

**IBEW LOCAL 915
HEALTH AND WELFARE FUND**



SUMMARY PLAN DESCRIPTION
AMENDED
MARCH 1, 2017

**IBEW LOCAL 915
HEALTH AND WELFARE FUND**

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CASE MANAGEMENT (800) 768-4695

SAV-RX (866) 233-4239
VISION SERVICE PLAN (800) 877-7195

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

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IMPORTANT MESSAGE

To: ALL ELIGIBLE PARTICIPANTS

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

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

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

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

The Plan uses CIGNA's Open Access Plus (OAP) Network as the Preferred Provider Organization (PPO). Please be sure your providers know this is the PPO our Plan uses. If your ID Card does not show this please contact Southern Benefit Administrators for a new ID Card. Please remember that although the Plan uses CIGNA's OAP Network, CIGNA does not provide any insurance. Medical and Dental Benefits are fully self-funded. CareAllies continues to provide hospital pre-certification and case management services.

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

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

Life Insurance and Accidental Death and Dismemberment benefits are provided under a fully insured arrangement with 5 Star Life Insurance Company. You should provide the Fund Office with a signed beneficiary card. If you have not completed one, or don't recall who you named as beneficiary, please contact the Fund Office for a beneficiary designation form.

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

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

Sincerely,

THE BOARD OF TRUSTEES

GRANDFATHERED STATUS

The Trustees believe that our Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

IMPORTANT INFORMATION

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

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

Fund Office

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

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

CIGNA

Pre-certification: (800) 768-4695
OAP Providers: (800) 768-4695

CIGNA Website: www.cignasharedadministration.com
CareAllies www.myCareAllies.com

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

Vision Service Plan (800) 877-7195

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

FREQUENTLY ASKED QUESTIONS

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

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

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

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

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

Q. Are all employees covered?

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

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

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

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

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

Q. What is the deductible?

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

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

A. No. Dependents include the spouse of the member and his children to 26 years of age. Children who are eligible for other employer sponsored health coverage are not eligible as dependents under this Plan.

Q. Does the Plan cover me on the job?

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

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

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

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

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

HOW TO USE THE PLAN

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

Our Plan utilizes CIGNA's Open Access Plus (OAP) Network. CIGNA 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 OAP directory to help in locating a participating medical provider. You can contact CIGNA at (800) 768-4695 to find an OAP provider. You can also find a OAP provider by using CIGNA's website at www.cignasharedadministration.com

If you need to make an appointment with a doctor, or if you do not have a doctor, you should call the OAP'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 OAP. Once you have located a doctor, call him for an appointment. When you arrive they will likely ask for a copy of your insurance I.D. card. If you do not have one please contact the Fund Office.

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

If you are scheduled to be admitted to the hospital, or for outpatient surgery, be sure to contact the pre-certification at CareAllies at (800) 768-4695.

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.

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

It is your responsibility to be sure pre-certification is obtained and to confirm your provider is in the OAP network when services are rendered.

MORE IMPORTANT INFORMATION

OPEN ACCESS PLUS (OAP)

Throughout this booklet you will find many references to the Open Access Plus Network provided by CIGNA. The Trustees have entered into an agreement with CIGNA to use their Open Access Plus Network, OAP for short. The discounts available through the OAP 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 CareAllies, and the phone number is: **1-800-768-4695**

CareAllies 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 CareAllies. 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-OAP hospital charges, surgical charges and medical service charges related to that hospital stay. If an OAP hospital confinement is not pre-certified the room and board expenses will not be considered a covered expense. Expenses for outpatient surgery which is not certified will be paid at 50%, or subject to a \$300 penalty, whichever is less.

HOSPITAL AND SURGICAL 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)

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

First-year apprentices who become eligible on and after January 1, 2016 will have non-spousal coverage. Coverage will be provided to the Apprentice and his covered children under age 26. Spousal coverage will be provided on an elective basis at a cost of \$200 per month. Election and payment must be made within 30 days of attaining initial eligibility.

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;

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

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

In order for these Expedited Eligibility rules to apply the Employee must be eligible for benefits under the group insurance Plan provided by his employer or eligible for benefits under the former

IBEW Local Union's Welfare Plan. Evidence of eligibility for benefits may be provided by a HIPAA certification of creditable coverage or by the Administrative Manager of the Welfare Plan.

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

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

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

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

of Eligibility” provisions in section “H”, of these Eligibility Rules.

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

Expedited Eligibility for Newly Organized Employees

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

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

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

Once a Newly Organized Employee satisfies these Expedited Eligibility requirements and subsequently meets the Initial Eligibility requirements of the regular rules of eligibility (Paragraph 1 above) of 1,000 hours in 12 consecutive months, or 600 hours in 6 consecutive months of employment, eligibility will be maintained on a quarterly basis under the regular rules of eligibility. Until the Continuation of Eligibility (Section B) requirements are met the Newly Organized Employee will not be entitled to (a) eligibility

during a disability period pursuant to the “Disability Credits” section “C” or (b) reinstatement of eligibility pursuant the “Reinstatement of Eligibility” provisions in section “H”, of these Eligibility Rules.

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

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

Employees who work under the CE or CW classification and enter the apprentice program will be entitled to family coverage during the Eligibility Period immediately following the Qualifying Period during which they begin working in the apprentice classification. Continuing eligibility for the next Eligibility Period will be in accordance with the Continuation of Eligibility requirements.

B. CONTINUATION OF ELIGIBILITY

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

<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	October1 through December 31

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

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

The minimum requirement for employees working under the agreement with Busch Gardens is increased to 420 hours per quarter.

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

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

C. DISABILITY CREDITS

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

D. HOUR BANK

All hours reported in a Qualifying Period by participating Employers on the employee's behalf that are in excess of 500 hours will be credited to his individual Hour Bank. These hours will be withdrawn as necessary to continue his eligibility as set forth in Section B.

