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425 Eagle Rock Ave.
Suite 105
Roseland, NJ 07068

I.E. Shaffer & Co.
830 Bear Tavern Road
West Trenton, NJ 08628

I.B.E.W. LOCAL UNION NO. 102 WELFARE FUND

To All Participants **October 2019**

Enclosed please find a restated Welfare Fund booklet (SPD), which provides an up-to-date description of your plan of benefits, including all plan changes through September 2019.

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

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

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

Claim and benefit questions should be addressed to:

Fabian & Byrn LLC
425 Eagle Rock Ave., Suite 105
Roseland, NJ 07068
Telephone: 888-423-9102
Fax: 973-228-4295

Eligibility, hours and pension questions should be addressed to:

I.E. Shaffer & Co.
830 Bear Tavern Rd.
West Trenton, NJ 08628
Telephone: 800-792-3666
Fax: 609-883-7580

Sincerely,
BOARD OF TRUSTEES

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MEDICARE PRIMARY MEMBERS

If your Medicare Plan is your primary coverage and the IBEW Local 102 is your supplement, it is not necessary to use In-Network Providers of this Plan*. You should be seeking doctors and providers that accept Medicare Assignment in order for you to arrive at your lowest out-of-pocket expenses. If the provider accepts Medicare Assignment and your IBEW Local 102 Plan annual $400.00 deductible is satisfied, your IBEW Local 102 Plan will pay the balance of the Medicare approved amount.

*In addition to accepting Medicare Assignment, if the provider also participates with the Blue Cross/ Blue Shield Direct Access Plan, (an In-Network provider) the annual deductible will be waived.

If you use doctors or providers who do not accept Medicare assignment and your IBEW Local 102 Plan annual $400.00 deductible is satisfied, your IBEW Local 102 Plan will pay you the balance after Medicare, up to the Medicare approved amount.

Call the claims office at 888-423-9102 to inquire if Medicare crossover can be set up. The Fund only recommends this if your providers are all within the State of New Jersey.

Note: If you do not sign up for Medicare Part B, this Plan will process all claims as if Medicare Part B were chosen and your benefits will be reduced by the amount that Medicare would have paid.

Your IBEW Local 102 Medicare Supplement Plan follows the Medicare Plan of Benefits to determine coverage, therefore if Medicare approves a procedure or service your Local 102 Plan will consider that procedure or service to be covered under the Local 102 Plan. If Medicare does not allow a procedure or service or considers any benefit to be exhausted then your Local 102 Plan will deny the procedure or service as not covered. If any Medicare Benefit is exhausted then that benefit will be considered to be exhausted under your Local 102 Plan as well. The Medicare guidelines do not apply to the vision or hearing benefit or the Dental Plan.

If you are to be admitted to a hospital, you are not required to comply with the Local 102 Plan Hospital Pre-Admission Certification required of Non-Medicare Primary Members. You must follow the Medicare requirements for Hospital Admission.

Mental Health Benefits must be approved by Medicare to receive coverage. Authorization through Intervention Strategies is not required.

The Dental and Hearing Benefit Plans are the same for Medicare Participants as they are for the Active Plan B Members of IBEW Local 102.

MEDICARE PART D Prescription drug PLAN BENEFIT

Express Scripts Medicare® (PDP)

Benefit Overview

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

<table>
<tr><td>Plan Premium</td><td colspan="4">Your group benefits administrator will tell you the amount that you pay for your plan. If you have any questions, please contact the Retiree Customer Service Center at the number below.</td></tr>
<tr><td>Deductible Stage</td><td colspan="4">As your plan does not have a deductible this section does not apply to you.</td></tr>
<tr><td>Initial Coverage Stage</td><td colspan="4">You will pay the following until your total yearly drug costs (what you and the plan pay) reach $3,700:</td></tr>
<tr><td rowspan="5"></td><td>Tier</td><td>Retail
One-Month
(31 day) Supply</td><td>Retail
Three-Month
(90-day) Supply</td><td>Home Delivery
Three-Month
(90-day) Supply</td></tr>
<tr><td>Tier 1:
Generic drugs</td><td>$10</td><td>$30</td><td>$25</td></tr>
<tr><td>Tier 2: Preferred
Brand Drugs</td><td>50% Max $47</td><td>50% Max $141</td><td>50% Max $130</td></tr>
<tr><td>Tier 3:
Non-Preferred
Drugs</td><td>50% Max $300</td><td>50% Max $900</td><td>50% Max $850</td></tr>
<tr><td>Tier 4:
Specialty Tier
Drugs</td><td>$100</td><td>$300</td><td>$275</td></tr>
<tr><td>Initial Coverage Stage</td><td colspan="4">If your doctor prescribes less than a full month’s supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.
You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts Pharmacy℠. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.
If you have any questions about this coverage, please contact Labor First at 862-206-7156 or toll free at 844-818-1066, Monday through Friday, 8:00 a.m. - 5:00 p.m., Eastern Time.</td></tr>
<tr><td>Coverage Gap Stage</td><td colspan="4">After your total yearly drug costs reach $3,700, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage, until you qualify for the Catastrophic Coverage stage.</td></tr>
<tr><td>Catastrophic Coverage Stage</td><td colspan="4">After your yearly out-of-pocket drug costs reach $4,950, you will pay the greater of 5% coinsurance or:
• a $3.30 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage
• an $8.25 copayment for all other covered drugs, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage.</td></tr>
</table>

IMPORTANT MEDICARE PART D PRESCRIPTION PLAN INFORMATION

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact the plan or the Retiree Customer Service Center for more details.

Additional Information About This Coverage

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit our website at **www.Express-Scripts.com.**
- Your plan uses a formulary (a list of covered drugs). The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
- To access your plan's list of covered drugs, visit our website at **www.Express-Scripts.com.**
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- Each month, you may need to pay a monthly premium amount to continue your participation in this plan. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is $0.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Who is eligible for this plan?

You are eligible for this plan if you are entitled to Medicare Part A and/or are enrolled in Medicare Part B, live in the plan's service area, are a U.S. citizen or are lawfully present in the United States and are eligible for benefits from IBEW 102.

You can be in only one Medicare prescription drug plan at a time. If you are currently enrolled in a Medicare Advantage (MA) Plan that **includes Medicare prescription drug coverage**, your enrollment in this plan may end that enrollment. In addition, you may not be enrolled in an individual MA Plan—even one without prescription drug coverage—at the same time as this plan. You may, however, be enrolled in this plan and an MA-only plan if it has been coordinated through your employer. Please contact your group benefits administrator if you have questions about other plan types and the impact your enrollment in this plan may have.

Important: If you choose a prescription drug plan outside your former employer/retiree group's offering, this decision may impact other benefits, such as medical coverage. Please contact your group benefits administrator for more information before making a decision to leave this plan, or for information about other options that may be available to you.

Will my income affect my Medicare Part D premium (if applicable)?

Some people may have to pay an extra amount because of their yearly income. If your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is more than $85,000 for individuals and married individuals filing separately or $170,000 for married individuals filing jointly, you'll have to pay extra for your Medicare prescription drug coverage. This extra amount is called the Part D income- related monthly adjustment amount. If you have to pay an extra amount, Social Security—not your Medicare plan—will send a letter telling you what the extra amount will be and how to pay it. No matter how your plan premium is paid, the extra amount will be withheld from your Social Security or Office of Personnel Management benefit check. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium. If you have any questions about this extra amount, contact Social Security at 800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 800-325-0778.

Express Scripts Medicare is a Medicare prescription drug plan, which is in addition to your coverage under Medicare Part A and/or Part B. Your enrollment in this plan doesn't affect your coverage under Medicare Part A and/or Part B. It is your responsibility to inform Express Scripts Medicare of any prescription drug coverage that you have or may get in the future. You can be in only one Medicare prescription drug plan at a time.

continued

You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your Evidence of Coverage to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

By joining this Medicare prescription drug plan, you acknowledge that Express Scripts Medicare can release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that Express Scripts Medicare can release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The Centers for Medicare & Medicaid Services must approve Express Scripts' plan each year. You can continue to get Medicare coverage as a member of this plan only as long as both Express Scripts and your previous employer or retiree group choose to continue to offer this plan, and CMS renews its approval of Express Scripts' plan.

This information is not a complete description of benefits. Contact the plan or the Retiree Customer Service Center for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

SCHEDULE OF BENEFITS Plan A and B

FOR YOU AND YOUR DEPENDENTS

MANAGED CARE NETWORK – HORIZON DIRECT ACCESS

The Fund has contracted with a Managed Care Network to provide services to you and your Dependents. At the time of service, you or your Dependents may use an In-Network or an Out-of-Network provider. If you or a covered Dependent use the services of an In-Network Provider, the benefit for such services will be reimbursed at a higher benefit level, as shown in this Schedule.

If you or a covered Dependent use the services of an Out-of-Network provider, the benefit for services will be reimbursed at a much lower benefit level and you will be responsible for the portion of the provider's bill that the Fund does not cover. The Out of Network Benefits are determined, using the IBEW Local Union No. 102 Welfare Fund's fee schedule. The annual deductible must be satisfied prior to the payment of Out-of-Network Benefits which are then paid as illustrated in the Schedule of Benefits Section.

The use of In-Network Providers will substantially reduce your out of pocket expenses.

HOSPITAL PRE-AUTHORIZATION CERTIFICATION

This Fund has contracted with Horizon Blue Cross and Blue Shield of New Jersey to perform Inpatient Hospital Pre-authorization Certification Services for all medical admissions. Prior to an Inpatient Hospital admission, the provider must call Horizon Blue Cross and Blue Shield of New Jersey at 800-664-2583 for a pre-authorization.

All inpatient admissions for mental health or substance abuse (substance abuse is only covered under Plan B) must be pre-authorized by Intervention Strategies at 800-663-0404.

If a required pre-authorization certification is not obtained for a Hospital Admission, any benefits payable under this Plan relating to the hospitalization and/or surgery will be subject to one of the following:

1. if the admission would have been approved as Medically Necessary, benefits will be subject to a 50% benefit reduction for eligible charges up to a maximum of $500; or

2. any admission that would not have been approved as Medically Necessary will not be a covered expense and the member or his dependent will be responsible for 100% of the non-covered charges.

SCHEDULE OF BENEFITS Plan A and B

BENEFIT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Inpatient Hospital Plan A Pre-authorization required through Horizon BCBS at 800-664-2583 for medical hospitalizations and Intervention Strategies at 800-663-0404 for mental health hospitalizations. See page 31	100% of contracted rate for up to 120 days per calendar year. This is a combined benefit for all inpatient admissions, including medical and mental health. Treatment for substance abuse is not covered under Plan A.	80% of fee schedule for up to 120 days per calendar year. This is a combined benefit for all inpatient admissions, including medical and mental health. Treatment for substance abuse is not covered under Plan A. The 20% coinsurance does not apply to the annual major medical out of pocket maximum and will never qualify for 100% payment.
Inpatient Hospital Plan B Pre-authorization required through Horizon BCBS at 800-664-2583 for medical hospitalizations and Intervention Strategies at 800-663-0404 for mental health or substance abuse hospitalizations. See page 31	100% of contracted rate for up to 180 days per calendar year. This is a combined benefit for all inpatient admissions, including medical, mental health and substance abuse.	80% of fee schedule for up to 180 days per calendar year. This is a combined benefit for all inpatient admissions including medical, mental health and substance abuse. The 20% coinsurance does not apply to the annual major medical out of pocket maximum and will never qualify for 100% payment.
Outpatient Hospital	100% of contracted rate after a $100 copay. The copay is waived for Radiation, Chemotherapy treatments and Mammograms.	80% of fee schedule after a $100 copay. The 20% coinsurance does not apply to the annual major medical out of pocket maximum and will never qualify for 100% payment.
Emergency Room Hospital charges	100% of contracted rate after a $100 copay.	100% of fee schedule after a $100 copay.
Emergency Room Doctor charges	100% of contracted rate.	100% of fee schedule.
Emergency Ambulance charges Ground Transportation only See page 38	100% of contracted rate.	100% of the fee schedule
Surgical Facility (Ambulatory)	100% of contracted rate after a $100 copay.	80% of fee schedule after a $100 copay. The 20% coinsurance does not apply to the annual major medical out of pocket maximum and will never qualify for 100% payment. No coverage for out of network pain management services.
Hospice Pre-authorization required through Horizon BCBS at 800-664-2583. See page 36	100% of contracted rate. Precertification required.	100% of fee schedule Precertification required.

BENEFIT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Anesthesiologist	100% of contracted rate.	80% of fee schedule. No coverage for out of network pain management services.
Surgeon Fees	100% of contracted rate.	70% of fee schedule after deductible. No coverage for out of network pain management services.
Bariatric Surgery and Services Pre-authorization required through Horizon BCBS at 800-664-2583 $15,000 lifetime limit See page 39	100% of contracted rate up to up to a $15,000 lifetime benefit for all related services including surgeon, hospital, anesthesia, follow up and complications.	70% of fee schedule after deductible up to $15,000 lifetime benefit for all related services including surgeon, hospital, anesthesia, follow up and complications.
Extraction of full bony impacted wisdom teeth	100% up to $325 for the extraction. 100% of contracted rate for anesthesia.	70% of fee schedule after deductible up to maximum payout of $325 per tooth. 80% of fee schedule for anesthesia.
Pain Management Procedures See page 53	100% of contracted rate based on medical necessity.	No coverage for out of network providers. If the doctor is out of network, there will be no coverage for the facility, anesthesia and/or other related services, even if those providers are in the network.
In-Hospital Physician	100% of contracted rate.	70% of fee schedule after deductible.
Physician Office Visits See page 34	100% of contracted rate after $25 copay per visit.	70% of fee schedule after deductible.
Laboratory Charges	100% of contracted rate** **$100 outpatient copay will apply if these services are billed by a facility.	70% of fee schedule after deductible. $100 copay and 80% of fee schedule for services billed as a facility. No coverage for out of network drug testing.
Physical/Occupational Therapy 36 combined visits per calendar year See page 38	100% of contracted rate after $25 copay per visit.	70% of fee schedule after deductible for services rendered in the office. $100 copay and 80% of fee schedule for services billed as a facility.
Speech Therapy 12 visits per calendar year	100% of contracted rate after $25 copay per visit.	70% of fee schedule after deductible for services rendered in the office. $100 copay and 80% of fee schedule for services billed as a facility.
Vision Therapy 12 visits per calendar year	100% of contracted rate after $25 copay per visit.	70% of fee schedule after deductible for services rendered in the office. $100 copay and 80% of fee schedule for services billed as a facility.

