

**PLAN DOCUMENT AND  
SUMMARY PLAN DESCRIPTION  
FOR**

**ALTON IBEW/NECA HEALTH AND WELFARE PLAN**

**MAY 1, 2015**

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## INTRODUCTION

This document is a description of the Alton IBEW/NECA Health and Welfare Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Board of Trustees fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Participants are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Cost Management Services.** Explains the methods used to curb unnecessary and excessive charges.

**This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

**Defined Terms.** Explains the rules for filing claims and the claim appeal process.

**Plan Exclusions.** Shows what charges are **not** covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provisions.** Explains the Plan's rights to recover payment of charges when a Participant has a claim against another person because of injuries sustained.

**Continuation Coverage Rights Under COBRA.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

**ERISA Information.** Explains the Plan's structure and the Participants' rights under the Plan.



## SECTION I. DEFINITIONS

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the regular payroll of a Contributing Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

**Ambulatory Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Calendar Year** means January 1<sup>st</sup> through December 31<sup>st</sup> of the same year.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Contributing Employer** means an Employer who has agreed to contribute to this Plan in a Collective Bargaining Agreement or other written agreement.

**Co-payment or Co-pay** is a specified dollar amount that must be paid by the Participant for specific services. Co-payment amounts are set forth in the Schedule of Benefits.

**Covered Charge(s)** means charges for services and supplies covered under the Plan as set forth in this Booklet that meet the following criteria:

- (1) the charges must be for a service or supply prescribed by a physician.
- (2) the charges must be for a service or supply which is Medically Necessary in connection with the diagnosis or therapeutic treatment of an Injury or Illness.
- (3) the charges must not exceed the lesser of:
  - a. the Usual and Reasonable Charges for such treatment, or
  - b. in the case of a Network Provider, the discounted fee negotiated between the Medical Network and Medical Benefits Manager and the Network Provider.
- (4) the charges must not be excluded under the Exclusions and Limitations sections of this Plan.

**Custodial Care** is a type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a person, whether or not Disabled, in the activities of daily living. Such activities include, but are not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting out of bed, and supervision over medication which can normally be self-administered.

**Deductible** is the dollar amount of expenses for Covered Charges that a Participant is responsible for paying before benefits subject to the Deductible are paid by the Plan.

**Disability or Disabled** means:

- in the case of an Active Employee, that the Employee is unable to perform his regular work solely as a result of an Injury or Illness; or
- in the case of any other covered individual, that the individual is prevented from engaging in all the normal activities of a person of like age and sex and in good health solely as a result of an Injury or Illness.

**Durable Medical Equipment** means Medically Necessary equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

**Employee** means a person who is an Active Employee of a Contributing Employer and is regularly scheduled to work for said Contributing Employer in an Employee/Employer relationship.

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**ERISA** is the Employee Retirement Income Security Act of 1974, as amended.

**Experimental and/or Investigative** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, medical treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its

safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the U.S. Food and Drug Administration for general use.

**Foster Child** means individual under the limiting age shown in the Dependent Eligibility section of this Plan who is placed with a covered Employee by an authorized placement agency or judgment, decree or other order of any court of competent jurisdiction.

**Generic** means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any U.S. Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour-a-day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

**Hour Bank** is an individual account established and credited with certain hours for which the Contributing Employer pays on behalf of an Employee, as set out below. These hours are used for initial and continued eligibility under this Plan. All contribution hours in excess of the number required for initial and continued eligibility will be maintained in the Employee's Hour Bank account, up to a maximum of 840 hours. Such hours shall be used for continued eligibility during periods of unemployment, underemployment, disability, retirement or the death of the Participant (for Dependent eligibility).

**Illness** means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

**Incurred** means Covered Charges are Incurred on the date the service is rendered or the supply obtained. With respect to a course of treatment or procedure that includes several steps or phases of treatment, Covered Charges are Incurred for the various steps or phases of treatment as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Charges for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

**Infertility** means incapable of producing offspring.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Intensive Care Unit** is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms or wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Late Enrollee** means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

**Legal Guardian** means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Participant.

**Maintenance Care** means services and supplies primarily to maintain a level of physical or mental function.

**Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medical Emergency** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medical Non-Emergency Care** means care which can safely and adequately be provided other than in a Hospital.

**Medically Necessary** care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**Medicare** is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**Morbid Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Participant.

**Network Provider** is a provider who, by contract with Coventry PPO ASO Options Network agrees to accept the allowable (negotiated/contracted) charge as full payment of Covered Charges, except for Deductibles, Copays and/or Coinsurance. Any Deductibles and/or Copays are the responsibility of the Participant.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Non-Network Provider** is a provider who does not have a contract with Coventry PPO ASA Options Network and may charge more than the Usual, Customary and Reasonable Charge. Any amount in excess of the Usual, Customary and Reasonable Charge is the responsibility of the Participant.

**Outpatient Care and/or Services** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Participant** or Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means the Alton IBEW/NECA Health and Welfare Plan, which is a benefits plan for certain Employees of Contributing Employers to the Alton IBEW/NECA Health and Welfare Plan and is described in this document.

**Plan Administrator** is the Joint Board of Trustees of the Alton IBEW/NECA Health and Welfare Plan, consisting of an equal number of Union and Employer Trustees, which is the named fiduciary of the Plan and has all discretionary authority and control over the operation, interpretation and administration of the Plan. The Plan Administrator may choose to hire a consultant and/or contract administrators to perform specified duties in relation to the Plan. The Plan Administrator also has the right to amend, modify or terminate the Plan at any time or in any manner.

**Plan Sponsor** is the Joint Board of Trustees.

**Plan Year** is the 12-consecutive month period from November 1<sup>st</sup> to October 31<sup>st</sup>.

**Preferred Drug** is a Prescription Drug that is on the preferred (formulary) list of FDA approved Prescription Drugs and supplies developed by the Prescription Drug Program which represents the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. The list of Preferred Drugs is subject to the periodic review and modification of the Prescription Drug Program.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following: a Food and Drug Administration approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription;" injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Retired Employee** is a former Active Employee of a Contributing Employer who meets the eligibility requirements of this Plan and elects to contribute to the Plan the contribution required from the Retired Employee.

**Second Surgical Opinion** is an opinion rendered by a second Physician if the first Physician recommends a surgical procedure for a Participant. Benefits will be payable for the second opinion only if the second Physician:

- (1) is a Board Certified Specialist;
- (2) does not have a financial arrangement with the Physician who first recommended the surgery;
- (3) is acting as a consultant only; and
- (4) does not perform the surgery.

**Sickness is:**

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

**Skilled Nursing Facility** is a facility that fully meets all of these tests.

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24-hour-per-day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

**Spinal Manipulation/Chiropractic Care** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Spouse** means the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The term "Spouse" also means any individual to whom you are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes same sex marriages, even if you are domiciled in a state that does not recognize such marriage. The term "Spouse" shall not mean domestic partners or individuals in civil unions.

**Substance Abuse** is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Temporomandibular Joint (TMJ) syndrome** is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

**Total Disability (Totally Disabled)** means a physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

- (1) in the case of an Employee/Member, the complete inability to perform any and every duty of his occupation or employment; and
- (2) in the case of a Dependent, a COBRA beneficiary or a Retired Employee, it means the complete inability to perform the normal activities of a person of like age and sex in good health.

**Urgent Care Facility** is a freestanding facility which is engaged primarily in providing minor emergency and episodic medical care which has a board certified Physician, a registered nurse (R.N.) and a registered x-ray technician in attendance at all times. The facility also has x-ray and laboratory equipment and a life support system. An Urgent Care Facility does not include a clinic located at, operated in conjunction with, or in any way made a part of a regular Hospital.

**Usual and Reasonable Charge** is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

**Utilization Review** is a review and determination as to the appropriateness and Medical Necessity of services and supplies.

**Waiting Period** is the period of time that must pass before coverage for an individual who is otherwise eligible to enroll in Plan coverage becomes effective. If you are a late enrollee (see Section II.C.4) or a special enrollee (see Sections II.C.5-6), the period before your late or special enrollment is not a Waiting Period.



## **SECTION II. ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE**

**Note:** This Section describes the eligibility rules for Active Employees and their Dependents. The eligibility rules for Retired Employees are explained in Section VII of the Plan.

### **A. ELIGIBILITY FOR ACTIVE EMPLOYEES**

#### **1. Eligible Classes of Employees**

The following Classes of Employees are eligible.

- a. All Bargaining Unit Employees employed by a Contributing Employer on whose behalf a Union acts as bargaining agent and who are covered by a collective bargaining agreement requiring contributions by the Contributing Employer to this Fund;
- b. All active full-time Employees (working 20 hours or more a week) of a Contributing Employer who are not included in the bargaining unit, but who are employed in a managerial, supervisory or clerical capacity, on behalf of all of whom the Contributing Employer agrees to make contributions to this Fund;
- c. All active full-time Employees of the Union on behalf of all of whom said Union agrees to make contributions to this Fund; and

#### **2. Initial Eligibility Requirements for Active Employee Coverage**

Enrollment is mandatory. Initial eligibility for Employee coverage will begin after the following requirements are met:

- a. The Employee completes an enrollment form and submits the enrollment form to the Fund.
- b. Construction Bargaining Unit Employees—on the first day of the second calendar month which follows any six (6) consecutive month period or less in which the Employee has been credited with 420 contribution hours paid by a Contributing Employer. Eligibility is determined using the “Hour Bank” system.
- c. Non-Bargaining Unit Employees (based on monthly contribution rate)—on the first day of the second calendar month following the month in which contributions are paid by the Contributing Employer and received by the Fund.

Enrollment forms may be submitted at any time.

#### **3. Continued Eligibility Requirements for Active Employee Coverage**

- a. Construction Bargaining Unit Employees—eligibility will continue from month to month as long as a minimum of 140 hours is available in the Employee’s Hour Bank account. Hour Bank hours accumulated in excess of 140 will be used to continue eligibility into the second calendar month after the month that the minimum balance was maintained. In the event an Employee has fewer than 140 hours available in his Hour Bank, he may

continue eligibility by self-payment of the difference between his Hour Bank and 140 hours multiplied by the hourly contribution rate.

- b. Non-Bargaining Unit Employees—eligibility will continue from month to month as long as the monthly contribution is made by the Contributing Employer. Each month that sufficient contributions are made on behalf of an Employee enables the employee to be eligible during the second calendar month after the month the contribution was made. For each month that the Employer contribution is made, a credit of 20 contribution hours will be applied to the Employee’s Hour Bank for use in earning future eligibility. The required balance is 140 hours or more in the Hour Bank for eligibility to continue in the event the Contributing Employer does not make a monthly contribution for the Employee. Hour Bank hours accumulated in excess of 140 hours will be used to continue eligibility into the second calendar month after the month that the minimum balance was maintained.
- c. An Active Employee whose Hour Bank has been depleted may continue eligibility by self-payment in the amount of 140 multiplied by the hourly contribution rate for each month of continued coverage, as long as:
  - (1) For Construction Bargaining Unit Employees—the Employee continues to be available to perform bargaining unit work, including the maintenance of the union membership required to perform such work.
  - (2) For Non-Bargaining Unit Employees—the Employee continues employment with a Contributing Employer.

Effective August 19, 2015, the period of self-payment shall be limited to 18 months during which no contributions have been made on an Employee’s behalf by a Contributing Employer.

Loss of coverage as a result of cessation of self-payment or cessation of the right to self-pay will be considered a qualifying event for purposes of COBRA continuation coverage.

#### **4. Reinstatement of Eligibility**

If the Employee’s eligibility terminates, eligibility is reinstated on the first day of the second calendar month following the month in which he has 140 contribution hours credited within twelve months of termination of eligibility or 420 hours credited after twelve months.

#### **5. Reciprocity**

The Fund is a party to the IBEW/NECA Electronic Reciprocal Transfer System (ERTS).

In the Electrical Industry, many Employees are at times employed by employers under contract to contribute to one welfare fund and at other times employed by an employer under contract to contribute to another fund. Employees are able to maintain eligibility for benefits from this Fund if they work for an employer who contributes to another fund. Employees must register in person with ERTS at the

Local Union hall. Employees will be issued a log-on and password. If an employer contributes to a different fund on an Employee's behalf, the money will be electronically transferred to this Fund. Employees will be able to change their registration or stop transfers at any time. This system will allow Employees to continue their welfare benefits with minimal interruption.

## **B. ELIGIBILITY OF DEPENDENTS**

### **1. Eligible Classes of Dependents**

A Dependent is any one of the following persons:

(a) A covered Employee's Spouse.

The Plan Administrator may require documentation proving a marital relationship recognized by the Fund.

(b) A covered Employee's children from birth to the limiting age of 26 years. The Plan will cover a child through the end of the month in which the child's 26<sup>th</sup> birthday occurs.

The term "children" shall include natural children, adopted children, step-children, Foster Children and children placed with a covered Employee in anticipation of adoption.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of such child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order ("QMCSO") shall be considered as having a right to Dependent coverage under this Plan. A QMCSO is a medical support order that creates or recognizes the right of an alternate recipient to receive benefits for which a participant or beneficiary is eligible through the Fund or assigns to an alternate recipient the right of a participant or beneficiary to receive benefits through the Fund and meets ERISA's QMCSO requirements. You may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

If a covered Employee is the Legal Guardian of an unmarried child, to qualify as an eligible Dependent under the Plan the child must be dependent upon the covered Employee for over one-half of his support during the Plan Year. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

- (c) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance, and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

The following individuals are excluded as Dependents: other individuals living in the covered Employee's or Retired Employee's home, but who are not eligible as defined above; the legally separated or divorced former Spouse of the Employee or Retired Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee or Retired Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

## **2. Eligibility Requirements for Dependent Coverage**

A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

## **3. Effective Date of Dependent Coverage**

Dependent coverage will become effective on the date the Employee becomes eligible or the date the Employee first acquires the Dependent, whichever is later.

# **C. ENROLLMENT**

## **1. Open Enrollment**

The annual open enrollment period will be specified every year by the Plan Administrator. At this time covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them. Plan Participants will receive detailed information regarding open enrollment from the Plan.

Benefit choices made during the open enrollment period will become effective November 1 and remain in effect until the next October 31, unless there is a Special Enrollment event or a change in family status during the year (birth, death,

marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Benefit choices of late enrollees made during an open enrollment period will become effective November 1.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

## **2. Enrollment Requirements**

An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also.

## **3. Enrollment Requirements for Newborn Children**

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent. If the newborn child is required to be enrolled and is not enrolled on a timely basis, there will be no payment from the Plan and the parents will be responsible for all costs.

If the child is required to be enrolled and is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

## **4. Timely or Late Enrollment**

### **a. Timely Enrollment.**

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

### **b. Late Enrollment.**

An enrollment is "late" if it is not made within 31 days after the person becomes eligible for coverage or during a Special Enrollment Period. Late Enrolled Employees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to

resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a late enrollee.