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

E. TERMINATION OF ELIGIBILITY

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

3. There is no conversion option available under the Plan.
4. Furthermore, no person shall be eligible to participate in this Plan and to obtain Health and Welfare benefits hereunder unless such person is working for, or is available for work with, a contributing employer to this Plan in a category of work covered by the Collective Bargaining Agreement; provided, however, that this provision shall not be applicable to disabled employees, retired employees, employees working in salted employment, or employees who are working for, or available for work with a contributing employer of a reciprocating local union; and further provided that such termination will be immediate upon receipt of written notification of such person's status in the Administrative Office. If an employee is working at the trade for a non-contributing employer, he is deemed to be unavailable for work with a contributing employer. An employee terminated under this provision shall not be eligible for Self-Contributions as set forth in Section G.
5. Employees who continue to work for an employer who is seriously delinquent in making contributions to the Fund will have their eligibility terminated. The termination date of coverage will be determined by the Trustees but will generally be the last day of the month during which contributions for the second delinquent month are due. If an employee continues to work for the seriously delinquent employer his eligibility will be terminated and any hours in his "bank" will be forfeited.

F. UNIFORMED SERVICES

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

1. For **active uniformed service of 31 days or less** - The Employee will be credited with hours of contributions equal to 8 hours per day for each day (Monday-Friday) of active uniformed service provided that the Employee reports to work no later than the first regularly scheduled working period one week after termination of active duty.
2. 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 hour requirement during a Qualifying Period, you can make self-contributions to continue your coverage. There are two types of self-contributions. "Regular" self-contributions and "COBRA" self-contributions

REGULAR SELF-CONTRIBUTIONS

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

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

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

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

*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.

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.)

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** - 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.

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:

Monthly Installment Coverage	Due Date	Grace Period Ends
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:

1. A correct and on-time payment is not made to the Fund or
2. The Fund no longer provides group health coverage for any employees or
3. 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
4. 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 hours requirement. Further eligibility will be in accordance with Section B.

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

I. ELIGIBILITY RULES FOR NON-BARGAINING UNIT EMPLOYEES

- A. The following Rules and Regulations and Rules of Participation for Non-Bargaining Unit Employees who are employed by Local Union 915 or the Local 915 Apprenticeship Program.**
 1. Contributions shall be made at a rate established by the Board of Trustees on the basis of 173 hours per month. This rate may be higher for employees of the Local Union and its Apprenticeship

Program who were formerly working under the Collective Bargaining Agreement.

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.
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. NBU's who are employees of IBEW Local 915 and the Apprentice Program will not have their Contribution Bank frozen.

B. The following Rules and Regulations and Rules of Participation for Non-Bargaining Unit Employees who are owners or partners, directors, officers, stockholders, or other persons whether hourly or salaried employees of employers who have applied; been accepted by the Board of Trustees; have agreed to contribute on behalf of such employees; and agree to abide by the Rules of Participation. A new signatory employer will be entitled to participate provided this election is made within sixty (60) days after signing a Collective Bargaining Agreement with IBEW Local 915. The Board of Trustees may, from time to time, offer existing employers the ability to participate under this provision.

1. Participation in the I.B.E.W. LOCAL UNION NO. 915 HEALTH & WELFARE FUND (hereafter "Trust Fund", "Fund" or "Plan") and eligibility for Plan benefits for non-bargaining unit Employees

(hereafter also referred to as "NBU" or "non-unit Employees") of participating contributing Employers shall be governed by the following identified "Plan Documents" which have been made available to such Employers and their affected NBU (non-unit) Employees and are incorporated herein by reference as such:

- (a) the Trust Fund's current Restated Agreement and Declaration of Trust and as from time-to-time amended and/or restated;
- (b) the Trust Fund's current Summary Plan Description and as from time-to-time amended; and,
- (c) the Trust Fund's current Eligibility Rules as set forth in the Plan and as from time-to-time amended.

- 2. By submitting an "Application for Participation on Behalf of Non-Bargaining Employees" for acceptance by the Trust Fund's Board of Trustees (Trustees), each contributing Employer expressly agrees on behalf of itself and each of its participating non-bargaining unit employees to be bound by all of the terms and conditions of such Plan Documents and all future amendments and modifications thereto.
- 3. The Trustees of the Trust Fund shall have the power, in its sole and exclusive discretion: (i) to amend these "Rules of Participation for Non-Bargaining Unit Employees", as well as the Plan Documents referred to in paragraph one (¶1) above; and, (ii) to determine, interpret and resolve all questions or controversies in connection with the Fund, these Rules and related documents in connection with an Employer's or an NBU Employee's eligibility to participate, or continue to participate, as an NBU participant including, without limitation, determining and resolving conflicting or disputed facts, and interpretations and application of facts, in connection with all such matters, without prior notice to or consent by any contributing Employers or any of its or their participating non-bargaining unit Employees.
- 4. Contributing Employers and their participating non-unit Employees may examine the Plan Documents and any amendments or modifications thereto during normal business hours at the office of the Trust Fund's Administrative Manager which is currently:

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

5. By participating, contributing Employers ratify the appointment of all Employer Trustees to the Trust Fund heretofore made and those Employer Trustees which may be appointed hereafter.
6. Employer contributions shall be made continuously and without interruption, month-after-month, on the basis of the contribution rate or rates established by the Trustees from time-to-time in their sole and exclusive discretion. The current contribution rate owed on behalf of a participating employer on behalf of each full-time non-unit Employee is currently Eight Hundred and Fifty-six Dollars and thirty-five cents (\$856.35) per month due and payable to the Fund's receiving agent by the fifteenth (15th) of the month preceding the coverage month.
7. Contributing Employers shall identify and report on behalf of each of their full-time non-unit Employees to the Trust Fund, monthly, on a reporting form separate from that used to report the Employer's "unit" employees. In addition, each such Employer:
 - (a) shall identify and contribute on behalf of each of its full-time (employed thirty (30) or more hours per week) non-unit or NBU Employees timely prior to the commencement of NBU participation on its "Application for Participation On Behalf of Non-Bargaining Unit Employees"; and,
 - (b) shall identify and contribute on behalf of each full-time NBU Employee subsequently employed on a separate "Application for Participation On Behalf of Non-Bargaining Unit Employees" within thirty (30) days of his or her commencement of such employment; and,
 - (c) shall acknowledge that participation in and eligibility for benefits from the Trust Fund by each such NBU Employee is subject to advance approval by the Trustees and must be proposed for such participation, in writing, on forms approved by the Trustees within thirty (30) days of commencement of such non-unit employment with the employer or the Employer and each of its NBU Employees shall thereafter be prohibited from any NBU participation in the Fund.
8. For each enrolled NBU Employee, the Employer further expressly acknowledges and agrees:
 - (a) that all such contribution remittances must be post-marked,

