 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  
% Benefit Services, Inc.  
5621 Harney Road  
Tampa, Florida 33610  
(800) 950-9582 TOLL FREE

**Second qualifying event extension of 18 month period of continuation coverage**

If your family experiences another qualifying period while receiving 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 is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. 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  
% Benefit Services, Inc.  
5621 Harney Road  
Tampa, Florida 33610  
(800) 950-9582 TOLL FREE

**If you have questions**

If you have questions about your COBRA continuation coverage, you should contact Benefit Services Inc. or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa)

**Keep your Plan informed of address changes**

In order to protect your family's rights, you should keep the Plan Administrator 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 Plan Administrator.

## **PROVISIONS RELATING TO COMPLIANCE WITH THE HIPAA PRIVACY RULE**

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan Sponsor to take all actions required to be taken by the Group Health Plan (GHP) in connection with the HIPAA Privacy Rule.

- I. Definitions - All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein. The following additional definitions apply to compliance with the HIPAA Privacy Rule:
  - A. Plan, also referred to as “GHP”, means the IBEW Local 915 Health and Welfare Fund.
  - B. Plan Documents mean the GHP’s governing documents and instruments including, but not limited to, the IBEW Local 915 Health and Welfare Fund’s current plan of benefits (Plan) and Restated Agreement and Declaration of Trust (Trust) and as from time to time amended and/or restated.
  - C. Plan Sponsor means the “Plan Sponsor” as defined at section 3(16) (B) of ERISA, 29 U.S.C. 1002(16) (B). The Plan Sponsor is the Board of Trustees.
  
- II. The GHP’s disclosure of Protected Health Information to the Plan Sponsor – Required Certification of Compliance by Plan Sponsor.
  - A. Except as provided below with respect to the GHP’s disclosure of summary health information, the GHP will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance issuer or Business Associate with respect to the GHP, only if the GHP has received a certification (signed on behalf of the Plan Sponsor) that:
    - 1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the “504” provisions;
    - 2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this provision; and
    - 3. the Plan Sponsor agrees to comply with the Plan provisions as modified by this provision.

III. Permitted disclosure of individuals' Protected Health Information to the Plan Sponsor

- A. The GHP (and any business associate acting on behalf of the GHP), or any health insurance issuer servicing the GHP will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with this provision.
- B. All disclosures of the Protected Health Information of the GHP's individuals by the GHP's business associate or health insurance issuer, to the Plan Sponsor will comply with the restrictions and requirements of this provision and the "504" provisions.
- C. The GHP (and any business associate acting on behalf of the GHP), may not permit a health insurance issuer, to disclose individuals' Protected Health Information to the Plan Sponsor for employment related actions and decisions in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- D. The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Document and permitted by the "504" provisions.
- E. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the GHP (or from the GHP's business associate or health insurance issuer), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.
- F. The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- G. The Plan Sponsor will report to the GHP any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents and in the "504" provisions, of which the Plan Sponsor becomes aware.

**IV. Disclosure of Individuals' Protected Health Information – Disclosure by the Plan Sponsor**

- A. The Plan Sponsor will make the Protected Health Information of the individuals who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. 164.524.
- B. The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.S.R. 164.526.
- C. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.S.R. 164.528.
- D. The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the GHP available to the U.S. Department of Health and Human Services for purposes of determining compliance by the GHP with the HIPAA Privacy Rule.
- E. The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the GHP (or a business associate or health insurance issuer with respect to the GHP) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- F. The Plan Sponsor will ensure that the required adequate separation, described in paragraph VI below, is established and maintained.

**V. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor**

- A. The GHP, or a business associate or health insurance issuer with respect to the GHP, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as

provided for in the “504” provisions, if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health coverage under the GHP; or
2. Modifying, amending, or terminating the GHP.

- B. The GHP, or a business associate or health insurance issuer with respect to the GHP, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided in the “504” provisions.