SCHEDULE OF BENEFITS Plan A and B-continued

BENEFIT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Cardiac Rehabilitation 30 visits per calendar year	100% of contracted rate after $25 copay per visit.	70% of fee schedule after deductible for services rendered in the office. $100 copay and 80% of fee schedule for services billed as a facility.
Chiropractic/Acupuncture Plan A (Combined benefit) Nerve conduction studies and testing, TENS unit and durable medical equipment are not payable services when performed or provided by a chiropractor or acupuncturist.	100% of contracted rate after $25 copay per visit. Maximum of 26 visits per person, 80 visits per family, per calendar year.*	70% of fee schedule after deductible. Coverage is limited to a maximum of 20 visits per person, 40 visits per family, per calendar year.*
	*Under no circumstances will the Fund ever pay for more than 26 visits per person and 80 visits per family, per calendar year regardless of whether the provider is in or out of network.	
Chiropractic/Acupuncture Plan B (Combined benefit) Nerve conduction studies and testing, TENS unit and durable medical equipment are not payable services when performed or provided by a chiropractor or acupuncturist.	100% of contracted rate after $25 copay per visit. Maximum of 40 visits per person, 120 visits per family, per calendar year.*	70% of fee schedule after deductible. Coverage is limited to 26 visits per person, 80 visits per family, per calendar year.*
	*Under no circumstances will the Fund ever pay for more than 40 visits per person and 120 visits per family, per calendar year regardless of whether the provider is in or out of network.	
Allergy Injections or treatment	100% of contracted rate after $25 copay.	70% of fee schedule after deductible.
Durable Medical Equipment Pre-authorization required if cost of purchase or rental is $1500 or more.	80% of contracted rate. 20% coinsurance is not applied to yearly out of pocket. Pre-authorization for In-network providers is through Horizon Care @ Home at 855-243-3321.	70% of fee schedule after deductible. Pre-authorization for Out-of-network providers is through Horizon BCBS at 800-664-2583.
Home Health Care Maximum of 120 combined visits. Preauthorization required See page 34	100% of contracted rate. Services must begin within 14 days of a hospital discharge. Pre-authorization for In-network providers is through Horizon Care @ Home at 855-243-3321.	70% of fee schedule after deductible. Services must begin within 14 days of a hospital discharge. Pre-authorization for Out-of-network providers is through Horizon BCBS at 800-664-2583.

BENEFIT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Non Hospital Nursing Pre-authorization required. Pre-authorization for In-network providers is through Horizon Care @ Home at 855-243-3321. Pre-authorization for Out-of-network providers is through Horizon BCBS at 800-664-2583. See page 35	100% of contracted rate, up to a maximum of $10,000 per person per calendar year and the annual visit limit is combined with the Home Health Care benefit. Services must be preauthorized and services must begin within 14 days of a hospital discharge.	70% of fee schedule after deductible up to a maximum of $10,000 per person per calendar year and the annual visit limit is combined with the Home Health Care benefit. Services must be preauthorized and services must begin within 14 days of a hospital discharge.
Annual Physical Examinations See page 36	100% of contracted rate.	Not covered out of Network.
Routine Ob-Gyn Examinations See page 36.	100% of contracted rate. One annually for female dependents.	Not covered out of Network.
Well Child Care Examinations See page 37	100% of contracted rate.	Not covered out of Network.
Inpatient Mental Health Plan A Pre-authorization required through Intervention Strategies at 800-663-0404. See page 41	100% of contracted rate for up to 120 days per calendar year. This is a combined benefit for all inpatient admissions, including medical and mental health.	80% of fee schedule for up to 120 days per calendar year. This is a combined benefit for all inpatient admissions, including medical and mental health.
Inpatient Mental Health Plan B Pre-authorization required through Intervention Strategies at 800-663-0404. See page 41	100% of contracted rate for up to 180 days per calendar year. This is a combined benefit for all inpatient admissions, including medical/mental/substance.	80% of fee schedule for up to 180 days per calendar year. This is a combined benefit for all inpatient admissions, including medical/mental/substance.
Outpatient Mental Health Pre-authorization recommended through Intervention Strategies at 800-663-0404. See page 42	100% of contracted rate after a $25 copay.	70% of fee schedule after deductible for services rendered in the office. $100 copay and 80% of fee schedule for services billed as a facility

PRESCRIPTION DRUG BENEFIT (PLANS A AND B)

See section: PRESCRIPTION DRUG BENEFIT on page 49 for additional information and exclusions to the Plan.

Prescription Plan is administered by Global Pharmacuetical Benefits (GPB)
Prescription Customer Service Phone # 800-341-2234

Prescriptions will be dispensed in a 30 day supply.

*Additional cost to members when utilizing the Walgreen/Duane Reade Pharmacy Network or the CVS/Caremark Pharmacy Network. See details below.

DRUG TYPE	COPAYMENT (PAID BY PATIENT)
Generic	$10 copayment per 30 days
Preferred brand drugs	50% copayment with a $60 maximum per 30 days
Non-preferred brand drugs	50% copayment with a $300 maximum per 30 days
Specialty medications	Processed under applicable preferred/non-preferred rate
Contraceptives	$0 copayment
Novo Nordisk Insulin products, Victoza	$0 copayment
Other insulin products	$30 copayment
Truetrack diabetic strips	$0 copayment
All other diabetic supplies	50% copayment with a $300 maximum per item for a 30 day supply

Walgreen/Duane Reade Pharmacy Network*
Prescriptions will be dispensed in a 30 day supply.

DRUG TYPE	COPAYMENT (PAID BY PATIENT)
Generic	$15 copayment per 30 days
Preferred brand drugs	55% copayment with a $150 maximum per 30 days
Non-preferred brand drugs	55% copayment with a $350 maximum per 30 days
Specialty medications	Processed under applicable preferred/non-preferred rate
Contraceptives	$0 copayment
Novo Nordisk Insulin products, Victoza	$5 copayment
Other insulin products	$35 copayment
Truetrack diabetic strips	$5 copayment
All other diabetic supplies	55% copayment with a $350 maximum per item for a 30 day supply
* ADDITIONAL COST TO MEMBERS FOR USING THIS PHARMACY	

CVS/Caremark Pharmacy Network*
Prescriptions will be dispensed in a 30 day supply.

DRUG TYPE	COPAYMENT (PAID BY PATIENT)
Generic	$20 copayment per 30 days
Preferred brand drugs	60% copayment with a $150 maximum per 30 days
Non-preferred brand drugs	60% copayment with a $350 maximum per 30 days
Specialty medications	Processed under applicable preferred/non-preferred rate
Contraceptives	$0 copayment
Novo Nordisk Insulin products, Victoza	$10 copayment
Other insulin products	$40 copayment
Truetrack diabetic strips	$10 copayment
All other diabetic supplies	60% copayment with a $350 maximum per item for a 30 day supply
* ADDITIONAL COST TO MEMBERS FOR USING THIS PHARMACY	

GROWTH HORMONES

Growth hormones will be covered up to $10,000 per year for a maximum of 3 years under the following conditions:
1: The member must utilize Alliance Community Healthcare (See below).
2: The treatment must be approved for medical necessity by Alliance Community Healthcare.

Horizon Health Center DBA Alliance Community Healthcare Inc.

Alliance Community Healthcare has two locations:

Alliance Community Healthcare
115 Christopher Columbus Drive
Jersey City, NJ 07302

Local 102 Union Hall
50 Parsippany Road
Parsippany, NJ 07054

Melissa Colon is your concierge manager. She can be reached at 551-256-8404.
By utilizing services at Alliance Community Healthcare, Local 102 members and dependents are entitled to:

- Zero copays for medical services
- Zero copays for pharmacy
- A three month supply of eligible prescriptions is available through mail order at no cost for the member

ADDITIONAL BENEFITS FOR PLAN B MEMBERS ONLY

BENEFIT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Inpatient Hospital Substance Abuse For Plan B members only Pre-authorization required through Intervention Strategies at 800-663-0404. See page 42	100% of Contracted rate for up to 180 days per calendar year. This is a combined benefit for all inpatient admissions, including medical/mental/substance.	80% of fee schedule for up to 180 days per calendar year. This is a combined benefit for all inpatient admissions, including medical/mental/substance. The 20% coinsurance does not apply to the annual major medical out of pocket maximum and will never qualify for 100 % payment.
Outpatient Treatment for Substance Abuse For Plan B members only Pre-authorization recommended through Intervention Strategies at 800-663-0404. See page 43	100% of Contracted rate after $25 copay.	70% of fee schedule after deductible for services rendered in the office. 80% of fee schedule after a $100 copay for services billed as a facility. The 20% coinsurance does not apply to the annual major medical out of pocket maximum and will never qualify for 100% payment.
Vision (Routine) Plan B members only See page 43	$400 per person, $1000 per family maximum per calendar year. Paid at 100%. Includes exam, prescription glasses & contacts. Excludes sunglasses, work goggles, safety glasses, etc.	
Hearing Benefit Plan B members only See page 44	$3,000 per covered person every three years.	
TMJ Benefit Plan B members only See page 44	$1,000 per family per calendar year to cover temporomandibular joint disorder.	
Dental Expenses Plan B members only See page 44	Covered under the Dental Plan with the exception of full bony impacted teeth.	Covered under the Dental Plan with the exception of full bony impacted teeth.

DENTAL BENEFIT (Plan B only)

$5000 per family benefit (per calendar year)
Dental Implant benefit is $2000/person/calendar year
Maximum Payment for Orthodontia per lifetime: $2,000 per child (to age 19)
Dental plan is administered by Horizon Blue Cross Blue Shield of New Jersey
Dental Customer Service phone number: 800-433-6825

Preventive Services covered at 100% of fee schedule:

- 4 bitewings every 6 months
- Full mouth series or panoramic xray once every 3 years
- Cleanings and periodic exams, covered 3 times per calendar year
- Fluoride – to age 19, once every 6 months.
- Sealants – to age 14, once every 36 months, sound natural teeth only

Restorative Services covered at 80% of fee schedule:

- Amalgam and Composite
- Extractions
- Root Canal Therapy
- Oral Surgery
- Dentures – 5 year replacement rule applies
- Fixed Bridgework – 5 year replacement rule applies

Services covered at 50% of fee schedule

- Major Services covered at 50% of fee schedule:
- Crowns/Inlays – 5 year replacement rule applies
- Orthodontics covered at 50% of fee schedule: $2000 per dependent per lifetime – to age 19

COMPREHENSIVE MAJOR MEDICAL BENEFITS

Plan A: Note: Plan A does not include hearing, dental, vision, temporomandibular joint disorder (TMJ) or substance abuse benefits.

Deductible Amount (Out-of-Network Providers)

Per person, per calendar year: $ 500

Per family, per calendar year: $ 1000

Out of pocket (Out-of-Network claims only): $5,000 per person, $10,000 per family, per calendar year

After you have paid coinsurance on eligible expenses from Out-of-Network providers of $5,000 per individual or $10,000 per family, (only with respect to Covered Charges payable at 70%) the balance of eligible Out-of-Network charges for the remainder of the calendar year will be payable at 100%. Charges that do not accumulate towards the out of pocket maximum are the annual deductible, non-covered charges including charges that exceed the Local 102 Plan's Fee Schedule allowance, Out-of-Network Hospital, Ambulatory Surgical Centers or other facility coinsurance and copays, In-network copays or co-insurances and pharmacy copays.

Any unused portion of the Maximum Benefit is only payable for expenses incurred while you or your Dependent are eligible for coverage: (1) while this Plan is in force; or (2) under the Extended benefits provision of this Plan.

Plan B: Note: Plan B includes hearing, dental, vision, temporomandibular joint disorder (TMJ) and substance abuse benefits.

Deductible Amount (Out-of-Network Providers)

Per person, per calendar year: $ 400

Per family, per calendar year: $ 800

Out of pocket (Out-of-Network claims only): $2000 per person, $4000 per family, per calendar year

After you have paid coinsurance on eligible expenses from Out-of-Network providers of $2,000 per individual or $4,000 per family, (only with respect to Covered Charges payable at 70%) the balance of eligible Out-of-Network charges for the remainder of the calendar year will be payable at 100%. Charges that do not accumulate towards the out of pocket maximum are the annual deductible, non-covered charges including charges that exceed the Local 102 Plan's Fee Schedule allowance, Out-of-Network Hospital, Ambulatory Surgical Centers or other facility coinsurance and copays, In network copays or co-insurances and pharmacy copays.

Any unused portion of the Maximum Benefit is only payable for expenses incurred while you or your Dependent are eligible for coverage: (1) while this Plan is in force; or (2) under the Extended benefits provision of this Plan.

IBEW LOCAL UNION 102 WELFARE FUND

Eligibility Rules

You will become eligible for Plan "A" on the first day of the second calendar month following an employment period of not more than three (3) consecutive months during which you have been credited with 300 hours of service. Once you satisfy this requirement, you will remain eligible for at least 3 consecutive months. All eligibility shall be determined on the basis of gross hours paid.

To maintain your eligibility thereafter, you must be credited with at least 300 hours of service each calendar quarter. Your eligibility will terminate on the last day of the second calendar month which follows that calendar quarter during which you receive credit for less than 300 hours of service.

Your eligibility will terminate on	If you do not have 300 hours of service during the period of
February 28	October 1 to December 31
May 31	January 1 to March 31
August 31	April 1 to June 30
November 30	July 1 to September 30

Once you have been enrolled in Plan "A" for a continuous period of two consecutive years, effective on the first day of the twenty-fifth (25th) month, your coverage will be increased to Plan "B" which includes Dental, Vision and Hearing benefits. Eligibility via reserve hours and/or COBRA shall be acceptable toward satisfying this 2 year requirement. Once you have achieved Plan "B" status, you will always be eligible for Plan "B" benefits provided you work sufficient hours to maintain your eligibility. If you have a break in your eligibility after you achieve Plan "B" status, you will again be eligible for Plan "B" benefits as soon as you work the required hours of service as described above.

Reserve Hours

Your reserve hours are those hours of service which are in excess of the 300 hour eligibility requirement stated above. Your reserve hours will accumulate in your account up to a maximum of 600 hours. This reserve will be drawn upon to maintain your eligibility if you should fail to receive credit for at least 300 hours of service during a subsequent calendar quarter.

Reinstatement

Should your eligibility terminate, it will be reinstated provided you have at least 300 hours of service and/or reserve hours) in a three (3) consecutive month period which ends within 10 months from the date your eligibility terminated. Reinstatement of eligibility will become effective on the first day of the second month following the three (3) consecutive month period in which you are credited with at least 300 hours of service. If this requirement is not met, you will lose any unused reserve hours and be treated as a new employee. Accordingly, to become eligible for Plan "A" benefits you will be subject to the 300 hours of service requirement stated above.

Self-Pay Provision

A self-pay option is available to employees who terminate coverage and who missed maintaining their eligibility by 100 hours or less. In this event, you have the opportunity to make contributions on your own behalf to the Welfare Fund for the hours necessary to meet the 300 hour requirement at the journeyman hourly employer contribution rate. For example, if you have 150 hours of service during a calendar quarter, and you have 110 remaining reserve hours, you will have a total of 260 hours towards the requirement of 300 hours leaving you short of the requirement by 40 hours. In this situation, you would be permitted to make a contribution on your own behalf for the 40 hours at the journeyman hourly employer contribution rate, to maintain your eligibility for an additional three (3) months.

Disability Credit

After having satisfied the eligibility requirement, if you are unable to work because of Illness or Injury, you will receive credit for up to 25 hours of service for each week of total disability, up to a maximum of 2,400 hours of service for any one period of continuous disability. Non-bargaining unit employees and participants on COBRA are not eligible for disability credit.

Non-Bargaining Unit Employees

If you are a non-bargaining unit employee of an eligible participating employer that has elected to contribute on behalf of all of its non-bargaining employees, you will become eligible for Plan "A" benefits on the first day of the third (3rd) calendar month following your employment and for which your employer has made the required contribution. Once you have been enrolled in Plan "A" for a continuous period of two consecutive years, effective on the first day of the twenty-fifth (25th) month, your coverage will be increased to Plan "B" which includes Dental, Vision and Hearing benefits. Eligibility via COBRA shall be acceptable toward satisfying this 2 year requirement. Reserve hours and disability credits are not applicable to non-bargaining unit employees. Your eligibility will terminate on the last day of the month following the month in which your employment with your contributing employer terminates.