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

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

Examples only –rates have changed: If an Employer has ten (10) full-time NBU Employees enrolled for NBU participation, Seven Thousand Five Hundred Dollars (\$7,500.00) shall be due and payable to the Fund by the fifteenth (15th) day of the month. If that sum was not post-marked, delivery-dated or received until the sixteenth (16th) day preceding the coverage month, the sum owed equals \$7,575.00 (comprised of \$7,500.00 plus 1% of that sum). If the \$7,500.00 was not sent or received until the twentieth (20th) day preceding the coverage month, it is five (5) days late so the delinquent NBU contributions owed total \$7,875.00 (comprised of \$7,500.00 plus 5% of that sum). If the delinquent contributions are not sent or received until the first (1st) day of the coverage month, all NBU participation and coverage shall be terminated as of midnight on the last day of the prior month. In no event shall any delinquent NBU contributions be accepted until all late liquidated damage assessments are also paid at that time.

- 9. Employer contributions shall continue to be made without interruption, on a monthly basis, and payment must be post-marked, delivery-dated or received in advance of the coverage month.
- 10. The Employer agrees to pay the Trust Fund's reasonable attorney's fees and costs if it is determined that the Employer has

breached any of the provisions of its Participation Agreement or these "Rules of Participation for Non-Bargaining Unit Employees".

11. Such Employer contributions on behalf of its non-unit Employees must be continuous and without interruption. Further, under no circumstances will the Trust Fund accept an Employer's contributions for participation by its NBU Employees if the Employer's "unit" employees' contributions are then delinquent.
12. These "Rules of Participation for Non-Bargaining Unit Employees" apply to all Employers that are signatory to or otherwise bound by the terms of one or more Collective Bargaining Agreements or Other Written Agreements entered into by and between the I.B.E.W. Local Union No. 915 and the Florida West Coast Chapter of N.E.C.A. as of the date of the Trustees' adoption hereof and/or the effective date of the Trust Fund's approval of the Employer's "Application for Participation On Behalf of Non-Bargaining Unit Employees".
13. An Employer's entitlement to continued participation in the Trust Fund on behalf of its NBU Employees shall terminate immediately upon the occurrence of any of the following conditions:
 - (a) If the Employer is no longer signatory to the then-current Collective Bargaining Agreement which provides for participation in the Trust Fund for its "unit" or bargaining unit employees; or,
 - (b) If the Employer fails to comply with any provisions of these "Rules of Participation for Non-Bargaining Unit Employees" as from time-to-time amended and/or restated by the Trustees.
14. Each Employer, and each NBU Employee enrolled for NBU participation in the Fund, acknowledges and agrees:
 - (a) Effective May 1, 2007 and continuing thereafter, no NBU Employee shall be entitled to disability credits nor to any accumulation in the Hour Bank but until that date, if a NBU Employee previously participating had established an hour bank credit, that credit will be frozen and, except for these exclusions, each NBU Employee will be entitled to all other provisions of the Fund's Health and Welfare Plan; and,
 - (b) the NBU Employer shall notify the Fund, on a form provided by it, within three (3) business days of an NBU Employee's

separation of employment or else it shall remit such additional contributions for such periods and in such amounts as the Fund's Trustees, in their sole and exclusive discretion, deem appropriate; and,

- (c) that no partial or pro rata refund of any NBU contributions remitted to the Fund on behalf of any NBU Employee shall be due or payable to such Employer or Employee by the Fund for any period of a month following the separation of Employment of any NBU Employee(s); and,
- (d) that NBU participation and coverage for each NBU Employee who has separated from employment shall terminate as of midnight: (i) before May 1, 2007, on the last date of the month during which the last hours were reported; and, (ii) effective May 1, 2007 and continuing thereafter, the last day of the month of the NBU Employee's separation of employment, unless the NBU Employee timely elects COBRA continuation coverage.

15. The payment of fringe benefit contributions by an Employer does not constitute participation in the Trust Fund unless an "Application for Participation On Behalf of Non-Bargaining Unit Employees" and related documents are submitted by the Employer and approved by the Fund Trustees, in writing, and further provided the Employer's participation (and/or entitlement to continued participation) in the Trust Fund has not been terminated as provided in the Plan Documents or these Rules.
16. This Participation Agreement and any resulting rights or obligations arising therefrom may be canceled and terminated at any time by either party, the Board of Trustees of the Trust Fund or any contributing Employer, effective prospectively only upon the receipt of written notice of such termination by the other party.
17. Coverage for individuals under this provision will commence on the first day of the calendar month following receipt of employer contributions, and terminate at the end of the month during which the last contributions were made. Examples; If contributions for May are received by April 15, coverage is effective May 1. If an individual is last reported in the month of May his eligibility will terminate as of midnight May 31.

J. RETIREES

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

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

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

1. Previously an Eligible Employee of the Plan and maintaining continuous coverage from active participant to retired participant; and
2. Attained at least age 60 or are totally disabled (as defined by the Federal Social Security Act) and receiving Social Security benefits; and
3. No longer employed in the electrical industry.

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

K. DEPENDENTS OF DECEASED EMPLOYEES

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

L. AMOUNT OF COVERAGE

The amounts for which an eligible person is covered under the Plan shall be those amounts specified in the Plan of Benefits 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 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 20th day of the month in order for coverage to be in effect the following month. For example contributions for March coverage must be made by February 20.