**VI. Required separation between the GHP and the Plan Sponsor**

- A. In accordance with the “504” provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to or have the potential to access individuals’ Protected Health Information received from the GHP or from a business associate or health insurance issuer servicing the GHP. In addition to the Board of Trustees, classes may include, for example:  
Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit.
- B. This list reflects the employees, classes of employees, or workforce members of the Plan Sponsor who receive or have the potential to access individuals’ Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the GHP. These individuals will have access to individuals’ Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals’ Protected Health Information in violation of, or noncompliance with, this provision.
- C. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the GHP and will cooperate with the GHP to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

## **STANDARDS FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR:**

Protected Health Information (PHI), to include Electronic Protected Health Information (ePHI), as both of those terms are defined in CFR 45 section 160.103 of the implementing regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), shall be disclosed to the Plan Sponsor, and may be used by the Plan Sponsor, only in accordance with the following terms and conditions. As used herein, "Plan Sponsor" shall mean, in accordance with Section 3 (16)(B) of the Employee Retirement and Income Security Act, the Trustees of the Fund jointly and individually, as designated under the terms of the Agreement and Declaration of Trust under which the Fund is established. "Plan" and "Fund" shall mean the IBEW Local 915 Health and Welfare Fund.

1. Certification by Trustees. HIPAA requires that PHI will be disclosed to the Trustees only upon receipt of certification made by the Trustees that the Plan Document has been amended to incorporate the appropriate provisions. The Trustees hereby make such certification by execution of this document.
2. Disclosure of PHI to Trustees. The Plan shall disclose PHI in the form of summary health information to the Trustees only to the extent necessary for the Trustees to perform the following functions:
  - (a) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
  - (b) Modifying, amending or terminating the Plan.

Further, the Plan shall disclose to the Trustees PHI necessary to carry out other plan administrative functions that the plan sponsor performs, such as the review of claims appeals, consistent with the Plan Document and with applicable provisions of HIPAA.

3. Uses and Disclosures of PHI by Trustees. With regard to the use and disclosure of PHI, the Trustees hereby agree to:
  - (a) Not use or further disclose such information other than as permitted or required by the Plan Document or as required by law;
  - (b) Ensure that any agents, including any sub-contractors, to whom they provide PHI received from the Plan agree to the same restrictions and conditions that apply to the Trustees with respect to such information and further agree to implement reasonable and appropriate security measures to protect ePHI;

- (c) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that they may create, receive, maintain or transmit on behalf of the Plan;
  - (d) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
  - (e) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which they become aware;
  - (f) Report to the Plan any incident involving the security of ePHI of which they become aware;
  - (g) Make available PHI to Plan participants in accordance with the separate Participant Privacy Policies and Procedures established by the Trustees;
  - (h) Make their internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with applicable portions of HIPAA;
  - (i) If feasible, return or destroy all protected PHI received from the Plan that the Trustees still maintain in any form and retain no copies of such information when no longer needed for the purpose for which such disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
  - (j) Ensure that the adequate separation required in sub-section 5. below is established and is supported by reasonable and appropriate security measures.
4. Disclosures between a Health Insurance Issuer or an HMO and the Trustees. No Health Insurance Issuer or HMO with respect to the Plan may disclose PHI to the Trustees except as described under sub-section 2. above and as described in the following sentence. The Plan and any health insurance issuer or HMO with respect to the Plan may disclose to the Trustees information on whether an individual is participating in the Plan, or is in enrolled in or has disenrolled from a Health Insurance Issuer or an HMO offered by the Plan.
5. Adequate Separation between the Plan and the Trustees. PHI will be used only for Plan administration. The Trustees shall not disclose PHI to any person or entity with whom or which the Fund does not have in effect a current "Business Associate" Agreement, and any such disclosures shall be

made only in accordance with the terms of such Agreements and of the separate Security Policies and Procedures and Participant Privacy Policies and Procedures established and maintained by the Trustees.

6. Reports of Non-Compliance. Reports of non-compliance by persons or entities described in 5 above with the provisions outlined herein shall be reported to the Plan's "Privacy Official" designated in the separate Participant Privacy Policies and Procedures adopted by the Trustees. Such non-compliance shall be investigated and disposed of in accordance with those policies and procedures.
7. Reports of Security Incidents. Reports of incidents involving the security of ePHI shall be reported to the Plan's "Security Official" designated in the separate Security Policies and Procedures adopted by the Trustees. Such incidents shall be investigated and disposed of in accordance with those policies and procedures.