Summary Plan Description

of the

IBEW LOCAL 728 FAMILY HEALTHCARE FUND

Effective January 1, 2020

IBEW LOCAL 728 FAMILY HEALTHCARE FUND

To All Eligible Participants:

We are pleased to present this Summary Plan Document ("SPD"), which describes the major features of the IBEW LOCAL 728 FAMILY HEALTHCARE FUND. The Plan is managed and operated by the Fund's Board of Trustees and is designed so that you can receive the most comprehensive benefits possible within the resources available to the Fund.

This booklet is an easy-to-read description of the Plan. It describes eligibility rules, benefits, claim procedures and information about the administration of the Plan. The Plan is governed by certain documents, including your Collective Bargaining Agreement or Participation Agreement, the Plan Document, the Trust Agreement, and agreements with insurance companies and other service providers. We have tried to describe the benefits here just as they are written in those documents. However, if there is any difference between the terms of this booklet and those of the governing documents, the governing documents or contract provisions will control. Capitalized terms in this SPD are used in the same manner as they are used in the Plan Document.

Please keep this booklet in a safe place for quick reference. If you have any questions about your eligibility or the benefits to which you are entitled, please contact the Plan's Third Party Administrator, National Employee Benefits Administrators (NEBA) at 1-800-822-5899.

Sincerely,

BOARD OF TRUSTEES

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IBEW LOCAL 728 FAMILY HEALTHCARE FUND

A Multiemployer Health and Welfare Benefit Plan

IMPORTANT INFORMATION

The Plan is sponsored and administered under the joint control of labor and management trustees. The Board of Trustees consists of both Union and Employer representatives, selected by the International Brotherhood of Electrical Workers (IBEW) Local 728 ("the Union") and the Employers who have entered into Collective Bargaining Agreements ("CBA") with the Union requiring contributions to the Plan for the benefit of their Employees.

The Plan is sponsored by the:

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The Plan is administered by the **BOARD OF TRUSTEES** with the assistance of the:

THIRD PARTY ADMINISTRATOR

National Employee Benefits Administrators, Inc. ("NEBA")
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, Florida 33028
1-800-822-5899

The Third Party Administrator ("NEBA") handles day to day administration for the Plan. The Board of Trustees is the Plan Administrator. You can call the Third Party Administrator with any questions relating to the Plan.

PLAN IDENTIFICATION INFORMATION

Federal Identification Number: 59-6134297

Plan Number: 501

PLAN YEAR

The Plan Year is based on the calendar year beginning on January 1st each year.

FUND COUNSEL and AGENT FOR LEGAL PROCESS

Howard Susskind, Esq.
Sugarman & Susskind, PA
100 Miracle Mile, Suite 300
Coral Gables, Florida 33134

Service of Process may also be made upon a Plan Trustee or upon the Board of Trustees, the Plan Administrator, c/o NEBA.

GENERAL PLAN DESCRIPTION

Health and Welfare Benefit Plan

The Plan is an employee benefit plan that provides medical, prescription drug, dental, loss of time, death, and accidental death or dismemberment benefits to participants as provided under the terms of the Plan and pursuant to applicable Collective Bargaining Agreements or Participation Agreements. The Plan is subject to and must comply with the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

Funding Sources for Benefits

The Plan is primarily funded by Employer contributions made as required under the terms of applicable Collective Bargaining Agreements and Participation Agreements. All contributions are held in a Trust Fund managed by the Board of Trustees as provided in the Trust Agreement. The Trust Fund's assets include all contributions and investment earnings. All benefits and expenses of the Plan, including premiums for any insurance policies obtained by the Board of Trustees as the method of providing benefits, are paid using Trust Fund assets.

Rights and Responsibilities of the Board of Trustees

The Board of Trustees has full and exclusive power and authority, in its sole discretion, to:

(a) construe and interpret the terms of the Plan,

(b) determine the status and rights of participants, beneficiaries and other persons,

(c) determine all questions of coverage and eligibility for benefits,

(d) make rulings and prescribe procedures,

(e) gather needed information,

(f) exercise all of the power and authority contemplated by ERISA with respect to the Plan,

(g) employ or appoint persons to help or advise in any administrative functions,

(h) appoint investment managers and trustees, and

(i) do all other things needed to operate, manage and administer the Plan.

Any decisions of the Board of Trustees shall be final and binding on all parties, including Employees, Dependents, beneficiaries, Employers, Unions, and all other persons involved or affected. In addition to the Board of Trustees the Plan may have other fiduciaries, advisors and service providers. The Board of Trustees may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others.

Plan Amendment and Termination

The Plan may be amended by the Trustees, in their discretion, upon majority vote of the Trustees. All amendments shall be in writing and signed by the Trustees.

The Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time:

(a) to terminate or amend either the amount or conditions with respect to any benefits even though such termination or amendment affects claims which have already been incurred;

(b) to alter or postpone the method of payment of any benefit; and

(c) to amend or rescind any other provisions of the rules and regulations contained herein.

Circumstances under which the Plan may be terminated include, but are not limited to:

(a) When there are no longer sufficient assets to continue the benefits of the Plan.

(b) When there are no longer any Employers who are required to make contributions under an applicable Collective Bargaining Agreement; or

(c) When the last surviving Covered Person entitled to receive benefits has died.

In the event of termination of the Plan, the Board of Trustees shall, within the limits of the Fund's resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining assets of the Fund be used in a manner which best carries out the basic purpose for which the Fund was established.

Right to Examine Relevant Documents

The Plan is maintained pursuant to one or more Collective Bargaining Agreements. Collective Bargaining Agreements are contracts between an Employer and a Union that require certain health care benefits for covered Employees. Copies of such agreements may be obtained by participants and beneficiaries by submitting a written request to the Plan Administrator. Copies of the agreements are also available for examination at the office of the Third Party Administrator.

A complete list of the employers and employee organizations sponsoring this Plan may be obtained by participants and beneficiaries by submitting a written request to the Third Party Administrator. The list is also available for examination by participants and beneficiaries at the office of the Third Party Administrator. Participants and beneficiaries may also receive from the Third Party Administrator, upon written request, information as to whether a particular employer or employee

organization participates in the Plan; if the employer or employee organization does participate in the Plan then contact information is also available.

You also have the right to examine documents governing the Plan at the office of the Third Party Administrator, such as insurance contracts, and you have a right to examine the Plan's annual report (Form 5500 Series) that is filed each year.

I. PERSONS ELIGIBLE FOR BENEFITS

A. JOURNEYMAN EMPLOYEES AND APPRENTICES

The following eligibility rules apply to you if you are classified as a Journeyman Employee or as an Apprentice and you work for one or more Employers that are required to contribute to the Plan on your behalf under a Collective Bargaining Agreement (CBA). **Apprentices are generally treated the same as Journeyman Employees, and references to Journeyman Employees include Apprentices unless otherwise stated.** These eligibility rules do not apply to CWCE Employees, as explained in the next section.

Available for Work

In order to maintain eligibility for benefits, you must either be working for an Employer who has entered into a Collective Bargaining Agreement which obligates the Employer to make contributions to this Fund, or be Available for Work with such an Employer, as defined in the Glossary. This condition shall not apply to any Journeyman Employee who cannot work due to illness, disability, or retirement. A Journeyman Employee shall be presumed to be unavailable for full-time work with a contributing Employer if such person is employed full-time performing work in the trade for a non-signatory employer.

Plan Contributions

Your Employer will start to make contributions to the Plan on your behalf once you start working in a job classification under a CBA that requires health plan contributions. As explained further below, once contributions have been made to the Plan on your behalf for the minimum number of required hours you will be eligible for benefits during the Benefit Month that corresponds to the Eligibility/Work Month in which the hour requirement was satisfied.

Eligibility/Work Months and Benefit Months

As a Journeyman Employee you may be eligible for Plan benefits during a "Benefit Month" based on contributions made to the Fund for your work during an "Eligibility/Work Month". The definitions of these terms are:

> ***Eligibility/Work Month:*** A period of one calendar month during which a Journeyman Employee works under the terms of the applicable collective bargaining agreement and the hours are accumulated to determine if the Journeyman Employee has met eligibility requirements for coverage in the corresponding Benefit Month.
>
> ***Benefit Month:*** A period of one calendar month during which a Journeyman Employee who has met eligibility requirements during the corresponding Eligibility/Work Month is eligible to receive benefits under the terms of the Plan.

The minimum monthly hour requirement for continued coverage is 130 hours. Contributions for at least 130 hours in an Eligibility/Work Month must be received on your behalf in order for you to be eligible for benefits during the corresponding Benefit Month. There are, however, some exceptions to this rule, described further below. The Eligibility/Work Months and Benefit Months are as follows:

CORRESPONDING ELIGIBILITY/WORK MONTHS AND BENEFIT MONTHS

Eligibility/Work Month	Benefit Month
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

Initial Eligibility

The rules for initial eligibility are slightly different from the rules for continued eligibility.

1. You will become eligible for Plan benefits on the first day of the Benefit Month that corresponds to the first Eligibility/Work Month in which contributions for at least 130 hours have been made to the Plan on your behalf.

2. You may also earn initial eligibility for coverage if contributions are made on your behalf for two consecutive months with an average of at least 100 hours per month. Initial eligibility begins on the first day of the Benefit Month that corresponds to the second month in which such contributions were made.

