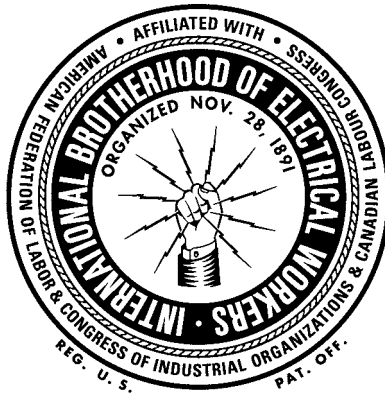


SUMMARY PLAN DESCRIPTION JOINT WELFARE FUND

LOCAL UNION NO. 164 I.B.E.W.



The Hudson, Bergen and Essex Division
of the Northern New Jersey Chapter
of the National Electrical Contractors Association

Amended and Restated Effective January 1, 2018

This is the Welfare Plan Document governing the Local 164 Welfare Plan

JOINT WELFARE FUND

LOCAL UNION NO. 164, I.B.E.W.

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**JOINT WELFARE FUND
LOCAL UNION NO. 164, I.B.E.W.**

425 Eagle Rock Ave., Suite 105
Roseland, New Jersey 07068

To All Participants

January 2018

Enclosed please find a restated Welfare Fund booklet (SPD), which provides an up-to-date description of your plan of benefits, including all plan changes through January 2018.

Your health benefit program continues to reflect the objective of the Trustees, which is to provide the best possible plan of benefits responsive to the needs of you and your family. To accomplish this, the Trustees maintain close supervision of the program in a constant effort to expand and add new coverage on the basis of employer contributions for hours worked, investment income generated on these contributions, and most importantly, need. However, the plan of benefits outlined in this booklet for both active and retired participants is not guaranteed and is subject to change at any time, based on prudent decisions made by the Trustees and supported by the Welfare Fund's professional advisors, which include legal counsel, consultants, actuaries and accountants.

The value of your benefit plan can be measured not only in terms of money, but also in the security and peace of mind that it brings. We urge you to read this booklet carefully so you may become thoroughly familiar with all the benefits available to you.

It is your responsibility to read the booklet and be aware of its contents. Our third-party Administrator is ready to answer any questions you may have and to assist you in any way possible. As always, if additional assistance is required, please contact the third party Administrator for the Joint Welfare Fund Office.

Please address any questions to:

Fabian & Byrn LLC

425 Eagle Rock Ave., Suite 105

Roseland, NJ 07068

Telephone: 877-228-4202 Fax: 973-228-4240

Sincerely,

BOARD OF TRUSTEES

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SCHEDULE OF BENEFITS PLAN A & PLAN B

Upon completing the eligibility requirements described on pages 1 and 2, the following benefits will be provided when medically necessary for eligible members covered by the current Collective Bargaining Agreement between the Northern New Jersey Chapter of the National Electrical Contractors Association and Local Union:

FOR PARTICIPANTS ONLY

MAXIMUM BENEFIT

Death Benefits\$50,000

Accidental Dismemberment Benefit

For the loss of both hands, both feet, both eyes or any two such members.....\$50,000

For the loss of one hand, one foot, or one eye.....\$25,000

For the loss of thumb and index finger of the same hand\$12,500

Weekly Disability Benefits

(In addition to New Jersey Temporary Disability benefits or Workers' Compensation)

For up to the full twenty-six (26) weeks of disability\$100

SCHEDULE OF BENEFITS PLAN A & PLAN B

FOR PARTICIPANTS, DEPENDENTS AND ELIGIBLE PENSIONERS AND THEIR DEPENDENTS UNDER AGE 65 (NOT ELIGIBLE FOR MEDICARE)

Benefit

In-Network

Out-of-Network

Hospital Benefits

see page 15

A pre-certification is required and penalty imposed for failure to pre-certify.

A pre-certification is required and penalty imposed for failure to pre-certify.

Daily Room and Board Benefit (Maximum 100 days per confinement)
See page 16

Full Coverage (100% of Allowable Charges) after \$200 Co-Payment

50% Coverage of fee schedule after \$200 Co-payment and out-of-network deductible has been met.

Miscellaneous Hospital Expenses (Maximum 100 days per confinement)
See page 19

Full Coverage (100% of Allowable Charges)

50% Coverage of fee schedule after the out of network deductible has been met.

Facility Outpatient Benefits and Ambulatory Surgical Centers
see page 17

Full Coverage (100% of Allowable Charges) after \$25 Co-Payment

50% Coverage of fee schedule after \$25 Co-payment and out-of-network deductible has been met.

Out of network pain management services are not covered.

Emergency Room Benefits
see page 18

Full Coverage (100% of Allowable Charges) after \$200 Co-Payment

100% of fee schedule after \$200 Co-Payment

Benefit	In-Network	Out-of-Network
Major Medical Benefits See page 19	Full Coverage (100% of Allowable Charges) after \$25 Co-Payment (Co-Payment does not apply to surgical, x-ray and laboratory treatment services).	50% Coverage of fee schedule after deductible with an annual \$2500 out-of-pocket expense (including deductible) per individual; 100% of coverage thereafter. Out of network pain management services are not covered.
Office Visits	Full Coverage (100% of Allowable Charges) after \$25 Co-Payment	50% Coverage of fee schedule after deductible. Out of network pain management services are not covered.
Podiatry	Full Coverage (100% of Allowable Charges) after \$25 Co-Payment	50% Coverage of fee schedule after deductible
Allergy Shots	Full Coverage (100% of Allowable Charges) after \$25 Co-Payment	50% Coverage of fee schedule after deductible
Anesthesia Services See page 21	Full Coverage (100% of Allowable Charges)	50% Coverage of fee schedule after deductible. Out of network pain management services are not covered.
Ambulance Services see page 21 for coverage limitations	90% Coverage of Allowable Charges	50% Coverage of fee schedule after deductible
Therapeutic Services/ Physical Therapy see page 21	Full Coverage of Allowable Charges after \$25 Co-payment	50% Coverage of In-Network Rates after deductible
Chiropractic/Acupuncture Services see page 22	Coverage for a maximum of 40 visits per calendar year to a legally qualified provider, up to \$50 per day	Coverage for a maximum of 40 visits per calendar year to a legally qualified provider, up to \$50 per day
Well Child Care Services see page 22	Full Coverage (100% of Allowable Charges)	50% Coverage of fee schedule after deductible
Adult Well Woman Care see page 22	Full Coverage (100% of Allowable Charges)	50% Coverage of fee schedule after deductible
Adult Well Man Care see page 22	Full Coverage (100% of Allowable Charges)	50% Coverage of fee schedule after deductible

Benefit	In-Network	Out-of-Network
Infertility Benefits see page 23	50% of Allowable charges for covered procedures	50% of fee schedule after deductible for covered procedures
Skilled Nursing Facility Benefits see page 24	Two days = 1 Hospital day. Full Coverage (100% of Allowable Charges). A precertification is mandatory	Two days = 1 Hospital day. 50% of fee schedule. A precertification is mandatory
Birthing Center Benefits see page 24	Full Coverage (100% of Allowable Charges) after \$200 Co-Payment	50% Coverage of fee schedule after \$200 Co-Payment and out-of-network deductible has been met
Home Health Care Benefits see page 24	100% Coverage of Allowable Charges after \$25 Co-Payment for a maximum of 8 hours per day and 240 hours per calendar year; must be provided by a Registered Nurse or Licensed Practical Nurse; requires pre-authorization	50% Coverage of fee schedule after deductible for a maximum of 8 hours per day and 240 hours per calendar year; must be provided by a Registered Nurse or Licensed Practical Nurse; requires pre-authorization
Durable Medical Equipment see page 25	Rental or purchase covered at 80% of Allowable Charges	Rental or purchase covered at 50% of fee schedule after deductible
Growth Hormone Therapy see page 26	Covered to a maximum annual allowance of \$10,000 and a maximum period of 3 years	Covered to a maximum annual allowance of \$10,000 and a maximum period of 3 years
Diabetic Supplies see page 26	90% Coverage of Allowable Charges for supplies. Global Pharmaceutical Benefits, LLC is the network provider for supplies	50% Coverage of fee schedule after deductible for supplies and 50% Coverage of fee schedule after deductible for education
	Education - 100% of Allowable charges apply after \$25 Co-payment	Education - 50% of fee schedule after deductible. Facility co-payment will apply.
Annual Physical Checkup see page 27	Full Coverage (100% of Allowable Charges) to a maximum allowance of between \$250 and \$400 depending on age and gender; Co-Payment does not apply	No benefit for non-network providers. You may use Adult Well Care services (see page III).

Benefit	In-Network	Out-of-Network
Private Duty Nursing Benefits see page 27	Must be provided by a Registered Nurse or Licensed Practical Nurse; requires pre-authorization. Full Coverage (100% of Allowable Charges) after \$25 Co-Payment. Maximum time for a nurse is 8 hours a day and calendar year hour maximum is 240 hours.	Must be provided by a Registered Nurse or Licensed Practical Nurse; requires pre-authorization. 50% Coverage of fee schedule after deductible. Maximum time for a nurse is 8 hours a day and calendar year hour maximum is 240 hours.
Mental Health and Substance Abuse Benefits		
see page 28		
Inpatient care	Full coverage 100% of allowable charge after a \$200.00 co-payment. Combined maximum of 100 inpatient days, partial hospitalization is covered as a 2:1 benefit. Pre-authorization required through Intervention Strategies	50% of the fee schedule after a \$200 co-payment and the deductible has been met. Combined maximum of 100 hospitalization Inpatient days, partial is covered as a 2:1 benefit. Pre-authorization required through Intervention Strategies
Outpatient care	Full Coverage (100% of Allowable Charges) after \$25 Co-Payment per visit.	50% Coverage of fee schedule after deductible.
Mental Health Prescription Drug Benefits	90% Coverage of the Allowable Charge	80% Coverage of the Allowable Charge
Hearing Aids see page 26	\$1500 for each ear every 3 years for purchase, and/or repair of hearing aid	\$1500 for each ear every 3 years for purchase, and/or repair of hearing aid
Pain Management Services	Full coverage (100% of allowable charges) after \$25 Facility or office visit	No coverage for any out of network pain management including professional services (the doctor), facility (the surgery center or hospital), anesthesia and/or any other related testing.

SCHEDULE OF BENEFITS PLAN A ONLY

FOR PARTICIPANTS, DEPENDENTS AND ELIGIBLE PENSIONERS AND THEIR DEPENDENTS UNDER AGE 65 (NOT ELIGIBLE FOR MEDICARE)

Benefit	In-Network	Out-of-Network
Prescription Drug Benefits see page 30 \$10 Surcharge on co-pays at CVS/Caremark pharmacies. \$5 Surcharge on co-pays at Walgreens/Duane Reade pharmacies.	100% Coverage of the Allowable Charge after \$15 generic/ \$25 brand co-payment. \$1,300 family maximum per calendar year. After \$1,300 maximum is met, reimbursement up to 80% of Allowable Charge.	100% Coverage of the Allowable Charge after \$15 generic/\$25 brand co-payment. \$1300 family maximum per calendar year. After the \$1300 maximum is met, 80% reimbursement up to Allowable Charge.
Vision Benefits see page 33	\$85 maximum for exam \$300 maximum for any combination of contact lens fitting, contacts, lenses and frames; coverage is once every 24 months.	\$85 maximum for exam \$300 maximum for any combination of contact lens fitting, contacts, lenses and frames; coverage is once every 24 months.
Dental Benefits See page 34 \$2,000 per family per benefit year.	100% of allowable charges	100% of fee schedule

SCHEDULE OF ADDITIONAL BENEFITS PLAN B ONLY

Upon completing two consecutive years of continuous eligibility as described in the section entitled “Eligibility Provisions”, the following additional benefits are furnished:

FOR PARTICIPANTS AND DEPENDENTS AND PENSIONERS AND THEIR DEPENDENTS (UNDER AGE 65)

Benefit	In-Network	Out-of-Network
Prescription Drug Benefits see page 30 \$10 Surcharge on co-pays at CVS/Caremark pharmacies \$5 surcharge on co-pays at Walgreens/Duane Reade pharmacies	100% Coverage after \$15 generic/ \$25 brand co-payment (at network pharmacies); \$5,000 family maximum per calendar year. After \$5,000 maximum is met, 80% reimbursement up to the Allowable Charge.	100% Coverage of the Allowable Charge after \$15 generic/\$25 brand co-payment. \$5000 family maximum per calendar year. After the \$5000 maximum is met, 80% reimbursement up to the Allowable Charge.
Vision Benefits see page 33	\$85 maximum for exam \$300 maximum per year for any combination of contact lens fitting, contacts, lenses and frames	\$85 maximum for exam \$300 maximum per year for any combination of contact lens fitting, contacts, lenses and frames
Dental Benefits See page 34 \$5,000 per family per benefit year.	100% of allowable charges	100% of fee schedule

SCHEDULE OF BENEFITS ELIGIBLE PENSIONERS AND THEIR SPOUSES OVER AGE 65

In order to qualify for pensioner benefits, a participant must satisfy the eligibility rules described on page 7.

The Welfare Fund will supplement the benefits provided by Medicare to the extent that the benefits paid by Medicare are less than the benefits that would have been paid by the Welfare Fund in the absence of Medicare, subject to the Joint Welfare Fund, Local Union 164, I.B.E.W. fee schedule and medical necessity and plan deductible. Effective 3/1/08 there will be an additional 30 day extension over the Medicare limits for inpatient facility stays if pre-authorized through Fabian & Byrn LLC. The phone number to call for pre-authorization is 877-228-4202.

In addition, the Fund provides a pensioner death benefit in the amount of \$5,000.

Pensioners receiving a pension benefit from Local 164 will receive health benefits under the Plan of benefits for which they were eligible.

Pensioners receiving a pension benefit from the former Local 52 pension plan and who were receiving health benefits under the former Local 52 health plan are covered under Plan A.

ELIGIBILITY

You will become a "Participant," which means you are eligible for benefits, if you are working in "Covered Employment." A Participant, for purposes of Welfare Fund eligibility, includes Electricians (and Apprentices); Union Office Staff, Residential Wiremen and Trainees. "Covered Employment" means employment covered under Collective Bargaining Agreements between Local Union No. 164 of the International Brotherhood of Electrical Workers (I.B.E.W.) and an employer obligated to contribute to the Joint Welfare Fund of Local Union No.164 I.B.E.W. A Participant also includes a prior Participant employed by a Contributing Employer in work not covered by a Local 164 Collective Bargaining Agreement, but for whom the Contributing Employer is obligated to contribute to the Welfare Fund pursuant to a Local 164 Alumni Participation Agreement.

INITIAL ELIGIBILITY

NOTIFICATION OF HOURS

You must notify the Fund Office upon your initial accumulation of the applicable hours for eligibility, as described below.

EMPLOYEES OF NEWLY ORGANIZED EMPLOYERS & APPRENTICES OF LOCAL UNION 164

Apprentices serving their apprenticeship in Local 164 I.B.E.W. and employees of newly organized employers. A "newly organized employer" is an employer that, on or after January 1, 2000, establishes a Collective Bargaining Agreement with Local 164 I.B.E.W.

Plan A

You will *initially* become a Participant after you have had contributions paid on your behalf for 100

hours of work in Covered Employment during a month at the specified prevailing Journeyman rate in the current Collective Bargaining Agreement between the Northern New Jersey Chapter of the National Electrical Contractors Association and Local Union No. 164, I.B.E.W. This includes employment with another I.B.E.W. jurisdiction if there is a Reciprocal Agreement with the Local 164 I.B.E.W. Plan. Eligibility will commence on the first day of the following month in which you fulfill the above contribution requirement.

To become eligible for benefits for the remainder of the year, you must have at least 100 hours of work for each month consecutively until you have a total of 500 hours. Once you have 500 hours you will be eligible for the remainder of that calendar year. Eligibility will be based on a “rolling” 500 hours. If you become an apprentice in Local 164 I.B.E.W. or are a “newly organized employee” and you cannot earn 500 hours in the remainder of the year, you can use “rollover hours” to maintain eligibility. Your hours and eligibility are rolled over to the next year. Once you have 500 hours you will be eligible for the remainder of that calendar year. Regardless of hours worked, a new member (apprentice or newly organized employee) must be in Plan A for two years before becoming eligible for Plan B.

“Rollover hours” only apply to a first year apprentice in the Local 164 IBEW or a newly organized employee.

If you are engaged in fewer than 100 hours of work in Covered Employment during a month after you have become eligible, but prior to accumulating a total of 500 hours, you will lose your eligibility and benefit coverage will terminate at end of the month in which you are engaged in fewer than 100 hours of work in Covered Employment.

For example:

You begin working in covered Employment on October 7, 2017. During the period between October 1, 2017 and October 31, 2017, you work 100 hours in Covered Employment, and your employer makes contributions to the Fund based on these hours at the specified prevailing Apprentice/Journeyman rate. You will initially become eligible under Plan A on November 1, 2017. In November you work 200 hours in covered Employment, in December you work 100 hours in covered Employment. At the end of December, the year to date hours you worked in covered Employment for 2017 would be 400 hours. In January 2018 you work 100 hours in covered Employment; the 400 hours from 2017 will be Rolled Over to 2018 making the total hours worked In Covered Employment 500 hours. You are now eligible for benefits for the remainder of the year (that is, until December 31, 2018) on the first day of February 2018 when your total hours in covered Employment amount to 500 hours.

ALL OTHER EMPLOYEES

Plan A

You will become eligible for Plan A benefits after you have had contributions paid on your behalf for 1200 hours of work in Covered Employment during a twelve consecutive month period at the specified prevailing Journeyman rate in the current Collective Bargaining Agreement between the Northern New Jersey Chapter of the National Electrical Contractors Association and Local Union No. 164, I.B.E.W.

These contributions must be accumulated within each of 12 consecutive months. Eligibility will commence on the first day of the month following the date you first have 1200 hours of work in Covered Employment. The Fund Office will provide you with an enrollment kit. You must complete and submit all appropriate enrollment forms to the Fund Office in order to become a Participant.

For example:

You begin working in Covered Employment on September 20, 2016. During the period between September 20, 2016 and August 20, 2017, you work 1200 hours in Covered Employment, and your employer makes contributions to the Fund based on these hours at the specified prevailing Journeyman rate. You will become eligible under Plan A on September 1, 2017.

Plan B

Upon retaining eligibility for 24 consecutive months of eligibility under Plan A (see “Maintenance of Eligibility” below), you and your dependents become eligible for additional benefits itemized in the Plan B Schedule of Benefits.