The time between the date a late enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period. Coverage begins on November 1<sup>st</sup>.

## **5. Special Enrollment Rights**

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Alton IBEW/NECA Health and Welfare Plan, P.O. Box 6088, St. Louis, Missouri 63139.

## **6. Special Enrollment Periods**

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- a. Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:
  - i. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual;
  - ii. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment;
  - iii. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated; and

- iv. The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
- b. For purposes of these rules, a loss of eligibility occurs if one of the following occurs:
- i. The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g.: part-time employees).
  - ii. The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
  - iii. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
  - iv. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

- c. Dependent beneficiaries. If:
- i. The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
  - ii. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at

the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

- d. The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:
  - i. in the case of marriage, the first day of the first month beginning after the date the completed request for information is received;
  - ii. in the case of a Dependent's birth, as of the date of birth; or
  - iii. in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

**7. Medicaid and State Child Health Insurance Programs**

An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if:

- a. The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.
- b. The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.



## **SECTION III. TERMINATION OF COVERAGE**

### **A. WHEN EMPLOYEE COVERAGE TERMINATES**

Employee coverage will terminate on the earliest of these dates for the following:

#### **1. Construction Bargaining Unit Employees:**

- a. the last day of the month in which the Employee fails to satisfy the requirements for continued eligibility in accordance with Section II.A.3 or in accordance with the COBRA Continuation Option in Section IV;
- b. the first day of the month following the month in which the collective bargaining agreement under which the Employee is working no longer provides for the rate of contribution for participation; notwithstanding the foregoing, if the Employee has sufficient Hour Bank hours to purchase a second month of coverage, then the effective date of termination of coverage is the first day of the second month following the month in which the collective bargaining agreement under which the Employee is working no longer provides for the rate of contribution for participation; or
- c. the last day of coverage available to the Employee from the use of Hour Bank hour reserves or COBRA Continuation coverage following the date the person enters the Armed Forces of the United States.

#### **2. Non-Bargaining Unit Employees:**

- a. the last day of the second calendar month in which the Employee fails to satisfy the requirements for continued eligibility in accordance with Section II.A.3 or in accordance with the COBRA Continuation Option in Section IV;
- b. the first day of the month following the month in which the Contributing Employer fails to make the required monthly contribution on the non-bargaining non-construction Employee's behalf; or
- c. the last day of coverage available to the Employee from the use of COBRA Continuation coverage following the date the person enters the Armed Forces of the United States.

#### **3. Continuation of Coverage During Periods of Disability**

##### **a. Construction Bargaining Unit Employees.**

If an Employee becomes Disabled while eligible under the Plan, eligibility may be continued for a maximum of 21 months from the date of the accident or Illness while the Employee is Disabled. Continued eligibility due to a Disability is not contingent upon Hour Bank hours. However, if an Employee has accrued Hour Bank hours, such hours shall be used to continue eligibility. Hour Bank balances less than 140 hours will be forfeited.

However, Disabled Employees eligible for coverage in accordance with this provision may not begin self-contribution for Supplemental Retiree Benefits following the completion of the 21 months disability self-payment period

available to Bargaining and Non-Bargaining/Non-Construction Group Employees. Coverage under this provision must begin on the effective date of his first retirement.

Disability months will be counted from the first day of the month following the month in which the Disability began. To maintain Disability eligibility, Hour Bank hours will first be drawn down at a rate of 140 hours per month. When Hour Bank hours are reduced to zero, coverage will continue with no further contribution requirement for the remainder of the 21 month maximum, provided the Employee remains Disabled. Notwithstanding any other provisions of this Section 2, the Employee will not be eligible for the continuation of coverage for any month during which the Employee received unemployment compensation benefits from any government entity. The 21 month Disability coverage provided in this paragraph applies once for each separate Disability.

If an eligible Employee was Disabled for less than 21 months, he will be eligible to continue his eligibility under the COBRA Continuation Option.

If an Employee has exhausted the allowed 21 month maximum, he may continue eligibility in accordance with the COBRA Continuation Option.

If an Employee is Disabled and obtains a physician's statement permitting him to perform light duty work, and he performs light duty work, he will not have his eligibility continued for this 21 month period. "Light duty work" is any kind of work that requires less physical exertion or strain. *An Employee may be required by the Plan to confirm the Disability to determine whether or not he is eligible for this benefit.*

**b. Non-Bargaining Unit Employees.**

If an Employee becomes Disabled while eligible under the Plan, coverage may be continued for a maximum of 21 months while he remains Totally Disabled.

However, Disabled Employees eligible for coverage in accordance with this provision may not begin self-contributions for Supplemental Retiree Benefits following the completion of the 21 month Disability self-payment period available to Bargaining and Non-Bargaining/Non-Construction Group Employees. Coverage under this provision must begin on the effective date of his first retirement.

Disability months will be counted from the first day of the month following the month in which the Disability began. To maintain Disability eligibility, Hour Bank hours will first be drawn down at a rate of 140 hours per month. When Hour Bank hours are reduced to zero, coverage will continue with no further contribution requirement for the remainder of the 21 month maximum, provided the Employee remains Disabled.

If an eligible Employee was Disabled for less than 21 months he will be eligible to continue his eligibility under the COBRA Continuation Option.

If an Employee has exhausted the allowed 21 month maximum, he may continue eligibility under the COBRA Continuation Option. Thereafter, he must have returned to active, actual, full-time work (40 hours per week) (as opposed to merely having hours imputed and/or reported on his or her behalf) and must have earned eligibility for at least three (3) consecutive months of eligibility, based on Employer contributions for purposes of requalifying for the “21 month” extension of welfare benefits.

**4. Rehiring a Terminated Employee.**

A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

**5. Employees on Military Leave.**

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (“USERRA”) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- a. The maximum period of coverage of a person and the person’s Dependents under such an election shall be the lesser of:
  - i. The 24 month period beginning on the date on which the person’s absence begins; or
  - ii. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- b. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee’s share, if any, for the coverage.
- c. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator, Alton IBEW/NECA Health and Welfare Plan, P.O. Box 6088, St. Louis, Missouri 63139. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

## **B. WHEN DEPENDENT COVERAGE TERMINATES**

A Dependent's coverage will terminate on the earliest of the following dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see Section IV entitled "Continuation Coverage Rights under COBRA"):

1. The date the Plan or Dependent coverage under the Plan is terminated;
2. The last day of the month that the Employee's coverage under the Plan terminates for any reason, including death. (See Section IV entitled "Continuation Coverage Rights under COBRA");
3. The last day of the month a covered Spouse loses coverage due to loss of dependency status. (See Section IV entitled "Continuation Coverage Rights under COBRA");
4. The last day of the month that a Dependent ceases to be a Dependent as defined by the Plan. (See Section IV entitled "Continuation Coverage Rights under COBRA"); and
5. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

## **C. RESCISSION OF COVERAGE**

### **1. Fraud or Intentional Misrepresentation of Material Fact**

The Plan has the right to terminate or rescind (retroactively terminate) an Employee, Retired Employee, or Dependent's coverage if you or a Dependent commit an act, practice, or omission that constitutes fraud or you or a Dependent make an intentional material misrepresentation of fact in applying for, obtaining, or maintaining coverage or benefits under the Plan. The Trustees shall have the right to determine whether such fraud or intentional misrepresentation of material fact has occurred. In the event of a rescission of coverage, you or your Dependent will be given 30 days advance written notice of such rescission. The Plan may prospectively terminate your coverage for fraud or intentional misrepresentation of material fact without advance written notice.

The Plan will refund all contributions paid for rescinded coverage; however, claims paid will be offset against any paid contributions prior to refund. The Plan reserves the right to collect additional monies if claims are paid in excess of the amount of paid contributions.

Any written notice under this provision will include, at least:

- a. The name(s) of the affected individual(s);
- b. The name of the Plan;
- c. The date the coverage will be rescinded (30 days from the notice date);
- d. The date coverage will be retroactively terminated;
- e. The reason(s) for the rescission; and

f. An explanation of the Plan's appeal procedures

**2. Failure to Pay Premiums or Contributions**

The Plan has the right to rescind coverage under the Plan for any covered individual for failure to pay any required contributions or premiums required for coverage. No advance written notice shall be required.

## **SECTION IV. CONTINUATION COVERAGE RIGHTS UNDER COBRA**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage under the Plan would otherwise end. This Section is intended to inform you, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in regulations issued by the Department of the Treasury and the Department of Labor. This Section is intended to reflect the law and does not grant or take away any rights that apply under applicable law. Instructions on COBRA rights and procedures, as well as election forms and other information, will be provided by the Plan Administrator to Covered Persons who become qualified beneficiaries under COBRA.

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

### **A. WHAT IS COBRA CONTINUATION COVERAGE?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "Dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a qualified beneficiary. The Retired Employee's Spouse, surviving Spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**B. WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the Employee;
- Commencement of a proceeding in bankruptcy with respect to the Employer; or
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. If mailed, your notice must be postmarked no later than the 60<sup>th</sup> day after the qualifying event occurs and the notice must include:

- The name and address of the Employee covered under the Plan;
- The name(s) and address(es) of the qualified beneficiary(ies); and
- The qualifying event and the date it happened.

If the qualifying event is divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Notice should be mailed to the address set forth below under Plan Contact Information.

### **C. HOW IS COBRA CONTINUATION COVERAGE PROVIDED?**

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. All other qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

#### ***Disability extension of 18-month period of COBRA continuation coverage***

If you or anyone in your family covered under the Plan is determined by Social Security to be Disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The Disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for the Disability extension, the qualified beneficiary must provide the Plan Administrator with written notice of the Disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18 month maximum coverage. This notice, along with a copy of the Disability determination, should be sent to the Plan Administrator at the address set forth below under Plan Contact Information.

If a qualified beneficiary becomes entitled to a Disability extension and then there is a final determination by the Social Security Administration that the qualified beneficiary is no longer Disabled, the qualified beneficiary must notify the Plan Administrator of that determination within 30 days after the date of the final determination.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the Spouse and any Dependent children getting COBRA continuation coverage if the Employee or former Employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second qualifying event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.



You must notify the Plan Administrator within 60 days after the second qualifying event occurs. If mailed, your notice must be postmarked no later than the 60<sup>th</sup> day after the second qualifying event occurs and the notice must include:

- The name and address of the Employee covered under the Plan;
- The name(s) and address(es) of the qualified beneficiary(ies); and
- The qualifying event and the date it happened.

**D. PAYMENT FOR COBRA CONTINUATION COVERAGE**

Under the plan, qualified beneficiaries who elect COBRA continuation coverage must make timely payment of premiums for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any period for which coverage is obtained pursuant to the Disability extension discussed above.

Timely payment means a payment made by the first day of the month for which coverage is to be provided (the “due date”) or within a 30-day grace period beginning on that due date. However, the Plan will not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is sent to the Plan.

**E. WHEN DOES COBRA CONTINUATION COVERAGE END?**

All rights to COBRA continuation coverage permanently end on the earliest of the following occurrences:

- The expiration of the applicable maximum COBRA continuation period;
- The qualified beneficiaries failure to make a payment before the end of the applicable grace period;
- If it occurs after the date that COBRA is elected, the qualified beneficiary becomes covered under another group plan;
- If it occurs after the date that COBRA is elected, the qualified beneficiary becomes entitled to Medicare. A person will be considered to be entitled to Medicare when the person is enrolled for either Medicare Part A or Part B. Please note that enrollment in Part A is automatic when you qualify for it;
- For COBRA continuation coverage that is extended due to Disability, the first day of the first month that begins more than 30 days after the date that a Disabled qualified beneficiary is finally determined by the Social Security Administration to be no longer Disabled; or
- The date upon when the Employer for whom the Employee worked ceases to provide any group health plan (including a successor plan) to any employee.

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

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

**G. IF YOU HAVE QUESTIONS**

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

**H. KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES**

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**I. PLAN CONTACT INFORMATION**

Any notice that you must provide in accordance with this Section must be in writing. You must mail, e-mail, fax, or hand-deliver your notice to the following:

Alton IBEW/NECA Health & Welfare Plan  
c/o IBEW/NECA Service Center  
Attn: Plan Administrator  
P.O. Box 6088  
St. Louis, Missouri 63139

## **SECTION V. MEDICAL BENEFITS**

### **A. BENEFITS**

Except as otherwise specifically provided, the Plan covers only those health services and supplies that are listed as covered and that are deemed Medically Necessary to treat an injury or illness and not excluded under the limitations and exclusions set forth in this Section V. Covered transplants must be rendered by a Center of Excellence Facility.

The provisions of this Section V set out the health care services and supplies covered under this Plan and are provided to assist you and your dependents with determining the level of coverage, the Prior Authorization procedures, and the limitations and exclusions that apply for Covered Services. If a service is Medically Necessary but is not specifically listed (even if not otherwise excluded), the service is not a covered service.

### **B. FEATURES OF MEDICAL BENEFITS PLAN**

#### **1. Network of Providers**

The Plan has contracted with Coventry Health Care, an Aetna Company, to arrange for the provision of medical care to Participants at lower costs through access to Coventry's PPO ASO Options Network of doctors, Hospitals, and other medical care providers (Network Providers) who will provide services and supplies at negotiated rates that are typically lower than the rates of Out-of-Network Providers. Participants do not have to elect a primary care Physician, and referrals are not required. The Plan offers Participants the freedom to choose their own providers while encouraging them to utilize the services of Network Providers for their health care needs whenever possible to increase Plan benefits and help control the Plan's overall costs.

A list of Coventry Health Care Providers is available online at [www.chcmissouri.com](http://www.chcmissouri.com).

The benefit level is determined by the provider who is used. When Participants obtain health care services from a Network Provider, the Plan will pay benefits as shown in the Network Provider column of the Medical Benefits Schedule.

Covered services received from providers who are outside Coventry's PPO ASO Network (Out-of-Network Providers) will be reimbursed at the lower Out-of-Network benefit shown in the Medical Benefits Schedule.

All Plan provisions and exceptions apply to both Network and Out-of-Network Providers, unless otherwise indicated.

When services are obtained from a Network Provider, the provider will submit the expenses on the patient's behalf. Payment for such services will be sent directly to the Network Provider.

**2. Co-payments (Co-pays)**

For certain covered services, you are responsible for a Co-payment amount before the Plan pays any benefits. The Co-payment must be paid before the Calendar Year Deductible and the Co-insurance amount are applied. Co-payments should be paid directly to the provider at the time of service. Co-payments do not count toward the Calendar Year Deductible. Co-payments are shown in the Medical Benefits Schedule.