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

O. POWER OF TRUSTEES

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

SECTION II

SCHEDULE OF BENEFITS

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

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

Major Medical Benefits for each covered person:

	<u>OAP PROVIDER</u>	<u>NON-OAP PROVIDER</u>
Calendar Year Deductible	\$350 per individual \$1,050 per family	\$350 per individual \$1,400 per family
Calendar year Maximum	UNLIMITED	UNLIMITED
<u>Percentages Payable after satisfaction of Calendar Year Deductible</u>		
Hospital Services	85%	50%
Hospital admissions must be pre-certified through CareAllies - Failure to comply will result in a denial of room and board expenses for PPO hospitals and a \$300 penalty for non-ppo hospitals.		
Supplemental Accident Benefit (ER Excluded)	100% of first \$300	No first dollar coverage
Physicians	85%	50%
Surgery (Outpatient septoplasty and lithotripsy procedures require pre-certification)	85%	50%
Diagnostic Laboratory and x-rays outside Dr's. office	85%	50%
Inpatient Mental & Nervous Treatment	85%	50%
Outpatient Mental & Nervous Treatment	85%	50%
Ambulance Service	85%	80%
Hospice Care - Limited to 30-days or per six-month benefit period	85%	50%
Skilled Nursing Facility	85%	50%

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

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

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

ROUTINE PHYSICAL EXAM BENEFIT

Routine Physical Exams with an OAP 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. Employees and spouses who have a Routine Physical Exam will be entitled to a \$350 refund of expenses applied to the Calendar Year Deductible in that same year.

Routine Physical Exams with an OAP provider for dependent children will be reimbursed up to 100% of \$200. This benefit is not subject to the Calendar Year Deductible. Exams for dependent children do not provide credit toward the Calendar Year Deductible.

Expenses for screening colonoscopies with OAP providers are covered as any other illness.

SLEEP DISORDERS

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

CHIROPRACTIC TREATMENT

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

FACILITIES NOT COVERED

There are several medical facilities that offer spine surgery but do not participate in the Plan's Preferred Provider Organization (PPO), CIGNA Open Access Plus network. Charges for services provided by these providers incurred on and after March 1, 2017 will not be considered "eligible expenses" under this Plan.

The providers who currently fall under this exclusion are:

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

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

PRESCRIPTION DRUG CARD SERVICE PROGRAM (SAV-RX)

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

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

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

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

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.

VISION BENEFITS

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

Coverage from a VSP Doctor

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

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

Contact Lens Care – every 12 months

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

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

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

Out-of-Network Reimbursement Amounts

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

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

COST MANAGEMENT SERVICES PRE-ADMISSION REVIEW SERVICE

- (1) Payment of Covered Hospital Charges.** Participating hospital are responsible for pre-admission certification. For non-participating hospitals you are responsible for pre-certification. Failure to obtain the pre-certification will result in a 25% reduction in the allowable expense from the hospital.
- (2) Pre-admission Review.** This review will determine the number of days of hospital confinement authorized for payment of the scheduled benefit. The Employee is responsible for calling for pre-certification and obtaining pre-authorization of a non-participating hospital confinement from CareAllies.
- (3) Non-emergency Confinement.** Before a Covered Person is confined in a non-participating hospital, a request for Pre-admission Review must be submitted. The request must be made by phone, in advance, by calling toll-free (800) 768-4695.
- (4) Emergency Confinement.** This is a hospital confinement for a covered Injury or Sickness that, unless treated at once on an inpatient basis, would either be a threat to life or seriously impair bodily functions. Pre-certification must be contacted within 48-hours after the start of an emergency admission.
- (5) Extra Confinement Days.** If extra days of confinement are necessary, CareAllies must be notified. This request must be made before the extra days are used.

PRE-SURGICAL REVIEW SERVICE

- (1) Payment of Covered Surgical Charges.** This service applies to covered charges for surgery and anesthesia billed by a Physician for surgical procedures being performed on an outpatient basis. CareAllies will advise if the procedure is approved, whether it may be done as an inpatient or outpatient, or if a second opinion is necessary. The Plan's scheduled benefits will be paid for covered charges when CareAllies is contacted, otherwise, the related charges will be paid at 50%.
- (2) Pre-surgical Review.** Prior to performing an outpatient surgical procedure, CareAllies must be contacted. This is done by calling toll-free to (800)-768-4695. CareAllies may suggest that the procedure be performed as a hospital inpatient, or require a second opinion to confirm the need for surgery.

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

- (a) a Board Certified Specialist in the area in which the operation is concerned; and
- (b) not financially associated with the surgeon originally recommending surgery.

If the second opinion does not confirm the need for surgery a third opinion is required to obtain the scheduled benefits for the surgery. Even if the third opinion does not confirm the need for surgery, full Plan benefits will be paid if

the Covered Person desires the procedure. All such consultations will be paid at the rate of 100% of the Usual and Reasonable Charge. Charges for second opinions and, if necessary, third opinions are not subject to the calendar year deductible.

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

INDIVIDUAL CASE MANAGEMENT

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

PLAN ADMINISTRATOR'S SOLE DISCRETION

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

MAJOR MEDICAL EXPENSES BENEFITS

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

Supplemental Accident Benefit - In the event of an accidental bodily injury the first \$300 of Surgical or Medical expenses will be reimbursed at 100%. Eligible expenses must be incurred within fourteen (14) days of the accident. This benefit is not subject to the Deductible. This benefit is not applicable to 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 "Benefit Limits" of the Plan.

DISCRETIONARY PAYMENT OF CLAIMS TO MEDICAL PROVIDERS -

At the sole discretion of the trustees of the Plan, health benefits payable hereunder may be paid directly to a health provider. Any direct payment to a medical provider is in lieu of payment to the participant or beneficiary.

ALLOCATION AND APPORTIONMENT OF BENEFITS -

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

MAXIMUM BENEFIT AMOUNT -

The maximum benefit amount effective January 1, 2014 is unlimited.