MAINTENANCE OF ELIGIBILITY

In order to maintain your eligibility for benefits under Plans A and B, you must have contributions paid on your behalf for 1,250 hours per calendar year at the specified prevailing Journeyman rate during the period covered by the current Collective Bargaining Agreement between the Northern New Jersey Chapter of the National Electrical Contractors Association and Local Union No. 164 I.B.E.W. or applicable rates as described in the eligibility requirements in this section.

Also, you must be actively seeking employment with Local Union #164, I.B.E.W. and must comply with the Drug Testing rules, regulations, and policies of Local Union #164. For purposes of maintaining eligibility, the calendar year ends with the last Sunday in December. This corresponds to the earnings year specified in the Collective Bargaining Agreement. However, you may maintain eligibility under the Hours Bank Program discussed below.

CONTINUING ELIGIBILITY - (“HOURS BANK PROGRAM”)

You are entitled to retain (or “bank”) your hours above the 1,250-hour requirement for maintenance of eligibility so that you may use them in later years when you do not have enough hours to maintain your eligibility. The first year for which an Hours Bank may be established begins on the January 1st following 5 continuous years of Plan coverage. In addition, you must have contributions paid on your behalf for more than 1,250 hours in a calendar year.

The Fund Office Staff will review hours worked each calendar year to determine which Participants worked more than 1,250 hours for eligibility purposes. A maximum of 500 hours can be banked each calendar year. Banked hours are permanent. They will not be lost unless they are used for eligibility purposes. You can continue to accumulate hours until a total of 5,000 hours are banked, which will allow for a maximum of 4 years of “banked benefits”.

Banked hours are applied to any year during which you would otherwise lose eligibility for Welfare

Fund benefits. In order to maintain eligibility, no more than 1,250 hours per calendar year will be allocated from your hours bank. You are entitled to retain (or “bank”) your hours above the 1,250-hour requirement for maintenance of eligibility so that you may use them in later years when you do not have enough hours to maintain your eligibility. If you do not have contributions for 1,250 hour you must use your banked hours to maintain coverage.

The Hours Bank can only be used for the purpose of maintaining eligibility while covered by a collective bargaining agreement with Local Union No. 164, I.B.E.W. or to provide benefits to early retirees anytime from their 55th birthday until their 59th birthday. You may not use your Hours Bank to maintain eligibility while you are self employed or employed by an organization that does not have a collective bargaining agreement with Local Union No.164, I.B.E.W.

Any contributions generated by employment outside the jurisdiction of Local Union No. 164 I.B.E.W. that are transferred to the Joint Welfare Fund of Local 164 pursuant to the I.B.E.W. National Reciprocal Agreement may be included in the Hours Bank to the same extent and using the same formula as would be applied for normal eligibility requirements. Reciprocal amounts will be converted into Local 164 Welfare Fund contribution amounts using the prevailing rate of contribution.

The record of Hours Bank will be maintained in the Fund Office. You may request a status report of your banked hours once a year (at no cost to you) by writing to the Fund Office. Additional report requests may result in an administrative charge to you by the Fund Office.

TERMINATION OF ELIGIBILITY

You will lose your eligibility for benefits on December 31 if, in the calendar year that ended, you had fewer than 1,250 hours of contributions – unless you have enough banked hours to bring you up to 1,250 total hours. In addition, when you were not working in Covered Employment, you were actively seeking work in Covered Employment and you can prove you were not working out of Covered Employment during that year.

You will also lose eligibility if at any time, regardless of hours worked, you are removed from the referral list for just cause, such as failure to comply with drug testing rules, regulations, and policies of Local Union #164. For additional information, see the referral agent.

The following periods shall **not** be counted in determining whether you have any employment for which contributions are made to the Welfare Fund:

- Periods during which you are disabled and receiving Workers’ Compensation benefits or benefits under the New Jersey Temporary Disability Act (up to 6 months).
- Credit for the first six months of disability shall be allowed on a basis of 30 hours a week.
- Credit for the second 6 months of extended disability on the same basis, if you are also collecting extended Short Term Disability Benefits.

REINSTATEMENT

If you lose eligibility under the rules set forth above, you will become eligible for benefits, again when you meet the following requirements to be reinstated. You will become eligible for benefits after you have had contributions paid on your behalf for 500 hours of work from Covered Employment, during the year; at the specified prevailing Journeyman rate in the current Collective Bargaining Agreement between the Northern New Jersey Chapter of Electrical Contractors Association and Local Union No. 164 IBEW. This includes employment covered by another I.B.E.W. plan. Only earnings from Covered Employment after the date of termination will be counted in determining whether you meet the requirements for eligibility.

Eligibility will commence on the first day of the month following the date you first have 500 hours of work in Covered Employment. You will be Reinstated to Plan A or Plan B under which you were last covered, provided that reinstatement to Plan B takes place within two years of termination.

If you have been terminated from the plan for three consecutive years and return to covered employment, your eligibility will be based on the rules for **EMPLOYEES OF NEWLY ORGANIZED EMPLOYERS.**

PENSIONER'S ELIGIBILITY

Participants who are receiving a pension from the Joint Pension Fund, Local 164, I.B.E.W., based on 20 or more pension credits and participants who are receiving a disability pension from that plan are eligible for the benefits shown in the Schedule of Benefits for Pensioners. However, a Pensioner must have been eligible for Welfare Fund benefits for 15 years of the 20 consecutive years immediately prior to the effective date of his or her pension. Eligible dependents of such Pensioners will also be eligible for these benefits. When participants retire, their medical coverage status as an active participant ceases immediately.

Retirees/Widows/Widowers Health Coverage Monthly Premium

Effective January 1, 2018, the amounts of the monthly premium for retiree health coverage are as follows:

For retirees not enrolled in Medicare Part A & B or another primary insurance, that are eligible for Welfare Fund benefits, the premium will now be:

- Single Coverage **\$150** per month, deducted from the Pension Benefit.
- Family Coverage **\$325** per month, deducted from the Pension Benefit.

The premiums will be automatically deducted from the pension benefit when possible. If you do not receive a monthly Pension Benefit, you must self-pay the premium.

Retirees under age 59 that do not have Welfare banked hours will pay the self pay rate in effect, in addition to the monthly premium.

For retirees enrolled in Medicare Part A & B or another primary insurance, that are eligible for Welfare Fund benefits, the premium will now be:

- Single Coverage **\$0.00** per month
- Family Coverage **\$25** per month

The premiums will be automatically deducted from the pension benefit when possible. If you do not receive a monthly Pension Benefit, you must self-pay the premium.

When you enroll in Medicare Part A & B or another *primary* insurance **we can only make the welfare premium adjustment when we are in receipt of a copy of your Medicare card or your primary insurance ID card.**

If a Retiree is eligible for Medicare Part A & B or another *primary* insurance and the spouse is not, the monthly welfare premium will be a combination of the single rates listed above plus \$25. The same will hold true if the retiree is ineligible for Medicare but the spouse is enrolled in Medicare Part A & B or another *primary* insurance.

Furthermore, a single participant who gets married will be charged the amount for Family. In addition, a participant who becomes single, the premium will be calculated under single coverage.

If you have primary insurance (other than the Joint Welfare Fund of LU #164 or Medicare) and it ceases, and you or your spouse are under 65 years of age, have not opted out of the Joint Welfare Fund, and are paying the applicable retiree health premium, you would be eligible to return to primary insurance with the Joint Welfare Fund of LU #164 and pay the monthly primary premium.

For Pensioners collecting a benefit, other than the Husband/Wife options, where the surviving spouse may not collect a pension benefit upon the death of the member, the surviving spouse will still be required to pay a premium during the 5 years of continued health plan coverage. Failure to make the premium payment will result in coverage being terminated.

Coverage of “disability pensioners” (participants who are receiving a pension from the Joint Pension Fund, Local 164, I.B.E.W. without the requirement of a Social Security disability award) who are receiving a pension based on 20 or more pension credits and participants who are receiving a “disability pension” (a pension payable upon the receipt of a social security disability award) from that plan are eligible for the benefits shown in the Schedule of Benefits for Pensioners. However, a Pensioner must have been eligible for Welfare Fund benefits for 15 years of the 20 consecutive years immediately prior to the effective date of his or her pension. If you do not have a full complement of bank hours, the retiree health premium outlined above (for retirees effective on or after January 2006) will be in addition to the current cost of the self-payment. The premiums will be automatically deducted from the pension benefit when possible.

DEPENDENT ELIGIBILITY

Your dependents will be eligible for benefits on the same date as you. Eligible dependents include:

- your lawful spouse and your dependent children from birth up to twenty-six years of age;
- Same sex partner recognized under state-mandated civil unions;

- an adopted child or a child placed for adoption with you provided the child is dependent on you for support and maintenance. Stepchildren and foster children are also eligible for coverage if they are solely dependent on you for support.

When a claim is submitted on behalf of a stepchild, an adopted child or a child placed for adoption, or a foster child, please include an affidavit that such child is dependent on you for support and maintenance (stepchildren and foster care children must be *solely* dependent on you for support and maintenance). In addition, please submit a copy of the Divorce Agreement or the Death Certificate concerning stepchildren. The Fund Office will furnish you with an appropriate form upon request.

Obligation to verify dependent status:

In addition to satisfying these requirements, a condition of eligibility is that you must supply any information that is reasonably requested in order to determine his or her dependent benefit rights. This includes completion of the enrollment card that is kept on file in the Fund Office, marriage certificate, birth certificates and civil union license or certificate, or the equivalent. Failure to supply necessary information may cause a delay in the processing of claims.

SPECIAL ENROLLMENT FOR YOUR ELIGIBLE DEPENDENTS

If you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption, you may enroll your newly acquired spouse and/or dependent child(ren) no later than 30 days after the date of marriage, birth, adoption, or placement for adoption.

If you **did not enroll your spouse for coverage within 30 days of the date he or she became eligible for coverage**, and if you subsequently acquire a dependent child by birth, adoption, or placement for adoption, you may enroll your spouse together with your newly acquired dependent child no later than 30 days after the date of your newly acquired dependent child's birth, adoption or placement for adoption.

WHEN COVERAGE BEGINS FOLLOWING SPECIAL ENROLLMENT

- Except for coverage of a newborn or newly adopted dependent child, your spouse's coverage and/or that of any other dependent child(ren) will become effective on the date of the event creating the special enrollment opportunity.
- Coverage of a newborn or newly adopted dependent child who is enrolled no later than 30 days after birth will become effective as of the date of the child's birth.
- Coverage of a newly adopted dependent child who is enrolled later than 30 days after the adoption or placement for adoption will be effective as of date of the adoption or placement for adoption, whichever occurs first.

However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

WHEN YOUR SPOUSE OR DEPENDENT CHILD(REN) LOSE OTHER COVERAGE

If:

- you did not enroll your spouse and/or any dependent child(ren) for coverage when they first became eligible for coverage because they had health coverage under any other health insurance policy or program or employer plan; **and**
- your spouse and/or any dependent child(ren) cease to be covered by that other health insurance policy or plan; you may enroll your spouse or dependent child(ren) no later than 30 days after the termination of their coverage under that other health insurance policy or plan, if that other coverage terminated because:
- of the loss of eligibility for that other coverage because of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation; or
- of the termination of employer contributions towards that other coverage; or
- it was COBRA Continuation Coverage, and it was “exhausted”.

COBRA Continuation Coverage is “exhausted” if it ceases for any reason other than cause (for example, making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA;
- or because the 18-month or 36-month period of COBRA Continuation Coverage has expired.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

According to federal law, a Qualified Medical Child Support Order (QMCSO) is a child support order of a court or state administrative agency that usually results from a divorce or legal separation, that has been received by the Plan, and that:

- designates one parent to pay for a child’s health plan coverage;
- indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- contains a reasonable description of the type of coverage to be provided under the designated parent’s health care Plan or the manner in which such type of coverage is to be determined;
- states the period for which the QMCSO applies;
- identifies each health plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Fund to provide any type or form of benefit or any option that the Fund does not otherwise provide, or if it requires a person who is not covered by the Fund to provide coverage for a Dependent Child, except as required by a state's Medicaid related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any of the participant's Dependent Children, the Fund Director or its designee will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the participant, the other parent, the child, and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the participant is covered by the Fund, the Fund Administrator or its designee will so notify the parents and each child, and advise them of the Fund's procedures that must be followed to provide coverage of the Dependent Child(ren).

No coverage will be provided for any dependent child under a QMCSO unless the applicable contributions for that dependent child's coverage are paid, and all of the Fund's requirements for coverage of that dependent child have been satisfied.

A copy of the Fund's QMCSO procedures is available at the Fund Office upon request.

SPECIAL CIRCUMSTANCES

FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- the birth, adoption, or placement with you for adoption of a child;
- to provide care for a spouse, child, or parent who is seriously ill; or
- your own serious illness.
- During your leave, you can continue all of your medical coverage and other benefits offered through the Fund. You are generally eligible for a leave under the FMLA if you:
 - have worked for a covered employer for at least 12 months;
 - have worked at least 1,250 hours over the previous 12 months; and
 - work for an employer that employs at least 50 employees within 75 miles of the location at which you work.

The Fund will maintain the employee's eligibility status until the end of the leave, provided the contributing employer properly grants the leave under the FMLA and the contributing employer makes the required notification to the Fund. Call your employer to determine whether you are eligible for FMLA leave. Call the Fund office if you have questions about the continuation of medical coverage.

If you do not return to covered employment after your leave ends, you are entitled to COBRA Continuation Coverage, as outlined on page 63.

MILITARY LEAVE

If you are on active duty for 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on active duty for more than 31 days, USERRA permits you to continue medical and dental coverage for you and your dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA. See page 63 for a full explanation of the COBRA coverage provision, which will allow you to continue your medical and dental coverage.

In addition, your dependent(s) may be eligible for health care coverage under the Civilian Health & Medical Program of the Uniformed Services (CHAMPUS). This plan will coordinate coverage with CHAMPUS.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from “service in the uniformed services,” your full eligibility will be reinstated on the day you return to work with a Participating Employer, provided that you return to employment within:

1. ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or
2. fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (180) days; or
3. at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

Questions: If you have any questions about taking a leave, please speak directly with your employer. If you have any questions about how a leave of absence affects your benefits, please contact the Fund Office. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

HOW TO FILE A MEDICAL CLAIM

(FOR OUT-OF-NETWORK BENEFITS)

1. You may access claim reimbursement forms online at www.ibew164.org or by writing or calling Fabian & Byrn LLC.
2. If you have paid the out-of-network medical provider in full, attach a detailed receipt from the provider's office to our claim form, showing payment has been made to the provider. If the non-participating provider has not collected payment from you, they need to submit the claim to their local Blue Cross Blue Shield plan.
3. All member reimbursement claim forms must be mailed to:
Fabian & Byrn LLC, 425 Eagle Rock Avenue, Suite 105, Roseland, NJ 07068
4. Originals (copies should be kept for your personal files) of all member paid claims such as your physician, hospital and laboratory bills, should be sent to Fabian & Byrn LLC.
5. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.
6. All claims must be filed no later than one year from the date the service was rendered.
Any claims submitted more than twelve months after the service was rendered for payment will not be honored for payment by the Joint Welfare Fund and will be the member's responsibility.

(FOR IN NETWORK CLAIMS)

1. The provider must submit claims to their local Blue Cross Blue Shield Plan.
2. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.
3. All claims must be filed no later than one year from the date the service was rendered.
Any claims submitted more than twelve months after the service was rendered for payment will not be honored for payment by the Joint Welfare Fund and will be the member's responsibility.

For all submitted claims:

The Joint Welfare Fund has the right of recovery under the following circumstances:

1. when benefit payments are made in reliance on any false or fraudulent statement, information, or proof submitted by a claimant;
2. when benefit payments are made in error (e.g. when the Joint Welfare Fund is not aware that charges are related to an automobile or motorcycle accident);
3. when the amount of the benefit payments made by the Fund is more than it should have been;
4. when benefit payments are made in advance to assist when you or your covered dependent incurs medical expenses as a result of an accident or illness for which payment may be

available from another source. (See provisions set forth in chapter entitled “Reimbursement and Subrogation.”)

5. If it is discovered that benefit payments were made in reliance on any false or fraudulent statements, information or proof, all previous claims submitted will be subject to a comprehensive audit to determine appropriateness of past payments. Any payments made in excess of the appropriate payment schedule will be repaid immediately by you or recouped from any future claim payment made to you by the Joint Welfare Fund. The Fund may also criminally prosecute you. In addition, the Joint Welfare Fund has a program of periodic random claim audits to detect fraud.

NOTE: Processing of a claim may be held up if a complete, up-to-date enrollment card is not on file with the Fund Office.

Non Assignability of Benefits

The Plan may, in its sole and exclusive discretion, make direct payments to a provider of your medical services. However, except as applicable law may otherwise require, no amount payable for benefits here under shall be subject in any matter to alienation by assignment of any kind. Any attempt to assign any such amount whether present or hereafter payable, shall be void. If payment is made directly to you it would be your responsibility to pay the provider.

In accordance with the Plan’s claims and appeals procedures, the Plan will allow a personal representative (including a provider), authorized by a Participant or beneficiary, to act on their behalf for claims and appeal purposes only. The Plan’s recognition of such personal representative for this purpose shall not be construed as a waiver of the Plan’s prohibition against assignments as indicated above.

WHAT TO DO IF YOU AND/OR YOUR COVERED DEPENDENT IS INVOLVED IN AN ACCIDENT/INCIDENT

If you and/or your covered dependent is involved in an accident/incident, you must immediately notify Fabian & Byrn LLC and supply the following information:

1. date of accident/incident;
2. type of accident/incident (i.e. automobile, motorcycle, fall down, assault, medical/dental malpractice, dog bite, self-inflicted, etc.);
3. name, address and telephone number of your attorney, if any;
4. body parts affected as a result of the accident/incident (i.e. back, neck, head, etc.);
5. name and address of any other party or insurance company, which may be financially responsible for the injury or illness, including name and telephone number of representative assigned to your or your covered dependent’s claim;
6. names of any and all providers that have rendered medical treatment.

If you have been injured in an automobile accident, please advise your provider that the Joint Welfare Fund of Local 164 will not cover medical expenses incurred as a result of an automobile accident where state Personal Injury Protection (PIP) insurance is available. (See pages 37 and 49.)

If you have been injured in a motorcycle accident, please advise your provider that the Joint Welfare Fund of Local 164 will not cover any charges incurred as a result of a motorcycle accident. (See page 38.)

Also, please refer to page 50 entitled “Reimbursement and Subrogation”.