**3. Co-insurance**

Co-insurance is the amount you pay after first making any applicable Co-payment and then satisfying the calendar year Deductible. Generally, your Co-insurance obligation for Network Providers is 5% and 35% for Out-of-Network Providers. After you have paid any applicable Co-payment and then satisfied the Calendar Year Deductible, for the balance of the Covered Charges, you are required to pay the difference between the percentage shown in the Medical Benefits Schedule and 100%. The Plan's share of the balance of the Covered Charges is the remaining percentage.

**4. Calendar Year Deductible**

The Deductible, as shown in the Medical Benefits Schedule, is the amount of Covered Charges that must be incurred by you, after paying any applicable Co-payment, before the Plan will pay benefits. You are responsible for the calendar year Deductible before the Plan pays any benefits, other than services or items for which the Calendar Year Deductible does not apply. Co-payment amounts do not count toward the Calendar Year Deductible. The Calendar Year Deductible does not apply toward the Out-of-Pocket Limit.

a. Family Calendar Year Deductible

When the Family Calendar Year Deductible, as shown in the Medical Benefits Schedule, has been met by the members of a family (Employee or Retired Employee and Dependents), the Individual Calendar Year Deductibles for all members of the family will be considered satisfied for that Calendar Year.

b. Deductible for a Common Accident

If two or more Participants in a single family are injured in the same accident, the Participants are not required to meet separate Individual Calendar Year Deductibles for treatment of injuries incurred in the accident. Instead, only one Individual Calendar Year Deductible will be required for them for expenses arising from the accident.

**5. Out-of-Pocket Maximum**

The individual Out-of-Pocket Maximum is a limit on the dollar amount of Co-insurance a Participant must pay out-of-pocket for specified Covered Services in a calendar year. The family Out-of-Pocket Maximum is the limit on the total dollar amount of Co-insurance Participants of the same family covered under this Plan

must pay for specified Covered Services in a Calendar Year. Once the Out-of-Pocket Maximum is met, Covered Services are paid by the Plan at 100% (except for excluded charges). The Calendar Year Deductible does not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximums are set forth in the Medical Benefits Schedule.

The following expenses do not count toward the Out-of-Pocket Maximum and will not be payable at 100% in the event the Out-of-Pocket Maximum has been met:

- a. Expenses that are not covered by the Plan;
- b. Non-Network expenses that exceed the allowable charge;
- c. Penalties for failure to comply with Utilization Review requirements;
- d. Transplant treatment rendered at a non-Center of Excellence Facility;
- e. Calendar Year Deductible;
- f. Co-payments; and
- g. Chiropractic expenses.

## **6. Prior Authorization Requirements**

Prior authorization is the process for authorizing the non-emergency use of facilities, diagnostic testing, and other health services before care is provided. **You are required to obtain prior authorization for certain benefits under the Plan before the services are rendered or the supplies are received. If prior authorization of those benefits is not obtained, a claim for those benefits under the Plan may be denied regardless of whether the service or supply is otherwise covered by the Plan or the Plan's reimbursement may be reduced, and you may be responsible for the full cost of the service or supply.**

If you receive services or supplies that are subject to prior authorization and your health care provider is a Network Provider, the Network Provider is responsible for obtaining the required prior authorization. If your health care provider is an Out-of-Network Provider, it is your responsibility or your Dependent's responsibility to make sure prior authorization is received. You or your Out-of-Network Provider must contact the Medical Network and Medical Benefits Manager to obtain the required prior authorization. You are responsible for obtaining prior authorization if your Out-of-Network Provider fails to do so.

Prior authorization is required for the following items and services:

- a. All hospital admissions, including observations
- b. All admissions to skilled nursing facilities or inpatient specialty care programs such as rehabilitation; hospice; **mental health and substance abuse (please see list of pre-certification requirements for Mental Health listed below)**
- c. All surgical procedures at an outpatient or surgical center. **(Does not include Coventry Autopay List)**
- d. Pain management injections including epidural, facet and trigger point injections—in office only (Outpatient facilities not covered)

- e. Transplants
- f. Rehabilitation/therapy: cardiac, occupational, physical, pulmonary, speech
- g. The following outpatient diagnostic/services:
  - MRI/MRA
  - All cardiac stress imaging
  - Cardiac nuclear scans
  - Hysteroscopy
  - CT scans
  - PET scans
  - Colonoscopies (Under the age of 50)
  - Neuropsychological testing
- h. \*All pregnancy related services, including but not limited to:
  - global obstetrical care
- i. Brachytherapy
- j. \*Chiropractic services over 25 visits
- k. Chemotherapy (off label use only)
- l. Durable medical equipment over \$250 and all rental equipment (Does not follow autopay list. Authorization needed for oxygen, CPM, TENS units)
- m. Experimental and investigational treatments or services
- n. Genetic counseling
- o. Genetic testing
- p. Sclerotherapy
- q. Home health care
- r. Home hospice care
- s. Hyperbaric treatments
- t. Infertility services
- u. Injectable medications (Requests for self-administered injectables or injectable medications administered in the office setting should be directed to LDI for authorization)
- v. Injectable or infusion done in a facility setting, need to be authorized by the Plan in advance
- w. Intensity modulated radiotherapy
- x. Lesion removal in office or facility (See List of Authorization Requirements by Code on Coventry Health Care of Missouri's website)
- y. In home infusion therapy
- z. Prosthetic devices; orthotics
- aa. Orthopedic devices over \$250 dispensed from the office
- bb. Non-emergency ambulance transfers
- cc. Proton beam treatment
- dd. Radiation therapy (See List of Authorization Requirements by Code on Coventry Health Care of Missouri's website)
- ee. Sleep studies

## **Mental Health Pre-Authorization Requirements**

- a. Inpatient
- b. Partial hospitalization programs (PHPs)
- c. Intensive outpatient programs (IOPs)
- d. Psychological testing
- e. Neuropsychological testing
- f. Outpatient electroconvulsive therapy (ECT)
- g. Biofeedback
- h. Amytal interview
- i. Psychiatric home care services
- j. Residential treatment centers
- k. Applied behavioral analysis

\*Only notification is required

### **7. Utilization Review Requirement**

Utilization review is a program to help insure that all Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- a. Prior authorization for certain items and services listed above;
- b. Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- c. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- d. Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain prior authorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

#### **Here's how the program works.**

**Prior Authorization.** Before a Participant enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in

conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Participant. Contact the utilization review administrator **at least 48 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Plan
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment.

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Participant's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Participant either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Participant to receive additional services or to stay in the Medical Care Facility for a greater length of time than the time for which prior authorization was received, the attending Physician must request the additional services or days.

### **Pre-Admission Testing Service**

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

1. performed on an outpatient basis within seven days before a Hospital confinement;
2. related to the condition which causes the confinement; and
3. performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable at 95% for In-Network services and 85% for Out-of-Network services even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

### **8. Case Management**

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded



under the Plan. The alternative benefits, called “Case Management,” shall be determined on a case-by-case basis, and the Plan’s determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Participant, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient’s attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient’s family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

**Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participant**

**Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.**

**C. MEDICAL BENEFITS SCHEDULE**

<b>Description of Medical Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Calendar Year Deductible</b>		
• <b>Individual</b>		\$200
• <b>Family</b>		\$600
<b>Calendar Year Out-of-Pocket Maximum</b> (Does not include Deductible and Copays)		
• <b>Individual</b>		\$1,500
• <b>Family</b>		\$3,000
<p><b>Prior Authorization Requirements:</b> Prior authorization from Coventry must be obtained for the items and services identified in Section V.B.6. If prior authorization is not obtained, a claim for those benefits under the Plan may be denied, regardless of whether the service or supply is otherwise covered by the Plan, the Plan’s reimbursement may be reduced, and you may be responsible for the full cost of the service or supply. Any reduction will not apply toward the Calendar Year Deductible or Out-of-Pocket Maximum and will not be paid at 100% if the Out-of-Pocket Maximum is met. If you use an In-Network Provider, the In-Network Provider is generally responsible for obtaining prior authorization from Coventry. If you use an Out-of-Network Provider, you or your provider should contact Coventry to obtain prior authorization. <b>You may contact Coventry at Coventry Health Care, Inc., 550 Maryville Centre Drive, Suite 300, St. Louis, Missouri 63141-5818, Member Services: (800) 775-3540.</b></p>		
<p><b>Hospital Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul> <p>Prior authorization is required for all inpatient admissions and services and outpatient services and diagnostic procedures and tests.</p>	95% after Deductible	65% after Deductible
<p><b>Emergency Room Services</b></p> <p>Including emergency room Physician and related expenses</p> <ul style="list-style-type: none"> <li>• Medical Emergency (as defined by the Plan) Normal Inpatient benefits will apply if admitted as an Inpatient. If admitted as an Inpatient, benefits will be paid at the In-Network benefit level until the patient is stabilized and able to be moved to an In-Network facility.</li> </ul>	95% after Deductible	95% after Deductible
<b>Urgent Care Services</b>	\$75 Copay then 100% no Deductible	\$75 copay then 65% no Deductible
<b>Hospital Pre-Admission Testing</b>	95% after Deductible	65% after Deductible
<p><b>Outpatient Surgical</b></p> <p>Prior authorization is required for all outpatient surgical services.</p>	95% after Deductible	65% after Deductible

Description of Medical Benefits	In-Network	Out-of-Network
<p><b>Physician Office Visits</b> Copay is per visit for all services provided in and billed by the Physician's office.</p>		
<ul style="list-style-type: none"> <li>• Office visit with or without x-ray, lab, surgery and allergy injections. Contact Coventry for prior authorization for self-administered injectable drugs and specialty drugs administered in an office setting.</li> </ul>	<p>\$15 Copay then 100% no Deductible</p>	<p>65% after Deductible</p>
<ul style="list-style-type: none"> <li>• X-ray and lab services ordered in connection with an office visit, but performed at an independent facility or Hospital.</li> </ul>	<p>95% after Deductible</p>	<p>65% after Deductible</p>
<p><b>Other Physician Services</b></p> <ul style="list-style-type: none"> <li>• Hospital Visits</li> <li>• Surgeon and Assistant Surgeon</li> <li>• Anesthesiologist</li> <li>• Radiologist and Pathologist</li> </ul> <p>Out-of-Network Providers will be paid at the In-Network level if you use an In-Network facility or Physician that utilizes an Out-of-Network Provider for services.</p>	<p>95% after Deductible</p>	<p>65% after Deductible</p>
<p><b>Birth Control Injectables (e.g., Depo-Provera)</b> Physician's fee to inject (the medication must be obtained through the Prescription Drug Program).</p>	<p>\$15 Copay then 100% no Deductible</p>	<p>75% after Deductible</p>
<p><b>Preventive Care</b></p> <ul style="list-style-type: none"> <li>• Physician fees for fitting and insertion of birth control devices - one per calendar year. (Device must be obtained through the Prescription Drug Program.)</li> <li>• Routine mammograms – one per Calendar Year.</li> <li>• Routine pap smears – one per Calendar Year.</li> <li>• Prostate Specific Antigen (PSA) – one per Calendar Year beginning at age 50.</li> <li>• Physical Exam, including diagnostic lab, x-ray and flu shots.</li> </ul>	<p>100% no Deductible</p>	<p>65% after Deductible</p>

Description of Medical Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> <li>• Screening Colonoscopy – once every 5 Calendar Years beginning at age 50.</li> <li>• Childhood immunizations, through age 6 years.</li> <li>• Childhood preventative care, through age 17.</li> <li>• Meningococcal vaccine from ages 19 to 25.</li> <li>• Zoster vaccine (commonly known as “shingles shot”) over age 55.</li> </ul> <p>Preventive care services, including immunizations for Dependents and services identified by the United States Preventative Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices of the CDC, the Health Resources and Services Administration guidelines, and the American Academy of Pediatrics Bright Futures guidelines.</p>	100% no Deductible	100% no Deductible
<p><b>Skilled Nursing Facility</b> Must immediately follow an Inpatient Hospital stay. Limited to a maximum of 100 days per confinement.</p>	95% after Deductible	65% after Deductible
<p><b>Home Health Care</b> Limited to 60 visits per occurrence.</p>	95% after Deductible	65% after Deductible
<p><b>Hospice Care</b> Prior Authorization is required.</p>	95% after Deductible	65% after Deductible
<p><b>Physical/Massage Therapy</b> Prior authorization required. Maximum of 48 visits per Calendar Year.</p> <ul style="list-style-type: none"> <li>• Facility and Physician</li> </ul>	95% after Deductible	65% after Deductible
<p><b>Speech Therapy</b> Prior authorization required. Maximum of 48 visits per Calendar Year.</p> <ul style="list-style-type: none"> <li>• Facility and Physician</li> </ul>	95% after Deductible	65% after Deductible
<p><b>Occupational Therapy</b> Prior authorization required. Maximum of 48 visits per Calendar Year.</p> <ul style="list-style-type: none"> <li>• Facility and Physician</li> </ul>	95% after Deductible	65% after Deductible
<p><b>Maternity Care – Office Visits</b></p>	\$15 copay first visit only	65% after Deductible

<b>Description of Medical Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Maternity Care - Inpatient</b> Female Employees and Spouses Prior authorization required for a Hospital stay in excess of 48 hours for the mother and infant following a vaginal delivery and 96 hours following delivery by caesarian section.	95% after Deductible	65% after Deductible
<b>Well Newborn Care</b> Well newborn expenses for Hospital, Physician visits and circumcision while mother and baby are confined are paid as part of the mother's claim.	95% after Deductible	65% after Deductible
<b>Ambulance</b> Non-emergency ambulance transportation requires prior authorization.	85% after Deductible	85% after Deductible
<b>Durable Medical Equipment</b> All durable medical equipment rentals and/or repairs require prior authorization. Purchases over \$250 require prior authorization prior to purchase.	95% after Deductible	65% after Deductible
<b>Growth Hormones</b> Limited to one treatment plan per Calendar Year and four treatment plans per Lifetime.	Same as any other Illness	Same as any other Illness
<b>Hearing Aids</b> Once every five (5) years and a maximum of \$2,000 for both ears. The \$2,000 maximum does not apply to bone anchored hearing aids and one newborn hearing screening.	95% after Deductible	65% after Deductible
<b>Chiropractic Care</b> Prior authorization required. Maximum of 25 visits per Calendar Year. Additional visits will be covered if Medically Necessary.	50% after Deductible	50% after Deductible
<b>Note:</b> Chiropractic expenses do not accumulate towards the Out-of-Pocket Maximum, nor will they be paid at 100% if the maximum is met.		
<b>Temporomandibular Joint (TMJ) Syndrome</b> Surgical treatment and non-surgical treatment, limited to one surgery and one treatment program per Lifetime.	75% after Deductible	75% after Deductible

<b>Description of Medical Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Lasik Eye Surgery</b> Maximum benefit of \$1,500. Benefits provided to covered Employees and Dependents. <b>See Covered Charges for details.</b>	100% No Deductible applies	100% No Deductible Applies
<b>Organ Transplants (See Pre-Certification Requirements)</b>		
<ul style="list-style-type: none"> <li>Center of Excellence utilized</li> </ul>	95% after Deductible	65% after Deductible
<ul style="list-style-type: none"> <li>Non-Center of Excellence utilized. Expenses will not accumulate towards the Out-of-Pocket Maximum, nor will they be paid at 100% if the maximum is met.</li> </ul>	50% after Deductible	50% after Deductible
<ul style="list-style-type: none"> <li>Organ Procurement Benefit – subject to a \$20,000 per transplant maximum.</li> </ul>	100% No Deductible applies	100% No Deductible applies
<b>Nicotine Addiction Treatment/Program</b> Limited to one treatment/program per Lifetime	85% after Deductible	85% after Deductible
<b>Weight Loss Program</b> Limited to a Lifetime maximum of \$500	85% after Deductible	85% after Deductible
<b>All Other Covered Charges</b>	95% after Deductible	65% after Deductible
<b>Note:</b> Benefits for Retired Employees and Spouses of Retired Employees, who are eligible for Medicare due to the attainment of age 65, will be coordinated with Medicare and reimbursed at the Non-Network level of benefits. See Sections VII.C and X.F for information on coordination of benefits with Medicare. See the NOTE at the end of Section VII for information on coverage of specific items not covered by Medicare.		