Retiree Coverage

Following your retirement (for both bargaining and non-bargaining employees), you, your dependent spouse and your dependent children, if any (assuming they otherwise satisfy the definition of a dependent child) will be eligible for retiree benefits and permitted to continue your coverage provided you satisfy one of the following requirements:

If you retire prior to January 1, 2021

You have been eligible for benefits under the Welfare Fund as an active employee for at least 32 of the 40 calendar quarters immediately preceding your date of retirement and you have attained the age of 62 prior to retiring and are currently eligible for benefits at the time of your retirement.

If you retire on or after January 1, 2021

You have been eligible for benefits under the Welfare Fund as an active employee for at least 64 of the 80 calendar quarters immediately preceding your date of retirement and you have attained the age of 62 prior to retiring and are currently eligible for benefits at the time of your retirement.

And all of these requirements:

- You have ceased all work in the electrical construction industry for which contributions are required and have terminated your status as an eligible active employee of the Fund.
- You are eligible to receive a monthly retirement benefit from the IBEW Local 102 Pension Fund, or you have been eligible as a non-bargaining unit employee or under a "small works" agreement and are not otherwise eligible for an IBEW pension.

Please note that the benefits provided by this Plan are secondary to Medicare for retired members and their dependents who are eligible for Medicare. As this Plan will coordinate with Medicare on the basis that you have both Part A and Part B, you are encouraged to elect Part B coverage as soon as it is available to minimize your out-of-pocket expense.

If you retire prior to age 62, you will be permitted to continue your Plan "B" coverage until you attain age 62 by making the required contributions to the Plan. Currently, the required monthly contribution for participants under the age of 62 is equal to the applicable COBRA rate for Plan B coverage. Upon attaining the age of 62, the requirement that you be eligible for 32 of the preceding 40 calendar quarters or 64 of the preceding 80 calendar quarters will be applied to determine your eligibility for continued retiree coverage. You may not pay for your coverage beyond age 62 for the purpose of satisfying either the 32/40 or 64/80 rule described above. Please note that all required contribution amounts and COBRA rates are reviewed by the Board of Trustees on an annual basis and may be adjusted periodically.

If you are totally disabled, you, your dependent spouse and your dependent children, if any (assuming they otherwise satisfy the definition of a dependent child) will be eligible for insurance coverage provided you have been eligible as an active employee for at least 52 calendar quarters during the 60 calendar quarters preceding the latter of your date of disability or date of termination, or you have attained age 60 and have been eligible as an active employee for at least 32 calendar quarters during the 40 calendar quarters preceding your date of disability and you satisfy one of the following two requirements:

- Your disability shall have continued for six (6) consecutive months and you are receiving Federal Social Security Disability Pension Payments.
- The totality and permanence of your disability is established to the satisfaction of the Trustees based upon competent medical evidence presented to them.

In addition, you must have ceased all work in the electrical construction industry and have terminated your status as an eligible, active employee of the Fund.

Dependent Coverage in the Event of your Death

Following your death your dependents will remain eligible for health benefits until the earliest of the following dates:

1. The last day of a period of twelve (12) months following your death.
2. The date your spouse remarries.
3. The date your dependent becomes eligible for similar benefits under other group coverage.
4. The date your dependent ceases to be included in the definition of Dependent as stated in this Plan.

Once the 12 month period of "free" coverage expires, your dependents may continue their coverage under COBRA as described below.

Widows(ers) of retirees may continue their coverage for life or until they remarry or become eligible for other group coverage by making the required contributions to the Plan. The required contribution amount will be established by the Board of Trustees and reviewed and adjusted periodically.

Definition of Dependent

Eligible dependent refers to a spouse and each child, including a step child, legally adopted child or foster child up to the age of 26. In addition, an incapacitated child who became an insured dependent before attaining the applicable limiting age specified above, remained an insured dependent by reason of mental retardation, physical handicap or any other medically diagnosed permanent mental or physical condition that renders the child incapable of self-sustaining employment shall qualify as a dependent provided that such child is chiefly dependent upon the Employee for support and maintenance and shall remain an eligible dependent as long as the employee's coverage remains in force and the dependent remains unmarried and incapacitated. Proof of such dependent's incapacity must be submitted within thirty-one (31) days of his/her attainment of the limiting age.

Eligible dependents do NOT include the following:

1. Any dependent child who is covered by this program as an employee;
2. A legally divorced spouse;
3. A spouse or child on active duty in any military capacity, subject to the provisions of the Uniformed Services Employment and Reemployment Rights Act (USERRA) and the Civil Health Program of the Uniformed Services (CHAMPUS) ;
4. A dependent for whom health evidence is required but is either not submitted or not approved.

Normally, coverage for your dependents starts on the date your coverage begins or on the date you acquire an eligible dependent.

Fund Administration

The custodial parent or state agency will also be entitled to:

1. obtain from the Fund Administrator information necessary to obtain covered benefits for the Dependent child;
2. submit claims for covered services without your approval or the approval of the non-custodial parent; and
3. request that the Fund Administrator pay all or a part of the benefits to the custodial parent, the provider, or state agency but not later than at the time proof of claim is given the Fund Administrator.

COBRA

If you or your dependent loses eligibility, self-pay continuation of coverage is available under COBRA for 18 months which may be extended to 29 months if at the time of the loss of eligibility you or your dependent is determined to be disabled by the Social Security Administration. Your accumulated reserve hours will be applied before self-pay is required. Rates are subject to review by the Board of Trustees and may be adjusted periodically. Also, if you are only eligible for Plan "A" benefits at the time your coverage terminates, you may only continue Plan "A" benefits under COBRA. You may not "buy up" to Plan "B".

If your spouse and eligible dependent children lose eligibility due to your death, a divorce or legal separation or with respect to a dependent child his or her ceasing to satisfy the Plan's definition of an eligible dependent, self-pay continuation of coverage is available for 36 months.

If you are an out of work active participant, COBRA benefits will be extended to 36 months.

CONTINUATION OF COVERAGE

(SELF-PAY) AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA):

You and your eligible dependent(s) have the right to continue your medical coverage (and dental, vision or prescription drug coverage, if applicable) under this Plan on a self-pay basis, as described under the section titled CONTINUATION PERIOD, if coverage would otherwise terminate due to a Qualifying Event. This provision does not apply to Life or Accidental Death and Dismemberment.

Qualifying Event means one of the following occurrences which would otherwise terminate your or your Dependent's coverage in the absence of this provision:

1. termination of your employment, other than for gross misconduct;
2. your work hours are reduced;
3. your retirement;
4. your death;
5. your divorce or legal separation; or
6. with respect to your dependent child, his ceasing to satisfy the Plan's definition of an eligible Dependent.

ELECTION PERIOD

You and/or your dependent(s) may elect to continue coverage within 60 days of the later of:

1. the date you and/or your dependent(s) would otherwise lose coverage due to the qualifying event; or
2. the date you and/or your dependent(s) are notified of your right to elect the continuation coverage;
3. employee's entitled to Medicare if it results in a loss of coverage under this Plan;
4. the child's loss of dependent status.

If one of these subsequent qualifying events occurs, a dependent may be entitled to a second continuation period. This period will in no event continue beyond thirty- six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or placed for adoption with a covered Employee during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other dependent acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

It is you or your dependent's responsibility to notify the Fund Office of any of the following Qualifying Events: your divorce or legal separation; or your Dependent child ceases to be an eligible Dependent. You and/or your dependent(s) must provide such notification within 60 days after the later of:

1. the date of the Qualifying Event; or
2. the date your Dependent would otherwise lose coverage due to the Qualifying Event.

Such election must be in writing, on a form provided by the Fund Office. Elected benefits will be continued provided:

1. the election form is duly completed and returned to the Fund Office within the 60-day period noted above; and
2. the required premium is paid to the Fund Office within 45 days of your and/or your dependent's election.

CONTINUATION PERIOD

Coverage may continue, on a self-pay basis, as follows:

1. Coverage for you and/or your Dependent(s) may be continued for up to 18 months,* if coverage terminated due to the Person's:
    a. termination of employment, other than for gross misconduct;
    b. reduced work hours; or
    c. retirement.

*The 18-month period of continuation may be extended to 29 months if at the time of the qualifying event described in 1. a or 1. b above, you or your dependent are determined to be disabled by the Social Security Administration.

Proof of disability must be provided to the Fund Office within 60 days of the date the Social Security Administration makes this determination. This extended period of continuation coverage applies only to the person who has been determined to be disabled by the Social Security Administration.

2. Coverage for your dependent may be continued for up to 36 months, if coverage terminated due to:
   a. the Members death;
   b. divorce or legal separation; or
   c. with respect to your Dependent child, his ceasing to satisfy the Plan's definition of an eligible dependent.

If your dependent's coverage is continued for reasons listed under Item 1. of this section, and, during the initial Continuation Period, a Qualifying Event occurs which entitles the Dependent to continue coverage under Item 2. of this section, your dependent may elect to continue coverage up to a combined maximum of 36 months.

You and/or your dependent(s) who elect to continue coverage, shall be solely responsible for the payment of the premium for such continued coverage. If an election is made after the Qualifying Event, premium payment for continuation coverage during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the premium may be paid in monthly installments.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Thirty-six (36) months from the date continuation began because of a reduction of hours or termination of employment of the ***Employee***.
2. Thirty-six (36) months from the date continuation began for ***dependent***s whose coverage ended because of the death of the Employee, divorce or legal separation from the ***Employee***, or the child's loss of ***dependent*** status. However, if the spouse of an employee loses eligibility because of the death of the ***Employee***, continuation coverage is available for an indefinite period of time.
3. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment on the date specified by the ***Employer***.
4. The date coverage under this ***Plan*** ends and the ***Employer*** offers no other group health benefit Plan.
5. The date the ***covered person*** first becomes entitled to ***Medicare*** after the date of election of COBRA continuation coverage.
6. The date the ***covered person*** first becomes covered under any other group health Plan after the date of election of COBRA continuation coverage, with the exception of the ***pre-existing*** provision below.

continued on next page

7. ***Retirees***, and widows or widowers of ***retirees*** who died before the ***Employer's*** bankruptcy are entitled to lifetime continuation coverage. However, if a ***retiree*** dies after ***Employer's*** bankruptcy, the surviving spouse and ***dependent*** children may only elect an additional thirty six (36) months of continuation coverage after the death.

PRE-EXISTING CONDITIONS

In the event that a covered person becomes eligible for coverage under another Employer-sponsored group health Plan, and that group health Plan has exclusion or pre-existing limitation on a condition that is covered by this Plan, the covered person may remain covered under this Plan with continuation of coverage under the other Employer's group health Plan. This Plan shall be primary payor for the covered expenses that are excluded or limited under the other Employer sponsored group health Plan and secondary payor for all other expenses.

Dependent Covered by a Court or Administrative Order

In addition to the termination dates shown above, for a Dependent covered by a Court or Administrative Order, insurance under this Plan will terminate when written notice is received that the Order is no longer in effect.

Exception

Upon termination, a Dependent may be entitled to pay the premium and continue his insurance under this Plan. Refer to Continuation of Coverage Upon Termination in this Section.

EXTENSION OF HEALTH BENEFITS

EXTENSION OF BENEFITS

If you are Totally Disabled on the date your coverage ends, your coverage under the Plan ends, however, benefits may be extended. The benefits shall be extended for Covered Charges incurred for treatment of any medical condition if: (a) the expense would have been covered if your coverage under the Plan had continued; and (b) you remain continuously Totally Disabled to the date each such expense is incurred.

MATERNITY

Pregnancy, including Complications of Pregnancy, is treated the same as any other Illness under this Plan, Whether or not the word Illness is used, it also includes Complications of Pregnancy. If the coverage terminates, benefits will be extended for Covered Charges incurred as a direct result of your pregnancy if such pregnancy commenced before the Plan terminated. Benefits will be extended for you or your Dependent only if you or your Dependent meet the Plan Definition of totally disabled.

BENEFITS FOR CHARGES INCURRED FOR PREGNANCY WILL BE PAYABLE ON THE SAME BASIS AS AN ILLNESS FOR YOU OR YOUR Dependent SPOUSE. THERE ARE NO DEPENDENT CHILD MATERNITY BENEFITS UNDER THIS PLAN.

BENEFITS THAT ARE EXTENDED

Benefits are payable for the treatment of an Illness or Injury. The benefits payable shall be subject to the same maximums, limitations, and exclusions that were in effect on the date your coverage under this Plan ended.

Benefits under this section are payable until the first of the following:

1. the date you or your Dependent spouse are no longer Totally Disabled;
2. the date the Maximum Benefit under the Plan has been paid;
3. for Hospital and Dental benefits, 3 months from the date the coverage under the Plan ended; or
4. for Comprehensive Major Medical Benefits, 12 months from the date the coverage under the Plan ended.

DEFINITIONS OF TOTALLY DISABLED

Totally Disabled, with respect to you, means that, due solely to an Illness, a pregnancy, or an Injury, you are prevented from engaging in any gainful occupation or employment.

Totally Disabled, with respect to your Dependent, means that he, due solely to an Injury or Illness, is prevented from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

TOTAL AND PERMANENT DISABILITY PROVISION

If you become disabled while covered, the coverage will continue while you are disabled for the first 24 months of disability. You will be considered "totally disabled" during said period of your disability, if you are unable, solely because of Illness or Injury, to work as an electrician. To be considered totally disabled, you must be under the care of a Legally Qualified Physician and supply proof that you continue to be totally disabled which proof will be required at reasonable intervals by the Plan or be entitled to Social Security Disability Benefits, pursuant to a Social Security Award. If you fail to furnish proof of your disability, or if you refuse to be examined by a Physician (designated and paid by the Plan), you will no longer be considered Totally Disabled. If you actually start working at any substantial gainful activity during the above-mentioned 24 month period, you will no longer be considered disabled. At the conclusion of the 24 months of disability, this Plan will provide only secondary coverage to Medicare if you have obtained it. Secondary coverage shall provide a reduction of coverage up to the limitation of this Plan reduced by the amount of primary coverage provided by Medicare.

This disability coverage will apply also to Dependents who have become disabled and who qualify for Medicare coverage. There are additional limitations on coverage if a claimant is disabled as described in specific coverage limitations of this Plan.

MANAGED CARE NETWORK

HORIZON DIRECT ACCESS MANAGED CARE NETWORK

The Welfare Fund has implemented a physician network to make available participating providers in your area. All of our eligible Plan participants (members and Dependents) are invited to use the Horizon Direct Access Managed Care Network for providers in New Jersey, and the PPO Blue Card network for all providers outside the state of New Jersey.

If you are Medicare Primary you should be seeking Doctors and Providers that participate with and accept Medicare assignment in order to arrive at your lowest out-of-pocket expenses from your Benefit Plan. If you also choose an In-Network provider in the Fund's network, your annual deductible will be waived on those claims.

BENEFITS OF USING AN IN-NETWORK PROVIDER

If you use the services of an In-Network Provider, your out-of-pocket expenses will be lower, based on the In-Network Provider's discounted service fees and the Fund's In-Network plan design.

FREEDOM OF CHOICE & FINDING AN IN-NETWORK PROVIDER

You will have the option each time you seek care to go to an In-Network Provider or to an Out-of-Network Provider. You are not required to use In-Network Providers. Horizon will maintain a current list of In-Network Providers in the Network area to help you locate Providers. It is your responsibility to confirm that the provider you are seeing is In-Network in the plan prior to receiving care from that medical care provider. Remember, medical care providers may move into and out of the Network.