ELIGIBLE EXPENSES

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

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

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

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

- a. reconstruction of the breast on which the mastectomy was performed;
- b. surgery and reconstruction of the other breast to produce symmetrical appearance; and
- c. prostheses and physical complications of all stages of a mastectomy, including lymphedemas

Additional Expenses, if not included above for:

1. Treatment by a legally qualified physician and surgeon (excluding expenses which are related to surgical procedures);
2. Services of a licensed registered graduate nurse or of a licensed practical nurse rendered in or out of a hospital and also the services of a licensed undergraduate nurse provided such service is rendered in a hospital, other than by a person who ordinarily resides in the Covered Person's home or is a member of the Covered Person's immediate family (consisting of the Covered Person's spouse, children, brothers, sisters and parents);
3. Anesthetic and its administration (other than local infiltration or digital block anesthesia);
4. Treatment for physical, speech and occupational therapy as provided by a licensed therapist (other than a member of the Covered Person's immediate family defined above) for rehabilitation of an injury or sickness;
5. Dental treatment by a physician, dentist or dental surgeon for:
 - a. a fractured jaw as a result of an accident or for injury to sound natural teeth, including replacement of such teeth. Treatment must commence within three months of the accident and be completed within twelve months after the date of the accident;
 - b. surgical and non-surgical treatment of the temporomandibular joints up to a maximum of \$1,500 per calendar year. These expenses will not include kinesiography, electromyography, muscle testing, occlusal analysis, orthodontic treatment, crowns, inlays, onlays and other prosthodontic treatment;
 - c. excision of impacted wisdom teeth.
6. X-ray or radium treatment;

7. Home Health care services and supplies-the following home health care services and supplies will be covered, subject to the calendar year deductible and the appropriate coinsurance, when received in lieu of hospital confinement;
 - a. part time or intermittent nursing care by, or under the supervision of, a registered nurse (RN).
 - b. part time or intermittent home health aide services provided through a Home Health Care Agency. This does not include general housekeeping services.
 - c. physical, occupational and speech therapy.
 - d. medical supplies
 - e. laboratory services by or on behalf of the Hospital. These services are limited to one visit per day and 100 visits per year.
8. X-ray and laboratory examinations, excluding dental x-rays unless rendered for dental treatment of a fractured jaw or of injury to sound natural teeth within twelve months after the date of the accident;
9. Ambulance charges- for necessary local transportation of a Covered Person by professional ambulance service to the nearest hospital for In-Patient care, or to the nearest hospital for emergency accident care where the necessary treatment is available, or, if medically necessary from a hospital to another hospital or rehab facility for further inpatient care. In cases of life threatening sickness or injury, air ambulance or regularly scheduled commercial airplane or train services for the patient(s) will be permitted only to the nearest hospital providing the necessary facilities and not to exceed the cost of one round-trip fare for any one accident or sickness;
10. Medical Supplies - drugs and medicines obtainable only by prescription and dispensed by a licensed pharmacist; blood and blood plasma; artificial limbs and eyes; surgical dressings; casts; splints, trusses; braces; crutches; rental of wheel chairs, hospital bed, iron lung, and the rental of equipment for its administration to the extent such total rental costs do not exceed a reasonable purchase price, as determined by the Plan. **Coverage for prescription drugs is provided under the Prescription drug program only.**
11. Mammography charges- benefits will be paid subject to the 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. Diabetic strips and supplies, but not insulin. Insulin is available under the Prescription Drug Program.
16. Expenses incurred with Pain Management physicians or clinics must be with OAP providers. This includes drug screenings. Any referrals made by Pain Management clinics or physicians, as well as drug screenings, must be made to OAP providers.

COVERAGE OF PREGNANCY

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

NERVOUS OR MENTAL DISORDERS

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

CHILD HEALTH SUPERVISION SERVICES

These benefits are payable for covered dependent children of a covered person eligible for family coverage from the moment of birth to age 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, 85% for OAP providers and 50% for non-OAP providers.

ROUTINE PHYSICAL EXAM BENEFIT

A maximum benefit of \$350 per calendar year will be paid for a routine physical examination for an employee and spouse. The physical exam must be performed by an OAP 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. Employees and spouses who have an Annual Physical Exam will receive a credit of \$350 toward their Calendar Year Deductible during the same year as the Exam.

Routine Physical Exams with an OAP provider for dependent children will be reimbursed at 100% up to \$200. This benefit is not subject to the Calendar Year Deductible. Exams for dependent children do not provide credit toward the Calendar Year Deductible.

ORGAN AND TISSUE TRANSPLANT BENEFITS

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

Procedures Covered

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

Provisions

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

The covered person who is the organ or tissue recipient must provide two written medical opinions verifying the need for transplant surgery. The medical opinions must be from Board Certified specialists in the involved field of surgery. The opinions must verify that conventional treatment would be unsatisfactory, unavailable and/or more hazardous than a transplant.

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

Limitations

The only transplant procedures covered under this Plan are those noted in Section I above.

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

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

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

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

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

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

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

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

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

EXCLUSIONS, EXCEPTIONS AND LIMITATIONS

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

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

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

The following presumptions shall apply to this exclusion:

- a. The filing of a Notice of Injury or Claim for 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 personal hygiene, comfort or convenience including but not limited to telephone, television, cosmetics, guest trays, magazines, beds or cots for family members or other guests.
6. The part of an expense for care and treatment of an injury or sickness that is in excess of the usual and reasonable charge.
7. Any loss that is due to a declared or undeclared act of war.
8. Any loss due to an intentionally self-inflicted injury, unless the self-inflicted injury is proven to be the result of a medical condition, including depression.
9. Care, treatment, services and supplies directly or indirectly provided for realignment of teeth or jaws, including but not limited to atrophy of the lower jaw, occlusion, maxillofacial surgery and retrognathia. Expenses incurred for treatment of temporomandibular joint dysfunction (TMJ) will be covered provided treatment is for medical conditions caused by the temporomandibular joint dysfunction.
10. Professional services performed by a person who ordinarily resides in the covered 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.
11. Care and treatment provided for cosmetic reasons, whether or not recommended for psychological reasons. This exclusion will not apply if the care and treatment:
 - is for repair of damage from an accidental bodily injury;
 - is due solely to surgical removal of all or part of the breast tissue of an injury or sickness to the breast or;

is for correction of an abnormal congenital condition in a newborn child.