### **PRESCRIPTION DRUG BENEFIT SCHEDULE**

<b>DESCRIPTION OF PRESCRIPTION DRUG BENEFITS</b>	<b>PRESCRIPTION DRUG PROGRAM PAYS</b>
<b><u>Drugs available only through the Prescription Drug Program</u></b>	
Contact LDI at 1-866-516-3121 or visit <a href="http://www.LDIrx.com">www.LDIrx.com</a> for a list of covered drugs or for more information.	
<ul style="list-style-type: none"> <li>Retail (34 day supply)</li> </ul>	100% after \$5 Copay – Generic \$15 Copay – Brand Name Preferred \$30 Copay – Brand Name non-Preferred
<ul style="list-style-type: none"> <li>Mail Order (90 day supply)</li> </ul>	100% after \$10 Copay – Generic \$30 Copay – Brand Name Preferred \$60 Copay – Brand Name non-Preferred

## D. COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

1. **Diabetic Education Program.** A diabetic education program recognized by the American Diabetes Association for the diagnosed diabetic to provide the following:
  - a. initial visit focusing on the disease and complications,
  - b. second visit focusing on diet and exercise,
  - c. two follow-up visits at one month and three months to check progress.

2. **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Medical Benefits Schedule.

A home health care visit will be considered a periodic visit by either a nurse or therapist.

3. **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Participant's condition as being terminal, determined that the person is not expected to live more than six (6) months, and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Medical Benefits Schedule.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children).

4. **Hospital Care.** Eligible Hospital expenses include:
  - the actual amount charged for a ward or semi-private room;
  - private room: the Hospital's average semi-private room rate, except when deemed Medically Necessary by the Physician; or, in "private-room-only" Hospitals, 90% of the private room rate of the Hospital;
  - the actual amount charged for an intensive care unit or other special care unit when Medically Necessary;
  - all other Medically Necessary services and supplies furnished by a Hospital for patient care on an inpatient or outpatient basis;

- Treatment in a Hospital emergency room or other emergency care facility;
  - Hospital confinement expenses for dental services if the attending Physician certifies that hospitalization is necessary to safeguard the health of the patient and the services are eligible under the Plan.
5. **Nicotine Addiction Treatment/Program.** Nicotine addiction treatment or programs, including but not limited to auricular therapy, acupuncture, hypnosis, and over-the-counter (OTC) smoking cessation products, are covered up to a maximum shown in the Medical Benefits Schedule. Although acupuncture, hypnosis, over-the-counter (OTC) smoking cessation products are excluded under Plan Exclusions, they will be covered under the nicotine addiction program. The Prescription Drug Program also covers approved smoking cessation products upon the prescription and recommendation of a Physician.
6. **Physician Care.** The professional services of a Physician for:
- a. medical care, including home and office visits
  - b. diagnostic services; and
  - c. performing surgical procedures
    - i. Multiple surgical procedures will be a Covered Charge subject to the following conditions:
      - If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedure(s): 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered “incidental” and no benefits will be provided for such procedures;
      - If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon’s primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and
      - If an assistant surgeon is required, the assistant surgeon’s Covered Charge will not exceed 20% of the surgeon’s Usual and Reasonable allowance.
7. **Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.



Coverage for the mother and her newborn child in the Hospital includes 48 hours of post-natal maternity care for vaginal delivery and 96 hours of post-natal maternity care for caesarean delivery.

Treatment of complications of Pregnancy for female Employees and Spouses.

The Plan does not provide coverage for a Dependent child's pregnancy.

8. **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable subject to the following conditions:
- a. the patient is confined as a bed patient in the facility; and
  - b. the confinement starts immediately following a Hospital confinement or a period of Home Health Care Utilization; and
  - c. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
  - d. the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Participant's care in Skilled Nursing Facilities are payable as described in the Medical Benefits Schedule.

9. **Weight Loss Programs.** The Plan shall include coverage for Morbid Obesity as follows:

Surgical treatment for Morbid Obesity will only be covered if all the following conditions are met:

- a. The Participant has either (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.
- b. The Participant has at least a 24-month history of Morbid Obesity as documented in such person's medical records.
- c. The Participant does not have an underlying diagnosed medical condition that would cause Morbid Obesity (e.g., an endocrine disorder) that can be corrected by means other than surgical treatment.
- d. The Participant has completed full growth (18 years old or supporting documentation of complete bone growth).
- e. The Participant has failed to achieve and maintain significant weight loss and such person has participated in a Physician-supervised nutrition and exercise program for at least six (6) months (occurring within the 24-month period prior to the proposed surgical treatment) and such participation is documented in his or her medical records.
- f. The Participant must be evaluated by a licensed professional counselor, psychologist or psychiatrist within 12 months prior to the proposed surgical treatment. The evaluation should document the following:

- i. that there is no significant psychological problem that would limit the ability of the Participant to understand the procedure and comply with any medical and/or surgical recommendations;
- ii. any psychological co-morbidities that may be contributing to the Participant's inability to lose weight or a diagnosed eating disorder; and
- iii. the Participant's willingness to comply with the preoperative and postoperative treatment plans.

The following surgery will not be eligible as treatment of Morbid Obesity under the Plan:

- a. Loop gastric bypass;
- b. Gastroplasty, more commonly known as "stomach stapling" (not to be confused with vertical band gastroplasty); and
- c. Mini gastric bypass.

10. **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- a. **Abortions** only when the attending Physician certifies that the life of the mother would be endangered if the fetus were carried to term.
- b. **Allergy** testing.
- c. Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- d. **Ambulatory** Surgical Facility.
- e. **Anesthetic**; oxygen, blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- f. **Birthing** Center.
- g. **Blood** and/or plasma, if not donated or replaced, and the equipment for its administration.
- h. **Cardiac rehabilitation**, as deemed Medically Necessary, provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- i. Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- j. Initial **contact lenses** or glasses required following cataract surgery.

- k. Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase. All durable medical equipment rentals and/or repairs require prior authorization. Any durable medical equipment purchases over \$250 require prior authorization.
- l. **Genetic** counseling, including charges for Chorionic Villi Sampling (CVS), when such tests are prescribed by the attending Physician as Medically Necessary.
- m. **Hearing aids**, subject to the limitations and maximums shown in the Medical Benefits Schedule.
- n. **Hospital** pre-admission testing.
- o. Care, supplies and services for the diagnosis of **infertility**.
- p. Medically Necessary services for care and treatment of **jaw joint conditions**, including Temporomandibular Joint syndrome (**TMJ**).  
Charges for TMJ are subject to the limits as described in the Medical Benefits Schedule.
- q. **Laboratory studies**. Covered Charges for diagnostic and preventive lab testing and services.
- r. **Lasik Eye Surgery**. Lasik Eye Surgery benefits are provided for covered Employees and Dependents. Expenses do not apply to the Calendar Year Deductible, Out-of-Pocket Maximum and/or the specific aggregate maximums. Coverage is limited to a maximum benefit of \$1,500.
- s. Treatment of **Mental Disorders and Substance Abuse**. For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.  
  
Psychiatrists (M.D.), psychologists (Ph.D.) counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals. Prior authorization is required for all mental disorder and substance abuse inpatient services and outpatient diagnostic procedures and tests.
- t. Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:
  - i. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

- ii. Emergency repair due to Injury to sound natural teeth.
- iii. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- iv. Excision of benign bony growths of the jaw and hard palate.
- v. External incision and drainage of cellulitis.
- vi. Incision of sensory sinuses, salivary glands or ducts.
- vii. Removal of impacted teeth.
- viii. Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- u. **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Charges for Occupational therapy are subject to the limits described in the Medical Benefits Schedule.

- v. **Human Organ and Tissue Transplants.** Coverage is provided for charges incurred in connection with human organ or tissue transplants, plus generally accepted practices involving other transplants which are approved by the American Medical Association, provided they meet the following criteria:
  - i. Prior authorization is required.
  - ii. All other conventional means of treatment have been unsuccessful in treating the condition.
  - iii. A second opinion must be rendered as to the Medical Necessity of the transplant, by a board certified specialist involved in the field of surgery applicable. The second opinion must concur that no other course of treatment would be effective in treating the applicable condition.
  - iv. The condition is covered by the Plan.
  - v. The Participant has no other concurrent terminal disease or condition.
  - vi. The Participant is obligated to pay for the transplant; (i.e., it is not covered by a government agency or transplant program).
  - vii. The condition does not arise from the individual's employment.
  - viii. The transplant is not considered Experimental or Investigative.

Transplants which may be covered by the Plan, include but are not limited to:

- i. Kidney Transplants;

- ii. Liver Transplants;
- iii. Heart Transplants;
- iv. Heart-Lung Transplants; and
- v. Pancreas Transplants.

The following procedures are not covered by the Plan:

- i. Transplants using animal organs.
- ii. Use of artificial heart plus any other applicable organ.
- iii. Any other procedure which has not been approved by the U.S. Department of Health and Human Services or the appropriate government agency.

The Plan provides coverage for the following transplant expenses:

- i. Charges Incurred in the evaluation, screening, and candidacy determination process.
- ii. Charges incurred for organ transplantation.
- iii. Charges for organ procurement, subject to the maximum shown in the Medical Benefits Schedule, including donor expenses not covered under the donor's plan of benefits.
  - coverage for organ procurement from a non-living donor.
  - coverage for organ procurement from a living donor will be provided and the following costs will be considered: costs involved in screening the potential donor; transporting the donor to and from the site of the transplant; as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care.
- iv. Charges incurred for follow up care, including immune-suppressant therapy.
- v. Charges for lodging and transportation related to the organ or tissue transplant.

No other expenses in connection with replacement of organs or tissue are covered by this Plan.

- w. The initial purchase, fitting and repair of **orthotic appliances**, such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Prior authorization is required for orthotic appliances that cost \$250 or more.
- x. **Outpatient** surgery.
- y. **Oxygen** and rental of equipment required for its use, not to exceed the purchase price of such equipment.

- z. **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

Charges for Physical therapy are subject to the limits as described in the Medical Benefits Schedule.

- aa. Routine **Preventive Care**. Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Medical Benefits Schedule.

**Charges for Routine Well Adult Care**. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

**Charges for Routine Well Child Care**. Routine well child care is care by a Physician that is not for an Injury or Sickness.

- bb. **Private Duty Nursing**. Non-custodial services of a private duty Nurse when Medically Necessary.
- cc. The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts. All prosthetics require Prior Authorization.
- dd. **Reconstructive Surgery**. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- i. reconstruction of the breast on which a mastectomy has been performed,
- ii. surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- iii. coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

- ee. **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness.

Charges for Speech therapy are subject to the limits as described in the Medical Benefits Schedule.

- ff. **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.
- gg. **Sterilization** procedures.
- hh. **Support stockings**, such as Jobst stockings, limited to two (2) pair per Calendar Year.

- ii. **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- jj. **Voluntary Second Surgical Opinions** (or third opinions if the second opinion does not confirm the need for surgery) performed by a Board Certified Specialist, including any necessary x-ray and laboratory examinations recommended by the Physician rendering the second/third opinion.

kk. Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care.

Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Charges for Routine Physician Care.

The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

ll. Diagnostic **x-rays**.

## E. PLAN EXCLUSIONS

**Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan Section.**

**For all Medical Benefits shown in the Medical Benefits Schedule, a charge for the following is not covered:**

1. **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.
2. **Acupuncture**
3. **Adoption expenses**
4. **Alternative Medicine.** Including but not limited to, biofeedback, hydrotherapy, aromatherapy, naturopathy, and homeopathic and holistic treatment.
5. **Appointments.** Expenses for broken appointments or telephone calls.
6. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.
7. **Contraceptives** regardless of diagnosis, treatment or intended use, except for the Physician's fees for the cost of fitting/insertion of contraceptive devices obtained through the Prescription Drug Program and the cost of injecting contraceptive medications obtained through the Prescription Drug Program as shown on the Medical Benefits Schedule.
8. **Cosmetic Surgery,** except as specified in the Covered Charges subsection.
9. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
10. **Dental Services.** Services and supplies for dental services, treatment of teeth or periodontium or occlusive re-alignment of the mandible or maxilla or oral surgery, except as specified in Covered Charges subsection. Benefits will not be considered for treatment related to the preparation or fitting of dentures, including dental implants.
11. **Donor expenses** for an eligible Participant under this Plan for a recipient that is not eligible under this Plan.
12. **Educational or vocational testing.** Services for educational or vocational testing or training.
13. **Equipment** such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heating pads, hot water bottles, water beds, vaporizers, heat lamps, electrolysis, vacuum devices, and any other clothing or equipment which could be used in the absence of an Illness or Injury.
14. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.



15. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
16. **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
17. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan. However, see the Medical Benefits Schedule for a description of Lasik Benefit.
18. **Foreign travel.** Care, treatment or supplies out of U.S. if travel is for the sole purpose of obtaining medical services.
19. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
20. **Growth hormone** therapy except for a documented growth hormone deficiency, Turner's Syndrome, growth delay due to cranial radiation, or chronic renal disease, and subject to the maximums specified in the Medical Benefits Schedule.
21. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
22. **Hearing Aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered in the Medical Benefits Schedule.
23. **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
24. **Hypnosis.**
25. **I.Q. Testing.**
26. **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, committed by the Participant or as a result of a riot or public disturbance in which the Participant was participating. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

27. **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence, except, on or after December 1, 2015, as described in the Covered Prescription Drugs section.
28. **Infertility.** Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation.
29. **Mailing** and/or shipping and handling expenses.
30. **Massage therapist.**
31. **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.
32. **Medical Reports.** Expenses for preparing medical reports, itemized bills, or benefit request forms.
33. **Modifications to the home** or property of a Participant, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts or ramps.
34. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
35. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
36. **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
37. **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
38. **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
39. **Non-Medical Practitioners.** Services or supplies provided by non-medical practitioners such as, but not limited to, Christian Science Practitioners and Faith Healers.
40. **Non-prescription** drugs or medicines.
41. **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
42. **Nutritional counseling** except for the initial consultation which is Medically Necessary because of a medical condition such as diabetes or heart disease.
43. **Occupational.** Care and treatment of an Injury or Sickness that is occupational—that is, arises from work for wage or profit including self-employment.

44. **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
45. **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
46. **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only.
47. **Pre-natal testing.** Any expense incurred for pre-natal testing, including amniocentesis, when done for the purpose of determining the sex of the child or without Medical Necessity.
48. **Prescription Drugs** or medicines. Prescription Drugs are **only** covered under the Prescription Drug Program. Refer to Section VI for an overview of the Prescription Drug Program.
49. **Purchase or rental** of luxury medical equipment when standard equipment is appropriate for the Participant's condition (i.e., motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).
50. **Relative giving services.** Professional services performed by a person who ordinarily resides in the Participant's home or is related to the Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
51. **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Medical Benefits Schedule.
52. **Second/third opinion.** Charges for a second/third opinion from a Physician affiliated with the Physician rendering the first opinion.
53. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
54. **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
55. **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
56. **Splinting of teeth.**
57. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

58. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.
59. **Utilization Review Organization.** Services not approved by the Utilization Review Organization as Medically Necessary.
60. **War.** Any loss that is due to a declared or undeclared act of war.

## **F. PROVIDER SELF-AUDIT PROGRAM**

The self-audit program is designed to provide a cash incentive to eligible Employees who discover and arrange for recovery of overcharges made on their own or their Dependents' Hospital or provider bills which in turn result in benefit dollars saved for the Plan. The rules of the program are stated below.

### **1. Cash Incentive**

The cash incentive paid to an Employee for recovering an amount that was initially overcharged on a bill for that Employee or his Dependent shall be 25% of the actual amount of the overcharge that the Hospital or provider agrees is invalid. You are responsible for contacting and negotiating the overcharges with the Hospital or provider. To receive any cash award due to an overcharge, a Participant must have satisfied the Deductible for the Calendar Year in which the overcharge occurred.

### **2. Maximum**

The maximum paid by the Plan in any Calendar Year to an Employee under this program shall not exceed \$500. Overcharges totaling less than \$25 shall not be eligible for the cash incentive.

### **3. Covered Charges**

For purposes of the cash incentive, only expenses which the Plan covers (e.g., not telephone bills, television rentals, or newspapers) shall be considered in determining the amount payable to the Employee under this program. Claims involving coordination of benefits will be eligible only if this Plan is primary payer.

### **4. Proof of Eligibility**

Proof of eligibility for a cash incentive must be submitted to the Plan in the form of a copy of the initial Hospital or provider bill with the overcharges circled, and a copy of the adjusted bill showing that the Hospital or provider removed the overcharged amount. Such proof must be submitted to the Plan within 45 days following the date of discharge from the Hospital or receipt of care from a provider. Within 30 days after receipt of proof and verification that the overcharge has been recovered, the Plan shall disburse to the Employee a check in the amount of the cash incentive.

**5. Resolution of Differences**

The Plan shall not get involved in resolving any differences between the Employee and the Hospital or provider with respect to disputed charges. Employees shall be solely responsible for handling such disputes.

**6. Amendment, Modification or Termination of the Provider Self-Audit Program**

The Plan has the sole right, at any time, to amend or modify these rules or terminate the Provider Self-Audit Program entirely.

## **SECTION VI. PRESCRIPTION DRUG BENEFIT**

### **A. PHARMACY DRUG CHARGE**

Participating pharmacies have contracted with the Plan to charge Participants reduced fees for covered Prescription Drugs.

### **B. COPAYMENTS**

The Prescription Drug card benefit provides up to a 34-day supply of covered medications when filled at participating Pharmacies. The Generic, Preferred Brand Name and non-Preferred Brand Name Copays shown in the Schedule of Prescription Drug Benefits apply to each Prescription Drug or refill. The Prescription Drug Copay does not apply to the medical Plan Deductible or Out-of-Pocket Maximum. At the time of purchase, the drug card should be presented to the pharmacist and the Copay should be paid.

When a prescription is filled on an emergency basis at a non-participating Pharmacy, full payment for the drug will be required at the time of purchase. Thereafter, a claim must be filed with the Prescription Drug Program for reimbursement.

### **C. MAIL ORDER DRUG BENEFIT OPTION**

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Participants significant savings on their prescriptions.

### **D. COVERED PRESCRIPTION DRUGS**

1. All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes contraceptives (e.g., oral, diaphragms, IUDs and injectables such as Depo Provera), but excludes any drugs stated as not covered under this Plan.
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
3. Insulin and other diabetic supplies (e.g., insulin needles and syringes, blood glucose test strips, urine glucose test strips, lancets, swabs, novopen and insulin pump needles) when prescribed by a Physician. Other injectables are not covered.
4. Tretinoin agents used in treatment of acne (i.e., Retin-A).
5. Smoking cessation products (must have at least one ingredient that is a legend drug).
6. Respiratory therapy supplies (e.g., aerochamber, spacers).
7. Effective December 1, 2015, drugs approved by the FDA for the treatment of impotence when prescribed by a Physician. Covered prescriptions for impotence drugs are limited to the Funds' PBM standard limits for oral impotence medications, currently a limit of 8 per month or 30 for daily use. Limits are subject to increase/decrease based upon future changes of PBM standard limits.

## **E. LIMITS TO THIS BENEFIT**

This benefit only applies when a Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

## **F. EXPENSES NOT COVERED**

This benefit will not cover a charge for any of the following:

1. **Administration.** Any charge for the administration of a covered Prescription Drug.
2. **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
3. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
4. **Cosmetic uses.** Drugs for cosmetic uses, except as stated above.
5. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
6. **Experimental.** Experimental drugs and medicines, even though a charge is made to the Participant.
7. **FDA.** Any drug not approved by the Food and Drug Administration.
8. **Fluoride products.**
9. **Growth hormones.**
10. **Homeopathic medications.**
11. **Immunization.** Immunization agents or biological sera.
12. **Impotence.** Prior to December 1, 2015, a charge for impotence medication.
13. **Infertility.** A charge for infertility medication.
14. **Injectable.** All injectables and non-insulin syringes, except as stated in the Covered Prescription Drugs subsection above.
15. **Inpatient medication.** A drug or medicine that is to be taken by the Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
16. **Investigational.** A drug or medicine labeled: "Caution—limited by federal law to investigational use".
17. **Medical exclusions.** A charge excluded under Medical Plan Exclusion.

18. **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
19. **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
20. **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
21. **Ostomy supplies.**
22. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
23. **Serums,** toxoids, vaccines.
24. **Vitamins.**

Since new drugs are continually under research and development it will be necessary to contact the Prescription Drug Program regarding coverage of these drugs. Certain drugs that may be classified as lifestyle and non-therapeutic drugs may not be covered by the Plan, but the Prescription Drug Program will be more explicit regarding the availability and consideration of specific drugs.

**Contact the Managed Prescription Drug Program for a complete list of covered and non-covered Prescription Drugs and for any questions regarding the Prescription Drug card benefits or mail order Prescription Drug benefits.**



## **SECTION VII. RETIREE BENEFITS**

### **A. RETIRED EMPLOYEE ELIGIBILITY**

#### **1. Initial Eligibility Requirement for Retired Employee Coverage**

An Employee shall be eligible as a Retired Employee upon satisfaction of the following requirements.

1. Makes written application to the Fund Office (including executing such automatic check withdrawal form as the Fund Office may require); or
2. Is at least age 55 or Totally Disabled and has been awarded a retirement or disability pension from one of the following:
  - The National Electrical Benefit Fund; or
  - Any other pension fund in which union trustees are selected by one or more Local Unions affiliated with the I.B.E.W.; or
  - The Social Security Administration. Entitlement to a Social Security Disability Award shall be considered a form of retirement and the retirement date will be considered to be the Social Security entitlement date.

Any Employee who is not eligible for one of the pension benefits set out above may qualify and satisfy this condition by submitting proof of retirement that is approved by the Board of Trustees.

3. The Employee must be eligible for benefits provided under the Plan during the month in which he retires or in the month immediately prior to his retirement date.
4. The Employee has been eligible for benefits in at least 45 of the 60 months immediately prior to retirement;
5. The Employee submits written application for participation within 90 days from the last day worked or 90 days from the date of the award letter as it appears on the award letter or within 90 days from the expiration of the Employee's accumulated Hour Bank hours; and
6. The Employee makes payment in advance for the initial self-contribution. Hour Bank hours remaining in an Employee's account on the effective date of retirement shall be used in determining the initial self-contribution amount. Any hours worked prior to and received after the effective date of retirement will also be used to determine future retiree self-contributions. The first required self-contribution amount must be received in advance of the month it is first due.

#### **2. Self-Contribution Amounts**

The Supplemental Retiree Benefit Plan is based on self-contributions.

For Retirees with an effective date of retirement prior to January 1, 2002, the monthly self-contribution rate for single or family benefits shall be equal to:

1. 100% of the Active Employee hourly contribution rate multiplied by 160 for Retirees or surviving Spouses younger than age 62.
2. 75% of the Active Employee hourly contribution rate multiplied by 160 for Disabled Retirees younger than age 65, (not yet eligible for Medicare), or surviving Spouses (not yet eligible for Medicare) of a deceased Medicare eligible Retiree.
3. 50% of the Active Employee hourly contribution rate multiplied by 160 for Retirees or surviving Spouses who are Medicare qualified, or Early Retirees who are between ages 62 and 65.

For Retirees with an effective date of retirement after January 1, 2002, the self-contribution rates are:

1. 100% of the Active Employee hourly contribution rate multiplied by 160 for Retirees between ages 55 and 61.
2. 75% of the Active Employee hourly contribution rate multiplied by 160 for Retirees between ages 62 and 64.
3. 65% of the Active Employee hourly contribution rate multiplied by 160 for Retirees age 65 and over.
4. 75% of the Active Employee hourly contribution rate multiplied by 160 for disabled or non-Medicare eligible surviving Spouses.

The Board of Trustees shall determine the portion of the self-contribution amounts to be paid by Retired Employees for single and/or family coverage. This information will be communicated to Retirees from time to time.

Payments must be made in advance and can be paid monthly, quarterly, semi-annually or annually. No billings will be sent, as each Employee, surviving Spouse, Retiree or Disabled Retiree eligible under this provision shall be solely responsible for the submission of timely payments.

The Retiree Plan premiums may be made by check or by Automatic Deposit (ACH). Information on ACH and ACH authorization forms will be included in the retirement packet provided by the Fund Office.

### **3. Continued Eligibility Requirement for Retired Employee Coverage**

The second self-contribution payment must be received in full by the 15<sup>th</sup> day of the month in which the first payment was due. Thereafter, eligibility will be continued for each month that the self-contribution is received in full by the 15<sup>th</sup> day of the month preceding the month for which coverage is desired.

## **B TERMINATION OF COVERAGE FOR RETIRED EMPLOYEES**

Coverage will terminate on the last day of the month in which the Retired Employee fails to make the self-contribution amount in accordance with the Retired Employee eligibility provisions in Section VII.A. Such coverage shall not be reinstated.

If a Retired Employee's coverage terminates because the Retired Employee has returned to status as an Active Employee, after having made some Retired Employee plan self-

contribution payments, the Retired Employee must satisfy the requirements and Initial Eligibility rules as stated previously to again become eligible for benefits as an Active Employee. To maintain retiree Plan eligibility, self-contributions should be made for those months in which the Employee has returned to active work but is not yet eligible as an Active Employee.

A Retired Employee who has regained active status and, during said period of service has hours credited to his Hour Bank, will use those banked hours at the rate that they were paid in rather than at a reduced retiree rate. Upon loss of active status eligibility, the Employee may return to Retired Employee self-pay status.

**C. MEDICARE SUPPLEMENT BENEFITS FOR RETIRED EMPLOYEES AGE 65 AND OLDER**

This Plan shall coordinate benefits with Medicare using a Supplemental approach in accordance with the following rules:

1. the Plan Deductible must be satisfied;
2. this Plan covers the Deductibles and Copayments not covered by Medicare Part A;
3. this Plan covers 20% of “Medicare-Eligible Expenses” after the Medicare Part B Calendar Year Deductible is satisfied;
4. this Plan covers charges “as if” Medicare has been accepted by a provider and charges will be paid “as if” assigned;
5. this Plan covers the first three (3) pints of blood under Medicare Part A or Medicare Part B each Calendar Year;
6. this Plan covers transplant expenses approved by Medicare; and
7. the term “Medicare-Eligible Expenses” shall mean health care expenses covered by Medicare to the extent recognized by Medicare. Charges not recognized as Medicare-Eligible will not be covered by this Plan.

If a Participant was eligible at any time to enroll in Parts A and/or B of Medicare or Medicare+ Choice (Part C) but did not do so, benefits payable under this Plan will be determined as if the Participant had enrolled.

Reimbursement will be made based on the Non-Network benefit level for all services. Network benefit levels are not applicable when this Plan is secondary to Medicare and the supplemental coordination of benefits approach is used.

**NOTE:** The following items that are not covered by Medicare will be covered at the out-of-network benefit level shown in the Medical Benefits Schedule: Hearing Aids, Nicotine Addiction Treatment/Programs, and Weight Loss Treatments and the Shingles Vaccine.

## **SECTION VIII. OTHER BENEFITS OFFERED**

### **A. LIFE INSURANCE**

Life Insurance benefits are provided for certain eligible Employees and their Spouses and Dependents. These benefits are described in the Certificate of Coverage issued by The Guardian. The insurance certificate is incorporated herein by reference.

The certificate includes the following written materials:

- Nature of coverage provided to covered individuals;
- Conditions pertaining to eligibility to receive coverage (other than general conditions pertaining to eligibility for participation in the Plan) and circumstances under which coverage may be denied;
- Procedures to be followed in filing claims;
- Procedures available for the review of claims which are denied in whole or in part; and
- Circumstances which may result in disqualification, ineligibility, or loss or suspension of benefits.

Requests for written materials governing the Life Insurance benefits may be directed to:

The Guardian  
7 Hanover Square  
New York, NY 10004

or to the Fund Office.