The current Network is Horizon Direct Access Managed Care Network for providers in New Jersey, and the PPO Blue Card network for all providers outside the state of New Jersey. To locate In-Network Providers please telephone 800-810-2583 or access the website at www.horizonblue.com

Note: You must present your Identification Card (ID Card) to medical care providers at the time of service. Your ID Card includes important claims submission, eligibility, plan design, and pre-certification information. Showing your ID Card is especially important when you use In-Network Providers because your ID Card will include a Plan logo, and may include special plan design and billing information.

OUT-OF-NETWORK PROVIDERS (NON-PARTICIPATING PROVIDERS)

Please be advised that benefits paid on Out-of-Network Providers are paid using the Local 102 fee schedule. The member or patient will incur much higher out of pocket expenses which they will be responsible for. Out-of-Network or Non-Participating Providers of professional services are paid (after the annual deductible is satisfied) at 70% of the Local 102 fee schedule. This means that your out of pocket costs will be substantially higher if you choose to use Out-of-Network Providers.

UTILIZATION REVIEW PROGRAM REQUIREMENTS

Whether you choose to go to an In-Network or Out-of-Network Provider, the Hospital Preadmission Certification and Continued Stay Review Program contained in this Plan must be used in order to assure that full benefits are payable under this Plan.

HOSPITAL PREAUTHORIZATION CERTIFICATION

Hospital Pre-authorization Certification is a program administered by Horizon Blue Cross Blue Shield of New Jersey. It is a program which requires that pre-authorization is obtained for a proposed medical Inpatient Hospital Admission. The objective of this program is to verify Medical Necessity and to determine if alternate treatment can be made effectively in a setting, or through a facility, other than a Hospital.

Note: Pre-authorization certification for mental, behavioral or substance abuse treatment is done through Intervention Strategies at 800-663-0404.

WHEN MUST THE PRE-AUTHORIZATION CERTIFICATION PROGRAM BE USED?

The program must be used **WHENEVER** a Physician recommends hospitalization for you or an eligible Dependent.

WHAT MUST BE DONE WHEN A HOSPITAL ADMISSION IS RECOMMENDED FOR EITHER YOU OR AN ELIGIBLE DEPENDENT?

The Hospital pre-authorization certification program requires that the reasons for a proposed hospitalization be reviewed by Horizon Blue Cross Blue Shield of New Jersey at least 24 hours prior to ANY Hospital admission. To obtain this review, the hospital or your physician must call Horizon Blue Cross Blue Shield of New Jersey at its TOLL-FREE number at 800-664-2583.

The Horizon Blue Cross Blue Shield of New Jersey Medical Professional, in consultation with your Physician, will determine whether hospitalization is Medically Necessary, or if equally effective treatment can be provided in an alternate setting.

After completion of the review, the Horizon Blue Cross Blue Shield of New Jersey representative will notify you, your Physician and the Hospital of the findings. If hospitalization is approved, the Horizon Blue Cross Blue Shield of New Jersey representative will assign an initial number of approved Hospital days.

WHAT HAPPENS IF ADDITIONAL DAYS OF CONFINEMENT ARE REQUIRED?

If the initially approved Hospital days have been used and you or your Dependent remain confined, the Horizon Blue Cross Blue Shield of New Jersey representative will discuss with your Physician the Continued Stay Review (CSR) process and the rationale for continued hospitalization.

If it is agreed that continued hospitalization is medically justified, additional days will be approved.

WHAT HAPPENS WHEN AN EMERGENCY HOSPITALIZATION OCCURS AND THERE IS NO TIME TO GO THROUGH THE PREADMISSION CERTIFICATION PROCESS?

In the event you or your Dependent are Hospital confined on an Emergency admission basis, you, a responsible family member or the attending Physician must call the Horizon Blue Cross Blue Shield of New Jersey unit at its toll free number at 800-664-2583 within 72 hours of the admission to notify the Horizon Blue Cross Blue Shield of New Jersey representative of the confinement and provide the information required to establish an initial number of approved Hospital days.

Emergency Hospitalization means a confinement required as the result of an unforeseen medical situation that requires immediate medical treatment to prevent loss of life or permanent damage to the organs or systems of the body.

WHAT WILL HAPPEN IF YOU OR AN ELIGIBLE DEPENDENT DO NOT USE THE HOSPITAL PREAUTHORIZATION PROGRAM FOR A HOSPITAL CONFINEMENT?

If you or your Eligible Dependent do not use the Hospital Pre-authorization Certification program for a Hospital confinement, any benefits payable under the Hospital Benefit will be subject to one of the following:

1. if the admission would have been approved by Horizon Blue Cross Blue Shield of New Jersey as Medically Necessary, all benefits payable relating to the hospitalization will be subject to a 50% benefit reduction, up to a maximum of $500; or
2. any admission that would not have been approved as Medically Necessary by Horizon Blue Cross Blue Shield of New Jersey, will not be a covered expense and the covered person will be responsible for 100% of the non-covered charges.

Payment will not be made for any days spent in the Hospital in excess of the number of days which would have been approved unless, after investigation, the excess days are found to have been Medically Necessary.

ANY REDUCTION IN BENEFITS WILL NOT BE CONSIDERED COVERED CHARGES UNDER THE COMPREHENSIVE MAJOR MEDICAL BENEFIT.

While this program will require some additional action on your part, it will provide you and your eligible Dependents with the assurance that a hospitalization is necessary and that your Hospital stay is not prolonged beyond the time medically required.

REMEMBER! You must use the Pre-authorization Certification program any time your Physician recommends Hospital confinement for you or your eligible Dependent.

HOSPITAL BENEFITS

Benefits will be paid upon receipt of proof that you or your Dependent, while covered hereunder, becomes confined to a Hospital as the result of an Injury or Illness that is not employment related. Such confinement must be Medically Necessary for benefits to be payable.

ROOM AND BOARD

Covered Charges under this Benefit will include charges incurred for daily room and board, including floor nursing and other per diem charges up to the amount shown in the Schedule of Benefits.

ADDITIONAL HOSPITAL CHARGES

Covered Charges under this Benefit will include Hospital services:

1. for medical care and treatment, other than for Room and Board, special and floor nursing professional services and other per diem charges;
2. the administration of anesthesia by a Physician or a professional anesthetist; and
3. for local ambulance service to the Hospital from the place of accident or illness.

Expenses incurred for Additional Hospital Charges will be payable:

1. if they are incurred in the Hospital during a period for which Room and Board charges have been made and are payable;
2. for services furnished on the day of and in connection with a surgical procedure; or
3. for emergency treatment furnished for an Injury or medical emergency within 48 hours after the Injury; as if they were incurred during a Hospital confinement.

PREADMISSION TESTING

Covered Charges under this Benefit will include the charges incurred for diagnostic tests performed and X-rays taken prior to the scheduled procedure in the Hospital. The scheduled admission must be for an Injury or Illness that is covered under this Plan; the tests must be for the diagnosis of such a condition; and the tests and X-rays must be ordered by a Physician.

The charges will be covered even if the admission is postponed or cancelled if:

1. the tests show a condition that requires treatment before the admission;
2. a medical condition develops that delays the admission;
3. a Hospital bed is not available on the scheduled admission date; or
4. the tests indicate that, contrary to the Physician's expectations, the admission is not necessary.

SKILLED NURSING FACILITY

Covered charges will be payable for the first 120 days per calendar year of confinement at a Skilled Nursing Facility, excluding any charge over the semiprivate room limit if private accommodations are used. The confinement must begin within 14 days after a period of confinement in a Hospital due to the same disability. The maximum benefit payable for each day of confinement is the semi-private room limit if private accommodations are used. No benefit is payable for any days of confinement over the convalescent maximum number of days.

Benefits are payable for:

1. room and board, but not to exceed the Hospital's average semiprivate room and board rate, including charges for services, such as general nursing care in connection with room occupancy;
2. use of special treatment rooms, X-rays and laboratory examinations; physical, occupational, or speech therapy; oxygen and other gas therapy; and other medical services customarily provided by a Convalescent Nursing Home, except private duty or special nursing services or Physician's services; and
3. drugs, biologicals, solutions, dressings and casts, but no other supplies. If any individual is confined in a separate part of a Hospital which is a convalescent facility, any benefits payable for the confinement will be convalescent facility benefits and not Hospital benefits.

Limitations

No benefits are payable for care of drug addiction, chronic brain syndrome, alcoholism, mental retardation, senile deterioration, any mental disorder, or any other situation which is restricted by any other limitations set forth in this Plan.

EXPENSES THAT ARE NOT COVERED

In addition to GENERAL EXCLUSIONS, no benefits are payable under the Hospital Benefit for:

1. professional surgical, dental or medical fees;
2. charges for nursing, other than for floor nursing services.

OFFICE VISIT BENEFIT

This benefit will be payable if you or your Dependents, while covered, incur charges for home or office medical treatment by a Physician. For benefits to be payable, the medical condition must be due to an Injury or Illness that is covered under the Plan and not employment-related.

YOUR BENEFITS

The benefits payable are for treatment that is Medically Necessary. Benefits are payable for Physician's visits, up to the Maximum Payment shown in the Schedule of Benefits.

EXPENSES THAT ARE NOT COVERED

In addition to the GENERAL EXCLUSIONS, no benefits are payable under this section for any visits made on the date of an operation, except for treatment by a Physician other than the surgeon(s) who performed the operation.

HOME HEALTH CARE BENEFIT

Benefits will be payable, if while covered, you or your Dependent have incurred charges for the Medically Necessary services of a Home Health Care Agency. For benefits to be payable under this provision, such home health services must begin within 14 days of a Hospital discharge. The services rendered must be in accordance with the Home Health Care Plan and due to an Injury or Illness that is covered under the Plan and is not employment-related. Covered Charges will include charges incurred for Medically Necessary Home Health Care visits for:

1. part-time or intermittent home nursing care by a registered nurse, or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available;
2. part-time or intermittent home health aide services which consist primarily of medical or therapeutic caring for the patient by other than a registered or licensed practical nurse;
3. physical, occupational or speech therapy, if provided by the Home Health Care Agency;
4. medical supplies, drugs and medications prescribed by a Physician, and laboratory services by or on behalf of a Home Health Care Agency to the extent such items would have been covered under this Plan had an individual been hospitalized or in a skilled nursing facility.

"Home Health Care Expenses" means those nursing and other home health care services rendered to you or your Dependent in your place of residence under the following conditions:

1. part-time or intermittent nursing care by or under the supervision of a registered nurse. If full-time or 24-hour services are needed on a short-term basis, such care will be covered, for a maximum of three days; in addition to the combined visit maximum of 120 combined visits per calendar year for all home care services, an additional benefit limit of $10,000 per calendar year applies to this benefit;
2. part-time or intermittent home health aide services which consist primarily of caring for the patient. If full-time or 24-hour services are needed on a short-term basis, such care will be covered, for a maximum of three days;
3. physical, occupational or speech therapy, if provided by the Home Health Care Agency;
4. medical social work;
5. nutrition services; and
6. medical supplies, appliances and equipment; drugs and medicines that can be obtained only upon the written prescription of a Physician; laboratory services and special meals; diagnostic and therapeutic services.

Benefits will be payable for a maximum of 120 visits combined for all home care services per calendar year but not to exceed the number of days of confinement in a Hospital that would have been required, if home health care had not been provided. In addition to the 120 visit limit, the non-hospital nursing benefit has an additional benefit limitation of $10,000 per calendar year.

Each visit by a member of a home health care team shall be considered as one home health care visit. Four hours of home health aide service shall be considered as one home health care visit.

EXCLUSIONS

In addition to GENERAL EXCLUSIONS, no benefits are payable under this benefit for:

1. services or supplies not included in the Home Health Care Plan;
2. services of a person who is a member of you or your spouse's immediate family;
3. Custodial Care;
4. transportation services; or
5. any period during which you or your Dependent are not under the continuing care of a Physician.

HOSPICE CARE BENEFIT

This benefit will be payable for charges incurred for Hospice Care as Medically Necessary expenses. In addition, Bereavement Counseling and Respite Care will be provided:

1. to an individual who qualifies for a Hospice Care program; and
2. to you or your Dependent's Immediate Family. "Immediate Family" means the dying person's spouse, mother, father and children.

Hospice Care means care and supplies provided or coordinated by a Hospice Agency to a person with a life expectancy of 6 months or less. Benefits for Hospice Care will cease on the earliest of:

1. the date the individual dies; or
2. the date the individual no longer qualifies for the Hospice Care program; or
3. when the lifetime maximum benefit has been paid.

Respite Care means Hospice Care provided in the home or a licensed health care facility to provide temporary relief to the family or other care givers for emergencies and the daily demands of caring for the person. Benefits for Respite Care are limited to 5 days of care in any 30 day period.

Covered Hospice Care Expenses are limited to the following:

1. nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.);
2. home health aide services;
3. speech therapy, physical therapy, and respiratory therapy provided by persons licensed by the state to provide such services;
4. medical social services by licensed or trained social workers, psychologists, or counselors;
5. nutrition services provided by a licensed dietician;
6. short-term Inpatient Hospice Care, but not more than 30 days; and
7. disposable supplies that would have been covered as an Inpatient.

HOSPICE CARE EXCLUSIONS

The following are excluded from Hospice Care:

1. services or supplies for personal comfort or convenience, such as homemaker services or babysitting, except in conjunction with Respite Care; and
2. food services or meals other than nutritional counseling.

ADULT PHYSICAL EXAM AND WELL-CARE BENEFITS

You, your enrolled spouse and any covered adult children are covered for one routine physical exam each per calendar year, regardless of medical necessity, as long as care is provided by an In-Network Provider. This includes a complete medical history, immunizations, injections, plus routine diagnostic tests necessary because of your age, sex and medical background. We will also cover well care for you and your enrolled spouse, as long as care is provided by an In-Network provider. This includes routine physical exams and immunizations regardless of medical necessity. Also included are routine diagnostic X-ray and laboratory services as well as mammograms and pap tests.

WELL-CHILD CARE BENEFITS

We will cover well-baby care and immunizations for your enrolled child, as long as care is provided by an In-Network Provider. This includes routine physical exams and immunizations regardless of medical necessity.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

This benefit will be payable if you or your Dependent, while covered, incur Covered Charges which exceed the Annual Deductible Amount. This benefit provides you with additional coverage for any Injury or Illness which is eligible for coverage under the plan. Treatment resulting from employment-related illness or injury are not covered by the plan.

YOUR BENEFITS

Benefits are payable, as shown in the Schedule of benefits, for Covered Charges that you incur within a calendar year, which are in excess of the Annual Deductible.

THE DEDUCTIBLE

The Deductible is an "out-of-pocket" expense which you or your Dependent are required to pay for before you are entitled to the Comprehensive Major Medical Benefit. The Deductible Amount, per individual, is shown on page 20.

The Deductible applies once in each calendar year.
The Deductible applies to charges made for services rendered by Out-of-Network Providers.

FAMILY DEDUCTIBLE

After your family members have satisfied the Aggregate Family Deductible Amount in a calendar year, no further Deductible will be required of your family for the remainder of that calendar year.