12. Radial and hexagonal keratotomy or other eye surgery to correct near and far sightedness, astigmatism, or other refractive errors. Also, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
13. Audiology tests, hearing aids, or the fitting of such items.
14. Routine physical exams, lab tests, and routine chest x-rays beyond any such coverage specifically allowed by the Plan except mammograms and pap smears at medically recommended intervals.
15. Services or supplies provided mainly as a rest cure, maintenance or custodial care, or which are palliative in nature. This exclusion also applies to any services or treatment that cannot reasonably be expected to lessen the patient's disability enough to enable the patient to live outside of an institution.
16. The following care, treatment or supplies for the feet:
Orthopedic shoes; orthotics or orthopedic appliances including orthopedic prescription devices to be attached to or placed in shoes; treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations; and treatment of corns, calluses or toenails, except the surgical removal of nail roots or treatment required in connection with metabolic or peripheral-vascular disease.
17. Spare items of the nature of: braces of the leg, arm, back or neck; artificial arms, legs or eyes; or lenses for the eye.
18. Unless required by law, services that are of the nature of stress management, family planning, marital counseling, social counseling, educational or vocations testing or training and treatment of behavior problems and behavioral modification therapy, biofeedback and other forms of self-care or self-help training.
19. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
20. Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment,

elevators or stair lifts, hot water bottles, rubber gloves, home enema equipment, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs, devices for simulating natural female body contours (except for post-mastectomy surgery), first-aid supplies and non-hospital adjustable beds.

21. Care and treatment of obesity, weight loss, or dietary control including but not limited to weight loss programs, liposuction and gastric stapling, whether or not it is, in any case, a part of the treatment plan for another sickness.
22. Care, treatment and counseling for gender identification, sex transformations, sexual impotency, and sexual dysfunction including any complications arising therefrom. This exclusion will not apply to expenses incurred for the surgical implant of a penile prosthesis, if medically necessary.
23. Care and treatment for reversal of surgical sterilization.
24. Care and treatment for infertility, artificial insemination or in-vitro fertilization and any charges for a surrogate mother to bear a child, for inseminating a surrogate mother with a covered person's sperm, and any complications thereof.
25. Pre-natal testing, including amniocentesis, when done for the purpose of determining the sex of the child or without medical diagnosis.
26. Care and treatment for hair loss.
27. Exercise programs, travel and lodging for treatment of any condition, whether or not recommended by a Physician.
28. Abortion, except that a legal abortion performed on any covered person, including a dependent daughter, will be covered if the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of incest or rape.
29. Care and treatment of pregnancy, childbirth, and miscarriage of an eligible dependent other than the covered Employee's spouse.
30. Acupuncture, acupressure, or hypnosis, except when performed by a Physician in lieu of anesthesia.
31. Charges incurred due to handling of nuclear materials.

32. Charges for prescription drugs are only covered under the Prescription Drug Program. 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.
33. For injuries sustained while committing a felony, while participating in a riot or civil insurrection, or if caused during a covered person's violation of local, state, or federal law. This exclusion will not apply to acts of domestic violence.
34. Charges for chelation therapy; except for treatment of acute arsenic, gold, mercury or lead poisoning.
35. Charges for missed appointments or for completion of claim forms.
36. Care and treatment for alcoholism, chemical dependency and drug abuse.
37. Care and treatment for sickness or injuries sustained as the result of the misuse of any controlled substance when not prescribed by a Physician.
38. Care and treatment for senile deterioration, Alzheimer's Syndrome or organic mental and nervous disorders, except as specifically set forth in the Schedule of Benefits.
39. Care or treatment of any illness or injury incurred or aggravated while in the uniformed service.
40. Expenses incurred outside the United States, unless the participant or dependent is a U.S. resident and the charges are incurred while traveling on business or for pleasure.

VISION BENEFITS

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

DUAL CHOICE BENEFITS

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

You can use the VSP Network Doctors:

VSP has arranged for a number of doctors in your area (VSP doctors) who will provide professional vision care for you and your dependents. VSP guarantees quality and cost control.

Except for a small co-payment for examinations and lenses and/or frames, VSP doctors provide examinations, professional services, lenses and frames at no additional cost to you, provided you stay within the limits of the Plan. Please refer to the Schedule of Benefits. VSP pays the VSP doctors for the rest of the covered services and supplies provided to you.

Any additional vision care, services and/or materials not covered by VSP can be arranged between you and the VSP doctor, based on the wholesale cost difference and a modest service fee.

You can use your own non-network doctor:

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

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

COVERED VISION CARE SERVICES AND SUPPLIES

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

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

Lenses – Allowable once per 12-month period.

Frames – Allowable once per 24-month period.

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

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

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

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

HOW TO GET VISION CARE BENEFITS

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

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

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

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

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

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

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

SERVICES AND MATERIALS NOT COVERED

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

Orthoptics or vision training and any associated supplemental training
Non-prescription glasses and contact lenses
Two pairs of glasses instead of bifocals
Complete replacement of glasses for those that are lost or broken (except at the normal intervals when services are otherwise available)
Medical or surgical treatment of the eyes outside of discounts provided for laser vision correction
Experimental vision services, treatments, and materials
Vision care expenses which may be excluded under the Plan's Limitations and Exclusions.

EXTENSION OF VISION CARE BENEFITS

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

SECTION III GENERAL PROVISIONS

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

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

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.

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

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

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

NO THIRD PARTY BENEFICIARY

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

RIGHT OF REFUND OR SUBROGATION

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

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

In the event that benefits are paid as a result of any occupational injury or sickness, the Plan and/or Trustees will be subrogated to the rights of the covered person and those entitled by law to proceed against any 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. Charges which are in excess of previously agreed upon discounted billings, under either Plan, will not be considered Allowable Expenses.

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

This Plan shall not be required to determine the existence of any other Plan, or the amount of benefits payable under any Plan other than this

Plan. The payment of benefits under this Plan shall be affected by the benefits payable under other Plans only if this Plan is furnished with information concerning the existence of such other Plans by the employer, any insurance company, organization or covered person.