### **B. ACCIDENTAL DEATH AND DISMEMBERMENT**

Accidental Death and Dismemberment benefits are provided to certain eligible Employees and are described in the Certificate of Coverage issued by The Guardian. The insurance certificate is incorporated herein by reference.

The certificate includes the following written materials:

- Nature of coverage provided to covered individuals;
- Conditions pertaining to eligibility to receive coverage (other than general conditions pertaining to eligibility for participation in the Plan) and circumstances under which coverage may be denied;
- Procedures to be followed in filing claims;
- Procedures available for the review of claims which are denied in whole or in part; and
- Circumstances which may result in disqualification, ineligibility, or loss or suspension of benefits.

Requests for written materials governing the Life Insurance benefits may be directed to:

The Guardian  
7 Hanover Square  
New York, NY 10004

or to the Fund Office.

**C. WEEKLY DISABILITY INCOME BENEFITS**

Weekly Disability Income benefits are provided for certain eligible Employees. These benefits are described in the Certificate of Coverage issued by The Guardian. The insurance certificate is incorporated herein by reference.

The certificate includes the following written materials:

- Nature of coverage provided to covered individuals;
- Conditions pertaining to eligibility to receive coverage (other than general conditions pertaining to eligibility for participation in the Plan) and circumstances under which coverage may be denied;
- Procedures to be followed in filing claims;
- Procedures available for the review of claims which are denied in whole or in part; and
- Circumstances which may result in disqualification, ineligibility, or loss or suspension of benefits.

Requests for written materials governing the Weekly Disability Income benefits may be directed to:

The Guardian  
7 Hanover Square  
New York, NY 10004

or to the Fund Office.

**D. VISION BENEFITS**

Vision benefits are provided for certain eligible Employees and their Dependents. These benefits are described in the Certificate of Coverage issued by Vision Service Provider (VSP). The insurance certificate is incorporated herein by reference.

The certificate includes the following written materials:

- Nature of coverage provided to covered individuals;
- Conditions pertaining to eligibility to receive coverage (other than general conditions pertaining to eligibility for participation in the Plan) and circumstances under which coverage may be denied;
- Procedures to be followed in filing claims;
- Procedures available for the review of claims which are denied in whole or in part; and

- Circumstances which may result in disqualification, ineligibility, or loss or suspension of benefits.

Requests for written materials governing the Vision benefits may be directed to:

VSP  
3333 Quality Drive  
Rancho Cordova, CA 95670

or to the Fund Office.

#### **E. DENTAL BENEFITS**

Dental benefits are provided for certain eligible Employees and their Dependents. These benefits are described in the Certificate of Coverage issued by The Guardian. The insurance certificate is incorporated herein by reference.

The certificate includes the following written materials:

- Nature of coverage provided to covered individuals;
- Conditions pertaining to eligibility to receive coverage (other than general conditions pertaining to eligibility for participation in the Plan) and circumstances under which coverage may be denied;
- Procedures to be followed in filing claims;
- Procedures available for the review of claims which are denied in whole or in part; and
- Circumstances which may result in disqualification, ineligibility, or loss or suspension of benefits.

Requests for written materials governing the Dental benefits may be directed to:

The Guardian  
7 Hanover Square  
New York, NY 10004

or to the Fund Office.

## SECTION IX. HOW TO SUBMIT A CLAIM

**Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Participant is entitled to them.**

### **A. LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, WEEKLY DISABILITY, VISION AND DENTAL CLAIMS**

Claim procedures for life insurance benefits, accidental death and dismemberment benefits, and weekly disability income benefits are described in the group insurance certificate(s) issued by The Guardian.

Procedures for obtaining services and benefits from Vision Service Provider (VSP), as well as formal claim and appeal procedures, are described in the certificate of coverage and other materials issued to you by Vision Service Provider.

Procedures for obtaining dental services and benefits from The Guardian, as well as formal claim and appeal procedures, are described in the certificate of coverage and other materials issued to you by The Guardian.

### **B. HOW TO FILE A MEDICAL CLAIM**

#### **1. How to File a Medical Benefits Claim**

Generally, both In-Network and Out-of-Network Providers will file medical benefits claims with Coventry on your behalf. However, if you or a dependent obtain items or services from an Out-of-Network Provider, it is your responsibility to make sure a claim is filed. If you or a dependent pay an Out-of-Network Provider for items or services, you may file a claim for reimbursement. You may obtain claim forms from either Coventry or the Fund Office.

The Fund Office address and telephone number is:

Alton IBEW/NECA Health & Welfare Plan  
c/o IBEW/NECA Service Center  
Attn: Plan Administrator  
P.O. Box 6088  
St. Louis, Missouri 63139  
Phone: (314) 752-2330  
Fax: (314) 752-2339

Coventry's address and telephone number for medical claims is:

Coventry Health Care of Missouri, Inc.  
Claims Department  
P.O. Box 7121  
London, Kentucky 40742-7121  
Phone: (800) 755-3540

#### **2. Deadline for Filing a Medical Benefits Claim**

Claims must be filed within one (1) year after the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges

were incurred. Claims filed later than that date may be declined or reduced unless it is not reasonably possible to submit the claim in that time.

The Plan will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

### **3. Medical Benefits Claims Procedure**

Following is a description of how the Plan processes Claims for benefits. A “Claim” is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan’s reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. “Days” means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

#### **a. Urgent Care Claim**

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant’s medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
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Insufficient information on the Claim, or failure to follow the Plan’s procedure for filing Claim:

Notification to claimant, orally or in writing	24 hours
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Response by claimant, orally or in writing	48 hours
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Benefit determination, orally or in writing	48 hours
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Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

**b. Pre-Service Claim**

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days

Ongoing courses of treatment:

Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	15 days per benefit appeal
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

**c. Post-Service Claim**

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	30 days per benefit appeal

**d. Notice to Claimant of Adverse Benefit Determinations**

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- i. The specific reason or reasons for the adverse determination.
- ii. Reference to the specific Plan provision on which the determination was based.
- iii. A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- iv. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
- v. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relative to the Claim.
- vi. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
- vii. If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

#### **4. Medical Benefits Appeals**

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision to:

Alton IBEW/NECA Health & Welfare Plan  
c/o IBEW/NECA Service Center  
Attn: Plan Administrator  
P.O. Box 6088  
St. Louis, Missouri 63139

No specific form is required. As part of the appeal process, the claimant (or his or her authorized representative) may submit written comments, documents, records and other information relating to the claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- i. was relied upon in making the benefit determination;
- ii. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- iii. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- iv. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Joint Board of Trustees shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment.

Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

The Board of Trustees will issue a written decision to the claimant, which decision will be made at the next regularly scheduled meeting of the Board that occurs more than 30 days after the date on which the Board receives the appeal. If special circumstances require an extension to the next quarterly meeting, the claimant will be advised in advance of the extension and the special circumstances which require the extension. The written decision of the Board will include the following information:

- i. The specific reason or reasons for the Board's decision.
- ii. Reference to the specific plan provisions on which the determination of the Board is based.
- iii. A statement that the claimant is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.
- iv. A statement that there is no other appeal available to the claimant under the Plan and a statement that the claimant has the right to bring an action under Section 502(a) of ERISA.

**5. Claim Limitations Period**

After your appeal is complete, you have the right to file a civil action under Section 502(a) of ERISA if you are unhappy with the Trustees' decision regarding your appeal. You must file any such action no later than two years after the date the final appeal decision is issued. If you do not file the action within that time period, you will lose your right to do so.

## **SECTION X. COORDINATION OF BENEFITS**

### **A. GENERALLY**

The coordination of benefits provision is intended to prevent the payment of benefits which exceed expenses. It applies when you or any eligible Dependent covered by this Plan is also covered by any other plan or plans. COB also applies when you or your Dependent is covered by this Plan in more than one capacity. For example, you may be covered as an Active Employee or Retired Eligible Employee and as an eligible Dependent of an Active Employee or Retired Eligible Employee. Alternatively, an eligible Dependent may be covered as the natural or adopted child of one Active Employee or Retired Eligible Employee and as the stepchild of another Active Employee or Retired Eligible Employee. When more than one coverage exists, one plan normally pays its benefits in full and the other plan or plans pay reduced benefits. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Covered Expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

### **B. DEFINITIONS FOR THIS COB PROVISION**

1. “Coordinating Plan” means any of the following coverages, including policy coverage, and any coverage that is declared to be “excess” to all other coverages, which provide benefit payments or services to a Covered Individual that may include Hospital, medical, surgical, prescription drug, dental or vision care:
  - This Plan.
  - Any group, blanket or franchise health insurance.
  - A group contractual prepayment or indemnity plan.
  - A Health Maintenance Organization (HMO), whether group practice or individual practice association.
  - A labor-management trusted plan or a union welfare plan.
  - An employer or multi-employer plan or employee benefit plan.
  - A government program.
  - Insurance required or provided by statute.
  - Insurance provided by a school or school district to cover Injuries incurred as a result of school sponsored athletic activities, whether or not the eligible Dependent was enrolled in the program or if application was made for such enrollment.
  - Medical payments coverage under automobile (including uninsured or underinsured motorist coverage), homeowners and general liability insurance policies, regardless of whether individual or group, fault or no fault.

“Coordinating Plan” does not include any individual or family policies or contracts or public medical assistance programs. Eligibility for coverage will not be affected by the fact that a person is eligible for or is provided medical assistance under

Medicaid, that is, a state plan for medical assistance approved under Title XIX of the Social Security Act. In addition, this Coordination of Benefits provision will not apply to benefits a person is entitled to receive under Medicaid.

2. “Claimant” means the Covered Individual for whom the claim is made.
3. “Covered Expense” means any expense which is covered by at least one Coordinating Plan during a Claim Period. Where a Coordinating Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Claim Period will also be considered a Covered Expense. In the case of a Health Maintenance Organization (“HMO”), or other in-network only plans, this Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full for items or services. When an HMO or in-network only plan is the primary plan under these rules and the Claimant does not use an HMO or network provider, this Plan will not consider any charge that would have been covered by the HMO or in-network only plan had the Claimant used the services of an HMO or in-network provider as a Covered Expense.

### **C. HOW COB WORKS**

The Primary Plan (which is the Coordinating Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The Secondary Plan (which is the Coordinating Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and the benefits paid by the Primary Plan will not exceed 100% of total Covered Expense. When paying as the Secondary Plan, the Benefit Office will apply the lower of its own re-pricing or the Primary Plan’s re-pricing of the claims.

When this Plan is Secondary, this Plan will pay for Covered Expenses in accordance with its terms and conditions, including, for example, application of the appropriate Co-pay, Deductible and Co-insurance. If the amount of Covered Expenses that the Primary Plan does not pay exceeds what this Plan would have paid if it was not coordinating with the Primary Plan, this Plan will limit its payment to the amount of Covered Expenses that this Plan would have paid if it was not coordinating with the Primary Plan. If the amount of Covered Expenses paid by this Plan is less than the amount of Covered Expenses that this Plan would have paid if it was not coordinating with the Primary Plan, the difference or “savings” that this Plan realizes as a result of the Primary Plan paying a portion of the Covered Expenses may be set aside as a credit reserve and will be used to offset any Co-pay, Deductible or Co-insurance that the Covered Individual is required to pay during the rest of the calendar year.

The “Order of Benefit Determination” paragraph below explains the order in which Coordinating Plans must pay.

## 1. Order of Benefit Determination

- a. When another Coordinating Plan does not have a COB provision or provides that it always pays second, that Coordinating Plan must pay its benefits first.

There is one exception—coverage obtained by virtue of membership in a group designed to supplement part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coordinating Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide Out-of-Network benefits.

- b. When another Coordinating Plan does have a COB provision, the first of the following rules which apply governs:

- i. If a Coordinating Plan covers the Claimant other than as a Dependent, for example, as an Eligible Employee, subscriber or retiree, then that Coordinating Plan will pay its benefits before the Coordinating Plan that covers the Claimant as a Dependent.

Please note: The Medicare laws may change the above rule. When the Claimant is covered as a Dependent of the Claimant's Spouse who is actively employed, and the Claimant is also covered as a retiree or former employee, the Medicare statute and regulations provide that Medicare is primary to the Coordinating Plan that covers the Claimant as other than a Dependent and secondary to the Coordinating Plan that covers the Claimant as a Dependent. In such circumstances, the Coordinating Plan that covers the Claimant as a Dependent of an active employee pays first, Medicare pays second, and the Coordinating Plan that covers the person as other than a Dependent pays last.

- ii. If the Claimant is a Dependent child whose parents are not divorced or separated (whether or not the parents have been married), or a court decree awards joint custody of the child without specifying that one party has the responsibility to provide health care coverage, then the Coordinating Plan of the parent whose birthday is earlier in the calendar year will pay first; except:

- (a) If both parents' birthdays are on the same day, the Coordinating Plan of the parent covered longer will pay first; or

- (b) If another Coordinating Plan does not include this COB rule based on the parents' birthdays, but has the gender rule and if, as a result, the Coordinating Plans do not agree on the order of benefits, the birthday rule will determine the order of benefits.

- iii. If the Claimant is a Dependent child whose parents are not married, divorced or separated (whether or not the parents have ever been married), then the following rules apply:
  - (a) The Coordinating Plan which covers a child as a Dependent of a parent who by court decree must provide health coverage will pay first, provided, the Coordinating Plan of that parent has actual knowledge of the terms of the decree;
  - (b) When there is no court decree which requires one parent to provide health coverage to a Dependent child, the following rules will apply:
    - (i) The Coordinating Plan of the parent who has custody of the child will pay first;
    - (ii) Then, the Coordinating Plan of the Spouse of the parent who has custody of the child will pay;
    - (iii) Then the Coordinating Plan of the parent without custody will pay;
    - (iv) Finally, the Coordinating Plan of the Spouse of the noncustodial parent will pay.
- iv. If a Coordinating Plan covers the Claimant as an active employee (who is not terminated, laid off or retired) or the Dependent of an active employee, the Coordinating Plan will pay its benefits before a Coordinating Plan that covers the Claimant as a terminated, laid off or retired employee or the Dependent of a terminated, laid off or retired employee.
- v. The Coordinating Plan which covers the Claimant as a current employee or the Dependent of a current employee pays before the Coordinating Plan which covers the Claimant under COBRA or similar continuation coverage.
- vi. If none of the above rules apply, the Coordinating Plan which has covered the Claimant for the longer period of time will pay its benefits first.



**2. Excess Coverage**

If one or more of the other Coordinating Plans involved (as defined in this Coordination of Benefits provision) provides benefits on an Excess Insurance or Excess Coverage basis, this Coordinating Plan will pay as excess coverage.