EXPENSES THAT ARE COVERED

Except as excluded under Excluded Charges, Covered Charges under this benefit means the charges incurred for Medically Necessary treatments, services and supplies ordered by a Physician.
These include charges:

1. made by a Hospital from the first day for inpatient treatment. Covered room and board charges may not exceed the Hospital's average rate for semi-private rooms. If a Hospital does not have semiprivate rooms, the Covered Charges will not exceed the average rate for such rooms charged by Hospitals located in the surrounding geographical area;
2. charges made by a Hospital for outpatient treatment;
3. for diagnosis, treatment and surgery made by a Physician. No benefits are payable for visits and examinations given by the operating Physician on the day following the date of the surgical procedure;
4. for cholesterol testing;
5. for home care nursing by a registered nurse (R.N.) or Licensed Practical Nurse (LPN), pre-authorization is required and services will be payable subject to Plan limits and regulations;

6. for prosthetic appliances, such as artificial limbs or eyes, for the initial replacements. Benefits are not payable for orthopedic shoes or other supportive devices for the feet, casting for orthotics or orthotic functional testing;
7. for trusses, braces or supports, casts, splints and crutches;
8. for rental of Durable Medical Equipment such as wheelchairs and Hospital-type beds. The benefit limit for renting will not exceed the purchase cost;
9. for oxygen and rental of equipment for its administration. The benefit limit for renting will not exceed the purchase cost;
10. for professional ground ambulance service to transport an individual from the place where the Injury or Illness occurred to the closest Hospital where treatment can be given. If the original hospital is not equipped to handle the emergency, professional ground ambulance will be provided to a hospital that is equipped to treat the injury or illness.
11. for X-ray services and laboratory tests;
12. for radium, radioactive therapy and chemotherapy. This Plan also pays for charges made by a Hospital for X-ray and radioactive therapy treatment given by a Physician in the outpatient department of the Hospital while the individual is not confined as an inpatient.
13. for a second surgical opinion. This benefit will be payable for consultation
    a. by a Legally Qualified Physician on the need for a surgical procedure. The benefits are charges incurred for the consultation, and for any necessary laboratory tests and x-rays which are ordered by the consulting Physician.
    b. If this second opinion does not confirm the need for surgery, the covered individual may consult another Legally Qualified Physician for a third opinion. The benefits are paid based on the Plan design of benefits.
14. for anesthesia and its administration. No benefits are payable for the administration of anesthesia by the operating Physician or his assistant: or administration of local infiltration anesthesia where the charges for same exceed the cost of the surgical procedure being performed.
15. for physical or occupational therapy by a licensed therapist. This Plan limits the number of physical or occupational therapy treatments by calendar year. Any claim under this benefit for therapy in excess of 36 visits per year for the combined benefit is not covered.
16. for reconstructive breast surgery in connection with the treatment of breast cancer, including but not limited to: the costs of prosthesis, x-ray or radiation therapy and outpatient chemotherapy;
17. treatment of Wilm's tumor. Benefits include coverage for autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful;
18. for the administration or dialysis of blood or blood components. Covered Charges will include charges for the purpose of blood products and blood infusion equipment required for home treatment of hemophilia, provided such treatment is under the supervision of a state-approved hemophilia treatment center;

19. for organ transplants; donor costs will only be covered if both the recipient and the donor are eligible for benefits under the Local 102 Health Plan and shall be limited to $50,000.
20. for bariatric surgery; the Local 102 Health Plan includes coverage for Surgery for Morbid Obesity including but not limited to Gastric Restrictive Procedures such as Vertical Banded Gastroplasty, Adjustable Gastric Banding, and Gastric Bypass. All weight loss surgeries must be determined to be medically necessary, preapproved and preauthorized prior to benefits being paid under the Local 102 Plan.

    The maximum benefit payable by the Local 102 Health Plan for surgery for Morbid Obesity is $15,000 per person per lifetime. The $15,000 benefit applies to the surgery including physicians, hospital and all related charges including any complications as a result of the surgery. Any charges over and above the $15,000 payout will be declined as over the maximum allowed by the Plan. All claims will be adjudicated according to the Local 102 Health Plan.
21. for charges incurred for Acquired Immune Deficiency Syndrome (A.I.D.S.);
22. for a vasectomy;
23. for annual routine mammography screening when care is provided by an In-Network Providers only;
24. for charges incurred for treatment of a mental or nervous disorder when the treatment is received by the individual while confined as an inpatient in a Hospital. Services must be preauthorized by Intervention Strategies to be covered under the Local 102 Health Plan;
25. for charges incurred for outpatient treatment of mental and nervous disorders. Services should be preauthorized by Intervention Strategies;
26. for charges incurred for pregnancy and pregnancy-related conditions. The Local 102 Health Plan does not have a preexisting condition exclusion relating to pregnancy or any other medical conditions. However, this Plan does not cover charges incurred due to dependent child pregnancy or complications resulting from the pregnancy of a dependent child;
27. for charges incurred for a routine annual physical examination and/or routine Obstetrical and Gynecological visits when services are provided by In-Network Providers;
28. for chiropractic care or treatment by an acupuncturist. This is a limited benefit;
29. In-network charges incurred for preventive and primary care services for a Dependent child. Such coverage will consist of the following services:
    a. an initial Hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric Physicians designated by the Commissioner of Health;
    b. such coverage will be provided only to the extent that such services are provided by or under the supervision of:
        (1) a Physician, or in a Physician's office; or
        (2) another professional licensed by an appropriate licensing agency whose scope of practice includes the authority to provide the specified services provided in a Hospital, or in such professional's office;

c. at each visit, services in accordance with the prevailing clinical standards of such designated association, including:
    (1) a medical history;
    (2) a complete physical examination;
    (3) developmental assessment;
    (4) anticipatory guidance;
    (5) appropriate immunizations and laboratory tests which tests are ordered at the time of the visit and performed in the practitioner's office, as authorized by law, or in a clinical laboratory; and

d. necessary immunizations as determined by the Superintendent in consultation with the Commissioner of Health consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza Type B and hepatitis B which meet the standards approved by the United States Public Health Service for such biological products; and

30. for cardiac rehabilitation.
31 for wigs for patients who have lost their hair due to cancer treatments such as chemotherapy. This benefit is limited to $500.00 per calendar year and does not pay for maintenance of the wig;
32. for any preexisting medical conditions for which benefits are provided under the Local 102 Health Plan.

EXCLUDED CHARGES

In addition to the GENERAL EXCLUSIONS listed on page 51, no benefits are payable under this Benefit for:

1. transportation, except local ground ambulance service from the place where the Injury or Illness occurred to the first Hospital where treatment can be provided; If the original hospital is not equipped to handle the emergency professional ground ambulance will be provided to a hospital that is equipped to treat the injury or illness.
2. second surgical limitations - no benefits are payable:
    a. for consultation with a Physician who is not a Legally Qualified Physician, as defined;
    b. for more than two consultations in connection with the proposed surgery;
    c. for X-rays and tests not related to the proposed surgery;
    d. if you or your Dependent are not examined in person by the Physician who is rendering the opinion;
    e. if no written report is sent to the Plan by the examining Physician;
    f. if the consulting Physician also performs the surgery; or
    g. if the consulting Physician has a financial interest in the outcome of his opinion; or
    h. if the opinion is obtained with regard to an Illness or Injury arising out of, or in the course of your or your Dependent's employment;

3. physical exam limitations - no benefits are payable for:
    a. any professional fees, other than the fee of the In-network Physician who performed the physical examination;
    b. an examination required by an employer as a condition of employment, or which the employer is required to provide by virtue of a labor agreement;
    c. an examination required by a government body; or
    d. care that is provided by an Out-of-Network provider.

EMPLOYEE ASSISTANCE PROGRAM

INTERVENTION STRATEGIES INTERNATIONAL - EMPLOYEE ASSISTANCE PROGRAM

When it appears that you or your eligible dependents will require psychiatric, mental health or alcohol or substance abuse care, you must contact Intervention Strategies Employee Assistance Program at 800-663-0404.

If you do not contact Intervention Strategies prior to utilizing your mental health and substance abuse benefits, benefits may not be provided under this program.

Substance abuse benefits are only available to Plan B members.

MENTAL HEALTH BENEFITS

You must contact the Intervention Strategies Employee Assistance Program before using your mental health benefits. If you do not contact Intervention Strategies benefits may not be provided under this program. You may reach Intervention Strategies at 800-663-0404. Benefits are provided for inpatient and outpatient services.

Inpatient care for mental conditions (including psychoneurotic and personality disorders) is combined with the medical benefit for up to 120 inpatient days per person per calendar year for Plan A members, and up to 180 inpatient days per person per calendar year for Plan B members, Each day reduces the inpatient days available for general conditions. Partial hospitalization days or day care is available for mental conditions. Partial hospitalization days or day care is defined as care in a hospital or other approved facility for not less than four (4) hours or more than sixteen (16) hours in any 24-hour period. Every two (2) partial hospitalization days counts as one inpatient day.

INPATIENT BENEFITS

Benefits are provided for the following eligible mental health inpatient services:

1. bed and meals in a standard room;
2. all drugs and medicines used during your hospitalization which are approved by the Food and Drug Administration for use by the general public and are for FDA-approved uses (experimental drugs are not eligible);
3. laboratory tests, except for out-of-network drug testing and all X-rays;
4. psychological testing;
5. individual and group therapy and individual counseling;

continued on next page

6. counseling for the family of the person who is receiving covered inpatient services;
7. occupational therapy, but not diversional or recreational therapy or activity;
8. services of employees of the facility.

OUTPATIENT BENEFITS

Benefits are provided for mental health services received on an outpatient basis. Benefits are provided for the following services:

1. individual and group therapy and individual counseling.

You must contact the Intervention Strategies Employee Assistance Program before using your mental health benefits. If you do not contact Intervention Strategies, benefits may not be provided under this program. You may reach Intervention Strategies at 800-663-0404.

ADDITIONAL BENEFITS FOR PLAN B MEMBERS ONLY

ALCOHOL AND DRUG/SUBSTANCE ABUSE BENEFITS Plan B members only

DETOXIFICATION AND RESIDENTIAL FACILITY BENEFITS

You must contact the Intervention Strategies Employee Assistance Program before using your alcohol and substance abuse benefits. If you do not contact Intervention Strategies, benefits may not be provided under this program. You may reach Intervention Strategies at 800-663-0404.

Benefits are provided for services rendered in detoxification and residential facilities.

INPATIENT BENEFITS

Benefits are provided for the following eligible inpatient services for the treatment of alcoholism in detoxification and residential facilities:

1. bed and meals in a standard room;
2. all drugs and medicines used during your hospitalization which are approved by the Food and Drug Administration for use by the general public and are for FDA-approved uses (experimental drugs are not eligible);
3. laboratory tests, but not X-rays;
4. psychological testing;
5. individual and group therapy and individual counseling;
6. counseling for the family of the person who is receiving covered inpatient services;
7. occupational therapy, but not diversional or recreational therapy or activity;
8. services of employees of the facility.

Inpatient care for alcoholism, drug addiction/substance abuse, and mental conditions (including psychoneurotic and personality disorders) is combined with the medical benefit for up to 180 inpatient days per calendar per person per calendar year. Each day reduces the inpatient days available for general conditions. Partial hospitalization days or day care is available for alcohol,

mental and drug/ substance abuse conditions. Partial hospitalization days or day care is defined as care in a hospital or other approved facility for not less than four (4) hours or more than sixteen (16) hours in any 24-hour period. Every two (2) partial hospitalization days counts as one inpatient day.

AMBULATORY (OUTPATIENT) BENEFITS

Benefits are provided for alcoholism rehabilitation services received on an ambulatory basis in a residential facility or as aftercare in a detoxification facility.

Benefits are provided for the following services:

1. individual and group therapy and individual counseling;
2. counseling for the family of the person who is receiving eligible ambulatory service;
3. services of staff including the necessary trained professionals.

You must contact the Intervention Strategies Employee Assistance Program before using your alcohol or substance abuse benefits. If you do not contact Intervention Strategies, benefits may not be provided under this program. You may reach Intervention Strategies at 800-663-0404.

VISION BENEFIT Plan B only

This benefit will be payable if you or your Dependents, while covered, incur "Covered Vision Charges."

YOUR BENEFITS

Benefits are payable for Reasonable and Customary Covered Vision Charges incurred, up to the Maximum Payment shown in the Schedule of Benefits.

The Maximum Payment under this benefit will be payable for all Covered Vision Charges incurred during the benefit period per family.

DEFINITION

Covered Vision Charges means only expenses incurred for:

1. examinations performed by a licensed optometrist or ophthalmologist;
2. prescription lenses prescribed by such optometrist or ophthalmologist; and
3. frames purchased in conjunction with lenses newly prescribed by such persons.
4. charges for a surgical procedure to correct myopia (nearsightedness) or hyperopia (far sightedness)up to the Vision Benefit Maximum per calendar year as shown in the Schedule of Benefits section of this book. This is a Vision Benefit only and not payable under the Major Medical Plan.

EXPENSES THAT ARE NOT COVERED

In additions to GENERAL EXCLUSIONS, no benefits are payable under this section for:

1. any vision care services or supplies which are included as covered charges under any other benefit section included in this Plan, or under any other medical or vision care benefit plan carried or sponsored by your Employer, whether benefits are payable for all or part of the charges.

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2. special procedures, such as orthoptics or vision training, or for special supplies, such as non-prescription sunglasses and subnormal vision aids;
3. routine annual examinations in connection with you and/or your Dependent's employment or occupation;
4. expenses incurred as the result of any Injury or Illness that is employment-related or covered under any Workers' Compensation Law, Occupational Disease Law or similar law;
5. charges for services which you and/or your Dependent obtains, or is entitled to obtain, under any plan or program without charge, except Medicaid. This will include charges provided or paid for by the federal government at a Veteran's Administration facility for:
    a. an Injury or Illness related to military service; or
    b. you, or your Dependent, if you are retired from the armed forces.
6. expenses you or your Dependents are not legally obligated to pay;
7. services or supplies which are received while the individual is not covered or charges for lenses and frames which are furnished or ordered as a result of an examination which occurred prior to the date the individual becomes covered.

HEARING BENEFIT – Plan B only

Hearing aids and related services (such as hearing examinations and hearing aid fitting services) are eligible under your program. Your Plan will pay up to a maximum of $3000 per person every three years. These benefits are not subject to the deductible or co-insurance.

TEMPOROMANDIBULAR JOINT DISORDER (TMJ) Benefit – Plan B only

$1,000 per family per calendar year for Plan B members only, to cover temporomandibular joint disorder.

With the exception of this coverage for TMJ for Plan B members, no other coverage is available to members for this diagnosis.

DENTAL BENEFIT – Plan B only

Dental Benefits as described in the following pages are provided by Horizon Dental Options up to the yearly maximums.

Horizon Blue Cross Blue Shield of New Jersey
PO Box 1311
Minneapolis, MN 55440-1311
800-433-6825
Group #: 76146

FREE CHOICE OF DENTIST

You may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Horizon to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Horizon will make payment directly to the subscriber. You

will be responsible for any amounts charged by the dentist that are not covered by the Plan.

Maximum benefit can be derived by utilizing the services of a participating dentist.

DESCRIPTION OF COVERED SERVICES
Horizon Dental Options Programs cover the following services when they are rendered by a licensed dentist and when necessary and customary, as determined by the standards of generally accepted dental practice.

PREVENTIVE & DIAGNOSTIC SERVICES COVERED AT 100% of fee schedule
Diagnostic – Procedures such as examination and X-rays to assist the dentist in evaluating the existing conditions to determine the required dental treatment. Examinations are allowed three times per year.

PREVENTATIVE – Procedures to assist in preventing oral disease including prophylaxis three times per calendar year; topical application of fluoride solutions once every 6 months, to age 19 years; sealants to sound, natural teeth, once every 36 months to age 14 years.

RESTORATIVE SERVICES COVERED AT 80% of fee schedule
Amalgam or composite; extractions, root canal therapy; oral surgery, dentures (5 year replacement rule applies); fixed bridgework (5 year replacement rule applies).