PROVIDERS/ELIGIBLE MEDICAL EXPENSES

PROVIDERS

You have the option of receiving your medical care from a hospital or physician participating in a network of providers, or from any non-participating hospital or physician (with the exception of pain management services). Providers participating in a network have agreed to charge reduced rates (referred to as “Allowable Charges”, defined in the Glossary at the end of this booklet) for their services to participants using the network. If you choose an in-network provider, you can incur minimal or no out-of-pocket health care expenses.

Non-participating providers have made no similar agreement to charge reduced rates. Therefore, you must pay the non-participating provider any amount he or she charges which exceeds the amount the Plan covers (see “Eligible Medical Expenses” below).

ELIGIBLE MEDICAL EXPENSES

The Plan covers most medical services and supplies that are determined by the Trustees or their designees to be “Medically Necessary” (defined in the Glossary at the end of this booklet).

Eligible participating medical expenses are generally covered at 100% of Allowable charges after a co-pay is applied.

Eligible non-participating medical expenses are generally covered at 50% of the Local Union 164 I.B.E.W. Fee Schedule after the deductible has been met.

From time to time, the Fund may use professional medical organizations to determine if health care services are Medically Necessary. If the services do not meet the standards of medical necessity noted above, the expenses related to those services will not be deemed necessary treatment and will not be reimbursed by the Fund.

NETWORKS

Participants who reside in New Jersey may choose providers participating in the Horizon Blue Cross Blue Shield of New Jersey Direct Access Hospital Network and Direct Access network of professionals.

Participants who reside outside New Jersey may choose providers participating with Blue Card PPO. Benefit coverage is the same for each network.

Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ)

The Horizon Hospital Network provides extensive coverage throughout New Jersey which is currently comprised of 77 facilities at 96 locations. The Horizon Direct Access network is currently comprised of over 30,000 professionals.

Blue Card PPO

Blue Cross Blue Shield provides coverage throughout most of the continental United States. This network can be accessed through the website www.bcbs.com

***It is important to know your alpha prefix is ISC.

Provider Credentials

Both Horizon BCBSNJ and Blue Card PPO conduct thorough evaluations on hospitals and physicians prior to including them in their networks to ensure the highest standard in quality care. Hospitals in the network must have an appropriate location and available mix of services based on members' demographic and geographic distribution. Physicians must meet strict credentialing standards, such as state licensure and Board certification.

Changes in the Networks

It is important to note that additions to and deletions from both the Horizon BCBSNJ and Blue Card PPO networks happen constantly. **You should pay close attention to any notices of changes to the network that the Fund provides.** Additionally, you may obtain current information anytime on whether a provider participates in the network appropriate for you through the Internet at the following websites:

Horizon BCBSNJ: www.horizonblue.com or 1-800-810-2583

Blue Card PPO: www.bcbs.com

Neither website requires a password, but it is important to know your alpha prefix is ISC.

ONLINE ACCESS TO EXPLANATION OF BENEFITS AND CLAIMS HISTORY

The Local 164 website (www.ibew164.org) has a link that will allow you to check your medical and HRA (Health Reimbursement Account) claims history and print EOB's (explanation of benefits) and view your HRA balance and statements as needed. Your website user name will be the unique ID number from your Horizon BCBS card but without the 74 after ISC. For example: ISC741234567 will be a website user name of ISC1234567.

Here's how it works, go to the:

LOCAL 164 WEBSITE: www.ibew164.org (click on links)

CLICK ON: ABOUT US (choose Benefits Office)

Click on: IN THIS SECTION; Welfare Fund CLICK ON: e-benefit (check your claims)

YOUR WEBSITE USERNAME: Your Unique ID (Horizon BCBS ID#)

YOUR WEBSITE PASSWORD: Available upon request at 877-228-4202

Review all of the options on the site. Once you add your email information to the site the system will automatically notify you whenever a new claim is processed.

We strongly suggest that you change your password upon your first login. If you have any questions, please call Fabian and Byrn at 1-877-228-4202.

HOSPITAL BENEFITS

Hospital benefits are payable during confinement as a patient in a legally authorized hospital when recommended by a legally qualified physician. Institutions such as clinics, nursing homes, places of rest for the aged, and those operated primarily as schools, do not qualify as hospitals.

Hospital/Surgical Pretreatment Certification

Blue Cross Blue Shield (BCBS) administers our utilization management programs. These programs include pre-certification review, concurrent review, discharge planning, case management, hospice care and patient education.

For purposes of this paragraph, the following definitions apply:

Pre-certification review: A review by BCBS of the information regarding your condition prior to your receipt of treatment for that condition. You or your physician must contact BCBS at 1-800-664-2583 for pre-certification for **all** inpatient admissions regardless of whether a network or non-network provider is being used.

When you or your physician call BCBS, you or your physician will speak with a clinical screener who will ask questions about your condition. The screener will also ask for some personal information, such as your name, age, address, and insurance information. This information will be kept in strict confidence, and, beyond information required to process your claim, will not be shared with anyone affiliated with this Plan. Once it reviews the information regarding your condition, BCBS recommends appropriate services and facilities for the treatment of that condition. If you are admitted under emergency conditions, you or your physician must call BCBS within 48 hours of your admission.

The in-patient hospital co-payment is \$200.00. If you are admitted to the Hospital, through the Emergency Room, the Emergency Room co-payment is waived but the inpatient co-payment will still apply.

Case management: a program that coordinates care for individuals who require post-hospital services, either on a short-term or long-term basis.

Discharge planning: case management on a short-term basis (six or fewer weeks).

Patient education: a program of education on health issues which provides personalized, accessible information on a confidential basis through the Internet, as well as through a proactive management approach.

Hospice Care: a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit.

FAILURE TO OBTAIN AN APPROVAL FROM BCBS BEFORE SERVICES ARE PERFORMED COULD RESULT IN A 50% BENEFIT REDUCTION.

If a patient discharges themselves against medical advice, the claim will not be covered by the Fund.

SEMI-PRIVATE DAILY ROOM AND BOARD ALLOWANCE

For each day you or your eligible dependent is confined in a legally authorized hospital in a semi-private room, on the recommendation of a legally qualified physician, the Fund will pay an amount charged by the hospital for room and board for a maximum of 100 days per confinement.

The Fund will pay the full amount of Allowable Charges after a \$200 co-payment if your confinement is with an in-network Hospital, and 50% of fee schedule after a \$200 co-payment and out-of-network deductible has been met if your confinement is with an out-of-network Hospital. This 100-day maximum includes confinements for maternity care and organ transplants and includes days in intensive hospital care. It also includes inpatient days for behavioral health and substance abuse treatment.

Confinements in hospitals separated by fewer than 14 days are considered as having occurred during one continuous period of disability, unless the second confinement is due to an entirely different disability.

*Please note: Out-of-network hospital charges are not applied to the out-of-pocket limit.

MISCELLANEOUS HOSPITAL EXPENSES

In addition to the daily benefit for semi-private room and board, a benefit will be paid for up to 100 days per confinement for other necessary services and supplies furnished by the hospital and not included in the room charge. The Fund will pay the full amount of Allowable Charges if your confinement is with an in-network Hospital, and 50% of the fee schedule after deductible, if your confinement is with an out-of-network Hospital.

For purposes of this subsection, other necessary services and supplies are services provided by a hospital other than room and board, including, but not limited to, use of the operating room, recovery room, intensive care unit, and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

MATERNITY HOSPITAL STAYS

The maximum benefit payable for hospital and major medical expenses related to maternity is the same as for hospital and major medical expenses not related to maternity.

This plan complies with federal law that prohibits group health plans and health insurance issuers from restricting benefits for any hospital length of stay in connection with childbirth for the mother

or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

It is possible that a hospital facility that provides in-patient benefits is in-network while the physicians performing services at that facility are out-of-network. If you receive services from an out-of-network provider at an in-network facility, those services are deemed to be out-of-network. The only exception will be that the Joint Welfare Fund will pay to the out-of-network providers a fee, not to exceed \$500 for state-mandated hearing tests for newborn children.

HOSPITAL/FACILITY OUTPATIENT BENEFITS

Hospital/Facility Outpatient Benefits are benefits such as routine medical care, hospital services, and pre-admission testing, that you receive in the outpatient department of a hospital or facility.

In-Network: In-Network facility outpatient benefits are payable at the rate of 100% of the Allowable Charges, after a \$25 co-payment. In-Network outpatient services provided in an outpatient surgical center that is not a hospital facility are covered services.

Out-of-Network: Out-of-Network facility outpatient benefits are payable at the rate of 50% of the fee schedule, after the co-payment of \$25 and the out-of-network deductible have been met. Out of Network outpatient services provided in an outpatient surgical center that is not a hospital facility are covered services (with the exception of out of network pain management services). Benefits at such a facility are provided at 50% of fee schedule, after a \$25 co-payment and the deductible have been met.

*Please note: Out-of-network facility charges are not applied to the out-of-pocket limit.

INPATIENT AND OUTPATIENT FACILITY BENEFITS

It is possible that a hospital facility or surgical center that provides benefits is in-network, while the physicians performing the services at such facility or center are out-of-network physicians. If you receive services from an out-of-network physician at such facility or center, it is deemed that you received out-of-network physician services.

BE SURE TO CHECK YOUR PROVIDER DIRECTORY IN ADVANCE TO ASCERTAIN THE NETWORK STATUS OF THE PHYSICIANS AT ANY HOSPITAL FACILITY OR SURGICAL CENTER YOU PATRONIZE.

For purposes of this subsection, pre-admission testing encompasses laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis before a scheduled Hospital admission or outpatient surgery.

Emergency Medical Treatment

An allowance is payable only for expenses incurred in relation to the use of a hospital outpatient department for Emergency first aid treatment within 24 hours after the onset of an injury or illness requiring such treatment. The allowance also includes the use of the operating room facilities of the hospital for surgical operations.

This benefit does not cover incidental, routine or periodic physical examinations; pre-marital or similar examinations; or services not required in, or directly related to, the diagnosis of an emergency illness or injury.

- The use of the above-stated facilities of an in-network hospital is covered in full up to Allowable charges, subject to a \$200 co-payment.
- The use of the above-stated facilities of an out-of-network hospital is covered at 100% of the fee schedule, subject to a \$200 co-payment.
- If you are admitted into the Hospital, the Emergency Room co-payment will be waived but the inpatient hospital co-payment will apply.

Emergency first aid treatment within 24 hours after the onset of an injury or illness requiring such treatment is covered in full up to the Plan's fee schedule for expenses for out of network physician services and expenses for x-rays and laboratory tests.

Women's Health and Cancer Rights Act of 1998

This plan complies with the federal law that provides that group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient, for:

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

This coverage is subject to the plan's annual deductibles and coinsurance provisions.

MAJOR MEDICAL BENEFITS

Major Medical benefits are designed to pay medical or surgical expenses for you and your eligible dependents that are not provided or are limited under other sections of the Plan provisions.

DESCRIPTION OF BENEFITS

In-Network

Covered Major Medical Benefits, as described on page 20, are covered up to Allowable Charges, after application of the co-payment.

When you use a network provider, simply present your ID card at the time of your visit and pay the applicable co-payment. You will not have to file a claim form with respect to this visit.

The Co-Payment

The office visit and outpatient facility co-payment is \$25. The co-payment for Emergency room and in-patient hospital admissions is \$200.

You also have the option of using participating diagnostic and lab providers. This arrangement entitles you to full coverage for their services—there are no out-of-pocket expenses to you when you use these providers.

Out-of-Network

Unless otherwise stated, Covered Major Medical Benefits described below are covered at 50% of fee schedule, after application of the deductible.

The total out-of-pocket expense including the deductible for each individual during a calendar year is limited to \$2500, based on the fee schedule..

When you use a non-participating provider, you must follow the claim procedures discussed in the section entitled “How to File a Claim.”

The Deductible

When you use an out-of-network provider, you must pay the first \$500 of allowed charges based on the fee schedule for medical expenses incurred in a calendar year before any covered expenses are subject to reimbursement. This “cash” deductible applies for you and **each** of your eligible dependents.

OUT-OF-POCKET LIMIT

For in-network services, you pay the applicable co-payment with no lifetime maximum.

For out-of-network services, you pay the \$500 calendar year deductible and 50% of the first \$4,000.00 of the fee schedule allowance (\$2,000) for the calendar year, or \$2,500 total. Your subsequent expenses will be reimbursed at 100% of the fee schedule.* You also pay any amount in excess of the fee schedule allowance. This amount does not count toward your out-of-pocket limit.

*Please note: Out-of-network facility charges are not applied to out-of-pocket limit.

Timely Filing Limit

For the proper administration of this Fund, it is requested that all claims be submitted for payment within 90 days of the service date. However, any claim submitted after one year from when the claim was incurred, will not be honored for payment.

If additional information was requested to process a claim and that information was not received within the one year timely filing deadline, payment will not be honored for payment by the Joint Welfare Fund.

COVERED MAJOR MEDICAL BENEFITS

You are covered for the following medical care and services, if medically necessary and ordered by a physician:

Physician Services

Charges for diagnosis, treatment and surgery by a physician for non-occupational bodily injury or disease, including rendering of a second opinion for contemplated elective surgery.

Inpatient

Benefits are payable for procedures performed by a legally qualified physician in a hospital. The co-payment does not apply to any inpatient physician services.

Outpatient

Benefits are payable for services and procedures performed by a legally qualified physician in the outpatient department of a hospital, an office or home. The co-payment does not apply to outpatient physician services involved in providing x-ray/laboratory services .

Surgical Services

A surgical service is any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan Benefits.

Assistant surgeon and co-surgeon services will be reviewed for medical appropriateness and correct billing and coding guidelines. Joint Welfare Fund, Local Union No. 164 I.B.E.W. allows 20 % of the fee schedule for assistant surgeons and 62.5 % of the fee schedule for co-surgeon claims.

Maternity Care Services: The member or spouse is covered for all Medically Necessary obstetrical and maternity care services, including:

- Amniocentesis or chorionic villus sampling (CVS),
- Expenses of one childbirth course per pregnancy, if the course is provided at a participating facility.
- Termination of pregnancy, when the attending physician certifies that the pregnant woman's

health would be endangered if the fetus were carried to term, or that the child would be born with significant congenital deformities or defects.

Anesthesia Services: Full coverage (100% of allowable charges) for the administration of anesthesia, for in-network providers and 50% of the fee schedule for out-of-network providers after the deductible.

When the participant uses an out-of-network anesthesia provider because there was no network provider that could have been used, as determined by the Fund Director or its designee, this Plan will pay 100% of the fee schedule for this service, if the surgeon and facility were both participating.

Nursing Services: Charges made by a Registered Nurse or by a Licensed Practical Nurse if a Registered Nurse is not available and if recommended by a Physician. Pre-authorization by Horizon BCBSNJ is required. Benefit limit is 240 nursing hours per year and no more than 8 hours in a day.

Ambulance Services: Charges for local ground ambulance service, at 90% of Allowable Charges for in-network providers and 50% of the fee schedule for out-of-network providers, after satisfaction of the deductible.

Professional ambulance service to or from a local eligible facility from the place of injury or illness is covered. Only surface transportation is covered. The Fund will not pay for an air or sea ambulance.

Ambulance service for outpatient care of a non-accidental illness, such as an outpatient dialysis session, is not covered.

Physical Therapy: Charges are covered for physical therapy services, at the following rates:

In-Network:

Full Coverage of the Allowable Charge, after a \$25 Co-Payment.

Out-of-Network:

50% of the Joint Welfare Fund's Participating Providers rates, after the deductible.

Physical Therapy (PT) Claims will only be approved for payment if the member submits a copy of the physical therapy prescription written by a medical doctor. This script must provide the course of treatment. Any physical therapy claims submitted without the requested information stated above will be declined for payment.

Please note that Non-Participating Physical Therapy Providers will be reimbursed at 50% of the Joint Welfare Fund's Participating Providers rates.

Other non-psychiatric therapeutic services: Charges are covered for medically necessary services.

In Network:

Full coverage of the allowable charge after a \$25 co-payment.

Out of Network:

50% of fee schedule after the deductible.

Chiropractic and Acupuncture Services: For both in-network and out-of-network providers, charges are covered for a combined benefit of 40 visits per calendar year to a legally qualified chiropractor or acupuncturist, up to \$50 per visit. This benefit is not subject to the co-payment, where a network provider provides services, nor the deductible, where an out-of-network provider provides services. Member balances are not applied towards the out-of-pocket maximum.

If a claimant receives chiropractic/acupuncture care & physical therapy at the same facility on the same day only the chiropractic/acupuncture claim would be eligible for reimbursement. The physical therapy services will be denied, thus being the member's responsibility.

Well Child Care: We will cover well care and immunizations for your enrolled child. This includes routine physical exams and immunizations regardless of medical necessity.

In-Network:

Full coverage of the Allowable Charge.

Out-of-Network:

50% of the fee schedule after the deductible.

Routine Adult Visits:

Adult Well Woman Care:

You are covered as described below for the following services, if you are age 18 or older:

1. One gynecology examination and pap smear laboratory test per year.
2. A screening mammogram and interpretation of it:
 - Age 35-40 one baseline mammogram
 - Age 41-49 once every one or two years
 - Age 50 and up annually.
 - Additional mammograms that are Medically Necessary because of the patient's condition, subject to all other Plan provisions, including the deductible, coinsurance, co-payment and Exclusions provisions.

In-Network:

Full coverage of the Allowable Charge. No co-pay for In-Network mammography.

Out-of-Network:

50% of the fee schedule after the deductible. Out-of-Network facility co-pays apply.

Adult Well Man Care:

You are covered as described below for the following Adult Well Man Care Services, if you are age 50 or older:

1. One digital rectal examination per year, including a Prostatic Specific Antigen (PSA) blood test.
2. Additional diagnostic examinations and tests that are Medically Necessary because of the

patient's condition, subject to all other Plan provisions, including the deductible, coinsurance, co-payment and Exclusions provisions.

In-Network:

Full coverage of the Allowable Charge.

Out-of-Network:

50% of the fee schedule after the deductible.

Vasectomies and Tubal Ligations: Charges for vasectomies and tubal ligations are covered as described below. These procedures can be performed in a physician's office, an outpatient surgical center or in a hospital. Treatment must conform to hospital outpatient requirements. If inpatient hospitalization is not required for the procedure, you will not be covered for such hospitalization. Please check with your physician regarding which setting is best for your treatment.

*No co-payment on vasectomies or tubal ligations.

In-Network:

Full coverage of the Allowable Charge.

Out-of-Network:

50% of the fee schedule after the deductible.