- (4) Claim Determination Period means a period commencing with any January 1, and ending at 12 o'clock midnight on the following December 31st or that portion of such period during which the person on whose behalf the claim is based has been covered under this Plan.
- (5) Coordination with PIP and/or "No-Fault". In the State of Florida and in many other states, owners of private motor vehicles (excluding motorcycles) are required to obtain "No-Fault" insurance and personal injury protection (PIP) Benefits as required by law, without regard to any deductible which may be in effect and without regard to the purchase of such insurance by, or on behalf of, the Covered Person. Accordingly, if a Covered Person fails, for any reason whatsoever, to obtain and maintain "No-Fault" and/or PIP insurance as required by law, or if a deductible is included under such insurance, the Plan shall pay Benefits as if the Covered Person had such insurance in effect with no deductible.

C. Effect on Benefits

- (1) This provision shall apply in determining the benefits due a covered person under this Plan for any Claim Determination Period if the sum of the benefits that would be payable under this Plan in the absence of C.O.B., and the benefits that would normally be payable under all other Plans would exceed 100% of the expenses actually incurred.
- (2) As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under this Plan in the absence of C.O.B. for the Allowable Expenses incurred shall be reduced to the extent necessary so that the sum of (a) such reduced benefits and (b) all benefits paid or payable under all other Plans shall not exceed the Allowable Expenses.
- (3) The Plan which covers the person as an employee will be primary. Any other Plan will be secondary
- (4) If another Plan insuring or covering the person under this Plan contains a similar non-duplication of medical expense benefits provision, or has an "always secondary" provision, the following rules approved by the National Association of Insurance Commissioners will apply in determining the order of benefit determination.

- (5) For the purposes of this Section, the rules establishing the order of benefit determination are:
- (a) The benefits of a Plan which covers the person on whose behalf claim is based other than as a dependent, shall be determined before the benefits of a Plan which covers such person as a dependent;
 - (b) For children's expenses where both the mother and father have dependent coverage 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.

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

- D. Facility of Payment. Whenever payments which should have been made under this Plan are made under any other Plan, this Plan shall have the right in its sole discretion to pay to any organization making such

payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

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

COORDINATION OF BENEFITS AND MEDICARE

MEDICARE BENEFITS AT AGE 65

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

For Active Employees

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

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

MEDICARE BENEFITS DUE TO TOTAL DISABILITY

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

During the Medicare Waiting Period

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

After the Medicare Waiting Period

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

1. a primary Plan to Medicare for a person who is an active employee and entitled to Medicare benefits due to total disability other than end stage renal disease; and
2. a secondary Plan to Medicare for a person who is:
 - a. an active person who is entitled to Medicare benefits due to end stage renal disease; or
 - b. a retired person who is entitled to Medicare benefits due to total disability or end stage renal disease.

SECTION IV CLAIM PROCEDURES

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:

- * Go to the nearest physician, clinic, or hospital.
- * Contact the Cost Management Administrator at (800) 768-4695. 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 OAP, please contact the OAP. The OAP should be able to confirm the doctor participates in the OAP. 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 OAP providers.

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

If you are going to be admitted to the hospital please be sure to contact the Cost Management Administrator at (800) 768-4695.

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:

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

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:
due to matters beyond control of the Plan
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
 3. 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:
delay is caused by matters beyond control of the Plan
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
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;
 - (1) must reference the Plan provision on which determination is based
 - (2) must describe any additional information or material necessary to perfect the claim and an explanation of why such information is necessary
 - (3) 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
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.
10. If the above process does not resolve your appeal you may appeal to an external review organization. The result of that review will be final. Contact the Fund Office for more information.
11. Pursuant to Department of Labor Regulations, an authorized representative of a claimant is not precluded from acting on behalf of a claimant in pursuing a benefit claim or appeal of an adverse benefit determination. In order to assure that person purporting to be an authorized representative has been and continues to be authorized to act on behalf of the claimant, with respect to the particular benefit claim or appeal, any written benefit claim or appeal of an adverse benefit determination must bear the notarized signature of the claimant. (a general appointment is insufficient, the specific claim or appeal must bear the notarized signature of the claimant.) If evidence is presented that the claimant is disabled and/or incompetent to the extent that the signature of the claimant cannot be obtained, then such benefit claim or

appeal shall bear the notarized signature of the spouse of the claimant, a health care surrogate of the claimant or a person holding a plenary power of attorney for the claimant. A copy of the documents establishing the health care surrogate or power of attorney shall be furnished.

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

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

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 -

Could seriously jeopardize life or health of claimant, or the ability of the claimant to regain maximum function, or

In the opinion of a physician, with knowledge of claimant's condition, delay would subject the claimant to severe pain.

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.:

Was relied upon in making the benefit determination

Was submitted or generated in the course of making the benefit determination.

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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION V 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 5 Star Life Insurance Company. Stop-loss coverage, which provides reimbursement to the Fund for a portion of the benefits paid on catastrophic claims, is provided by HCC Life Insurance Company. Vision Benefits are insured with Vision Service Plan. All other disbursements of benefits are through the Trust Fund.

PLAN IDENTIFICATION NUMBER

Federal Identification Number Plan Number
59-6169977 501

THIS PLAN ADMINISTERED BY

The Board of Trustees
c/o Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN. 37070-1449

AGENT FOR SERVICE OF LEGAL PROCESS

THE BOARD OF TRUSTEES
c/o Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN. 37070-1449

PLAN YEAR

Each 12 month period beginning on January 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:

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

Leon Ward
IBEW Local 915
5621 Harney Road
Tampa, Fl. 33610

Tom Bedwell
IBEW Local 915
5621 Harney Road
Tampa, Fl. 33610

EMPLOYER:

Vance Anderson
% Electro Design Engineering
8133 Eagle Palm Dr.
Riverview, FL. 33548

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

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

PLAN INFORMATION

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

PLAN TERMINATION

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

- a. when there are no longer sufficient assets to continue the benefits of the Plan. In this regard, the Board of Trustees will first attempt to amend the Plan's benefits, alter or postpone the method of paying benefits or take other actions consistent with its obligations to maintain the maximum possible benefits within the limits of the Plan's resources;
- b. when there are no longer any Employers who are required to make contributions under the appropriate Collective Bargaining Agreement;
- c. when the last surviving participant or beneficiary entitled to receive benefits has died;
- d. with respect to a particular Employer, when that Employer ceases to be a contributing Employer according to the Plan's Trust Agreement or when that Employer is declared by the Board of Trustees to be in default; or with respect to a particular Employee, when that Employee ceases to be an eligible Employee according to the Plan's Rules and Regulations.