MAJOR SERVICES COVERED AT 50% of fee schedule.
Crowns/inlays (5 year replacement rule applies)

ORTHODONTIC BENEFITS COVERED AT 50% of fee schedule
$2000 per dependent, per lifetime (to age 19)

IMPLANT BENEFITS
There is a separate dental implant benefit for Plan B members and dependents of $2000 per person, per calendar year payable under the dental plan. Implant services may need to be pre-authorized through the Horizon dental plan. Call 800-433-6825 for further information regarding pre-authorization.

WHO IS ELIGIBLE?
All employees and their dependents for this dental care program will be covered from the first day of the month following the completion of the eligibility requirements as outlined in the Eligibility Rules Section of the Health and Welfare Fund Booklet for Plan B members.

Dependents of employees are also eligible for benefits as described.

Dependents are your lawful spouse and children from birth through the end of the month in which the age 26 is attained. Children include stepchildren, adopted children and foster children, provided such children are dependent upon the employee for support and maintenance.

WHEN DOES COVERAGE TERMINATE?

Coverage for employees and their eligible dependents shall cease on:

1. termination of the employee's eligibility for benefits with the Welfare Fund. Coverage for dependent spouse shall terminate on divorce from the covered employee.

Coverage for a dependent child shall terminate upon attaining the limiting contract age (See eligibility section above).

CONTINUATION OF COVERAGE

Under Federal Regulations, an employee, spouse or dependent child has the right to continue dental coverage if certain qualifying events are met.

Contact your Plan Administrator for additional details. See the section on COBRA, page 25.

The individual continuing coverage shall be responsible for the required premiums.

SERVICES NOT COVERED

The services not covered under the Dental Benefit are as follows:

1. services for injuries or conditions which are compensable under Workers' Compensation or Employers' Liability Laws; services which are provided to the eligible patient by the any Federal or State Government Agency or are provided without cost to the eligible patient by any municipality, county or other political subdivision;
2. services with respect to congenital or development malformations (including TMJ), cosmetic surgery and dentistry for purely cosmetic reasons;
3. minor tooth movement;
4. prescribed drugs, analgesics;
5. experimental procedures;
6. oral hygiene instruction;
7. services performed prior to effective date of coverage;
8. charges for hospitalization, including hospital visits;
9. broken appointments;
10. Laboratory tests; or
11. Adult fluoride treatments.

LIMITATIONS

Dental services are subject to the following limitations:

1. X-Rays: 4 bitewings every 6 months. Full mouth series or panoramic X-rays are provided only once every three (3) years.
2. Crowns, Inlays and Gold Restorations: Replacement will be made only after five (5) years have elapsed.
3. Prosthodontics: Prosthodontics appliances will be replaced only after five (5) years have elapsed.

OPTIONAL SERVICES

In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, Horizon will pay the applicable percentage of the lesser fee. The patient must pay the entire remainder of the dentist's fee.

1. **Crowns, Inlays and Gold Restorations** will be provided only when teeth cannot be restored adequately by using amalgam, porcelain, plastic or composite restorations.
2. **Dentures:** Horizon Dental Options will provide a standard cast chrome or acrylic denture. If, in the construction of the denture, the patient and the dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, Horizon Dental Options will allow an appropriate amount for the standard denture towards such treatment, and the patient must bear the difference in cost.
3. **Occlusions:** Horizon Dental Options will allow the cost of restorations required to replace missing teeth. Procedures, appliances or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional, and the cost is the responsibility of the patient. Such procedures include, but are not limited to, equilibration, periodontal, splinting, restoration of tooth structure lost from attrition and restoration for malalignment of the teeth.
4. **Restorations:** Composite restorations will be allowed for anterior teeth only. An allowance for amalgam restorations will be made on posterior teeth. Horizon Dental Options shall not be obligated to make payment for treatment plans submitted more than one year after the date of rendition of the service.

METHOD OF PAYMENT

Horizon's allowable charge for each procedure will be as follows:

1. **Horizon's participating dentists will be paid based upon the least of:**
   a. the Dentist's charged fee
   b. the Dentist's filed fee with Horizon
   c. Horizon's allowance for usual, customary and reasonable fees.
   (When services are performed by participating dentists, payment is made to the Dentist.)
2. **Non-participating dentists will be paid based upon the lesser of:**
   a. the Dentist's charged fee
   b. Horizon's allowance for the prevailing fee.

(When services are performed by non-participating dentists, payment is made to the Subscriber.)

HOW TO USE YOUR PROGRAM

Call 800-433-6825 to locate participating dentists in your area or you can access participating providers online at www.horizonblue.com

For dentists in the state of NJ, the plan is Horizon Dental Options.

Outside the state of NJ, the plan is DentalGrid+

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During your FIRST appointment, tell your dentist that you are covered under this Horizon Dental Program. Give him/her your Horizon Dental Card which includes the group name and the Horizon Group Number and your ID Number. Your dependents, if covered, should give your ID Number. Your Dentist will perform an examination and submit a pre-treatment estimate of benefits voucher to Horizon, if necessary, to determine how much of the charge will be your responsibility. Before treatment is started be sure you discuss with your dentist the total amount of his/her fee.

COORDINATION OF BENEFITS

In order to avoid duplication of payment for the same services, the benefits of the dental program are coordinated with other plans which are not purchased by the employee and which provide dental benefits. Generally, if you are covered by more than one plan, your expenses will be shared between the plans, up to the full amount of the allowable charges.

APPEAL PROCEDURE FOR DENIED DENTAL CLAIMS

Horizon will notify you if any services are denied, in whole or in part, stating the reason(s) for the denial on a copy of the Notification of Payment which will be sent to you. Within 60 days after receipt of a notice of denial, you may make a written request for review of such denial by addressing your request to Horizon Blue Cross Blue Shield of New Jersey, Appeals Unit, PO Box 551, Minneapolis, MN 55440-0551. You must state the reason(s) you believe Horizon should reconsider its determination of benefits. Before making a formal written request for review, you are encouraged to discuss your claim with your plan administrator.

Horizon shall make a full and fair review of your request for re-evaluation and may require additional documents as it deems necessary or desirable in making such a review. Unless referral to a review committee is required or other unusual circumstance arise, you should receive a decision on your request for review, in writing, within 30 days but no longer than 120 days after Horizon received your request. If the claimant disagrees with the results of the initial written appeal to Horizon BCBSNJ Programs, the claimant has the right to further appeal by sending to Horizon BCBCNJ Dental Programs any additional information or data to the claimant determines to be relevant to the appeal. Horizon BCBSNJ Dental will respond to the second appeal within 30 calendar days. If the benefit plan originates in New Jersey, the claimant also has the option to send the appeal to the following agency for Appeals regarding dental necessity and/or appropriateness: New Jersey Dental Association (NJDA) Peer Review Committee, One Dental Plaza, North Brunswick, NJ. 08902.

As this benefit is being provided as part of an ERISA benefit plan, if you are still not satisfied after exhausting all of your appeal rights, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974.

PRESCRIPTION DRUG BENEFIT

Medicare members, see page 7.

PRESCRIPTION BENEFITS MANAGER

GLOBAL PHARMACEUTICAL BENEFITS, LLC
One GatewayCenter
Suite 2600
Newark, NJ 07102
Phone # 800-341-2234

Benefits will be paid, if while insured under this benefit, a participant incurs medically necessary charges for prescription drugs for an illness or injury. Such drugs must be:

1. obtained by a physician's written prescription; and
2. dispensed by a licensed pharmacy.

COPAYMENT

The copayment is the amount that a participant must pay to the pharmacy for each prescription.

The copayments are shown in the Prescription Schedule of Benefits starting on page 16.

PARTICIPATING PHARMACY

Prescriptions may be filled at any pharmacy. However, only a Participating Pharmacy will accept the copayment as shown in the Schedule of Benefits. The bills for any prescription filled at a non-participating pharmacy must be filed as a paper claim with the Prescription Card Company and will be reimbursed at contracted rate for a participating pharmacy minus the copay. Prescriptions are not covered under your Major Medical Plan.

DEFINITIONS

Generic drug. This term means a drug approved by the Food and Drug Administration which is identified by its chemical name and not the manufacturers brand name.

Maintenance Drugs. Any prescription drug dispensed in a 90 day supply to treat a chronic or long term condition.

Participating Pharmacy. This term means a pharmacy participating with Global Pharmaceutical Benefits, LLC. Prescription Card Program.

Prescription. This term means a written order issued by a Physician for a drug. Prescription also includes a refill of such order.

continued on next page

Prescription drug. This term means:

1. legend drugs. Any drug whose label must bear the legend: Caution federal law prohibits dispensing without a prescription;
2. state restricted drugs. Any drug which can be dispensed in a state or jurisdiction by prescription only;
3. Compound Medications. Any drug mixture which contains at least one legend drug or state restricted drug;
4. injectable Insulin and the following diabetic supplies: insulin syringes and needles, urine testing strips for glucose, lancets, ketone testing strips, lancet devices, blood testing strips for glucose and ketone tablets;
5. allergy medicine;
6. tretinoin, all dosages forms (e.g. Retin-A), for acne only, for participants under age 26;
7. maintenance Drugs; and
8. prenatal vitamins and single entity vitamins.

SUBSTITUTION OF GENERIC FOR BRAND NAME DRUGS

If a brand name drug has a generic drug substitute, the generic drug may be dispensed for the brand name drug.

DISPENSING LIMITATIONS

The amount of drug per Prescription is limited to a 30 day supply through Global Pharmaceutical LLC. Certain maintenance medications may be available in 90 day supply if Alliance Community Healthcare is utilized.

See page 17 for additional information.

PRESCRIPTION DRUG PLAN EXCLUSIONS

In addition to the GENERAL EXCLUSIONS, no benefits are payable under this provision for:

1. Non-federal legend drugs, except injectable insulin;
2. therapeutic devices or appliances, including hypodermic needles, syringes (except for those used for injectable insulin), support garments and other nonmedical items, regardless of their intended use;
3. any charge for the administration of a Prescription drug or injectable insulin;
4. drugs labeled: Caution - limited by federal law to investigational use; or experimental drugs, even if a charge is made to the individual;
5. any Prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the original Prescription;
6. any drug dispensed during confinement in a Hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent Hospital, nursing home or similar institution which has on its premises a facility for dispensing pharmaceuticals;
7. any drug which may be provided without charge under local, state or federal programs;
8. immunization agents, biological sera, blood or blood plasma;

9. drugs whose sole purpose is to promote or stimulate hair growth;
10. growth hormones; except for limited benefit available through Alliance Community Healthcare
11. infertility medications;
12. appetite suppressants, unless used to treat Attention Deficit Disorder;
13. prescription which you or your dependent are entitled to receive without charge from any workers' compensation laws;
14. nutritional supplements, vitamins and minerals;
15. all proton pump inhibitors;
16. any prescription available over the counter;
17. all compounded drugs
18. all schedule II substances, except attention deficit medications;
19. any prescriptions refilled due to lost, misplaced, stolen, damaged or destroyed prescriptions.

GENERAL EXCLUSIONS TO HEALTH BENEFITS

In addition to any limits described under the sections which describe the health benefits, there are specific limitations and exclusions with regard to all benefits. Covered Charges do not include and no benefits are payable for:

1. services, supplies or treatment which are not prescribed as Medically Necessary by a Physician. This exclusion also applies to any Hospital confinement (or any part of a confinement) that is not recommended or approved by a Physician;
2. any portion of an expense that exceeds the Local 102 Fee Schedule for services, supplies or treatment;
3. cosmetic surgery or complications resulting from cosmetic surgery, unless required because of:
    a. an accidental bodily injury;
    b. reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part; or
    c. reconstructive surgery due to congenital disease or anomaly;
4. services or supplies furnished on account of Injury or other loss sustained as a result of war, or any act of war, whether declared or undeclared, or by any act of international armed conflict involving the armed forces of any international authority;
5. expenses incurred as a result of participation in a felony, riot or insurrection;
6. charges incurred as a result of an accidental bodily Injury arising out of or in the course of you or your Dependent's employment;
7. charges incurred as a result of an occupational disease. For the purposes of this Plan, "occupational disease" means a disease for which you or your Dependents are entitled to benefits under the applicable Workers' Compensation Law, Occupational Disease Law or similar law;
8. charges for services which you or your Dependent obtains, or is entitled to obtain, under

any plan or program without charges, except Medicaid. This will include charges provided or paid for by the federal government at a Veteran's Administration facility for:

a. an Injury or Illness related to military service; or

b. you or your Dependent, if you are retired from the armed services.

9. any charges which you or your Dependents are not legally obligated to pay;
10. charges for services or supplies for which benefits are furnished, paid for, or for which benefits are provided or required under any law of a national, state, or provincial government or instrumentality (this does not include a plan established by a government for its own employees or their Dependents).
11. Custodial Care;
12. experimental Procedures, except in the treatment of Wilm's tumor which may be considered experimental;
13. recreational or leisure therapy;
14. charges incurred in connection with radial keratotomy, Lasik surgery or any other surgical procedure performed to correct myopia (nearsightedness) or hyperopia (farsightedness); except as noted under the routine vision benefit for Plan B members.
15. services rendered by a person who is a member of your or your Dependent spouse's immediate family;
16. charges incurred in connection with infertility including but not limited to the following procedures:
    a. artificial insemination;
    b. in-vitro fertilization; or
    c. in-vivo fertilization;
17. charges for or related to sex change surgery or any treatment of gender identity disorders;
18. the reversal of a sterilization procedure;
19. organ transplants and artificial organs, except as a recipient thereof; donor costs will only be covered if both the recipient and the donor are eligible for benefits under the IBEW Local Union No 102 Welfare Fund and shall be limited to $50,000.
20. treatment for dietary control or weight reduction or treatment for obesity including but not limited to Gastric Restrictive Procedures such as Vertical Banded Gastroplasty, Adjustable Gastric Banding, and Gastric Bypass and any complications arising from surgery or treatment of weight reduction EXCEPT as specifically stated under the "Expenses That Are Covered" Section of this Plan on page 37.
21. nutritional supplements, vitamins, and minerals, chelation therapy and orthomolecular medicine;
22. care for learning disabilities and related behavioral problems, hyperkinetic syndromes, speech disorder, mental retardation and autism including applied behavioral analysis (ABA) assessment and/or therapy;

23. charges arising out of injuries incurred in an automobile where the Primary Participant or his Dependents have elected to waive medical coverage under any automobile insurance policy;
24. All expenses arising out of injuries on school property or during after school related activities along with sponsored athletic activities such as Little League, Pop Warner or any organized sports activity will be covered up to $2500.00 per accident. The Fund will pay as primary if there is another insurance involved;
25. services that are in the nature of educational or vocational testing or training;
26. treatment of weak or flat feet, orthopedic shoes and other supportive devices, including foot orthodics;
27. exhibition, test or stunt flying, crop dusting or seeding, herding, hunting or fire fighting while in an aircraft; riding in or on any motorized vehicle designed or used for racing, speed tests or exhibition purposes;
28. intentional self-destruction or self-inflicted Injury;
29. aromatherapy;
30. the purchase or rental of any exercise equipment or devices even when prescribed by a Physician (e.g. bikes, pools, treadmills, stairsteppers. etc.);
31. expenses associated with wellness, relaxation or therapeutic oriented services membership fees, even if prescribed by a Physician (e.g. golf clubs, sauna therapy, massage therapy, fitness clubs, pool membership, tennis clubs, vacation expenses, religious retreats, etc).
32. dependent child pregnancy or complications relating to that pregnancy;
33. biofeedback;
34. charges incurred for or in connection with penile implants.
35. the treatment of temporomandibular joint disorder (TMJ), except as noted under additional benefits for Plan B members on page 44;
36. out of network benefits for pain management services, including professional services (the doctor), facility (the surgical center or hospital), anesthesia and/or any other related charges. If the patient uses an out of network doctor for a pain management procedure, all related services for that date of service would be denied even if the related providers such as the anesthesiologist and the facility were in the network.
37. out of network benefits for drug testing services
38. services provided outside the United States: Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical emergency. Emergency expenses will be reimbursed to the member under the out of network benefit upon receipt of a medical claim (translated), proof of payment (converted into dollars) and medical records proving emergency (translated). Travel insurance is highly recommended.