Treatment of Infertility: Charges for the testing and treatment of infertility will be covered. However, all high-tech reproductive techniques and related expenses for services will be excluded from eligible coverage. Expenses for services, drugs and procedures related to but not inclusive of in-vitro fertilization, low tubal transfer, embryo transfer, zygote transfer, donor semen and reversal of sterilization procedures are not eligible for reimbursement. If you are not sure if a service or procedure is considered a high tech reproductive procedure, have your medical provider submit a written request for a determination by Fabian & Byrn LLC. Member balances are not applied towards the out-of-pocket maximum.

For all eligible claims, the Joint Welfare Fund will be responsible for 50% of the allowable charge for in network providers and will be subject to the normal major medical provisions. All claims from out of network providers will be paid at 50% of the fee schedule, subject to the annual deductible.

MAJOR MEDICAL BENEFITS LIMITATIONS AND EXCLUSIONS

In addition to the overall plan limitations outlined on page 36, specific exclusions or limitations apply to the Major Medical Benefits portion of the plan for the following expenses:

- Charges incurred due to dental work or treatment or dental x-rays including extraction of wisdom teeth, except as required because of accidental injury to sound natural teeth, or the necessity of oral surgery (except for the removal of wisdom teeth, which is only covered under the dental plan) ;
- Charges incurred due to eye refractions, eyeglasses or the fitting thereof;

- Charges for prescription drugs;
- Charges for growth hormone therapy, except as noted in the Plan;
- Charges for drug testing; and
- Out of network pain management services

ADDITIONAL MEDICAL BENEFITS

The following benefits are covered under this Plan, but are subject to a variety of co-payments and limits.

SKILLED NURSING FACILITY BENEFITS

You are covered for confinement in a Skilled Nursing Facility where confinement in such facility occurs no later than 48 hours after a confinement in a Hospital for a period of at least 5 days. See the definition of Skilled Nursing Facility in the Glossary at the end of this booklet.

If you wish confinement in a Skilled Nursing facility occurring later than 48 hours after a confinement in a Hospital for a period of at least 5 days, you must obtain pre-authorization.

This benefit requires the care management services of BCBS.

Each two-day period of confinement in a Skilled Nursing Facility counts as one hospital day.

Coverage includes charges for room (not exceeding the average daily semi-private room rate) and board; including special diets and general nursing services. Confinement in a Skilled Nursing Facility must be recommended by a Physician for an illness or an injury. The facility must be under full time supervision of a Physician or Registered Nurse. For approved services, you are covered up to allowable charges for in network providers and at 50% of the fee schedule after the deductible for out-of-network providers.

BIRTHING CENTER BENEFITS

The member or spouse is covered for confinement in a Birthing Center, up to Allowable Charges for in-network providers and at 50% of the fee schedule after the deductible for out-of-network providers and after the \$200 co-payment. See the definition of “Birthing Center” in the Glossary at the end of this booklet.

HOME HEALTH CARE BENEFITS

You are covered for intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency, when coordinated by Horizon BCBS, in full (100% of the Allowable Charge), after a \$25 copayment, for in-network providers and at 50% of the fee schedule after the deductible for out of network providers.

Both in-network and out-of-network Home Health Care Benefits are limited to 8 hours per day and a total of 240 hours per calendar year.

Home services other than Skilled Nursing Care are not covered. See the definitions for these terms in the Glossary at the end of this booklet.

Home Health Care Benefits Limitations and Exclusions

1. Expenses for any Home Health Care services other than part-time, intermittent skilled nursing services and supplies.
2. Expenses under a Home Health Care program for services that are provided:
 - by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or
 - when the patient is not under the continuing care of a Physician.
3. Expenses for a homemaker, custodial care, childcare, adult care or personal care attendant.

Hospice Care: Hospice is a concept of care for patients whose life expectancy is one month or less and active treatment to cure the disease has been determined ineffective. Under the hospice concept, the aim is to keep the family involved in caring for the terminally ill patient and to provide the support necessary to help the family cope with the stress involved in caring for the patient and adjusting to life without the patient.

The Hospice concept is based on four accepted principles:

1. the terminally ill patient and family are the unit of care,
2. an interdisciplinary team (BCBS) assesses the total needs of the patient and family and provides coordinated service to meet those needs,
3. pain and other symptoms associated with terminal illness are controlled but no heroic efforts are made to cure the patient,
4. bereavement follow-up is provided to the family.

Blue Cross Blue Shield (BCBS) will be the interdisciplinary team that will assess the needs of the patient and family and coordinate all the necessary services. When you or your physician call BCBS, you or your physician will speak with a clinical screener who will ask questions about your condition. The screener will also ask for some personal information, such as your name, age, address, and insurance information. This information will be kept in strict confidence, and, beyond information required to process your claim, will not be shared with anyone affiliated with this Plan. Contact Blue Cross Blue Shield at 1-800-664-2583. The hospice benefit is limited to one month.

DURABLE MEDICAL EQUIPMENT

You are covered for the rental or purchase of "Durable Medical Equipment", as defined in the Glossary at the back of this booklet, provided you first undergo a pre-certification review.

Pre-certification review

You or your physician must contact Blue Cross Blue Shield (BCBS) at 1-800-664-2583 for a pre-certification review in order to obtain coverage for the rental or purchase of Durable Medical Equipment totaling more than \$1500.

When you or your physician call BCBS, you or your physician will speak with a clinical screener who will ask questions about your condition. The screener will also ask for some personal information,

such as your name, age, address, and insurance information. This information will be kept in strict confidence, and, beyond information required to process your claim, will not be shared with anyone affiliated with this Plan.

Once it reviews the information regarding your condition, BCBS will determine whether you require Durable Medical Equipment. It will also recommend a provider of such equipment. You may patronize this provider, or one of your own choosing, but you will probably realize greater savings by patronizing the provider recommended by BCBS, as it negotiates discounted rates with providers.

In Network

The rental or purchase of Durable Medical Equipment is covered at 80% of Allowable Charges. The co-payment does not apply to this benefit.

Out-of-Network

The rental or purchase of Durable Medical Equipment will be reimbursed at 50% of the fee schedule after the deductible. You will not be reimbursed for any equipment, which can be purchased over the-counter from any pharmacy or can be purchased independently of a physician's prescription.

HEARING AID BENEFIT

Charges for up to \$1500 for each ear for the purchase and/or repair of any type of hearing aid are covered; this benefit is limited to every three years.

GROWTH HORMONE THERAPY

The Plan covers growth hormone therapy to a maximum annual allowance of \$10,000.

Reimbursement will only be made for claims pre-authorized through Fabian & Byrn LLC. Medical policy will monitor the treatment and confirm continued medical necessity for therapy every year. The Plan will only reimburse growth hormone therapy for a maximum of three years.

DIABETIC SUPPLIES

The Plan will cover you and your eligible dependents for education and the purchase of routine supplies used in the treatment of diabetes.

Diabetes Education: You will be covered for necessary diabetes self-management education. Necessary diabetes self-management education is education designed to ensure that individuals with diabetes are trained in the proper self-management and treatment of their diabetes. This education is limited to education provided:

- Upon diagnosis as a diabetic,
- Upon a physician's diagnosis of a significant change in your condition or symptoms requiring change in self-management, and
- Where a physician determines that re-education is necessary. You will be covered where this education is provided by a licensed health care provider legally authorized to prescribe, or the staff of such individual, during an office visit. Where you receive this education from a physician (or member of his or her staff) during an office visit, you will be

covered for an ordinary office visit to the physician. You will also be covered for this education when provided by a certified diabetes nurse-educator, certified nutritionist, certified dietitian or registered dietitian if referred by a physician or other licensed health care provider legally authorized to prescribe. This will apply only if this education is rendered in a group setting, unless group education is not available in your area. You will be covered for this education when rendered in your home if the Trustees determine that it is Medically Necessary for you to receive the education in your home.

In-Network

The purchase of routine supplies is covered at 90% of the Allowable Charge through Global Pharmaceutical Benefits, LLC. Education is covered at 100% of the allowable charge after a \$25 Copayment.

Out-of-Network

Education will be reimbursed at 50% of the fee schedule after deductible. Facility co-pay will apply. The purchase of routine supplies will be reimbursed at 50% of the fee schedule after deductible.

Claims submitted for reimbursement for the purchase of routine supplies used in the treatment of diabetes should be submitted on a monthly basis.

ANNUAL PHYSICAL EXAMINATIONS

The annual physical examination is provided through Hackensack University Medical Center: The Department of Corporate Wellness. The number to call to schedule the annual physical is 201-336-8686.

When you use this provider, the expense of an annual physical examination will be paid at 100% of the Allowable Charge, up to a maximum of from \$250 to \$400. Your eligible dependents are covered for this benefit. The annual physical examination will consist of the standard procedures appropriate to you based on your age and gender. If you undergo a procedure not included in this set of standard procedures, the co-payment will apply.

*Members who are Medicare primary are eligible for this benefit.

The Plan does not provide an out-of-network benefit for the annual physical. However, you can have a routine physical performed under the Adult Well Care Services benefit, with an in-network or out-of-network provider.

PRIVATE DUTY NURSING

You are covered for private duty nursing services when coordinated by BCBS. Both in-network and out-of-network private duty nursing benefits are limited to 8 hours per day and a total of 240 hours per calendar year.

In-Network:

You are covered in full (100% of Allowable Charges), after a \$25 copayment.

Out-of-Network:

You are covered at 50% of the fee schedule after the deductible.

PAIN MANAGEMENT SERVICES

There are no out of network benefits for pain management services, including professional services (the doctor), facility (the surgery center or hospital), anesthesia and/or any other related charges. Coverage for pain management services will be available only through in-network providers. In order to be covered, all associated claims for outpatient services must also be from participating providers. All pain management claims from non-participating providers will be denied on the basis that they are not covered expenses, including office visits and testing. If patient uses an out of network doctor for the pain management procedure, all related services for that date of service would be denied even if the related providers such as the anesthesiologist and facility were in the network, because the procedure is not covered.

MENTAL ILLNESS TREATMENT AND ALCOHOL AND/OR DRUG ABUSE TREATMENT

Behavioral Health Network

Intervention Strategies International (ISI) has been in the employee assistance and mental health arena for over 20 years. The staff is comprised of licensed, clinical experts (i.e. Ph.D., M.D., and LCSW) in the field of mental health and substance abuse. They have an extensive network of therapists throughout the state, with a variety of specialties who are devoted to helping others to overcome their personal obstacles.

If you or a dependent are facing an emotional, interpersonal, and behavioral and/or chemical dependency problem, you can speak to a mental health professional, confidentially, at ISI 24 hours a day, 7 days a week by calling **800-663-0404**. ISI will authorize inpatient, outpatient, substance abuse treatment and/or access emergency services for participants. You will be assigned to a professional who will evaluate the presenting problem through a clinical interview and create an individualized treatment plan. All claims must be submitted directly to Intervention Strategies. LLC

Inpatient Mental Illness and Alcohol and/or Substance Abuse Treatment

Inpatient treatment is covered for up to 100 inpatient days per calendar year (combined with the medical benefit). Partial hospitalization is also covered. Two partial hospitalization days are considered as one inpatient day. Included in the facilities in which a participant or dependent may be hospitalized are freestanding psychiatric or substance abuse facilities used exclusively for the treatment of mental disorders or substance abuse.

In-Network claims are paid at 100% of Allowable Charge after a \$200 co-payment.

Out-of-network claims are paid at 50% of the fee schedule after a \$200 co-payment and the out-of-network deductible has been met. All inpatient and partial hospitalization services must be pre-authorized through Intervention Strategies at 800 663-0404. Member balances are not applied towards the out-of-pocket maximum.

If a patient discharges themselves against medical advice, the claim will not be covered by the Fund.

Outpatient Mental Illness and Alcohol and/or Substance Abuse Treatment

Outpatient treatment is treatment provided to the patient while he or she is not confined in a hospital.

The co-payment applies to in-network outpatient mental illness and alcohol and/or substance abuse treatment coverage. The deductible applies to out-of-network outpatient treatment coverage. Member balances on facility claims are not applied towards the out-of-pocket maximum.

Psychiatric Services:

- In-Network: Charges for services rendered by a licensed psychiatrist, at Full Coverage (100% of Allowable Charges) after \$25 Co-Payment per visit for ongoing psychotherapy.
- Out-of-Network: Charges for services rendered by a licensed psychiatrist, at 50% Coverage of the fee schedule after deductible for ongoing psychotherapy.

Psychological Services: This benefit does **not** extend to providers other than licensed psychologists (such as therapists or counselors.)

In-Network:

Charges for services rendered by a licensed psychologist, at Full Coverage (100% of Allowable Charges) after \$25 Co-Payment per visit.

Out-of-Network:

Charges for services rendered by a licensed psychologist, at 50% Coverage of the fee schedule after deductible per visit.

Masters of Social Work:

In-Network:

Charges for services rendered by an individual holding a Masters of Social Work graduate degree, at Full Coverage (100% of Allowable Charges) after \$25 Co-Payment per visit.

Out-of-Network:

Charges for services rendered by an individual holding a Masters of Social Work graduate degree, at 50% coverage of the fee schedule after deductible per visit.

Mental Health Prescription Drug Benefits

Your expenses for prescription drugs used for the treatment of mental illness are covered at 90% of the Allowable Charge of the drug when you purchase the drug at a network pharmacy and at 80% of the Average Wholesale Price after the deductible when you purchase the drug at a non-network pharmacy. Mental Health Prescription Drugs are not eligible for greater than a 30-day supply.

See the section entitled “Prescription Drug Plan” for a description of the prescription drug network, and for information on your prescription drug I.D. card and filing a claim.

PRESCRIPTION DRUG PLAN

This benefit applies to Plan A & B participants and their covered dependents. However, the coverage varies slightly.

Plan A

The prescription drug program allows you and your family to receive up to \$1,300 in benefits each year if you are a Plan A participant, whether you purchase your prescription drugs from network or out-of-network pharmacies. You have the option of going to any licensed pharmacy. However, your benefits will be even greater if you purchase your prescriptions from network pharmacies, since they will charge less through their discount arrangement with the Plan. Once you have exceeded the family annual maximum, the Plan will cover 80% of the Allowable Charge. You will be responsible for the remaining 20%.

Plan B

The prescription drug program allows you and your family to receive up to \$5,000 in benefits each year if you are a Plan B participant, whether you purchase your prescription drugs from network or out-of-network pharmacies. You have the option of going to any licensed pharmacy. However, your benefits will be even greater if you purchase your prescriptions from network pharmacies, since they will charge less through their discount arrangement with the Plan. Once you have exceeded the family annual maximum, the Plan will cover 80% of the Allowable Charge. You will be responsible for the remaining 20%.

All plans will only cover up to a 30 day supply at a retail pharmacy.

GLOBAL PHARMACEUTICAL BENEFITS, LLC (GPB)

Global Pharmaceutical Benefits, LLC is the prescription drug Administrator the Plan enlists to issue prescription drug cards, and for utilization of its considerable network of pharmacies. If you purchase your prescription drugs at any of these pharmacies, you may achieve significant savings over the amounts you would pay at pharmacies outside this network. The member and pharmacy services phone number for Global Pharmaceutical Benefits is 800-341-2234.

COVERED DRUGS

The Plan's coverage applies to:

- Prescriptions that require compounding;
- Prescription for legend drugs (drugs that cannot be dispensed without a prescription);
- Insulin;
- Birth control;
- Dietary drug prescriptions prescribed by a licensed physician to treat morbidly obese participants. For this purpose, a morbidly obese participant is a participant who is at least 100 lbs. over the desired weight determined by a licensed physician. In addition, the coverage will be provided on a case-by-case basis and only if it is determined that the obesity is directly responsible for other health problems the participant is experiencing.

COVERED AMOUNTS

In-Network

Your expenses for prescriptions that are covered by the Plan will be reimbursed at the Allowable Charge of the drug minus the applicable “co-payment”. The co-payment is the flat dollar amount that you pay for each prescription. Your co-payment for covered drugs dispensed at an in-network pharmacy is \$15 for a generic and \$25 for brand name drugs. There will be a surcharge on all prescriptions filled at certain pharmacies. The CVS/Caremark pharmacy network will have a \$10 surcharge per script in addition to the co-payment or coinsurance. The Walgreen/Duane Reade Pharmacy network will have a \$5 surcharge per script in addition to the co-payment or coinsurance.

Mental health drugs have a 10% co-insurance or the normal co-payment, whichever is higher.

Diabetic supplies have a 10% co-insurance

Out-of-Network

For out-of-network licensed pharmacies, you will be reimbursed the Allowable Charge applicable to in-network prescriptions. You will be responsible for paying the difference between the Allowable Charge minus the co-payment or co-insurance and the amount the pharmacy actually charges.

HOW PAYMENT IS MADE FOR DRUGS

The identification card you receive from the Fund Office will identify you as eligible for discounted prices at network pharmacies. These discounts apply to all Participants of Plan A and Plan B and include all prescriptions, regardless of whether they are limited or excluded by the Plan’s coverage.

In-Network

The identification card you receive from the Fund Office provides the method of payment when you have your prescription filled at a pharmacy in the network. Simply show your card to the pharmacist and pay the applicable co-payment.

Out-of-Network

Prescription Drug Plan claim forms are available at Global Pharmaceutical Benefits. You simply need to attach the prescription receipt to the claim form. You must pay the pharmacist at the time you receive the prescription and file the necessary forms with GPB.

Payment will not be made for prescription drugs purchased more than 12 months prior to submission.

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

The Plan’s coverage does not apply to:

- Over-the-counter drugs, vitamins, diet supplements, etc., that, even though prescribed by a physician, can be legally purchased without a prescription;
- Non-federal legend drugs;
- Methadone;
- Naltrexone;

- Antabuse;
- Allergy Sera;
- Therapeutic devices or appliances;
- Immunizations agents and vaccines;
- Biological, blood or blood plasma;
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the member;
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order;
- Any prescription refilled due to lost, stolen, misplaced, destroyed or damaged prescriptions;
- Drugs intended for use in a physician's office or another setting other than home use;
- Investigational or experimental drugs, including compounded medications for non-FDA-approved use;
- Drugs prescribed for the purpose of losing weight, or growing hair. Such drugs include, but are not limited to, Retin A, Rogaine, Nicorette, anorexians and fertility medications;
- For Viagra and other comparable drugs, including quantities in excess of 12 tablets per 30-day period;
- Drugs administered to inpatients of any hospital;
- Drugs used for the treatment of mental illness, other than to the extent provided in the section entitled "Medical Illness Treatment";
- Any prescription not obtained from a licensed pharmacy;
- Any drugs which are classified as Proton Pump Inhibitors, such as Aciphex, Dexilant, Lansorprazole, Nexium, Omeprazole, Pantoprazole, Prevacid, Prevpac, Prilosec, Protonix, Vimovo and Zegerid.