SECTION VI DEFINITIONS

“Alternative Birthing Center” means: a birthing center operating as part of a Hospital; or a 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: hypermesis gravidarum; ectopic pregnancy that is ended; non-elective Cesarean section; and miscarriages.

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

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

- (1) An Employee’s spouse. The term “spouse” shall 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 children from birth to the end of the month during which the child attains age 26, unless the child is eligible for other employer sponsored health coverage. The term “children” shall include natural children; adopted children (from the moment of placement in the home after assumption and retention of a Legal obligation for total or partial support of a child in anticipation of adoption of such child); step children, children under legal guardianship, and an alternate recipient according to the terms of a qualified medical child support order.
- (3) An Employee’s dependent children who, upon attaining age 26, are mentally retarded or physically handicapped so as to be incapable of self-support provided such proof is furnished to the Plan Administrator within thirty (30) days of the date benefits would otherwise terminate. The Plan Administrator may require, at reasonable intervals during the two years following the dependent reaching the limiting age, subsequent proof of the child’s disability and dependency.

These persons are excluded as dependents:

- (1) a common law spouse whose marriage cannot be evidenced by a duly constituted marriage license issued by the appropriate state or other jurisdiction where the marriage occurred;
- (2) the legally separated or divorced former spouse of the Employee;
- (3) any person who is on active duty in any military service of any country;
- (2) 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.

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

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

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

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

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

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

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

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

“Open Access Plus” (OAP) is the managed care network provided by CIGNA. This is a preferred provider network but provides greater discounts than CIGNA’s PPO network.

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

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

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

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

“Skilled Nursing Facility” means an institution which (1) provides skilled nursing care under 24 hour supervision of a doctor or graduate Registered Nurse, (2) has available at all times the services of a doctor who is a staff

member of a hospital, (3) provides 24 hours-a-day nursing service by a graduate Registered Nurse, Licensed Vocational Nurse or skilled practical nurse and has a graduate Registered Nurse on duty at least 8 hours per day, (4) maintains a daily medical record for each patient, (5) is not a place for rest, custodial care, for the aged, for drug addicts or alcoholics, nor is a hotel or similar institution.

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

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

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

SECTION VII GENERAL PROVISIONS AND RESPONSIBILITIES FOR PLAN ADMINISTRATION

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

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.
2. To decide disputes which may arise relative to an Employee's rights.
3. To keep and maintain the Plan documents and all other records pertaining to the Plan.
4. To appoint a Claims Administrator to pay claims.
5. To perform all necessary reporting as required by ERISA.

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

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

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

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

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

AMENDING AND TERMINATING THE PLAN

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

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
% Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN. 37070-1449
(800) 831-4914 TOLL FREE

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

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), Southern Benefit Administrators 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
% Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN. 37070-1449
(800) 831-4914 TOLL FREE

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each 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 several ways this 18 month period of COBRA continuation coverage may be extended:

Maximum Period of 24 months for Service in the Armed Services

If you enter active duty in the Uniformed Services of the United States of America for a period of more than 31 days, the maximum period of COBRA coverage which you may elect is 24 months, provided you notify the Fund Office in writing within 60 days of your entry into active uniformed service.

Disability extension of 18 month period of continuation coverage

If you or anyone in your family covered under the Plan 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
% Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN. 37070-1449
(800) 831-4914 TOLL FREE

Second qualifying event extension of 18 month period of continuation coverage

If your family experiences another qualifying period while receiving 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
Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN. 37070-1449
(800) 831-4914 TOLL FREE

If you have questions

If you have questions about your COBRA continuation coverage, you should contact Southern Benefit Administrators 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

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.

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.

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.

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 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.

HIPAA Certificate of Creditable Coverage Procedures

A. Automatic Issuance of a Certificate of Creditable Coverage. The Fund will issue a Certificate of Creditable Coverage automatically as required by federal law including, as follows:

(1) Exhaustion of Lifetime Limit. Individuals who lose coverage due to the operation of a lifetime limit on all benefits will receive the Certificate as soon as possible after a claim is denied due to the operation of the lifetime limit.

(2) COBRA Events. Individuals who lose coverage due to a COBRA qualifying event will receive the Certificate together with the required COBRA notices.

Individuals who lose coverage due to a COBRA qualifying event and elect COBRA coverage will receive two Certificates: one upon the occurrence of the qualifying event and one upon the termination of COBRA.

(3) Other Terminations of Coverage. Individuals who lose coverage but do not experience a COBRA qualifying event will receive the Certificate within a reasonable time after coverage ceases or after the expiration of any grace period for nonpayment of premium. For example, an individual who loses coverage upon the termination of COBRA coverage will receive the Certificate within a reasonable time after the termination of COBRA.

B. Requests for Certificates. Individuals may request a Certificate even if the Fund previously provided one, at any time while the participant is covered under the Fund (regardless of whether it is as an active or retired employee) and these requests may be made by phone or in writing (including by facsimile) as set forth below. Individuals may request a Certificate, even if the Fund previously provided one, up to 24 months after the individual's loss of coverage under the Fund and these requests must be in writing (including by facsimile). To request a Certificate an individual must send a request for a Certificate to the Fund administrative office as follows:

IBEW LOCAL 915 HEALTH AND WELFARE FUND
c/o Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN. 37070-1449

Telephone (800) 831-4914
Facsimile: (615) 859-4699

C. Delivery of Certificates. The Fund will send the Certificate by first class mail. If the Certificate is addressed and mailed to the participant and the participant's spouse at the participant's last known address, then the notice requirement will be satisfied with regard to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate Certificate will be provided to the dependent at the dependent's last known address.

Sample Participant Appeal

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

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

Re: Employee Name, SS#, Name of Dependent

Gentlemen,

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

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

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

Thank you for your consideration,

Sincerely,

_____ Sign