AUTOMOBILE ACCIDENT

The IBEW Local Union No. 102 Welfare Fund will provide only secondary coverage for medical expenses arising out of automobile accidents up to a maximum benefit payable of $1,500.00 per individual, per accident, regardless of automobile coverage.

As a participant, you should not be advising your automobile insurance carrier(s) that you have alternative coverage through the IBEW Local Union No. 102 Welfare Fund for medical claims arising from automobile accidents.

You must make sure that your automobile policy has the PIP (Personal Injury Protection) under your automobile insurance policy listed as the primary payer of medical bills related to automobile accidents.

MOTORCYCLE/RECREATIONAL VEHICLE ACCIDENT

Claims arising out of injuries sustained as a result of a motorcycle or recreational vehicle accident will be adjudicated on a primary basis , but only after written documentation has been provided to Fabian & Byrn, LLC that all other forms of coverage (such as third party liability claims or uninsured motorist coverage) have been exhausted.

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

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

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

If you have been injured in an automobile accident please advise your provider that the IBEW Local Union No. 102 Welfare Fund will provide secondary coverage only for medical expenses arising out of automobile accidents up to a maximum benefit payable of $1,500.00 per individual, per accident, regardless of automobile coverage.

Also, please refer to the section titled "Subrogation and Reimbursement".

SUBROGATION AND REIMBURSEMENT

The Fund is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health fund or plan. In order to help a covered person in a time of need, however, the Fund may pay covered expenses that may be or become the responsibility of another person, provided that the Fund later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Fund, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Fund:

1. Assignment of Rights (Subrogation). The covered person automatically assigns to the Fund any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the Fund. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Fund to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the Fund's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The Fund shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Fund. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment of settlement, where the Fund has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers of the Employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust) as a result of an exercise of the covered person's rights of recovery (sometimes referred to as "proceeds").

The Fund shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Trustees, the Fund may reduce any future covered expenses otherwise available to the covered person under the Fund by an amount up to the total amount of Reimbursable Payments made by the Fund that is subject to the equitable lien.

This and any other provisions of the Fund regarding equitable liens and other equitable remedies are intended to meet the standards for enforcement that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the Fund regarding subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in Funds Reimbursement Activities. The covered person has an obligation to assist the Fund to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Fund with any information regarding the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the Fund's (or any Fund fiduciary's or designee's) enforcement of the terms of the Fund, including the exercise of the Fund's right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the Fund as a copayee for the amount of the Reimbursable Payments and notifying the Fund), (c) sign any document deemed by the Fund to be relevant to protecting the Fund's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Fund's rights.

   The Trustees may delegate the right to perform ministerial functions required to assert the Fund's rights; however, the Trustees shall retain discretionary authority with regard to asserting the Fund's recovery rights.

COORDINATION OF BENEFITS

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans are paying for the same expense. To avoid this costly problem, your health plan provides a Coordination of Benefits provision. This provision affects all of your medical coverage.

HOW DOES COORDINATION WORK

If you or your Dependents are also covered under another group plan, the total amount received from all plans will never be more than 100% of "allowable expenses." Benefits are reduced only to the extent necessary to prevent any person from making a profit on his coverage. Under no circumstances, will the Local 102 Health Plan pay more as secondary insurer, than they would have paid if the claim had been processed as primary.

If this COB provision applies, the Order of Benefit Determination Rules below should be looked at first. Those rules determine whether this Plan is a primary plan or a secondary plan. A "primary plan" means the Plan which pays benefits or provides services first under the rules. A "secondary plan" is any Plan that is not a primary plan. When there are more than two plans covering the individual, this Plan may be a primary plan as to one or more other Plans, and may be a secondary plan as to a different Plan or Plans.

If this Plan is:

1. a primary plan, COB will not apply and benefits will not be reduced; or
2. a secondary plan, COB will apply, and benefits may be reduced so that the total payment from all Plans will not exceed 100% of total Allowable Expenses. This reduction is described under Effect on Benefits below. Under no circumstances, will the Local 102 Plan pay more as secondary insurer, then they would have paid if the claim had been processed as primary.

PLANS CONSIDERED FOR COB

For purposes of COB, a "Plan" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

1. group insurance or group-type coverage, whether covered or uninsured. This includes coverage through Health Maintenance Organizations (HMOs) and other prepayment, group practice or individual practice coverage;
2. group Hospital indemnity benefit amounts in excess of $150 per day;
3. coverage under a governmental plan, or coverage required or provided by law.

ORDER OF BENEFIT DETERMINATION RULES

General

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary plan which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of this Plan; and
2. both those rules and this Plan's COB Rules, require that this Plan's benefits be determined before those of the other Plan.

Rules

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the covered individual as an employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the Person as a Dependent.
2. Dependent child/parents not separated or divorced. Except as stated in Rule 3, when this Plan and another Plan cover the same child as a Dependent of different individuals, called "parents":
    a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
    b. if both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have this "birthday rule" but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
3. Dependent child/separated or divorced. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    a. first, the Plan of the parent with custody of the child;
    b. then, the Plan of the spouse of the parent with the custody of the child; and
    c. finally, the Plan of the parent not having custody of the child.

    However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has the actual knowledge.

4. Active/inactive employee. The benefits of a Plan which covers you or your Dependent as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers the person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule 4 is ignored.
5. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered the employee, member or subscriber for the shorter term.

EFFECT ON BENEFITS

COB applies to this Plan when, in accordance with the Order of Benefit Determination Rules, this Plan is a Secondary plan as to one or more other Plans. In that event the benefits of this Plan may be reduced under this COB provision. Such other Plan or Plans are referred to as "the other Plans" immediately below.

Reduction in this Plan's Benefits

The benefits of this Plan will be reduced when the sum of:

1. the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
2. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;
3. exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other Plans do not total more than 100% of those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. The allowable expense considered for the purpose of claim processing by this plan will be determined by the amount approved by the primary plan.

"Allowable Expense" means a Reasonable and Customary item of expense for health care; when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. The Fund has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or individual. The Fund need not tell, or get the consent of, any individual to do this. Each covered person claiming benefits under this Plan must give the Fund any facts it needs to pay the claim.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under this Plan.

If it does, this Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Fund will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Fund is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. the individuals it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION OF BENEFITS AND MEDICARE

MEDICARE BENEFITS AT AGE 65

If you or your Dependent are entitled to benefits under Medicare because of attainment of age 65, the following rules will determine which Plan is primary under the Coordination of Benefits (COB) provision.

FOR ACTIVE MEMBERS AND THEIR DEPENDENTS

This Plan will be the primary plan to Medicare for an active Member, or a Dependent of an active Member, who is age 65 or older.

FOR RETIRED MEMBERS AND THEIR DEPENDENTS (IF COVERED UNDER THIS PLAN)

This Plan will be a secondary plan to Medicare for a retired Member, or a Dependent of a retired Member, who is age 65 or older.

To determine the amount of reduction for purposes of COB, the Company will include all benefits for which you or your Dependent are eligible under Medicare Parts A and B. Such benefits will be considered payable under Medicare, whether or not the individual registered for Part A benefits, or enrolled for Part B benefits.

This Plan will pay the balance of Medicare approved charges up to 100% of the Medicare allowable amount after the annual deductible has been satisfied.

MEDICARE BENEFITS DUE TO TOTAL DISABILITY

You or your Dependent may become entitled to Medicare benefits prior to age 65 due to total disability or end stage renal disease. The following rules apply with respect to COB and Medicare due to total disability or end stage renal disease prior to age 65. Upon attainment of age 65, the rules for COB and Medicare at age 65 will apply.

DURING MEDICARE WAITING PERIOD

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

AFTER MEDICARE WAITING PERIOD

After the Medicare waiting period has been met, and you or your Dependent are entitled to Medicare benefits, this Plan will be:

1. a primary plan to Medicare for an active Member, or his or her Dependent, who is entitled to Medicare benefits due to total disability for other than end stage renal disease; and
2. a secondary plan to Medicare for:
    a. an active Member, or his or her Dependent, who is entitled to Medicare benefits due to end stage renal disease; or
    b. a retired Member, or his or her Dependent, who is entitled to Medicare benefits due to total disability or end stage renal disease. “Medicare” meansthe medical benefits provided by Title XVIII of the Federal Social Security Act, as amended to date.

DEFINITIONS

These are some of the terms used in this booklet. Other terms are defined as they are used.

PLEASE READ THEM CAREFULLY. If you understand these definitions and how they are applied in administering the Plan, you will more fully appreciate the benefits provided and the manner in which claims are handled.

Whenever a pronoun is used in the masculine, it also includes the feminine, unless the context clearly indicates otherwise.

Birthing Center means a freestanding facility which meets fully every one of the following tests:

1. meets licensing standards;
2. is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care;
3. makes charges;
4. is directed by at least one Physician who is a specialist in obstetrics and gynecology;
5. has a Physician or certified nurse midwife present at all births and during the immediate postpartum period;
6. extends staff privilege to Physicians who practice obstetrics and gynecology in an area Hospital;
7. has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery;
8. provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a registered nurse (R.N.) or certified nurse midwife;
9. provides, or arranges with a facility in the area for diagnostic x-ray and laboratory services for the mother and child;
10. has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear;
11. is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life:
    a. if complications arise during labor; and
    b. if a child is born with an abnormality which impairs function or threatens life;
12. accepts only patients with low risk pregnancies;
13. has a written agreement with a Hospital in the area for emergency transfer of a patient or a child. Written procedures of such a transfer must be displayed and the staff must be aware of them;
14. provides an ongoing quality assurance program. This includes reviews by Physicians who do not own or direct the facility; and
15. keeps a medical record on each patient and child.

Custodial Care means treatment, services, or confinement, regardless of who recommends, prescribes, or performs them, or where they are provided, which could be rendered safely and reasonably by a person not medically skilled, and are designed mainly to help the patient with daily living activities. Custodial Care includes:

1. personal care such as help in: walking, getting in and out of bed, bathing, eating (including tube or gastrostomy), exercising, dressing, using the toilet or administration of an enema;
2. homemaking such as preparing meals or special diets;
3. moving the patient;
4. acting as companion or sitter; and
5. supervising medication which can usually be self-administered.

The Fund, and/or an independent medical review determines which services are Custodial Care.

The determination of Custodial Care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under the Plan.

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

The IBEW Local Union No 102 Welfare Fund fee schedule; or the health provider's actual charges.

The Fund will not always pay benefits equal to or based on the health care providers actual charges for health services or supplies, even after you have paid the applicable deductible and coinsurance. This is because the Plan covers only up to fee schedule allowance for health care services and supplies.

Hospital means an institution that:

1. is primarily engaged in providing, by or under the supervision of Physicians, inpatient diagnostic, and therapeutic services for the diagnosis, treatment and rehabilitation of injured, disabled or sick persons;
2. maintains clinical records on all patients;
3. has bylaws in effect with respect to its staff of Physicians;
4. has a requirement that every patient be under the care of a Physician;
5. provides 24-hour nursing service rendered or supervised by a registered professional nurse;
6. has in effect a Hospital utilization review plan;
7. is licensed pursuant to any state or agency of the state responsible for licensing Hospitals;
8. has accreditation under one of the programs of the Joint Commission on Accreditation of Health Care Organizations.

Unless specifically provided, the term "Hospital" does not include any institution, or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility, or facility for the

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aged or for the care and treatment of drug addicts or alcoholics, except as mandated by state law, nor does it mean any institution that makes a charge that you or your Dependent are not legally obligated to pay.

Illness means a sickness, disorder or disease that is not employment-related. Pregnancy is treated in the same manner as an Illness under this Plan for you or your Eligible Dependent. Dependent child pregnancies and complications of pregnancies are excluded under this plan.

In-Network Provider means a provider of health care services who participates in the Plan's Network.

Injury means physical damage to your or your Dependent's body caused by an accident, independent of all other causes. ***Only*** Injuries which are not employment-related are considered for benefits under this Plan.

Managed Care Network is a network of medical care providers (Hospitals, Physicians, laboratories, radiology facilities and other health care providers and facilities) that discount their normal service fees in exchange for prompt claim payment and increased patient volume.

Medically Necessary means any service, supply, treatment, or Hospital confinement (or part of a Hospital confinement) which:

1. is essential for the diagnosis or treatment of the Injury or Illness for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. is ordered by a Physician.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it medically necessary or make the expense a Covered Charge.

Medicare means the health insurance program set forth in Parts A and B, Title XVIII of the Social Security Act, as amended.

Out-of-Network Provider means a non-network provider of health care services who has not contracted with the Plan's Network.

Physician means a person duly licensed as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). The term "Physician" shall also include other duly licensed or certified practitioners, as required by state law for services which are:

1. within the scope of the license or certificate; and
2. covered under this Plan.

Totally Disabled means with respect to you, that due solely to Injury or Illness, you are prevented from engaging in any gainful occupation or employment. With respect to a covered Dependent, this means that he, due solely to Injury or Illness, is prevented from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

GENERAL INFORMATION

HEALTH BENEFITS AND EXAMINATIONS

All medical claims should be submitted to the Local Blue Cross, Blue Shield Plan where the service was rendered within 90 days after the date of loss.

If the member has paid in full for the service, a claim form should be sent directly to the Local 102 Claims Office.

HOW TO FILE A CLAIM (FOR OUT-OF-NETWORK MEDICAL OR VISION BENEFITS)

1. You may obtain medical claim forms for all benefits online at www.ibewlocal102.org or by writing or calling the Third-Party Administrator Fabian & Byrn, LLC. at 888 423-9102
2. If you have paid the out-of-network medical provider in full, attach a detailed receipt from the provider's office to the claim form, showing payment has been made to the provider. If the non-participating provider has not collected payment from you, the provider must submit the claim to their local Blue Cross Blue Shield plan.
3. Member reimbursement claim forms must be mailed to:
   Fabian & Byrn L.L.C.
   Local 102 Claims Department
   425 Eagle Rock Avenue, Suite 105
   Roseland, NJ 07068
4. Originals (copies should be kept for your personal files) of all member paid claims such as your physician, hospital and laboratory bills, should be sent to the Local 102 Claims Department.
5. For the proper administration of the Fund, it is requested that all claims be submitted for payment within 90 days of the service date. However, any claim submitted after the close of the year following in which the claim was incurred will not be honored for payment by IBEW.
6. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.
7. The IBEW Local 102 Welfare Fund has the right of recovery under the following circumstances:
   a. when benefit payments are made in reliance on any false, fraudulent statement, information, or proof submitted by a claimant;
   b. when benefit payments are made in error (e.g. when the Welfare Fund is not aware that charges are related to an automobile accident);
   c. when the amount of the benefit payments made by the Fund is more than it should have been;
   d. when benefit payments are made in advance to assist when you or your covered dependent incurs medical expenses as a result of an accident or illness for which payment may be available from another source (See provisions set forth in section titled "Subrogation and Reimbursement.")