Horizon Health Center

Local 164 members have access to Horizon Health Center. By utilizing this facility, members will have co-payments waived for office visits and covered prescriptions. Members will also be able to receive a 90 day supply for maintenance medications with a \$0.00 co-payment.

Horizon Health Center's goal is to provide the highest quality care for all patients in a timely and respectful manner.

You will need to bring your insurance card and a photo ID with you for each appointment.

As a preferred Member you are entitled to:

- **Zero copays for Medical Services**
- **Zero copays for Pharmacy* – up to a 90 Day Prescription Supply**

Your Concierge Manager is Melissa Colon who can be reached at (551) 256-8404 or emailed at mcolon@alliancecommunityhealth.org

On your first visit, please bring all of your prescription and over-the-counter medications with you. If you need to reach the physician after hours, you can reach the answering service at 201-451-6300. Office hours for patient care are 8:30 – 7:00 pm Monday through Friday.

Horizon Health Center Offices

Bergen Avenue Office
706 - 714 Bergen Ave
Jersey City, NJ 07306
Telephone: 201-451-6300

Columbus Drive Office
115 Christopher Columbus Drive
Jersey City, NJ 07302
Telephone: 201-451-6300

VISION BENEFITS

Coverage under this benefit applies to Plan A participants and their covered dependents once every 2 years; to Plan B participants and their covered dependents once every year.

There is a reimbursement of up to \$85 per person for a routine exam and/or refraction every 2 years for Plan A members and annually for Plan B members

There is a \$300 per person allowance for prescription glasses, contact lens fitting and/or contacts every 2 years for Plan A members and annually for Plan B members. Vision benefits do not include:

- Charges in excess of the above allowances;
- Charges for sunglasses;
- Charges for repairs due to breakage;
- Charges for mail order subscription fees and shipping and handling.

Reimbursement

Claims for exams from participating providers may be submitted by the provider directly to their local Blue Cross Blue Shield Plan. All other vision services need to be paid by the patient at the time of service and then the member must submit a medical/vision claim reimbursement form to:

Fabian & Byrn LLC
Local 164 Vision Reimbursement
425 Eagle Rock Avenue, Suite 105
Roseland, NJ 07068

Claim Forms may be obtained from www.ibew164.org or by calling Fabian & Byrn LLC at 877-228-4202. Return the form to Fabian & Byrn LLC together with an itemized receipt from the provider describing the type of service rendered, the amount charged, and the name of the person who received the optical service. Reimbursement will only be made to the member.

LASER VISION CORRECTION SURGERY

Laser Eye Surgery is a covered benefit for all participants and dependents. This benefit includes but is not limited to PRK (Photo Refractive Keratectomy) and Lasik Vision Correction. You are entitled to a \$500 allowance for each eye treated. This benefit has a lifetime maximum of \$500 per eye.

DENTAL BENEFITS

Dental benefits are administered through Horizon Dental Option Plan

When you use a dentist that participates with Horizon’s Dental Option Network, you will save the most money. Nonparticipating Dentists charge their normal fees and you will be responsible for much higher out-of-pocket costs. Payments to non-participating providers will be based on usual, customary and reasonable rates.

Summary of benefits for Horizon Dental Option Plan	
Annual Maximum per Family	Plan B- \$5000 per family Separate implant benefit for Plan B members and dependents of \$2500 per person, per calendar year. Plan A- \$2000 per family
Annual Deductible	No Deductible
Preventive Services Covered at 100%	Cleanings & Periodic Exam- 3 times per year.
	Fluoride – to age 19- once per 6 months.
	Sealants – to age 14- once per 36 months
Restorative Services Covered at 100%	Amalgam and Composite
	Extraction
	Root Canal
	Oral Surgery
Major Services Covered at 100%	Crowns/Inlays - 5 yr replacement rule applies
	Prosthetics - 5 yr replacement rule applies
	Fixed Bridges – 5 yr replacement rule applies
Orthodontics	Covered under the annual \$5000 family maximum, but there is an additional orthodontic benefit for Plan B dependents aged 19 and under of \$2000 per eligible dependent, per calendar year.

All major treatments must be Pre-Determined. To find a participating dental provider, please visit the Horizon website, www.horizonblue.com/directory and select the “Dentist” tab; or call Horizon Dental, 800-433-6825. All dental claim services will be administered by Horizon BCBSNJ.

Submit all dental claims to:

Horizon Blue Cross Blue Shield of New Jersey
PO Box 1311
Minneapolis, MN 55440-1311

Questions?

For Dental Customer Service, please call Horizon Dental at **1-800-433-6825**.

For Dental ID cards call the Fund office at 877-228-4202.

DENTAL BENEFITS LIMITATIONS AND EXCLUSIONS

The following are **not Covered** Dental Expenses:

- Charges for any dental procedures that are included as Covered Medical Expenses under the plan of Major Medical Expense Benefits sponsored by the Fund.
- Charges for which benefits are payable under any other Medical Expense Benefits plan sponsored by the Fund, whether benefits are payable as to all or only part of such charges.
- Charges for treatment by other than a dentist, except that cleaning or scaling of teeth may be performed by a licensed dental hygienist, if such treatment is rendered under the supervision and direction of the dentist, and except that treatment may be performed by a student at an accredited dental college if the claim for such treatment is made through the college.
- Charges for any replacement of an existing partial or full removable denture or fixed bridge work, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, unless evidence satisfactory to the Trustees is presented that:
 - (i) the existing dentures, bridgework or prosthetic devices cannot be made serviceable and that it was installed five years prior to replacement.
 - (ii) the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and that replacement takes place within twelve months from the date of the installation of the immediate temporary denture and while the individual is still covered under this Plan.
- Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures unless necessitated as a result of a non-occupational accidental bodily injury occurring while insured.
- Charges for prosthetic devices (including bridges and crowns) and the fitting thereof that were ordered while the individual was not insured under the plan, or that were ordered while the individual was insured under the plan but are finally installed or delivered to such individual more than thirty days after termination of coverage.
- Charges for any services or supplies that are for orthodontic treatment (including correction of malocclusion), unless specifically provided for in the Schedule of Covered Dental Services.
- Charges in connection with an occupational accidental bodily injury or disease.
- Precision or semi-precision attachments.

- Any services, appliances or restorations to change vertical dimension or restore occlusion.
- Crowns, bridges or procedures for the purpose of splinting.
- Services or supplies that do not meet accepted standards of care.
- Services or supplies for the treatment of TMJ dysfunction.
- Orthognathic surgery.
- Temporary crowns, bridges, dentures or implants.
- Oral hygiene instruction.
- Fluoride treatments are payable up to age 18.
- Sealant treatments are payable up to age 14.
- More than one periodontal surgical procedure per area in a 12-month period.

PAYMENT FOR PROSTHETIC DEVICES AND ROOT CANAL THERAPY

- All prosthetic devices and root canal therapy are paid upon preparation date.
 - Impressions were taken and/or teeth were prepared
 - Benefits do not extend from year to year

For Example:

If teeth were prepared for a prosthetic device and/or root canal therapy was started, the available benefit at that time is the allotment for the service.

MEDICAL BENEFITS GENERAL PLAN LIMITATIONS AND EXCLUSIONS

The Local 164 I.B.E.W. Welfare Plan of Benefits does not pay for the following:

- Inpatient hospitalization or other inpatient facilities for medical, behavioral health or substance abuse if the patient leaves the hospital against medical advice;
- Services, supplies and treatment not prescribed by a legally qualified physician or by a resident physician or intern of a hospital and/or those that are determined not to be medically necessary;
- Charges that the insured individual is not legally required to pay, except as noted below;
- Expenses for services, including hospital confinement, when benefits for them are provided to the covered person:
 - under any plan or program established under the laws or regulations of any government, including the federal, state, or local government or the government of any other political subdivision of the United States or of any other country or any political subdivision of any other country; or
 - under any plan or program in which any government participates other than as an employer; unless the governmental program provides otherwise;
- Charges incurred due to cosmetic surgery and complications resulting from cosmetic surgery, except as required because of accidental injury or congenital defects (however, this plan will comply with the Women’s Health and Cancer Rights Act of 1998);
- Expenses incurred as a result of participation in a felony, riot or insurrection;

- Custodial care;
- Biofeedback;
- Recreational or leisure therapy;
- Organ transplants and artificial organs, except as a recipient thereof;
- Nutritional supplements, vitamins, and minerals;
- Formula; except for specialized non-standard medically necessary infant formula prescribed by a pediatrician for infants diagnosed as having multiple food protein intolerance will be covered under the medical plan up until the baby's first birthday under the non-participating benefit. Member must submit a detailed receipt along with a letter of medical necessity or a prescription from the pediatrician for member reimbursement along with a Local 164 Medical claim form. Claims will be subject to the deductible and then payable at 50%. Any unreimbursed amounts may be submitted by the member for payment through the Health Reimbursement Account if applicable.
- Services that are in the nature of educational or vocational testing or training;
- Expenses for treatment of injuries sustained in the course of exhibition, test or stunt flying, crop dusting or seeding, herding, hunting or fire fighting while in an aircraft; riding in or on any motorized vehicle designed or used for racing, speed tests or exhibition purposes;
- Aromatherapy;
- The purchase or rental of any exercise equipment or devices even when prescribed by a Physician (e.g. bikes, pools, treadmills, stair steppers, etc.);
- Expenses associated with wellness, relaxation or therapeutic oriented services or membership fees, even if prescribed by a Physician (e.g. golf clubs, sauna therapy, massage therapy, fitness clubs, pool membership, tennis clubs, vacation expenses, religious retreats, etc.);
- Charges incurred due to transportation, except local ambulance service;
- Charges incurred due to war, declared or undeclared, including armed aggression;
- Charges incurred due to accidental bodily injuries or occupational disease arising out of and in the course of the individual's employment;
- Charges incurred as the result of an automobile accident where state Personal Injury Protection (PIP) insurance is available and/or has been exhausted or terminated;
- Charges arising out of injuries incurred in an automobile where the Covered Individual has elected to waive medical coverage under any automobile insurance policy;
- Operation of a Vehicle Under Influence of Alcohol or Drugs: Expenses incurred by any Covered Individual for injuries caused in a motor vehicle accident if the Covered Individual was operating the vehicle and the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, that the Covered Individual:
 - had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred; or
 - was under the influence of drugs that are illegal in the jurisdiction in which the accident occurred;

- Charges incurred as the result of a motorcycle accident;
- Charges incurred for maternity expenses for dependents other than a spouse;
- Charges incurred for maternity expenses for dependents on COBRA other than a spouse;
- Charges incurred for expenses associated with an elective abortion;
- Charges incurred for the treatment of infertility except as described on page 23;
- Charges for any medical services, supplies, or drugs or medicines that are determined to be experimental and/or investigational;
- Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee;
- Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees;
- Educational Services: Expenses for educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, auditory aids, speech aids, etc., even if they are required because of an injury, illness or disability of a Covered Individual;
- Employer-Provided Services: Expenses for services rendered through a medical department clinic or similar facility provided or maintained by the Company, or if benefits are otherwise provided under this Plan or any other plan that the Company contributes to or otherwise sponsors, such as HMOs;
- Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan Benefit limitation, Annual Maximum Plan Benefits, or Overall (“Lifetime”) Maximum Plan Benefits as described in the Medical Expense Coverage chapter of this document;
- Expenses Exceeding Fee schedule allowances: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Fee schedule allowance as defined in the Glossary at the end of this booklet;
- Expenses for Which a Third Party Is Responsible: Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See the provisions relating to Third Party Liability in the Duplicate Coverage chapter of this document for an explanation of the circumstances under which the Plan will advance the payment of Benefits until it is determined that the third party is required to pay for those services or supplies;
- Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided:
 - before the patient became covered under the Medical Plan; or
 - after the date the patient’s coverage ends, except under those conditions described in the chapter of this document describing when your medical coverage ends;
- Illegal Act: Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission or attempted commission, by the Covered Individual,

of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual. The Plan Administrator's discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal of failure to prosecute) in connection with the acts involved;

- Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual;
- No-Cost Services: Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan;
- Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual;
- Personal Comfort Items: Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Specialized Health Care Facility or to bed at home, guest meals, television, VCR, telephone barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc;
- Physical Examinations, Tests for Employment, School, etc.: Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, commercial drivers license (CDL) or by any third party as well as drug tests not related to your union employment;
- Private Room in a Hospital or Specialized Health Care Facility: The use of a private room in a Hospital or other Specialized Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or its designee;
- Relatives Providing Services: Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered Employee;
- Services Performed by Certain Health Care Practitioners:
 - Medical Students, Interns or Residents: Expenses for the services of a medical student, intern or resident.
 - Stand-By Physicians or Health Care Practitioners: Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a standby basis;
- Services Provided Outside the United States: Expenses for medical services or supplies

rendered or provided outside the United States, except for treatment for a medical emergency agency or when you are on temporary work assignment for the Company at a location outside the United States;

- Services Required Because of Failure to Follow Medical Advice;
- Telephone Calls:
 - Any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any purpose whatsoever, including, without limitation
 - Communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a Covered Individual.
 - Consultation with any Health Care Provider regarding medical management or care of a patient;
 - Coordinating medical management of a new or established patient;
 - Coordinating services of several different health professionals working on different aspects of a patient's care;
 - Discussing test results;
 - Initiating therapy or a plan of care that can be handled by telephone;
 - Providing advice to a new or established patient;
 - Providing counseling to anxious or distraught patients or family members;
- Attempted Suicide: Expenses any Covered Individual incurs arising from an attempted suicide or from self-inflicted injury (shall not be covered). This exclusion will not apply when the suicide germinated from a medical condition, such as depression;
- Psychiatric or psychological testing and/or assessment;
- ABA (Applied Behavioral Analysis) assessment and/or therapy.

DEATH BENEFITS

FOR PARTICIPANTS covered by the current Collective Bargaining Agreement between the Northern New Jersey Chapter of the National Electrical Contractors Association and Local Union

A benefit of \$50,000 will be paid to any beneficiary on behalf of an active Participant who dies due to any cause except suicide while this plan is in effect and eligibility is maintained.

You may change your beneficiary whenever you wish by completing a new enrollment card available from the Fund Office. Beneficiary forms should be returned to the Fund Office. If you die without naming a beneficiary, your benefits will be paid to your estate.

FOR PENSIONERS

A death benefit of \$5,000 will be paid to any beneficiary on behalf of a retired Participant who dies due to any cause except suicide while the Plan is in effect.

You may change your beneficiary whenever you wish by completing the appropriate form available from the Fund Office.

ACCIDENTAL DISMEMBERMENT BENEFITS

(OCCUPATIONAL AND NON-OCCUPATIONAL)

FOR PARTICIPANTS covered by the current Collective Bargaining Agreement between the Northern New Jersey Chapter of the National Electrical Contractors Association and Local Union

If, while covered by the Plan, you suffer dismemberment as a result of accidental bodily injury, on or off the job, and such loss is sustained within 90 days after the date of the accident, you will be paid the following:

- \$50,000 for loss of both hands, both feet, both eyes or any two such members
- \$25,000 for loss of one hand, one foot or one eye
- \$12,500 for loss of thumb and index finger (of the same hand)

In no case will more than \$50,000 be paid for all losses sustained through any one accident.

“Loss”, used with reference to hand or foot, means complete severance through or above the wrist or ankle joint; as used with reference to an eye, means irrevocable loss of the entire sight; and as used with reference to a thumb and index finger, means complete severance through or above the metacarpophalangeal joints.

Exclusions or Limitations

Since the purpose of this coverage is to provide benefits for losses due to accidents, no benefits are paid on account of a loss caused or contributed to by:

- bodily or mental infirmity;
- disease or bacterial infections;
- medical or surgical treatment;
- suicide, attempted suicide or intentionally self-inflicted injury;
- war or any act of war; or
- the commission of or attempt to commit a felony by you.

DISABILITY BENEFITS

FOR PARTICIPANTS covered by the current Collective Bargaining Agreement between the Northern New Jersey Chapter of the National Electrical Contractors Association and Local Union

SUPPLEMENTAL WEEKLY DISABILITY BENEFITS

(Occupational and Non-Occupational Supplemental Disability Benefit)

The Fund will pay you a weekly gross benefit of \$100 for up to 26 weeks when you are prevented from working due to an accident or illness. You must furnish copies of your New Jersey Workers' Compensation benefit checks or your New Jersey Temporary Disability Benefit vouchers to Fabian & Byrn on a weekly basis for the period disability credit is claimed. This weekly benefit is payable in addition to New Jersey Temporary Disability or Workers' Compensation Benefits. You will be credited 30 hours per week towards welfare benefits and 40 hours per week towards pension credit.

If you are still disabled after collecting the full 26 weeks, you will not be eligible for the monetary benefit, but you may be eligible to be credited with the welfare and pension hours. However, disability must be established to the satisfaction of the Trustees and you are required to submit, and periodically resubmit, to a medical examination by a physician designated by the Trustees.

To be entitled to disability benefits, the disability must commence while you are eligible for benefits. You are not entitled to this benefit if you are on COBRA.

DRUG AND ALCOHOL TESTING BENEFIT

A Participant is entitled to \$50.00 for every random drug test performed. A participant will not be eligible for this benefit if they are under an accelerated random program recommended by our Substance Abuse Professional (SAP) following a suspension.

HEALTH REIMBURSEMENT ACCOUNT

Effective January 1st, 2015 individual Health Reimbursement Accounts (HRA) were set up for active 164 members working within the territory and covered by the current Collective Bargaining Agreement between the Northern New Jersey Chapter of the National Electrical Contractors Association and Local Union.

A percentage of the monthly welfare contribution made for each member is put into an individual Health Reimbursement Account to help cover qualified medical expenses not covered by the Welfare Fund for the member and their eligible dependents that were incurred on or after January 1, 2015. Any remaining contributions at the end of the year will roll over into the next year. The timely filing limit to receive reimbursement is eighteen months. Any claims submitted with a date of service that is over 18 months old will not be honored for payment.

How to Receive Reimbursement for Out-of-Pocket Medical Expenses

The minimum reimbursement is \$100 which can be divided among different family members. **A separate HRA claim reimbursement form must be submitted for each individual family member.** HRA claim reimbursement forms are available online at www.ibew164.org.