**3. Medical Payments under Automobile, Homeowners and General Liability Policies**

This Plan will always be secondary to medical payments coverage under automobile, homeowners and general liability insurance policies. This Plan may pay as primary, however, on a claim that is subject to homeowner's medical payment coverage, provided that this Plan's normal liability for such claim is under \$1,500.

**4. Coordination of Benefits when Primary Plan's Requirements Not Met**

When this Plan's benefits are secondary to another Coordinating Plan or to Medicare (traditional Medicare, Medicare HMOs and other Medicare + Choice Plans), or would have been secondary had the Claimant enrolled in Medicare when eligible, and the Claimant elects not to follow the Primary Plan's requirements to receive maximum benefits, this Plan will coordinate benefits as though those requirements had been met and this Plan's benefits will be offset by the amount that would have been payable under the Primary Plan's benefits had the Primary Plan's requirements been met. This restriction will not apply in the case of an Emergency, as defined in this Plan.

**D. FACILITY OF PAYMENT**

If benefits which this Plan should have paid are instead paid by another Coordinating Plan, this Plan may reimburse the other Coordinating Plan. Amounts reimbursed are benefits of this Plan and are treated like other benefits in satisfying the liability of this Plan.

Should this Plan pay benefits which should have been paid by another Coordinating Plan, this Plan has the right to recoup those benefits from the other Coordinating Plan, the provider, the Covered Individual or any other person or organization that received or benefited from this Plan's payment.

**E. PRIMARY PLAN CANNOT SHIFT LIABILITY TO THIS PLAN**

Notwithstanding any other provisions of these Coordination of Benefits rules, the following paragraphs shall apply to prevent a Coordinating Plan that is primary under these rules from shifting its liability to this Plan:

1. When another Coordinating Plan, including one made up of separate contracts or arrangements, which is primary under this Plan's rules, contains a sub-plan/no loss provision, this Plan will not pay as the Secondary Plan until the Primary Plan has exhausted its benefits under any no loss or similar provisions.
2. If another Coordinating Plan, including one made up of separate contracts or arrangements, is primary under this Plan's rules, and it contains a provision that has the effect of capping its benefits for an individual covered under this Plan and

of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of this Plan's coordination of benefits rules, this Plan shall not be liable to provide benefits until the other Coordinating Plan provides its customary benefits as the Primary Plan without regard to such cap.

3. If another Coordinating Plan, including one made up of separate contracts or arrangements, is primary under this Plan's rules, no benefits of any kind will be provided by this Plan to or for the affected Covered Individual unless the amount and type of benefits paid by that other Coordinating Plan are unaffected by the Covered Individual's coverage under this Plan.

## **F. SPECIAL MEDICARE COB RULES**

### **1. Medicare for Active Employees and their Dependents**

If you are an Active Employee and either:

- you or your eligible Dependent Spouse is age 65 or older and eligible for Medicare for reasons other than kidney dialysis or end stage renal disease, or
- you or your eligible Dependent Spouse or child is disabled under Social Security and eligible for Medicare for reasons other than kidney dialysis or end stage renal disease,

This Plan is the Primary Plan and will pay its regular medical benefits. Medicare is the Secondary Plan and may supplement the benefit you or your eligible Dependent receives under this Plan.

### **2. Medicare for Former Active Employees and their Dependents Who Are Disabled**

If you are no longer an Active Employee but otherwise eligible for coverage under this Plan, and

- you or your eligible Dependent Spouse is age 65 or older and eligible for Medicare for reasons other than kidney dialysis or end stage renal disease, or
- you or your eligible Dependent is disabled under Social Security and eligible for Medicare for reasons other than kidney dialysis or end stage renal disease,

Medicare is the Primary Plan for each Medicare eligible Covered Individual. If you or your eligible Dependent is eligible for the Medicare Supplement Benefit, this Plan will pay secondary in accordance with the terms of the Medicare Supplement Benefit. If you or your eligible Dependent is not eligible for the Plan's Medicare Supplement Benefit, this Plan will pay secondary to Medicare without applying the terms of the Medicare Supplement Benefit.

**3. Medicare for Covered Individuals with End Stage Renal Disease (ESRD)**

If you or your under age 65 eligible Dependent is eligible for Medicare due solely to End Stage Renal Disease (ESRD), this Plan will be primary during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage.

If you or your eligible Dependent is entitled to Medicare based on being age 65 or over or disabled under Social Security, and the individual is no longer covered under this Plan because you are no longer an Active Employee, this Plan will continue to pay secondary to Medicare if the Covered Individual subsequently becomes eligible for Medicare ESRD benefits.

**4. When Medicare is Primary**

When Medicare is primary and this Plan is secondary, Medicare (Parts A and B) will be considered a Coordinating Plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare Parts A and B whether or not you or your Dependents are enrolled in Medicare Parts A and B or receiving Medicare benefits. If the Covered Individual does not enroll in Part A and Part B of Medicare, the Covered Individual's benefits under this Plan will be reduced by the amount of the Medicare benefits which would have been payable had the Covered Individual enrolled in Medicare Part A and Part B.

REMEMBER: Medicare provisions apply from the date you are first ELIGIBLE for Medicare regardless of whether you are actually enrolled or receiving benefits. For this reason, you need to exercise your options promptly.

**G. COVERED INDIVIDUAL RESPONSIBILITIES**

It is the responsibility of all Covered Individuals to provide complete and accurate information to the Benefit Office, including information pertaining to other health or dental care coverage and/or insurance benefits (including, but not limited to, dental coverage or benefits), which each Covered Individual may have or have access to.

**H. COORDINATION OF MEDICAL BENEFITS WITH DENTAL BENEFITS**

To the extent that a treatment, service, or supply is covered under both the medical provisions of this Plan and the dental provisions of this Plan, a claim for such treatment, service or supply, will be considered first under the dental provisions of the Plan and then under the medical provisions.

## **SECTION XI. PLAN'S RIGHT TO SUBROGATION AND REIMBURSEMENT**

### **A. GENERALLY**

If this Plan pays out any benefits to or on behalf of a "covered person" (as defined below) in connection with an Illness or an Injury for which a "third party" (as defined below) may be responsible, the Plan has the right to recover those benefits either directly from the third party or from the covered person. While these subrogation and reimbursement provisions are most often relevant in connection with automobile accidents, they also apply in any situation in which a covered person's Injury or Illness is caused by a third party. For example, these provisions apply if a covered person is injured by a faulty product, by medical malpractice, or by some defective condition of a third party's property.

### **B. DEFINITIONS**

For purposes of these reimbursement and subrogation provisions, a "covered person" is a person to or on whose behalf this Plan pays out benefits. The term "covered person" also includes such individual's Spouse, guardian, estate, heirs or other representative.

For purposes of these reimbursement and subrogation provisions, a "third party" is a person who caused the covered person's Injury or Illness and any other person or entity that has an obligation to pay compensation of any sort to the covered person as a result of that Injury or Illness. For example, both the insurer of the responsible third party and the insurer of the covered person are included in the meaning of "third party" to the extent such insurers are obliged to compensate the covered person as a result of the Injury or Illness. Thus, to the extent the injured person's own insurer is obliged to compensate the injured person under the injured person's uninsured or underinsured motorist coverages, the injured person's own insurer will be a "third party."

### **C. PLAN'S RIGHT TO REIMBURSEMENT**

If this Plan pays out benefits of any sort to or on behalf of a covered person in connection with an Illness or an Injury for which a third party may be responsible, such benefits are paid on the express condition that the covered person must reimburse the Plan from any settlement or recovery that the covered person receives from or through such a third party or parties. The Plan has the right to recover the amount of the benefits it paid out in connection with the Injury or Illness if the covered person recovers any amount from or through any third party or parties. The covered person's Spouse is also required to reimburse the Plan to the extent the Spouse recovers from any third party by reason of the Injury to the covered person.

The description or characterization of any recovery from any third party does not affect the Plan's right to reimbursement. By accepting benefits from the Plan, the covered person and his or her Spouse acknowledge the Plan's right to reimbursement and agree to make such reimbursement and agree to hold any recovery received from a third party in trust for the Plan, to the extent of the amount of benefits the Plan paid out in connection with that Injury or Illness. The covered person and his or her Spouse must reimburse the Plan in full from any recovery from any third party or parties for benefits the Plan paid in connection with the Injury or Illness before any other amounts are deducted from the

recovery paid by the third party or parties. However, the Plan, in the sole and absolute discretion of the Plan, based on all of the circumstances, including the total amounts of the recovery and the costs and attorney's fees incurred by the covered person, may determine it is in the best interests of the Plan to reduce their claim for reimbursement.

#### **D. PLAN'S RIGHT TO SUBROGATION**

"Subrogation" means the substitution of one person in the place of another with respect to a claim, demand or right.

To the extent of benefits it pays out, the Plan will be subrogated to all claims, demands, actions and rights of the action the covered person may have against any third party or parties. This means that to the extent the covered person has a claim against anyone as a result of an Injury or Illness for which the Plan pays out benefits, the Plan has a right to pursue the covered person's claim. In effect, the Plan "stands in the place" of the covered person with respect to such claim or claims. For example, if you are injured in an auto accident caused by another person and the Plan pays out benefits for the treatment of your Injury, the Plan could, on its own, sue the person who caused the accident or, if you sued that person, the Plan could join in your lawsuit.

The amount of the Plan's subrogation interest is equal to the amount it paid out in connection with the Injury or Illness, plus the attorney's fees and costs it incurs in pursuing the claim against the third party or parties.

The Plan may assert its claim against any third party even if the covered person does not, or the Plan may join in any action the covered person brings against any third party or parties. The Plan does not waive any of its rights to reimbursement by not independently asserting its claim against any third party or by not joining in any action brought by the covered person against any third party.

By accepting benefits from this Plan in connection with any Injury or Illness for which a third party may be responsible, the covered person expressly acknowledges the Plan's rights to subrogation and agrees to do nothing to prejudice those rights and to cooperate fully with the Plan in asserting those rights.

#### **E. LIEN AND SEGREGATION OF RECOVERY**

By accepting the advance payment of your expenses from the Fund, you and/or your Dependent agrees to the following:

1. The Plan will automatically have an equitable lien, to the extent of the advance, upon any recovery, whether by settlement, judgment or otherwise, by you and/or your Dependent. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.
2. The Plan holds in a constructive trust that portion of the recovery that is the extent of the advance. You, your Dependent, and those acting on your behalf, will place and maintain such portion of any recovery in a separate segregated account until

the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.

3. Should you, your Dependent or those acting on your behalf, fail to maintain this segregated account or comply with any of the Plan's reimbursement requirements, you stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed

#### **F. COVERED PERSON'S RESPONSIBILITIES**

In order to receive benefits from this Plan in connection with an Injury or Illness for which a third party may be responsible to compensate the covered person, that covered person (and, if applicable, his or her Spouse) must do all of the following:

1. notify the Plan when the covered person suffers an Injury or Illness for which a third party may be required to compensate the covered person;
2. provide the Plan with any and all documents and information regarding the Injury or Illness the Plan may request;
3. execute an agreement setting forth the Plan's rights and the covered person's obligations and the obligations of the covered person's Spouse under these subrogation and reimbursement provisions. If the covered person is represented by an attorney, the covered person must provide the Plan with the attorney's name and contact information and that attorney must also sign the subrogation agreement;
4. provide the Plan with notice if the covered person or the covered person's Spouse asserts a claim or claims against any third party and keep the Plan informed as to the status of such claim or claims;
5. obtain the written consent of the Plan or its designee prior to settling any claim to which this Plan is subrogated;
6. notify the Plan of any compensation the covered person or the covered person's Spouse receives from any third party in connection with the Injury or Illness and immediately reimburse the Plan upon the receipt of such compensation;
7. cooperate fully with the Plan in its efforts to protect and exercise its rights to subrogation and reimbursement; and
8. take no actions to compromise or impair the Plan's rights to reimbursement or subrogation.

If the covered person or the covered person's Spouse fails to comply with these obligations, the Plan will not pay out benefits in connection with that Injury or Illness. If the covered person or the covered person's Spouse fails to reimburse the Plan for the benefits it paid out from any recovery they receive from the third party or parties as required, the Plan may withhold future benefits due the covered person and his or her covered family members or may take any other such action necessary to enforce the Plan's right to reimbursement.

**G. REJECTION OF “MAKE-WHOLE” DOCTRINE**

This Plan specifically rejects the “make-whole” doctrine. The Plan’s rights to reimbursement and subrogation do not depend on whether the covered person or the covered person’s Spouse recovers from third parties monies sufficient to fully compensate the covered person or the covered person’s Spouse, or both, for their losses.

**H. REJECTION OF THE “COMMON FUND” DOCTRINE**

This Plan specifically rejects the “common fund” doctrine.

**I. REJECTION OF EQUITABLE DEFENSES**

To the extent not specifically identified, this Plan rejects all additional equitable defenses and no such defense shall be used to limit or alter the Plan’s right to recovery under these provisions.

**J. PLAN’S ENFORCEMENT OF THESE PROVISIONS**

In the event the covered person or his or her Spouse fails to fulfill his or her obligations under these reimbursement and subrogation provisions, the Plan may take any action the Trustees deem necessary to enforce the Plan’s rights under these provisions. The Plan may refuse to pay benefits in connection with the Injury or Illness if the covered person or the covered person’s Spouse fails to fulfill his or her obligation to provide information and documents or fails to execute the required reimbursement and subrogation agreement. If the Plan does pay benefits and the covered person or the covered person’s Spouse later fails to fulfill his or her duties, the Plan may withhold future benefits from the covered person and the covered person’s family members, may bring an action against the covered person and the covered person’s Spouse, or may recoup amounts it paid out from the providers to whom such amounts were paid or any other sources. Should the Trustees bring legal action to enforce the Plan’s rights under these reimbursement and subrogation provisions, and succeed in whole or in part in such action, the covered person or the covered person’s Spouse shall pay the legal fees and costs the Trustees incur in that action.

**K. FUTURE CLAIMS RELATING TO THE SAME INJURY OR ILLNESS**

Once the covered person’s claims against the third party or parties are resolved, the Plan will not pay out any additional benefits in connection with the Injury or Illness caused by the third party until the total claims that would otherwise be covered under the Plan exceed the total amount of compensation paid to or on behalf of the covered person and/or the covered person’s Spouse by the third party or parties. In such a situation only the excess portion of the otherwise covered claims will be treated as covered.

## **SECTION XII. NOTICE OF PRIVACY AND SECURITY PRACTICES**

This notice describes how medical information about you may be used and disclosed, how you can get access to this information, and informs you of your rights related to your health information. Read it carefully.

We are required by law to:

1. Maintain the privacy of your health information;
2. Give you this notice of our legal duties and privacy practices with respect to health information about you; and
3. Follow the terms of the notice that is currently in effect. This notice is effective September 23, 2013.