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

You will be notified of any benefits which have been denied, in whole or in part, or if any additional information is required.

EXAMINATIONS

The Fund Office has the right to have any covered individual examined as often as it may reasonably require while a claim is pending. The Company will also have the right to request an autopsy in case of death, where it is not forbidden by law.

ONLINE ACCESS TO EXPLANATIONS OF BENEFITS AND CLAIMS HISTORY

The third-party administrator, Fabian & Byrn, LLC has a website at www.fabianbyrn.com that will allow you to view and print your medical/dental claims history.

Your website user name will be your unique ID number from your Horizon BCBS card but without the 74 after the BEW. For example: BEW741234567 will be a website user ID name of BEW1234567.

Here's how it works.

Go to the Fabian & Byrn website: **www.fabianbyrn.com**

Click on: **e-benefit (check your claims)**

Your website user name: **Your unique ID (Horizon BCBS ID# without the 74)**

Your website password: **(Call 888-423-9102 to be mailed a password letter)**

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

CLAIM REVIEW AND APPEAL PROCEDURES

CLAIM REVIEW

The plan will notify you in writing if your claim has been denied in whole or in part. If you receive such notification, you may request a review of the denied claim by writing within 60 days of receipt of the denial, to Fabian and Byrn, LLC.

CLAIM APPEAL PROCEDURES

To submit an appeal, you must include the following information:

1. Your name(s) and address and provider(s) involved;
2. Your ID number;
3. The date of service;
4. The reason for the appeal;
5. The remedy sought;
6. Documentation to support the appeal.

Under normal circumstances, you will be notified of the final decision within 60 days of the date your request is received. If there are special circumstances requiring delay, the period of time may be extended by an additional 60 days. You will be notified of the final decision no later than 120 days after your request is received.

Review by the Board of Trustees

If you are not satisfied with the appeal decision issued by Fabian & Byrn, LLC, you may file a second appeal addressed to the Board of Trustees within 180 days of your receipt of their decision. The Board of Trustees will render their decision with the assistance of their professional advisors, when necessary. The Board of Trustees will review your appeal at their next scheduled meeting. The Board of Trustees has the discretionary authority to construe and interpret the Plan, and to decide benefit claims. The decision of the Board of Trustees will be in writing and will include the plan provisions on which the decision was based.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until 90 days have elapsed since you filed a request for review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. No lawsuit may be started more than 3 years after the final denial of your appeal.

SUMMARY PLAN DESCRIPTION

1. Name of the Plan
   IBEW Local Union No. 102 Welfare Fund

2. Plan Sponsor
   IBEW Local Union No. 102 Welfare Fund
   50 Parsippany Road, PO Box 5355
   Parsippany, NJ 07054
   973 -887-1718

3. Employer Identification Number: 22-6487222

4. Plan Number: 501

5. Plan Administrator
   I E Shaffer
   830 Bear Tavern Road
   PO Box 1028
   West Trenton, NJ 08628
   800-792-3666

6. Claims Administrator
   Fabian & Byrn LLC
   425 Eagle Rock Avenue
   Suite 105
   Roseland, New Jersey 07068
   888-IBEW-102 (888-423-9102)

7. Auditor - Certified Public Accountant
   Shaughnessy, Giella & Company Inc., PC.
   420 Rt 46 East, Suite 4
   Fairfield, NJ 07004
   973-882-0228

8. Designated agent for legal process
   Oransky, Scaraggi, Borg and Abbamonte
   175 Fairfield Avenue, Suite 1A
   West Caldwell, NJ 07006
   973-364-1200

   In addition, one or more of the Trustees may be served with legal process.

9. Who is Eligible
   All employees of contributing employers whose employment is the subject of a Collective Bargaining Agreement by and between the employers providing contributions to this Fund.

10. Type of Plan

    This is a welfare plan providing medical, prescription drug, dental, vision and hearing benefits. All participants are given a Group Benefit Plan Booklet which contains a detailed description of these benefits. If your booklet becomes misplaced, you may obtain a new copy from the Plan Administrator. The Booklet, together with this document, is the entire Summary Plan Description as required by the Employee Retirement Income Security Act of 1974. If there is any inconsistency between the information provided by the booklet and this Summary Plan Description document, this Summary Plan Description document is controlling.

11. The cost of the Plan is paid by the employer contributions to the Trust Fund. The health benefits are provided by the Fund.

12. The Plan's fiscal year ends on December 31st.

13. Joint Board of Trustees

UNION TRUSTEES	**EMPLOYER TRUSTEES**
Bernard Corrigan	James Estabrook, Esq.
David Fiore	Louis Vito
Mark Roche	Robert E. Williamson III

14. Loss of Benefits
    The Trustees may change or eliminate benefits under the Plan and may terminate the entire Plan or any portion of it. Your individual coverage terminates when you leave active service, when you are no longer in an eligible class or when the Trustees terminate(s) the Plan, whichever occurs first. See your Plan Administrator to determine what, if any, arrangements may be made to continue your coverage beyond the date you cease to be employed.

PLAN CHANGE OR TERMINATION

The Trustees reserve the right to change or discontinue (a) the types and amounts of benefits under the Plan and (b) the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Plan benefits and eligibility rules for active, retired or disabled participants:

1. are not guaranteed;
2. may be changed or discontinued by the Board of Trustees;
3. are subject to the rules and regulations adopted by the Board of Trustees;
4. are subject to the Trust Agreement which establishes and governs the Fund's operations; and
5. are subject to the provisions of the group insurance policies purchased by the Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

If the Plan is changed or discontinued, it will not affect your or your beneficiary's right to any covered benefit to which you have already become entitled.

WHAT YOU NEED TO KNOW ABOUT YOUR HEALTH PLAN

You are currently enrolled in a self-insured health plan which is administered by IBEW Local Union No. 102 Welfare Fund. This plan is known as an ERISA plan, which is authorized under the federal Employee Retirement Income Security Act (ERISA), which provides limited rules and regulations regarding the conduct of the plan (See Statements of ERISA Rights, page 71). IBEW Local Union No. 102 Welfare plan is exempt from complying with New Jersey state laws governing health insurance, including laws mandating coverage for specific health insurance benefits and laws granting individuals the right to appeal to independent entity final decisions by a managed care organization to reduce or deny treatment for a covered health care service. Therefore, even though the name IBEW Local Union No. 102 Welfare Fund may appear on your health insurance card or in correspondence about your coverage, you may not have the same legal rights as persons covered by state-regulated health plans.

The following is a list of state-mandated health insurance benefits that are not covered by your plan. Benefits for:

1. "off-label" use of certain drugs;
2. Post-natal care requirement.

In addition, although not required to do so by law, the IBEW Local Union 102 Welfare Health Plan voluntarily covers the following mandated benefits that are approved by the New Jersey legislature and signed into law by the governor. Benefits for:

1. purchase of blood products and blood infusion equipment for hemophilia,
2. automatic coverage of newborn children from the date of birth;
3. court ordered coverage for dependent children;

4. continuation of coverage for a handicapped child beyond the age limit;
5. provisions of Home Health Care;
6. inpatient benefits following the birth of a child;
7. reconstructive breast surgery;
8. immunizations for dependent children;
9. Wilm's tumor;
10. mammograms;
11. prostate cancer screening;
12. lead poisoning screening for Dependent children;
13. treatment for diabetes; and
14. pap smear.

Contact the U. S. Department of Labor Information Office, (866-487-2365) with questions about your plan's ERISA status. Any additional mandates will be published in future editions of *Employer Update.*

STATEMENT OF ERISA RIGHTS

YOUR RIGHTS UNDER ERISA

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

1. examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
2. obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
3. 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.

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 benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 $100

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a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits 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 the 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).

If you have any questions about the Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor - Management Services Administration, Department of Labor.

HEALTH INSURANCE PORTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability Act of 1996, also know as HIPAA, Public Law 104-191, HR3103, Kennedy-Kassebaum is for the purpose of improving the portability and continuity of health insurance coverage.

The following applies: Creditable Coverage
Creditable Coverage means the period of time that an individual has been covered by any of the following medical programs:

1. This Plan
2. Another group health plan
3. Non-group or individual health insurance coverage
4. Medicare (Part A or Part B)
5. Medicaid
6. The Active Military Health Program
7. The Civilian Health and Medical Care Program for Uniform Services (CHAMPUS)
8. American Indian Health Care Programs
9. A State Health Benefits Risk Pool
10. The Federal Employees Health Plan
11. A "public health plan"
12. The Peace Corp Health Program

A Plan's Pre-existing Condition Limitation Exclusion Period will be reduced by the Plan Member's Creditable Coverage provided there is less than a 63 day break in the time period the Plan Member has Creditable Coverage. ***Please Note*** that the IBEW Local 102 Health Plan does not contain a Preexisting Conditions Exclusion, therefore if you or your dependents are ill or a spouse is pregnant on the effective date of your coverage, the illness or pregnancy will be covered immediately.

Note: A Plan's Eligibility Waiting Period will not count toward the 63-day break in Creditable Coverage. The type of benefits provided by the previous Creditable Coverage shall be irrelevant in determining the period of Creditable Coverage that will be used to reduce a Plan's Pre-existing Condition Limitation Exclusion Period.

The Plan Member must submit proof of his/her prior Creditable Coverage by providing a written Certificate of Period of Creditable Coverage to a Plan.

DETERMINING CREDITABLE COVERAGE WHEN NO CERTIFICATE IS AVAILABLE

Individuals may establish Creditable Coverage through means other than certificates when the plan, for one reason or another, has failed to provide a certificate. A plan is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination. A plan shall treat the individual as having furnished a certificate if the individual attests to the period of Creditable Coverage, the individual presents relevant corroborating evidence of some Creditable Coverage during the period, and the individual cooperates with the Plan's efforts to verify the individual's coverage. Explanation of Benefits, correspondence from the plan indicating coverage, pay stubs showing payroll deductions, a health identification card, a certificate of coverage, records from medical provider, etc., would be taken into consideration.

Creditable Coverage may also be established through means other than documentation, such as by a telephone call from the Plan.

HIPAA PRIVACY STATEMENT

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan will use protected health information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to a covered person to whom health care is provided. These activities include, but are not limited to the following:

- Determination of eligibility, coverage and coinsurance amounts (for example, cost of a benefit or Plan maximums as determined for a covered person's claims);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing Employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;

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- Claims management and related data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquires about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
- Medical necessity reviews or reviews of appropriateness of care and justification of charges;
- Disclosure to consumer reporting agencies related to the collection of premium or reimbursement; and
- Reimbursement to the Plan;

Health Care Operations include, but are not limited to, the following activities:

- Qualify assessment;
- Population- based activities related to improving health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternative and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing or credential activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and creating, securing or placing a contract for reinsurance of risk relating to health care claims (including stop loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business Planning and development, such as conducting cost management and Planning-related analyses related to managing and operating the Plan, including formulary development and administration, development of improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to:
    a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
    b. Customer service, including the provisions of data analysis for policyholders, Plan sponsors or other customers;
- Resolution of internal grievances.

THE PLAN WILL USE AND DISCLOSE PHI TO THE PLAN ADMINISTRATOR AND AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE COVERED PERSON

With the authorization, the Plan will disclose PHI to other health benefit Plans, health insurance issuers or HMOs for purposes related to the administration of these Plans.

The Plan will disclose PHI to the Plan administrator only upon receipt of a certification from the Plan Administrator that the Plan Documents have been amended to incorporate the following provisions.

With respect to PHI, the Plan Administrator agrees to certain conditions.

The Plan Administrator agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;
- Not use or disclose PHI for employment- related actions and decisions unless authorized by a covered person;
- Not use or disclose PHI in connection with any other benefit or employee benefit Plan of the Plan Administrator unless authorized by covered person;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to a covered person in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal Practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purpose of determining the Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form, and retain no copies of such PHI when no longer needed.
- Reasonably and appropriately safeguard electronic PHI created, received, maintained or transmitted to or by the Plan Administrator on behalf on the Plan. Specifically, such safeguarding includes an obligation to:
    - Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that he Plan Administrator creates, receives, maintains or transmits on behalf of the plan;
    - Ensure that the adequate separation as required by 45 C.F.R. 164-504 (f) (20(iii) is supported by reasonable and appropriate security measures;
    - Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
    - Report to the Plan any Security incident of which it becomes aware.

NEWBORNS' ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Women's Health and Cancer Rights Act of 1998 (WHCRA) provides benefits for mastectomy related services including charges for Post-Mastectomy Elective Breast Reconstruction including:

1. Reconstruction of the other breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Coverage for prostheses (implants, special bras, etc.) and any physical complications during all mastectomy stages, including lymphedema.

FEDERAL MENTAL HEALTH PARITY ACT OF 1996

Federal Mental Health Parity Act of 1996 requires that dollar limitations be removed from benefit plans covering more than fifty (50) employees. The law allows the replacement of dollar values with time values. The effective date of this requirement is the renewal date of benefits plan on or after January 1, 1998.

The Act applies to mental and nervous disorders and not to alcohol and substance abuse.

CONFORMITY WITH APPLICABLE LAWS

This Plan shall be deemed to automatically be amended to conform as required by any applicable Law, Regulation or Order or Judgment of a Court of competent jurisdiction governing provisions of this Plan.

MILITARY MOBILIZATION

If an ***Employee*** or an ***Employee's dependent*** is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the ***Employee*** or an ***Employee's dependent*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Right Act (USERRA).

When the leave is less than thirty-one days, the ***Employee*** or an ***Employee's dependent*** may not be required to pay more than the Employee's share, if any, applicable to that coverage. If the leave is more than thirty- one (31) days, then the Employer may require the ***Employee*** or an ***Employee's dependent*** to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the ***Employee*** fails to return to employment within the time allowed.

The ***Employee*** or an ***Employee's dependent*** coverage will be reinstated without exclusion or a waiting period.

TRADE ADJUSTMENT ASSISTANCE

If a covered person's coverage under this Plan terminates due to circumstances which would qualify that covered person for a trade adjustment assistance (TAA) under the terms of the Trade Act of 1974 (19 U.S.C. 2101 et seq.) which covers workers whose employment has been adversely affected by international trade – increased imports or a shift in production to another county, and that covered person did not elect to continue coverage under the continuation of coverage provisions of this Plan during his or her initial sixty (60) day election period as specified herein, a second sixty (60) day election period will be granted. This sixty (60) day period shall begin on the first day of the month in which the covered person is determined to be a TAA- eligible individual. However, the election to continue coverage under this provision of this Plan cannot be made more than six (6) months after the date of the TAA- related loss of coverage.

If continued coverage is elected under this provision of the Plan, such coverage shall begin on and any applicable COBRA time frames shall be measured from the first day of the second election period and not on the date of the original qualifying event. All other requirements for continue coverage under the COBRA provisions of this Plan shall apply.

Any time between the date of the original qualifying event and the first of the second election period shall NOT count toward any determination of whether the individual has experienced a break in coverage (See Effective Date of Coverage).

ATTENTION

The Board of Trustees reserves the right to amend or modify the Plan, in whole or in part, at any time, including on a retroactive basis. The authority to make any such changes to the Plan rests with the Board of Trustees. Any such amendment or modification of the Plan shall be made by a resolution adopted by the Board of Trustees.

CAUTION

The Board of Trustees of the Plan has not empowered anyone else to speak for them with regard to the Plan. No NECA representative, employer, Local 102 union official, supervisor or shop steward is in a position to discuss your rights under the Plan with authority. Only the Board of Trustees is empowered to determine your rights under the Plan.