Reimbursement can be easily obtained by accessing your Explanations of Benefits (EOB's) through www.ibew164.org. Members can view and print EOB's by clicking on the e-benefit (check your claims) box. Detailed information regarding access to the website is listed on page 14 of this Summary Plan Description.

Most EOB's that show a member balance can be submitted for reimbursement through the HRA account. Certain EOB's do not require any additional documentation other than the HRA reimbursement claim form.

To receive reimbursement for \$25 office visit co-pays, all that is needed are the EOB's indicating a \$25 member balance, which can be printed from the website.

To receive reimbursement for prescription co-pays, all that is needed are the EOB's indicating the prescription member balance, which can be printed from the website.

All other medical or vision EOB's with member balances need to be submitted with additional supporting documentation. The Plan requires a paid receipt specific to the date of service for which you are requesting reimbursement. The receipt must indicate the name of the provider, the date of service and the amount paid for the service in addition to the EOB obtained through the website. The Fund does not reimburse for partial payments. The paid receipt must indicate that the services are paid in full. Reimbursement from the HRA account will not be made to the member until the service is paid in full.

Statements with multiple dates of service are not acceptable and will result in the denial of your reimbursement request.

Dental expenses not covered under your dental plan may also be submitted for reimbursement consideration under the Health Reimbursement Account. An explanation of benefits from the dental insurance company, indicating the member balance must be submitted with the HRA reimbursement claim form in addition to a paid receipt from the dentist, indicating date of service, amount paid and that the service is paid in full. The paid receipt must be specific to the date of service for which you are requesting reimbursement. Statements with multiple dates of service are not acceptable and will result in denial of your reimbursement request. Reimbursement from the HRA account will not be made to the member until the service is paid in full.

Reimbursement Requests

The maximum reimbursement amount that you can receive is equal to your account balance at the time your reimbursement request is processed. Any portion of a reimbursement request that exceeds your account balance will be pended until your account balance can cover the expense.

Example: Your HRA plan year begins in January and your employer contributes \$100 each month. In February, you have \$200 in your account, but you incur an expense for \$300. If you submit a reimbursement request that same month, you will be reimbursed for \$200 of the expense, and you will receive the additional \$100 when your employer puts the \$100 March contribution into your account.

Some expenses that are not covered under the Health Reimbursement Account

- Over-the-counter (OTC) medicines and drugs, unless prescribed by a medical provider in the state in which you purchase the OTC medicines
- Commercial drivers license (CDL) medical examinations
- Department of Transportation (DOT) medical examinations
- Cosmetic surgery
- Personal grooming products, vitamins, supplements and herbs used for general well-being

COORDINATION OF BENEFITS

DUPLICATE COVERAGE OF MEDICAL AND DENTAL EXPENSES

HOW DUPLICATE COVERAGE OCCURS

This section describes the circumstances when you or your covered dependents may be entitled to medical and/or dental Benefits under this Plan and may also be entitled to recover all or part of your medical and/or dental expenses from some other source. It also describes the rules that apply when this happens.

There are several circumstances that can occur as a result of which you and/or your covered Dependents could be reimbursed for your medical and/or dental expenses not only from this Plan but also from some other source. This can occur if you or a covered dependent is also covered by:

- **Another group health care plan;** or
- **Medicare or some other government program**, such as Medicaid or CHAMPUS, or any coverage either provided by a federal, state or local government or agency, or any coverage required by federal, state or local law, including, but not limited to, any motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law; or
- **Subrogated claims:** Duplicate coverage of medical and/or dental expenses can also occur if a third party is financially responsible for the injury or illness because that third party caused the injury or illness by negligent or intentionally wrongful action – e.g. slip and fall accidents due to a dangerous/hazardous condition; medical mistakes; assaults; dog bites, etc.

This Plan operates under rules that prevent it from paying Benefits which, together with the benefits from any other group health care plan, Medicare, coverage provided by a federal, state or local government or agency, coverage under any motor vehicle no-fault coverage (or any other coverage) for medical expenses or loss of earnings that is required by law, or recovery you may receive from a negligent or wrongful third party, would allow you to recover more than 100% of medical and/or dental expenses you incur. In many instances, you may recover less than 100% of those medical and/or dental expenses from the duplicate sources of coverage or recovery. In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its Benefits, but only subject to its right to recover them if and when you or your covered dependent actually recover some or all of your losses from a third party.

COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When and How Coordination of Benefits (COB) Applies

For the purposes of this Coordination of Benefits subchapter, the word “plan” refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the covered person or that provides

medical or dental services to the covered person. A “group plan” provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage.

Many families with more than one person working are covered by more than one medical or dental plan. If this is the case with your family, **you must let this Plan (or its insurer) know about all your coverage when you submit a claim.**

Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First: Order of Benefit Determination Rules

Group plans determine the sequences in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. Any group plan that does not use these same rules always pays its benefits first.

If the first rule does not establish a sequence or order of benefits, the next rule applies, and so on, until an order of benefits is established. The rules are:

Rule 1: Non-Dependent/Dependent

The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.

There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

- secondary to the plan covering the person as a dependent; and
- primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee); then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the year pays first; and the plan that covers the parent whose birthday falls later in the year pays second, if:

- the parents are married;
- the parents are not separated (whether or not they ever have been married); or
- a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

The word “birthday” refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does **not** apply during any Plan Year during which any Benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- The plan of the custodial parent pays first;
- The plan of the spouse of the custodial parent pays second;
- The plan of the non-custodial parent pays third; and
- The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active or Retired Employee

The plan that covers a person either as an active employee (that is, an employee who is not retired), or as that active employee’s dependent, pays first; and the plan that covers the same person as a retired employee, or as that retired employee’s dependent, pays second.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person’s dependent) pays first, and the plan providing continuation coverage to that same person pays second.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

The start of a new plan does **not** include a change:

- in the amount or scope of a plan's benefits;
- in the entity that pays, provides or administers the plan; or
- from one type of plan to another (such as from a single employer plan to a multiple employer plan).

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered person.

How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay the same Benefits that it would have paid had it paid first, **less** whatever payments were actually made by the plan (or plans) that paid first.

Administration of COB

To administer COB, the Plan reserves the right to:

- exchange information with other plans involved in paying claims;
- require that you or your Health Care Provider furnish any necessary information;
- reimburse any plan that made payments this Plan should have made; or
- recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.

If this Plan should have paid Benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be Benefits under

this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the Benefits available to you, you should file a claim under each plan that covers the person for the medical and/or dental expenses that were incurred. However, any person who claims Benefits under this Plan must give it all the information the Plan needs to apply COB.

MEDICARE AND OTHER GOVERNMENT PLANS

MEDICARE

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period. If Medicare, either because of disability or age covers you, your covered spouse or dependent child, you may either retain or cancel your coverage under this Plan.

If you, your spouse and/or your dependent child are covered by this Plan and by Medicare, as long as you remain actively employed, this Plan pays first and Medicare pays second.

However, if you become entitled to Medicare because of your disability, you will no longer be considered to be employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second. (If you retire and are/become entitled to Medicare because of your age (age 65 or over), Medicare will pay first and this Plan will pay second.

See Coordination of Benefits with Medicare on page 56 for more information.

MEDICARE AND END-STAGE RENAL DISEASE

If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for a limited period of time, 30 months. After this 30-month period, Medicare pays first and this Plan pays second.

Here's how COB works in ESRD situations:

- Medicare generally imposes a three-month waiting period at the onset of end-stage renal disease before Medicare becomes effective. Therefore, this Plan would pay benefits during the waiting period and then continue to pay first for an additional 30 months, while Medicare pays second during this latter time period. Therefore, this Plan will pay primary for a total time period of 33 months. Beginning with the 34th month, Medicare will pay first and this Plan will pay second.
- However, Medicare waives the waiting period if the patient enrolls in a self-dialysis training program or receives a kidney transplant within the first three months of diagnosis of ESRD. If the Medicare waiting period is waived, this Plan will pay first for the first 30 months and Medicare will pay second. Beginning with the 31st month, Medicare will pay first and this Plan will pay second.

MEDICAID

If both this Plan and Medicaid cover you, this Plan pays first and Medicaid pays second.

CHAMPUS

If both this Plan and CHAMPUS cover you, this Plan pays first and CHAMPUS pays second.

SERVICES RECEIVED IN A VETERANS AFFAIRS FACILITY

If you receive services in a U.S. Department of Veterans Affairs Hospital or facility for a military service-related illness or injury, benefits are not payable by this plan.

If you receive services in a U.S. Department of Veterans Affairs Hospital or facility for any other condition that is not a military service-related illness or injury, benefits are payable by this plan to the extent those services are medically necessary and the charges are usual and customary.

For members who have Medicare as a primary payer and secondary coverage through this plan, the Welfare Fund will require a Medicare Explanation of Benefits regarding how much Medicare would have paid if the provider was not a government agency. The remaining balance is eligible for payment under coordination of benefits with Medicare guidelines.

OTHER COVERAGE PROVIDED BY STATE OR FEDERAL LAW

If both this Plan and any other coverage provided by any other state or federal law cover you, the coverage provided by any other state or federal law pays first and this Plan pays second.

AUTOMOBILE INSURANCE

The Joint Welfare Fund will not provide coverage for medical expenses arising out of automobile accidents. Please make sure that your automobile insurance policy has Personal Injury Protection (PIP) listed as primary payer of medical bills related to an automobile accident. Individuals who insure their vehicles in states where Personal Injury Protection insurance is available have the option of selecting various deductibles for their PIP coverage. Electing a higher deductible might expose you or a covered dependent to increased out-of-pocket expenses. Below are some facts that you should be aware of before choosing a deductible option.

1. Personal injury protection (PIP) is a mandatory part of your automobile insurance policy. Among other things, it pays for medical expenses for personal injuries that arise from automobile-related accidents.
2. If you elect to select as secondary, terminate or waive PIP coverage, you still will not be covered for medical expenses that would have been covered under PIP insurance.
3. If you choose a deductible, it will apply to each person injured who is covered by your auto insurance for the first \$500, \$1,000 or \$2,500 in medical expenses. There is a new deductible for each accident.
4. The Joint Welfare Fund of Local 164, I.B.E.W. will not reimburse you for claims that fall under your PIP deductible or for claims that are incurred after PIP is exhausted or terminated.

5. Selecting a deductible will reduce your auto insurance premium. You should find out from your insurer the amount of the reduction because it may be minimal. If you or your dependent is injured in a car accident, you may be faced with considerable expenses that would have been reimbursed by your automobile insurer. These expenses, up to \$2,500 if you choose that deductible, may represent serious exposure on your part in view of the savings you might realize in your auto insurance premium. Therefore, you should carefully consider whether the additional risk involved with increasing the PIP deductible is the proper decision for you.

You should be aware of the foregoing when deciding whether to elect a PIP deductible amount for your auto insurance policy.

REIMBURSEMENT AND SUBROGATION

This Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any responsible third party, insurance company or another health plan. In order to help you and your eligible dependents (hereafter “covered persons”) in a time of need, however, this Plan may pay covered expenses that may be or become the responsibility of another party on the express condition and understanding that this Plan later receives 100% reimbursement for those payments without deductions for attorney fees and other legal expenses.

Therefore, in becoming covered by this Plan, as well as by submitting a claim for covered expenses, a covered person is subject to, and specifically agrees to, the following terms and conditions with respect to the amount of covered expenses paid or payable by the Plan:

1. Assignment of Rights (Subrogation): The covered person automatically assigns to the Plan any rights the covered person may have to recover monies in connection with an illness, injury, accident, sickness, occurrence, condition or other loss from any third party. These rights of recovery or causes of action against any third party include, but are not limited to, a claim of any type whatsoever, whether the claim exists or may exist, or the monies are or may be recovered from a third party through a claim, lawsuit, settlement, insurance policy or pool, uninsured or underinsured motorist or other policy or pool, governmental or private right of recovery, Workers Compensation or disability award or order, judgment, no-fault program, or personal injury protection, financial responsibility, medical benefit reimbursement insurance coverage not purchased by the covered person, by compromise, or in any other way from any third party, person, agency, organization or fund of money whether or not the payer caused or is legally responsible or liable for it, and regardless of whether such liability or responsibility is or is not denied or is in dispute (hereinafter called “any third party”).

2. Right to Reimbursement, Equitable Lien, and Constructive Trust: This Plan is granted and the covered person specifically consents to an equitable lien by agreement, or a constructive trust over, and this Plan has the right to reimbursement from, any monies that a covered person receives from or through any third party to the extent of Plan benefits paid or payable by this Plan on behalf of the covered person. This Plan's right to reimbursement, equitable lien and constructive trust extends to any covered person and any individuals or entities that may receive a recovery on behalf of a participant or beneficiary, such as the covered person's spouse, parents, and dependents, heirs, estates, trusts, representatives, trustees, or guardians of the covered person including attorneys, representatives, agents, successors or assigns (hereinafter "Covered Individuals").

3. First Priority/Rejection of Make Whole Doctrine: This assignment, right to subrogate, equitable lien by agreement, constructive trust, and right to reimbursement (hereinafter called "Rights of Recovery") applies on a first-dollar basis (i.e. has priority over other rights), applies whether the monies paid to (or for the benefit of) the covered person constitute a full or partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorneys fees, or other costs and expenses. As such, this Plan is entitled to its full lien and its full recovery of the total amount of benefits paid or payable, regardless of the amount of monies paid or awarded to the covered person by the third party, even if those monies are less than the full amount which you do seek or could seek against the third party, regardless of whether the monies are or are described as for medical expenses, and regardless of how they are described or what they are for, and regardless of whether full compensation from the third party is obtained or available. This Plan's Rights of Recovery shall be a prior lien against any proceeds recovered by any Covered Individuals, which right shall not be defeated or reduced by the application of any so-called "Make Whole Doctrine" or any doctrine purporting to defeat this Plan's recovery rights by allocating the proceeds exclusively to non-medical expenses or non-medical damages. No reduction of this Plan's full right to recover the total amount of Plan benefits is effective without the Plan's written consent. This Plan retains the sole and final discretion to decide whether and in what case such consent will be granted, if requested.

4. Rejection of Common Fund Doctrine: This Plan's Rights of Recovery apply to any recovery by the covered person without regard to legal fees and expenses of the covered person. The covered person shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, sickness, accident, or condition, and this Plan's recovery shall not be reduced by such legal fees or expenses unless the Plan Administrator, in his or her sole discretion, agrees in writing to discount the Plan's claim by an agreed-upon amount of such fees or expenses. This Plan specifically disavows any claims that a covered person may make under any federal or state common law defense including, but not limited to, the "Common Fund Doctrine", "Fund Doctrine" or "Attorney's Fund Doctrine."

5. Obligation to Cooperate: The covered person, as well as the covered person's attorney, representative or agent shall assist and cooperate with representatives the Plan designates, shall do everything necessary to enable this Plan to enforce its rights of subrogation and reimbursement (including but not limited to placing third parties on notice of the Fund's rights of recovery), and shall do nothing to impair, release, discharge or prejudice this Plan's Rights of Recovery. The Plan Administrator may require the covered person to complete and/or execute certain documentation this Plan deems necessary, helpful or appropriate to assist this Plan in the enforcement of its subrogation rights including, but not limited to, this Reimbursement and Subrogation provision.

6. Obligation to Notify: The covered person shall immediately notify this Plan if the covered person is involved in or suffers an illness, injury, accident, sickness, occurrence, condition or other loss or liability for which a third party may be liable and shall provide this Plan with any information concerning the covered person's entitlement or access to any other insurance (whether through automobile insurance, other group insurance or otherwise) and any other person or entity (including their insurer's) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person as well as the covered person's attorney, representative or agent shall again notify this Plan if the covered person pursues a claim to recover damages or other relief relating to any illness, injury, accident, sickness, occurrence, condition or other loss for which this Plan may make payments on the covered person's behalf and shall provide information as to the status of any claim against any third party and such documentation requested by this Plan every 12 months thereafter, whenever settlement is proposed, and whenever requested by this Plan. The covered person as well as the covered person's attorney, representative or agent shall immediately notify this Plan upon receiving any monies, award, judgment, settlement offer or compromise offer, or in any other way from any third party, person, agency, organization or fund of money and shall not settle or compromise any claims without this Plan's written consent.

7. Right to Exclude, Withhold or Suspend Covered Expenses: If any covered person, or the covered person's attorney, representative or agent fails or refuses to cooperate with this Reimbursement and Subrogation provision and this Plan's rights by disputing the Plan's lien, failing to advise this Plan of the status of the claim against any third party, withholding necessary information, failing to execute requested documentation, or in any way interfering with this Plan's rights, the Plan may withhold, suspend and exclude payment of any covered expenses otherwise available under the Plan. At the discretion of the Plan Administrator, this Plan may withhold or suspend payment of any or all covered expenses pending reimbursement, recognition of the Plan's lien, or issuance of a court order. This Plan may also reduce any future covered expenses otherwise available under this Plan, by an amount up to the total amount of monies recoverable from any third party for Plan benefits paid or payable by this Plan on behalf of the covered person.

8. Set Aside of Funds: Unless and until this Plan has received reimbursement in full, no monies from or through any third party may be distributed to the covered person without this Plan's written consent and these monies are, to the extent of benefits paid or payable by this Plan on behalf of the covered person, assets of and debts owed to this Plan. The covered person agrees to hold in trust for this Plan's benefit that portion of the total recovery from any third party that is due for benefits paid or payable by this Plan on behalf of the covered person. The covered person and his/her attorney agrees to hold in escrow in an appropriate attorney trust account of the attorney representing the covered person the portion of the total recovery from any third party that is due for benefits paid or payable by the Plan on behalf of the covered person. Such portion shall remain in escrow and shall not be released to the covered person and/or his/her representative or agent, and/or to any other entity or person until the Plan receives full satisfaction of its lien or right to reimbursement and provides written consent for the release of the monies. Both the covered person and his or her attorney will be personally liable if the monies subject to the Plan's lien are not held in an attorney trust account; released without the Plan's written consent and/or dissipated on non-traceable items, such as debt obligations.

As Trustee of the monies to which the Plan holds a lien for the benefit of the Plan, the covered person and/or his/her attorney or representative owes a fiduciary duty to the Plan to not disburse or dissipate those monies.

9. Sole Discretion: This Plan has sole and final discretion to determine whether to assert its rights under this Reimbursement and Subrogation provision as an equitable lien, through subrogation, or through reimbursement, to advance payments of benefits and require repayment, to offset against future payments, or through any combination or variation of these methods. The determination of which method(s) will be used in a particular case will be made to protect the interest of this Plan and its participants and is in the Plan's sole discretion.