### **A. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

We may use your health information, as described in each category below, for treatment purposes, for payment purposes, and for our health care operations. We provide for each of these categories an example of how your health information may be used.

#### **1. Treatment**

We may use or disclose your health information to facilitate your health care treatment. For example, we might disclose information to your health care provider to assist them in making a determination on a course of treatment for you.

#### **2. Payment**

We may use and disclose health information about you for purposes related to payment. For example, we may use your health information to obtain premiums or to determine our responsibility for coverage under the Plan. As another example, we may use your health information to coordinate benefits with another health plan.

#### **3. Health Care Operations**

We may use and disclose health information about you in order to carry out the day-to-day health care operations of our health plan. For example, we may use health information in connection with:

- a. Legal services;
- b. Audit services;
- c. Business planning and development;
- d. Business management of the Plan;
- e. Contracting for reinsurance; however, consistent with the Genetic Information Nondiscrimination Act (GINA), the Plan is prohibited from disclosing genetic information for underwriting purposes; and



- f. Reporting to the Trustees—for example, we may disclose information to the Board of Trustees of the Plan for reviewing and making determinations regarding appeals.

**B. THE PLAN’S DISCLOSURE OF PHI TO THE TRUSTEES**

In the course of business practices, the Plan may disclose information to the Board of Trustees of the Plan, acting as Plan Sponsor, for reviewing and making determinations regarding an appeal or for monitoring benefit claims or analyzing benefit structure and claim experience including those that may or do involve stop-loss insurance. Generally, the Plan will disclose PHI to the Plan Sponsor only if necessary for Plan operations. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;
2. Ensure that any agents, including subcontractors, to whom it provides PHI received from Health Plan agree to the same restrictions and conditions that apply to Plan Sponsor with respect to such information;
3. Not use or disclose PHI for employment-related actions and decisions;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of Plan Sponsor;
5. Report to Health Plan’s Privacy or Security Officer any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;
6. Make PHI available to an individual based on HIPAA access requirements;
7. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA amendment requirements;
8. Make available the information required to provide an accounting of disclosures;
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Health Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Health Plan’s compliance with HIPAA;
10. Ensure that adequate separation between the Health Plan and the Plan Sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(iii));
11. If feasible, return or destroy all PHI received from Health Plan that Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible;
12. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan;
13. Ensure “adequate separation” supported by reasonable and appropriate security measures. “Adequate separation” means the Plan Sponsor will use ePHI only for

Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures shall be subject to the Plan's disciplinary procedure; and

14. Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

## **C. OTHER POTENTIAL USES AND DISCLOSURES**

In addition to the general uses and disclosure of your information discussed above, there may be other special situations where it is necessary, and permissible, for us to use or disclose your health information. These situations are discussed below:

### **1. As Required by Law**

The Plan may use or disclose PHI to the extent that such use or disclosure is required by law and complies with and is limited to the relevant requirements of such law.

### **2. Public Health Activities**

For example, we may disclose information to a public health authority for the purpose of preventing or controlling disease.

### **3. Reporting Abuse, Neglect or Domestic Violence**

For example, circumstances may arise where we need to disclose to appropriate authorities suspected abuse or domestic violence.

### **4. Health Oversight Activities**

We may disclose health information to a health oversight agency for health oversight activities, including audits, health care fraud investigations, inspections, and other oversight activities authorized by law. For example, it may be necessary for us to disclose information pursuant to a Medicare audit.

### **5. Judicial or Administrative Proceedings**

For example, we may disclose information pursuant to a court order, subpoena, or a discovery request related to a trial proceeding.

### **6. Law Enforcement Purposes**

For example, it may be necessary for us to disclose information to law enforcement officials regarding the identification of suspects, fugitives, or missing persons.

### **7. Medical Directors, Coroners, and Funeral Directors**

In the event of your death, we may disclose your health information to medical directors, coroners, or funeral directors. For example, disclosure may be necessary for determining a cause of death.

8. **Organ and Tissue Donation**

We may disclose your information to organizations handling organ and tissue donation.

9. **Disclosures to Avert a Serious Threat to Health or Safety**

For example, we may disclose information to appropriate authorities in order to protect the safety of an individual.

10. **For Specialized Government Functions**

We may disclose health information pursuant to certain governmental functions, for example, for military or veteran activities; or national security activities.

11. **Workers' Compensation**

We may release information in accordance with applicable Workers' Compensation laws.

12. **Disclosures to the Plan Sponsor**

The Plan may disclose health information to the Trustees of the Plan in order to carry out plan administration functions.

**All Other Uses or Disclosures**

*We may not use or disclose your health information for any other purpose other than described above without your specific written authorization. You may revoke any such authorization in writing at any time. However, any revocation is limited to the extent that the Plan has already taken action in reliance upon your authorization.*

**D. YOUR RIGHTS REGARDING HEALTH INFORMATION**

Federal law provides you with several rights regarding your health information:

1. **Right to Inspect and Copy Your Health Information**

You have the right to inspect and copy the health information that we maintain about you. You must submit any request to inspect or copy your health information in writing. All such written requests should be forwarded to:

Alton IBEW/NECA Health & Welfare Plan  
5735 Elizabeth Avenue  
St. Louis, Missouri 63110

If you request a copy of your information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

2. **Right to Amend Your Health Information**

You have the right to request an amendment to your health information maintained by our Plan, for as long as the information is kept by our Plan. You may wish to request an amendment to your information if you feel that the information is inaccurate or incomplete. A request must state the reason you feel the amendment is necessary. You must make any request for amendment in writing. Your request should be submitted to the Privacy Officer at the address in No. 1 above.

3. **Right to an Accounting of Disclosures**

You have the right to receive an accounting of certain disclosures of your health information made by the Plan. This accounting does not include disclosures made pursuant to treatment, payment, healthcare operations, or your individual authorization. Your request should state the time period for which you would like an accounting, which cannot go beyond the six years prior to the date of your request. You are not entitled to an accounting of disclosures made prior to April 14, 2004. You are entitled to one free accounting within any 12-month period. We may charge you a reasonable fee for any other accounting made within this same 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred. You must submit a request for an accounting of disclosures in writing to the Privacy Officer at the address in No. 1 above.

4. **Right to Request Restrictions**

You have the right to request specific restrictions on our uses and disclosures of your health information. For example, you have the right to request that we not disclose any of your health information for treatment purposes. We do not have to agree to a requested restriction. Agreeing to a restriction is within our sole discretion.

5. **Right to Request Confidential Communications**

You have the right to request that we communicate specific information to you in a certain manner or at a certain location, if you feel that the communication might otherwise place you in danger. For example, you may request that an explanation of benefits be sent to your work rather than to your home if you feel that this information may put you in danger if sent to your home. Any request for a confidential communication must be made in writing and be accompanied by a statement that the confidential communication is necessary to avoid your personal endangerment. All requests should be submitted to the Privacy Officer at the address in No. 1 above.

6. **Right to a Paper Copy of This Notice**

You have the right to receive a paper copy of this notice at any time. To request a paper copy of this notice, please contact the Privacy Officer at the address in No. 1 above.

**E. REVISIONS TO THIS NOTICE**

We reserve the right to change the terms of this notice. Any changes to this notice will be effective for health information that we maintain about you. Should we revise this notice, we will promptly provide you with a new Notice by mailing you a written copy of the new notice.

**F. COMPLAINTS**

If you believe your privacy rights have been violated, you have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. Your privacy rights will not be affected by filing a complaint. Further, you

will not be retaliated against in any manner for filing a complaint. To file a complaint with the Plan, contact:

Alton IBEW/NECA Health & Welfare Plan  
5735 Elizabeth Avenue  
St. Louis, Missouri 63110

## **G. SECURITY**

The Plan is required to comply with the HIPAA Security Rule. The Security Rule addresses the security of electronically maintained protected health information. While security measures have always been in place, the Security Rule requires that certain safeguards be documented in Plan documents. Accordingly, the Trustees have implemented the following measures:

1. Administrative, physical, and technical safeguards have been implemented that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic health information the Trustees created, received, maintained, or transmitted on behalf of the Plan;
2. There is adequate separation (or firewall) between the information that is received from the Plan and other employment information and decisions, and this separation is supported by reasonable and appropriate security measures;
3. Any agent, including a subcontractor, to whom the Plan provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and
4. The Trustees will report to the Plan any security incident of which it becomes aware.

## **H. BREACH NOTIFICATION**

The Plan is subject to the new HITECH breach notification rules. In the unlikely event that your protected health information is breached, as that term is defined under HITECH, we will provide you with written notice of the breach. The notice will be sent without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notice will be written in plain language and will contain the following information:

1. A brief description of what happened, the date of the breach if known, and the date of discovery;
2. The type of PHI involved in the breach;
3. Any precautionary steps you should take;
4. What we are doing to mitigate the breach and prevent future breaches; and
5. How you may contact us to discuss the breach.

We will also report the breach to the U.S. Department of Health and Human Services.

### **SECTION XIII. PLAN ADMINISTRATION AND ERISA INFORMATION**

**A. PLAN NAME**

Alton IBEW/NECA Health and Welfare Plan

**B. PLAN NUMBER**

501

**C. PLAN TAX ID NUMBER**

20-0221802

**D. PLAN YEAR**

The Plan's financial records are maintained on a fiscal year basis ending each October 31<sup>st</sup>. Benefit records are maintained on a calendar year basis.

**E. PLAN SPONSOR AND PLAN ADMINISTRATOR**

Board of Trustees  
Alton IBEW/NECA Health and Welfare Plan  
IBEW/NECA Service Center  
P.O. Box 6088  
St. Louis, Missouri 63139  
Phone: (314) 752-2330  
Fax: (314) 752-5813

The Board of Trustees of the Alton IBEW/NECA Health and Welfare Plan is the Plan Sponsor and Plan Administrator. The Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by the Board of Trustees to serve as the Administrative Manager.

The Plan Administrator and/or Administrative Manager shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan and the Board of Trustees that Board of Trustees and Administrative Manager shall have the maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and Administrative Manager will be final and binding on all interested parties.

As of May 1, 2015, the Trustees are:

UNION TRUSTEES

Charles Yancey  
IBEW Local 649  
4051 Humbert Road  
Alton, Illinois 62002

Mark A. Woulfe  
IBEW Local 649  
4051 Humbert Road  
Alton, Illinois 62002

EMPLOYER TRUSTEES

Tom Brown  
Camp Electric & Heating Company  
3133 Washington Avenue  
Alton, Illinois 62002

Mark E. Kratschmer  
Wegman Electric  
1141 East Airline Drive  
East Alton, Illinois 62024

As of May 1, 2015, the Administrative Manager is:

Corey Wirth  
IBEW/NECA Service Center  
P.O. Box 6088  
St. Louis, Missouri 63139  
Phone: (314) 752-2330  
Fax: (314) 752-5813

**F. TYPE OF PLAN**

The Plan is an employee welfare benefit plan. The Plan provides medical and prescription drug benefits on a self-funded basis paid directly out of the assets of the Plan.

The Plan also provides the following insured benefits, which are furnished in accordance with group insurance policies purchased by the Plan and issued by insurance companies:

1. Dental
2. Vision
3. Life Insurance
4. Accidental Death and Dismemberment
5. Short-Term Disability

The funding for the benefits provided by the Plan is derived from the funds of the Contributing Employers and contributions made by covered Employees and Retirees.

**G. TYPE OF ADMINISTRATION**

The Board of Trustees administers the overall operation of this Plan.

1. Medical and Prescription Drug Benefits

The Trustees have entered into an agreement with Coventry Health Care of Missouri, Inc., an Aetna company, to provide Participants with access to a network of medical care providers and to provide claims administration services for medical care. Medical claims should be submitted to:

Coventry Health Care of Missouri, Inc.  
Claims Department  
P.O. Box 7121  
London, KY 40742-7121  
(800) 775-3540

Coventry Health Care of Missouri, Inc., is not financially responsible for the benefits provided by the Plan and is not a fiduciary under the Plan by virtue of administering medical care under the Plan.

The Trustees have entered into an agreement with LDI Integrated Pharmacy Services to provide Participants with access to a network of pharmacies and to provide claims administration services for prescriptions filled on an emergency basis at a non-participating pharmacy. Claims should be submitted to:

LDI Integrated Pharmacy Services  
Member Reimbursement  
701 Emerson Road, Suite 301  
Creve Coeur, MO 63141  
(866) 516-3121

#### **H. FUNDING METHOD CONTRIBUTIONS**

The Plan is established and maintained pursuant to collective bargaining agreements with IBEW Local 649. The Plan is funded with contributions from Employers signatory to the collective bargaining agreements with IBEW Local 649 and/or written agreements requiring contributions to the Plan, as well as any required contributions from participating Employees and retirees. The collective bargaining agreements are available for examination by Eligible Employees and beneficiaries at the Administrative Manager's office listed above. If, for any reason, you wish to review a collective bargaining agreement, please contact the Administrative Manager to make an appointment.

#### **I. HOLDING OF PLAN ASSETS**

Assets are held in a trust fund. These assets are held and invested at various financial institutions. More information is available upon request. The request should go to the Plan Administrator's office at (314) 752-2330 or addressed to:

Alton IBEW/NECA Health & Welfare Plan  
c/o IBEW/NECA Service Center  
Attn: Plan Administrator  
P.O. Box 6088  
St. Louis, Missouri 63139  
(314) 752-2330

#### **J. AGENT FOR SERVICE OF LEGAL PROCESS**

Legal process may be served upon the Board of Trustees by serving the Administrative Manager at the above address or my serving any individual Trustee.



**K. AMENDMENT AND TERMINATION OF THE PLAN**

The Plan may be amended or terminated by the Board of Trustees, subject to applicable collective bargaining agreement provisions. The benefits described in this SPD are those currently provided by the Plan. These benefits may be altered, modified, reduced, or terminated at any time the Trustees determine, in their sole discretion, such action is necessary. If the Plan is terminated, the rights of the Plan's Participants are limited to expenses incurred before termination.

**L. TRUSTEES ARE FIDUCIARIES**

The Trustees are fiduciaries with respect to the Plan. The Trustees, in exercising their powers and duties under the Plan, are doing so at all times in their fiduciary capacity.

**M. STATEMENT OF ERISA CERTAIN PLAN PARTICIPANT RIGHTS UNDER ERISA REQUIRED BY FEDERAL LAW**

As a participant in the Alton IBEW/NECA Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as 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 Plan 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 will have to pay for this coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

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

### **Prudent Actions by Plan Fiduciaries**

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

### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance With Your Questions**

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

**N. NOTICE OF GRANDFATHERED PLAN STATUS**

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at IBEW-NECA Local 1 Service Center, P.O. Box 6088, St. Louis, Missouri 63139, Phone: (314) 752-2330, Fax: (314) 752-5813. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.