10. Excess Insurance: If at the time of injury, sickness, disease or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

- a. The responsible party, its insurer, or any other source on behalf of that party;
- b. Any first party insurance through medical payment Coverage, personal injury protection, no-fault Coverage, uninsured or underinsured motorist Coverage;
- c. Any policy of insurance from any insurance company or guarantor of a third party;
- d. Workers' compensation or other liability insurance company; or
- e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance Coverage.

11. Separation of Funds: Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, the funds being held in trust for the Plan, or the Plan's right to subrogation and reimbursement.

12. Wrongful Death: In the event that the Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

SAMPLE REIMBURSEMENT AGREEMENT & ASSIGNMENT OF PROCEEDS

I, _____, have filed for benefits with the Joint Welfare Fund of Local Union #164, "the Plan". These claims are or may be due to injuries caused on or about _____ by the fault of another party (the "third" party").

I acknowledge that the Plan has a right to reimbursement of benefits paid by the Plan out of any recovery that I or my dependent obtains, regardless of whether recovery is by settlement, judgment or otherwise and regardless of how the recovery is described or characterized (e.g., compensation for pain and suffering, reimbursement for medical expenses).

In consideration of the payment of benefits by the Plan, [I] [we] agree as follows:

1. I promise to repay and hereby assign to the Plan the proceeds of any and all recovery obtained due to the injuries caused by the third party to the extent of any benefits provided by the Plan.
2. I agree to inform the Plan of the name of the third party, and its insurance carrier, if any. At this time, I believe the names are as follows:

Third Parties Insurance Carriers

3. I agree to notify my attorney, if any, of this Reimbursement Agreement and Assignment of Proceeds prior to signature.
4. I agree to do nothing to prejudice my rights against the third party and further agree to do everything reasonable to secure my right of recovery against the party responsible for my injuries, or the party's insurance carrier, if any. This includes, at the Fund's request, assigning my rights to sue the third party to the Fund, to the extent of the Fund's liability for payable benefits and to cooperate in such lawsuit.

In further consideration of the payment of benefits by the Plan, [I] [we] have read, understand, and will abide by, the "Reimbursement and Subrogation" provision set forth in the Plan's Summary Description.

Employee Signature: _____

Date of Signature: _____

Social Security Number: _____

Signature of the injured individual, _____

if different from the employee: _____

Date of Signature: _____

Social Security Number: _____

(NOTE: for minors or other protected persons, the signature of a parent or guardian on behalf of the minor or protected person is required.)

COORDINATION OF BENEFITS WITH MEDICARE

(HEALTH COVERAGE AFTER AGE 65) ELIGIBILITY FOR MEDICARE

Most persons 65 years of age or older are entitled to Medicare, a broad program of health benefits which includes hospital insurance (Part A) and medical insurance (Part B).

Disabled persons of any age who have been receiving Social Security Disability Benefits for at least 24 months and anyone with chronic renal (kidney) disease which requires hemodialysis or kidney transplant are also entitled to Medicare.

Generally, Medicare benefits are available only in the United States, Puerto Rico, the Virgin Islands, Guam and American Samoa. However, under certain conditions hospital confinements (and any related Part B expenses) are covered in areas that border the continental United States (that is, Canada and Mexico). Resident aliens are eligible for Medicare only if they are eligible for Social Security benefits or they have lived in the United States for at least five years.

If you are approaching age 65, it is important for you to realize that you are not automatically enrolled in Medicare (Parts A and B) at age 65 unless you have filed an application and established entitlement to a monthly Social Security retirement benefit. If you are 65 or over and eligible for Social Security retirement benefits but have not applied for them because you are still working, you may establish entitlement to hospital insurance benefits (Part A) by filing an application for hospital insurance benefits.

Once you have established your entitlement to hospital insurance benefits (Part A), you are automatically enrolled and covered for supplementary medical insurance benefits (Part B), unless you decline this coverage. If you are retired and have declined Medicare Part B insurance, your monthly premium to maintain your coverage under the Joint Welfare Fund will be the current self-pay amount plus the premium listed in the Pensioner's Eligibility section.

If you have not applied for Social Security benefits, and you are no longer working, you must file a Medicare application for Part B coverage during the three month period prior to the month in which you become age 65 in order for coverage to begin at the start of the month you reach age 65. If you do not enroll in Medicare during this three-month period, you will have to pay a higher monthly premium for Part B coverage. However, if you did not enroll within three months prior to reaching age 65 because you were still working and enrolled in the Fund's plan, you can later enroll in Medicare Part B when you retire—without a waiting period or a late penalty—if you enroll immediately upon coverage ending under this Plan.

After you retire and are age 65 or older, Medicare will pay first for any covered expenses, and this Plan will pay second. This Plan will pay the difference between the allowable charge and what Medicare pays. In no event will the total of your reimbursement from Medicare and this Plan exceed 100% of billed charges.

COORDINATION OF MEDICARE BENEFITS WITH THIS PLAN

The federal government requires that if the Participant is an active participant over age 65, he or she must make a choice as to his or her future benefits coverage. The Participant may elect to:

1. Continue coverage under the Plan, in which case the Welfare Fund will be the primary source of coverage and, if enrolled in Medicare Parts A and B, Medicare will become a secondary source of coverage, or
2. Reject the Plan's hospital and medical-surgical coverage in favor of having Medicare Parts A and B as the source of coverage. The Participant should be aware that if he or she drops the Welfare Fund coverage, then his or her family's coverage under the Plan will also end. Medicare will be the Participants' only hospital and medical-surgical insurance unless there is coverage through the spouse's employer or unless the Participant decides to purchase private health insurance. The Welfare Fund by law may not supplement Medicare coverage by paying second.

If the Participant is active and over age 65, elects to continue coverage under the Welfare Plan, he or she should continue to have hospital and medical/surgical claims submitted first to BCBS for payment and, if enrolled in Medicare, then file the claim with Medicare for any possible additional reimbursement.

This claim procedure also pertains to the spouse of an active Participant who is over age 65. This means that if the Participant is over age 65 and an active participant, he or she will collect from the Plan first and Medicare second.

If the Participant wishes to exercise his or her option and reject Fund coverage for hospitalization and medical-surgical benefits in favor of continuing solely with Medicare Parts A and B, the Participant may do so by notifying the Fund Office in writing. Coverage under the Welfare Fund will stop on the first day of the month following the day a written rejection notice is received or on the day the Participant becomes covered by Medicare, whichever is later. Also, once Welfare Fund coverage is rejected, the Participant will not be allowed to make a new election in the future.

When notifying the Fund Office of the Participant's rejection of Welfare Fund coverage, be sure to include the Participant's full name, social security number, and spouse's full name and social security number in the letter sent to the Fund Office. Also, you must send us a copy of the Medicare enrollment card showing the effective date of the Participant's Medicare coverage. The Board of Trustees urges the Participant not to reject the Welfare Fund's coverage in favor of Medicare Parts A and B since this Plan generally will reimburse more than Medicare.

The reason the Participant and his or her dependents age 65 and over may wish to enroll in Medicare Part B and pay the monthly Part B premium to Medicare while you continue to work is, Medicare will be a secondary insurer. This means that Medicare may still pay part of your medical and surgical bills after this Plan pays first.

The final decision whether or not to pay the Medicare Part B monthly premium is, of course the Participant's.

HEALTH CARE CLAIM REVIEW PROCEDURES AND APPEALS

When you submit a claim for benefits to the Plan Administrator, the Plan Administrator will determine if you are eligible for benefits and calculate the amount of benefits payable, if any.

Generally, all health care benefits will be paid as soon as administratively possible. The Plan Administrator will notify you of its initial decision within certain time frames (described below). If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, the Plan will give you written notice of its decision about your claim.

The Plan's Claim Procedures differ for the different types of claims as follows:

- **Urgent Care.** An initial determination will be made within 72 hours from receipt of your claim. If, during the review, additional information is needed from you to process your claim, you will be notified within 24 hours. You will then have 48 hours to respond. You may call the Plan Administrator to provide the information. You will be notified of the decision within 48 hours of when the additional information is submitted. Due to the nature of an urgent care claim, you may be notified of a decision by telephone. This will be followed by a written notice of the decision.
- **Pre-service.** An initial determination will be made within 15 days from receipt of your claim. If additional time is necessary, you will receive notice within that initial 15-day period explaining why there will be a delay in the decision. You will also be given a date, no later than 15 days after the initial 15-day period, when you will receive a decision. If, during the review, additional information is needed to process your claim, you will be notified within the time period explained above. You will have up to 45 days to provide the requested information. After 45 days, or if sooner, after the information is received, the Plan will make a determination.
- **Post-service.** The Plan will inform you of its decision on a post-service claim within 30 days of when you file the claim. If there will be a delay in making a decision on your claim in that 30-day period, you will receive a notice giving a date – no later than 15 days after the ending of the initial 30-day period- by which you can expect a decision. If, during the review, additional information is required, you will be notified within the required time period indicated above. You will have 45 days to provide the additional information. After you submit the additional information or at the end of the 45-day period, you will receive notice of the Plan's determination.
- **Concurrent Care.** You will be notified of any reduction or termination of a course of treatment (other than Plan termination or amendment) before the end of a previously approved period of time or number of treatments. Notifications of the reduction or

termination shall be sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account medical exigencies, and the Plan Administrator will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with claim notification procedures.

IF A CLAIM IS DENIED

If all or part of your claim is denied, the Plan will notify you in writing, providing:

- The specific reason or reasons for the decision;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a civil lawsuit under ERISA if you decide to appeal and the appeal is denied;
- A copy, or a statement that a copy is available to you at no cost upon request, of any internal rule, guideline, protocol or similar criteria that was relied on in making the decision;
- An explanation of the scientific or clinical judgment related to your condition, or a statement that a copy is available to you at no cost upon request, if your claim is denied due to medical necessity, experimental treatment or similar exclusion or limit;
- A statement explaining that the Plan will identify any medical or vocational expert from whom the Plan received advice with respect to your claim upon your request; and
- A notice, including a description of the expedited review process, if your appeal is due to the denial of an urgent care claim.

APPEALING A DENIED CLAIM

Health Care Benefits Appeal Procedures

The Plan Administrator and Board of Trustees, in making decisions on claims and appeals, will apply the terms of the Plan and any applicable guidelines, rules and schedules and will take into account all information you submit in making decisions on claims and appeals.

You may name a representative to act on your behalf. You must notify the Plan Administrator in writing of your representative's name, address, and telephone number. For urgent care claims,

a health care provider that has knowledge of your medical condition may act as your authorized representative.

If your claim is denied in whole or part, you (or your authorized representative) may, within 180 days after receiving notice of denial, appeal the denial by sending a written request for review to the Plan Administrator:

Fabian & Byrn LLC
425 Eagle Rock Avenue, Suite 105
Roseland, New Jersey 07068

You may appeal denials of urgent care claims either orally or in writing to the Plan Administrator. All information necessary to decide the appeal may be transmitted via telephone, facsimile or other available method.

Your written appeal (or oral appeal for urgent care claim denial) should state the reason for your appeal. You (or your authorized representative) may receive, upon request and free of charge, reasonable access to and copies of any documents relevant to your claim and may submit issues and comments in writing. A document is considered relevant if it was relied on in making the decision, was submitted, considered or generated (regardless if relied on) or demonstrates compliance with claim processing requirements.

APPEAL TIME FRAMES

If the Board of Trustees or its designated fiduciary reviews a second level appeal, the amount of time they have to issue a decision after receiving your appeal will depend on the type of claim.

- **Urgent Care.** Appeals of urgent claims will be decided within 72 hours after the Plan Administrator receives the appeal.
- **Pre-service.** Appeals of pre-service claims will be decided within 30 days after the Plan Administrator receives the appeal.
- **Post-service.** Appeals of post-service claims to the Board of Trustees will be decided at the next quarterly meeting of the Board of Trustees (or its authorized fiduciary designee) immediately after receiving your appeal, unless the Board of Trustees received your appeal within 30 days of the date of the meeting, in which case your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Board of Trustees, you will receive a decision no later than the third quarterly meeting, and you will be notified in writing of the need for the extension, why the extension is needed, and when a decision is expected. The Board of Trustees will send you a notice of this decision within five days of the decision.
- **Concurrent Care.** Appeals of concurrent care claims are governed by the provisions above for urgent care, pre-service, or post-service claims, whichever applies to the particular claim.

Notice of Appeal Denial

If all or part of your claim is denied on appeal, you will receive a written explanation that describes:

- The specific reason for the denial;
- The specific provisions of the Plan document on which the decision was based;
- Any additional information necessary to reconsider your claim (and why that information is necessary);
- Notice that you may receive, upon request, access to and free copies of documents and records relevant to your claim; and
- A statement of your right to bring a lawsuit under ERISA.

If an internal rule, guideline or protocol was relied on in making the decision, you will receive either a copy of the rule, guideline or protocol, or a statement that it was relied upon and is available upon request and free of charge. If the decision on a medical claim is based on medical necessity, experimental treatment or similar exclusion or limit, you will receive either an explanation of the scientific or clinical judgment related to your condition or a statement that such an explanation is available, free of charge, upon request. If the initial decision on a medical claim was based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination (but not a subordinate of such person). In reviewing a denied medical claim, the Board of Trustees will not automatically presume that the Plan Administrator's initial decision was correct. Rather, the medical claim will be reviewed independently based on all information you provided to the Board of Trustees, including any new information that you provide that was not reviewed during the Plan Administrator's initial decision.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act (ERISA) without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than one-hundred and eighty (180) days from the date of the Trustees' decision of the second level appeal (or, if the claim is for short-term disability benefits, more than three (3) years after the start of the disability). Any such legal action shall be commenced within the jurisdiction of the State of New Jersey

WHEN COVERAGE ENDS

Health Plan Coverage generally ends when your eligibility terminates as explained on page 4, Termination of Eligibility, or if your dependents lose their status as dependents under the Plan. However, you and/or your eligible dependents may be able to extend your medical and/or dental

coverage for a short time period as discussed below.

You and/or your dependents may also be able to continue your coverage for up to 18, 29, or 36 months if you pay the full cost of coverage plus a 2% administrative fee. See COBRA Coverage on page 63, and the subsection, Coordination of COBRA Coverage With Continued Dependents Benefits, below, for details.

DEPENDENT BENEFITS CONTINUED ON DEATH OF ACTIVE EMPLOYEE

If you die before having been covered continuously under this benefit program for five consecutive years, your covered dependents may continue their coverage under the Plan in which you participated for one full year from the first day of the month following the date of your death. If you die after having been covered continuously under this benefit program for five consecutive years, your covered dependents may continue their coverage under the Plan in which you participated (Plan “A” or “B”) for a maximum of five years following the normal termination of your benefits. However, benefits will terminate prior to the five-year period if your dependent becomes covered under another group health insurance plan, which does not apply a pre-existing condition limitation to that dependent. Also, if during the period of extended coverage your spouse remarries, that spouse will no longer be entitled to benefits from this Plan. If your spouse chooses to have the above mentioned Health Care, there is a monthly premium.

Please see page 5 under “Retirees/Widows/Widowers Health Coverage Monthly Premium.”

DEPENDENT BENEFITS CONTINUED ON PENSIONER’S DEATH

If you are a dependent of an insured Pensioner who dies while receiving a pension and you are under age 65, you will be covered for dependent benefits under the Plan the Pensioner participated in (Plan “A” or “B”) for five years.

If you are a dependent of an insured Pensioner who dies while receiving a pension, and you are over age 65, you will be covered for dependent benefits under Plan A for five years.

If your spouse chooses to have the above mentioned Health Care, there is a monthly premium.

Please see page 5 under “Retirees/Widows/Widowers Health Coverage Monthly Premium.”

However, if during the period of extended coverage you remarry, you will no longer be entitled to benefits from this Plan.

COORDINATION OF COBRA COVERAGE WITH CONTINUED DEPENDENTS BENEFITS

If you are a dependent covered for dependent benefits under the Plan as a result of the death of an active employee or a Pensioner, as discussed above, the COBRA Continuation Coverage period will be deemed to begin on the first day after you are no longer entitled to dependent benefits under the Plan.

EXTENSION OF MEDICAL COVERAGE

If you or your eligible dependents cease to be covered under the Local 164 Welfare Fund for any reason while under the care of a physician, coverage pertaining solely to the diagnosed illness under treatment while covered will be extended while under the physician's care, but not beyond the three-month period following the date of the cessation of coverage.

EXTENSION OF DENTAL COVERAGE

If you or your eligible dependents cease to be covered for any reason while under the care of a dentist, coverage pertaining solely to any dental procedure started while covered will be extended while under the dentist's care, but not beyond the three-month period following the date of cessation of coverage.

COBRA COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), allows you and your eligible dependents to continue health care coverage at your own expense under certain circumstances when health care coverage would otherwise end. Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Under COBRA, you and your covered dependents may continue the same coverage that you had before the COBRA-qualifying event, including:

- Medical coverage;
- Hospital coverage;
- Prescription drug coverage;
- Dental coverage;
- Vision coverage.

COBRA Eligibility (COBRA-Qualifying Events)

For You

COBRA coverage is available to you if coverage would otherwise end if:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.
- Your employment ends for any reason other than gross misconduct.

For Your Dependents

COBRA coverage is available to your eligible dependents if coverage would otherwise end if:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.
- You (the active employee) end employment for any reason other than gross misconduct.

- You (the active employee) die, get divorced, become legally separated, or become entitled to Medicare.
- Your dependent child ceases to be eligible for Fund coverage when he or she reaches the maximum age limit for coverage (age 26).
- When your child is over the age of 26 and is eligible for COBRA, the General Plan Limitations and Exclusions would apply.

COBRA AT-A-GLANCE

COBRA Coverage May Continue for:

If the Following Event Occurs AND Coverage Is Lost:

Maximum Length of COBRA Coverage:

You and Your Eligible Dependents

- Your employment ends (for example, you resign) for any reason except gross misconduct.
- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.

18 months (29 months if you or your eligible dependents are disabled*).

Your Eligible Dependents

- You die.
- You are divorced or legally separated.
- You become entitled to Medicare.
- Your child(ren) no longer qualifies as an eligible dependent under the Plan.

36 months.

*For more information about COBRA coverage for the disabled, see page 67.

How COBRA Coverage Works

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under the Plan, you and/or a family member must notify the Fund Office in writing of that event no later than 60 days after that event occurs. That notice should be sent to:

Fabian & Byrn LLC
 Joint Welfare Fund LU #164, IBEW
 425 Eagle Rock Ave., Suite 105
 Roseland, NJ 07068
 Telephone: 877-228-4202

Fabian & Byrn LLC will then send you information about COBRA coverage.

IF NOTICE IS NOT RECEIVED BY THE END OF THAT 60-DAY PERIOD, THE AFFECTED SPOUSE OR DEPENDENT WILL NOT BE ENTITLED TO CHOOSE COBRA CONTINUATION COVERAGE.

Your employer will usually notify Fabian & Byrn LLC of your death, termination of employment, reduction in hours, retirement, or entitlement to Medicare. However, you or your family should also notify Fabian & Byrn LLC promptly and in writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

How to Elect COBRA Continuation Coverage

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or when Fabian & Byrn LLC is notified on a timely basis that you died, divorced, or were legally separated, became entitled to Medicare, or that a dependent child loses dependent status, Fabian & Byrn LLC will give you and/or your covered dependents notice of the date on which your coverage ends and the information and forms you need to elect COBRA Continuation Coverage.

Under the law, you and/or your covered dependents will then have only 60 days from the date you or they receive that notice, with the necessary information and forms, to apply for COBRA Continuation Coverage.

IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN 60 DAYS AFTER RECEIVING THAT NOTICE, YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

COBRA Continuation Coverage may be elected for some members of the family and not others. In addition, one or more dependents may elect COBRA even if the employee does not elect it. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event. A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her.

The COBRA Continuation Coverage That Will Be Provided

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on the Cost of COBRA Continuation Coverage for information about how much COBRA will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your COBRA Continuation Coverage.

Cost of COBRA Coverage

Individuals who continue full coverage under COBRA pay 102% of the Plan's cost, on an aftertax basis, except in cases of extended COBRA coverage due to disability. See the section entitled "COBRA Coverage in Cases of Disability" for details.

Paying for COBRA Coverage

The amount you, your covered spouse, and/or your covered dependent child(ren) must pay for COBRA coverage will be payable monthly. The Plan is permitted to charge the full cost of coverage for similarly situated active employees and families, plus an additional 2% (for a total charge of 102%). The COBRA Continuation Coverage charge is different in cases of extended COBRA coverage due to disability. See that section for further information.

Fabian & Byrn LLC will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected. **If this payment is not made when due, COBRA Continuation Coverage will not take effect.** After that, payments are due on the first day of each month.

There will then be a grace period of 30 days to pay each of these monthly payments. **If payment of the amount due is not made by the end of this grace period, your COBRA coverage will terminate.**

Duration of COBRA Coverage

Your COBRA coverage can continue for up to 18, 29, or 36 months depending on the COBRA qualifying event.

The COBRA Continuation Coverage period begins on the date of loss of coverage (rather than on the date of the qualifying event).

18 Months

COBRA health coverage can continue for up to 18 months if you would otherwise lose Fund health coverage because of:

- Your reduction in hours;
- Your change from active to inactive work status due to your:
 - Resignation;
 - Discharge (except for discharge for gross misconduct);
 - Disability;
 - Strike;
 - Layoff;
 - Leave of absence (except for leave under the Family and Medical Leave Act (FMLA));
 - Retirement.

29 Months

COBRA health coverage can continue for up to a total of 29 months if you or an eligible dependent becomes permanently disabled (as determined by the Social Security Administration), within the

first 60 days of COBRA coverage, and you or your dependent notifies Fabian & Byrn LLC of the determination no later than 60 days after it was received and before the end of the initial 18-month COBRA period.

36 Months

COBRA health coverage for your dependents can continue for up to a total of 36 months from the date any one of the following COBRA-qualifying events occurs:

- Your death;
- Your divorce;
- You become entitled to Medicare;
- Your dependent is no longer eligible for Fund coverage.

COBRA Coverage in Cases of Disability

If you, your spouse, or any of your covered dependent child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage.
- The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- Fabian & Byrn LLC must be notified by you or by the disabled covered person or another family member that the determination was received:
 - No later than 60 days after it was received; and
 - Before the 18-month COBRA continuation period ends.

This extended period of COBRA coverage will end at the earlier of:

- The last day of the month, 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled.
- The end of 29 months from the date of the COBRA qualifying event.
- The date the disabled individual becomes entitled to Medicare.

Cost of COBRA Coverage in Cases of Disability

If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan will charge employees and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month period following the 18th month of COBRA Continuation Coverage. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

Acquiring a New Dependent(s) while Covered by COBRA

If you acquire a new dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA Continuation Coverage, you may add that dependent to your coverage for the balance of your COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage. To enroll your new dependent for COBRA coverage, you must notify Fabian & Byrn LLC **within 31 days** of acquiring the new dependent. There may be a change in your COBRA premium amount in order to cover the new dependent. This does not apply for dependent children choosing COBRA. If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36-month COBRA coverage period, COBRA coverage also will end for your newly added spouse. However, COBRA coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time. Check with Fabian & Byrn LLC for more details on how long COBRA coverage can last.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled for coverage under the terms of the plan and, when enrollment was previously offered under the plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

You must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

Multiple Qualifying Events while Covered by COBRA

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

For example, assume you lose your job (the first COBRA-qualifying event), and you enroll yourself and your covered eligible dependents for COBRA coverage. Three months after your COBRA coverage begins, your child turns 26 years old and is no longer eligible for Plan coverage.

Your child can continue COBRA coverage for 33 months, for a total of 36 months of COBRA coverage.

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the active employee) during the 18-month period of COBRA Continuation Coverage.

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of disability). As a result, if you experience a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

Medicare and Second Qualifying Events. If:

- (1) you become entitled to COBRA Continuation Coverage because of termination of employment or reduction in hours that occurred less than 18 months after the date you become entitled to Medicare and
- (2) your spouse and/or any dependent child has a second qualifying event as described in the first paragraph of this section, then your spouse and/or dependent child would be entitled to a 36-month period of COBRA Continuation Coverage beginning on the date you became entitled to Medicare. For example, you become entitled to Medicare. Ten months later, your employment terminates. Your spouse and/or dependent child who had a second qualifying event during the 18-month period of COBRA Continuation Coverage would be entitled to COBRA Continuation Coverage for a 36-month period beginning on the date you became entitled to Medicare.

When COBRA Coverage May Be Cut Short

Once COBRA coverage has been elected, it may be cut short on the occurrence of any of the following events:

- The first day of the time period for which you don't pay the COBRA premiums within the required time period;
- The date on which the Fund is terminated;
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become covered by another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the covered person may have;
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become entitled to Medicare (usually age 65);

- If you fail to follow the Fund’s policies and procedures and take actions that would result in termination of an active employee for cause. (For example, if you submit false claims to the Fund);
- When the employer that employed you prior to the qualifying event has stopped contributing to the Plan and (1) the employer establishes one or more group health plans covering a significant number of the employer’s employees formerly covered under this Plan, or (2) the employer starts contributing to another multi-employer plan that is a group health plan.

When COBRA Coverage Ends

Your COBRA coverage ends on the earliest of the date that:

- Any of the above-listed events occurs;
- The COBRA period (18, 29, or 36 months) ends.

Confirmation of Coverage to Health Care Providers

Under certain circumstances, federal rules require the Fund to inform your Health Care Providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following two circumstances.

1. If a Health Care Provider requests confirmation of coverage during the COBRA election period, and you, your spouse or your dependent child(ren) have not yet elected COBRA continuation coverage; then the Fund Office will give a complete response to the Health Care Provider about you and your dependents’ COBRA continuation rights during the election period.

The Fund cancels your and your dependents’ coverage as of the date coverage ends under the Plan. However, the Fund retroactively reinstates your coverage once COBRA continuation coverage is elected. If you have not yet elected COBRA, Fabian & Byrn LLC will inform the Health Care Provider that you do not currently have coverage, but that you and your dependents would have coverage retroactively to the date coverage was lost if you elect COBRA continuation coverage.

2. If, after you have elected COBRA continuation coverage, a Health Care Provider requests confirmation of coverage for a period for which Fabian & Byrn LLC has not yet received payment; then Fabian & Byrn LLC will give a complete response to the Health Care Provider about you and your dependents’ COBRA continuation rights during that period.

3. The Fund cancels your and your dependents’ coverage as of the first day of a period of coverage if it has not received your or your dependents’ COBRA payment. However, the Fund retroactively reinstates your coverage once the COBRA payment is made. If you and/or your dependents have not paid the applicable COBRA payment, Fabian & Byrn LLC will inform the Health Care Provider that you do not currently have coverage, but that you and your dependents would have coverage retroactively to the first day of the period of coverage if timely payment is made.

CERTIFICATION OF COVERAGE

When your medical and dental coverage ends, you and/or your covered Dependents are entitled by law to, and will be provided with, a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan (including, if applicable, COBRA coverage). Such a certificate will be provided to you shortly after the plan knows or has reason to know that coverage (including, if applicable, COBRA coverage) for you and/or your covered Dependent(s) has ended. In addition, such a certificate will be provided on receipt of a request for such a certificate that is received by Fabian & Byrn LLC within two years after the later of the date your coverage under this Plan has ended or the date your COBRA coverage ended. You may address your request to:

Fabian & Byrn LLC
Joint Welfare Fund LU# 164, IBEW
425 Eagle Rock Ave., Suite 105
Roseland, NJ 07068

If, within 62 days after your coverage under this Plan ends, you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered Dependents a health insurance policy, this certificate may be necessary to reduce any exclusion for Pre-existing Conditions that may apply to you and/or your covered Dependents in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan (including if applicable, COBRA coverage), and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your or their coverage under this Plan ends. If you (or any of your covered Dependents) elect COBRA Continuation coverage, another certificate will be sent to you (or them if COBRA Continuation Coverage is provided only to them) by first class mail shortly after the COBRA Continuation Coverage ends for any reason.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

You and your covered dependents 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 worksites 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's 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 the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan beneficiaries.

No one, including the employer, the 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

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 Fund Administrator.

If you have a claim for benefits that is denied, 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 medical child support order, you may file suit in Federal court.

If 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 if, for example, it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, 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.

GENERAL INFORMATION

FUND ADMINISTRATION

A joint Board of Trustees, consisting of four Union representatives and four Employer representatives, administers the Joint Welfare Fund, Local No. 164, I.B.E.W.

The name of the Third Party Fund Administrator is:

Fabian & Byrn LLC

Telephone: 877-228-4202

The names of the Union Trustees are:

Christopher Bioletti

Daniel Gumble

Stanley Jaworski

Kelly Whalen

The names of the Employer Trustees are:

Cheryl Adelong

Victor Daidone

Jim Estabrook

Dan Kelly

Board of Trustees' employer identification number: 22-1537766

Plan Number: 501

Fiscal year end date: December 31

The Board of Trustees has been designated as the agent for the service of legal process. In addition, service of legal process may be made on any individual Trustee.

FINANCIAL INFORMATION

Benefits are provided from the Welfare Fund's assets, which are accumulated under the provisions of collective bargaining agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to Participants and defraying reasonable administrative expenses. Employers make contributions to the Plan in accordance with their collective bargaining agreements with Local Union No. 164, I.B.E.W. In addition, contributions are received from Plans, which have Reciprocal Agreements with the Joint Welfare Fund of Local Union No. 164, I.B.E.W.

The collective bargaining agreements require contributions to the Plan on the basis of a fixed rate per hour worked. The Fund Office will provide the Participant, on written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the collective bargaining agreement.

The Fund's assets and reserves are invested in savings accounts and in short-term securities guaranteed by the Federal Government.

The Plan is maintained pursuant to collective bargaining agreements. A copy of a collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator, subject to a reasonable charge to cover the cost of furnishing it, and is available for examination by participants and beneficiaries at the Fund office.

PLAN BENEFITS

The types of benefits provided by the Plan are set forth in the Schedule of Benefits on pages II to VI.

PLAN PROVIDERS

The following are the names and addresses of the companies that provide services under the Plan:

Third-Party Administrator

Fabian & Byrn LLC
425 Eagle Rock Ave., Suite 105
Roseland, NJ 07068
Telephone: 877-228-4202

Hospital and Medical Provider

Horizon Blue Cross Blue Shield of New Jersey
3 Penn Plaza East
Newark, NJ 07015
www.horizonblue.com

Dental Provider

Horizon Blue Cross Blue Shield Dental Option Plan
P.O.Box 1311
Minneapolis, MN 55440-1311
Telephone: 800-433-6825
www.horizonblue.com

Behavioral Health Provider

Intervention Strategies International, Inc.
351 Evelyn Street, Third floor
Paramus, NJ 07652
Telephone: 800-663-0404

Prescription Benefits Manager

Global Pharmaceutical Benefits, LLC
222 Lafayette Street
Newark, NJ 07105
Telephone: 800-341-2234
www.globalpharmaceuticalbenefits.com

POWER OF TRUSTEES

The Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under this Plan, and (2) the eligibility rules, including those rules providing extended or accumulated eligibility, even if the extended eligibility has already been accumulated.

The Trustees reserve the right to amend or terminate this Plan, or any part of it, at any time. Amendments may be made in writing by the Trustees and become effective on the date specified in the document amending the Plan. The Trustees may terminate the Plan or any coverage under it, and the Trustees may add new coverages.

DISCRETIONARY AUTHORITY OF THE TRUSTEES AND THEIR DESIGNEES

In carrying out their respective responsibilities under the Plan, the Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Trustees or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you and your covered Dependents by any Health Care Provider. Neither the Plan, the Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

GLOSSARY

ALLOWABLE CHARGE

The allowable charge for Medically Necessary services or supplies will be determined by the Trustees or their designee.

- With respect to a health care provider or health care service charge in the Global Pharmaceutical, LLC, Horizon BCBSNJ Direct Access, Horizon Blue Cross Blue Shield Dental Option Plan or Intervention Strategies International, Inc. networks, the allowable charge will be determined as set forth in the agreement between the health care provider and the contracted network provider; or
- The healthcare provider's actual charge.

APPROPRIATE SERVICES

A medical or dental service or supply will be considered to be Appropriate if:

- It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

BIRTH (OR BIRTHING) CENTER

A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
 - It is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate post partum care, and care of a child born at the center.
 - It is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
 - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
 - It provides at least 2 beds or 2 birthing rooms.
 - It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.

- It has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
 - It has trained personnel and necessary equipment to handle emergency situations.
 - It has immediate access to a blood bank or blood supplies.
 - It has the capacity to administer local anesthetic and to perform minor surgery.
 - It maintains an adequate medical record for each patient which contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post partum summary.
 - It is expected to discharge or transfer patients within 48 hours following delivery.
3. A Birth (or Birthing) Center that is part of a Hospital, as defined in this chapter, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

COST-EFFECTIVE SERVICES

A medical or dental service or supply will be considered to be cost-effective if it is no more costly than any alternative Appropriate Service or Supply when considered in relation to all health care expenses incurred in connection with the service or supply.

DURABLE MEDICAL EQUIPMENT

A. Equipment that:

1. can withstand repeated use; **and**
2. is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; **and**
3. is not disposable or non-durable.

B. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails), electric and manual wheel chairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

EMERGENCY

A medical or behavioral condition, the onset of which is sudden. It manifests itself by symptoms of such severity, including severe pain, that a prudent layperson with an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention would result in:

- placing the health of the afflicted person in serious jeopardy;
- placing the health of an individual with a behavioral health condition or others in serious jeopardy;
- causing serious impairment to the individual's bodily functions;
- causing serious dysfunction of any bodily organ or part;
- causing serious disfigurement of the afflicted individual.

FEE SCHEDULE

For services or supplies received from providers not participating in the network, the allowable for medically necessary services will be the lowest of:

The Joint Welfare Fund, Local Union 164, I.B.E.W. fee schedule;

or, the health care provider's actual charges.

The Fund will not always pay benefits equal to or based on the health care provider's actual charge for health care services or supplies, even after you have paid the applicable deductible and coinsurance. This is because the Plan covers only up to the Fee Schedule allowance for health care services and supplies.

HOSPITAL

A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that:

1. is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
2. is approved by Medicare as a Hospital; and
3. provides care and treatment by physicians and nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.
4. A Hospital may include facilities for mental, nervous and/or substance abuse treatment that are licensed and operated according to law.
5. Any portion of a Hospital used as an ambulatory surgical facility, Birth (or Birthing) Center, convalescent care facility, extended care facility, hospice, Skilled Nursing Facility, subacute care facility, or other residential treatment facility or place for rest, custodial care, or the aged shall not be regarded as a Hospital for any purpose related to this Plan.

MEDICALLY NECESSARY

A service or supply will be determined to be Medically Necessary by the Trustees or their designee if it:

- is provided by or under the direction of a Physician (or Dentist if a dental service or supply is involved); and
- is determined to be necessary in terms of generally accepted medical standards; and
- meets **all** of the following requirements:
 - It is consistent with the symptoms or diagnosis and treatment of the illness or injury;
 - It is not provided solely for the convenience of the patient, Physician, Hospital, health care provider, or health care facility;
 - It is an "Appropriate" Service or Supply given the patient's circumstances and condition;
 - It is a cost-efficient supply or level of service that can be safely provided to the patient; and
 - It is safe and effective for the illness or injury for which it is used.
- The fact that your Physician or Dentist may provide, order, recommend or approve a

service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

- A Hospitalization or confinement to a specialized health care facility will **not** be considered to be Medically Necessary if the patient's illness or injury could safely and Appropriately be diagnosed or treated while not confined.
- A medical or dental service or supply will **not** be considered to be Medically Necessary if it is furnished only because of where it is provided if the service or supply could safely and Appropriately be furnished in a Physician's or Dentist's office or other less costly facility.
- The non-availability of a bed in another specialized health care facility, or the non-availability of a health care practitioner to provide medical services will **not** result in a determination that continued confinement in a Hospital or other specialized health care facility is Medically Necessary.
- A medical or dental service or supply will **not** be considered to be Medically Necessary if it does not require the technical skills of a health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any health care practitioner, or any Hospital or specialized health care facility.

SKILLED NURSING CARE

A. Services performed by a licensed nurse (RN, LVN or LPN) if the services:

1. Are ordered by and provided under the direction of a physician; **and**
2. Are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; **and**
3. Require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse.

B. Examples of Skilled Nursing Care services include, but are not limited to, the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

SKILLED NURSING FACILITY

A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; **and**
2. It is regularly engaged in providing room and board and continuously provides 24-hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed physician; **and**

3. It provides services under the supervision of physicians; **and**
4. It provides nursing services by or under the supervision of a licensed registered nurse (RN), with one licensed registered nurse on duty at all times; **and**
5. It maintains a daily medical record of each patient who is under the care of a licensed physician; **and**
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; **and**
7. It is not a hotel or motel.
8. A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