3. Journeyman Employees who have been ineligible for benefits for a period of six or more consecutive months are treated in the same manner as employees who have not been previously eligible for benefits. Accordingly, such an employee will also earn eligibility for coverage if contributions are made on his or her behalf for two consecutive months with an average of at least 100 hours per month. Such eligibility begins on the first day of the Benefit Month that corresponds to the second month in which such contributions were made.

Hours for Continued Eligibility

For purposes of maintaining continued eligibility, hours can be accumulated by using one or more of the following:

(a) Hours worked for which an Employer makes contributions to the Plan on your behalf;

(b) Reciprocity hours, pursuant to a reciprocal agreement approved by the Board of Trustees;

(c) Hours in your hour bank account, under applicable rules described below;

(d) Self-contributions, under applicable rules described below;

(e) Disability credits, under applicable rules described below.

Rules for Continued Eligibility

1. After you've earned initial eligibility, your coverage will continue for each subsequent Benefit Month for which at least 130 hours of contributions are made on your behalf for the corresponding Eligibility/Work Month.

2. If contributions on your behalf during an Eligibility/Work Month aren't enough to earn eligibility, and you have hours in you hour bank, hours in your hour bank account will be used to maintain continued eligibility, as described below.

3. If you have a minimum of 100 hours of paid contributions on your behalf by a contributing Employer during any Eligibility/Work Month, but not enough to earn eligibility in the corresponding Benefit Month, and you have exhausted your hour bank, then you have the option to make a self-contribution to remain eligible for benefits, as described below.

4. If you are disabled you may be eligible to receive disability credits to continue coverage, as described below.

Hour Bank

Journeyman Employees who have satisfied initial eligibility for coverage are eligible for an hour bank account. Your hour bank account can later be used to continue your coverage if you are short hours in a subsequent Eligibility/Work Month. Any hours in excess of 140 reported and paid on your behalf in an Eligibility/Work Month will be credited to your hour bank account. The maximum accumulation in an hour bank account is 780 hours.

If you have less than 130 hours reported and paid on your behalf for an Eligibility/Work Month, and you have enough hours in your hour bank account, then the Plan Administrator will deduct the necessary hours from your hour bank account so that you will be eligible for coverage in the corresponding Benefit Month.

If you have less than 130 hours reported and paid on your behalf for an Eligibility/Work Month, and you do not have sufficient hours in your hour bank to remain eligible for coverage in the corresponding Benefit Month, then you may be eligible to make a self-contribution for the difference, as described below.

If you have less than 130 hours reported and paid on your behalf for an Eligibility/Work Month; you have hours in your hour bank but they are not sufficient to remain eligible for coverage in the corresponding Benefit Month; and either you are not eligible to make a self-contribution or you choose not to make the self-contribution, then the hours in your account will not be deducted and

you will not be eligible for coverage in the corresponding Benefit Month. The remaining hours in your hour bank can subsequently be used to re-establish eligibility for benefits within 6 months from the end of the Eligibility/Work Month. Hours that are not used within this 6 month window are forfeited.

Your hour bank account is not a vested benefit. This means that they are not promised to you and you are not entitled to them. The hours in hour bank accounts may be limited, changed or removed at any time within the discretion and control of the Board of Trustees. Hour bank accounts have no monetary value.

Self-Contributions

A Journeyman Employee who has a minimum of 100 hours contributed on his behalf during an Eligibility/Work Month has the option to make a self-contribution to maintain continuing coverage during the corresponding Benefit Month. All hour bank hours must be used to maintain eligibility prior to making a self-contribution.

The self-contribution amount is the difference between the number of hours contributed to the Fund by contributing Employers on your behalf (and hour bank hours if applicable) and 130, multiplied by the applicable contribution rate.

You must remain employed by a contributing Employer, or be Available for Work with a contributing Employer, in order to make self-contributions for continued coverage. You must also be an active employee covered under the Plan at the time of the hours shortage.

Disability Credits

A disabled Journeyman Employee who was eligible for Plan benefits when his disability began shall be credited with the total number of hours required to maintain eligibility for each calendar month of proven disability, up to a maximum of 6 months in any 12 month period.

For the purpose of continued coverage for a disabled Journeyman Employee, a month of proven disability is any calendar month in which an employee can medically prove that he has been totally disabled for at least twenty consecutive days in the month.

Reinstatement

If your eligibility for benefits ends, and you continue working or return to work, your eligibility will be reinstated on the first day of the Benefit Month that corresponds to the Eligibility/Work Month during which contributions are made on your behalf for at least 130 hours. You may use remaining hours in an hour bank to re-establish eligibility only as provided above.

If you have been ineligible for benefits for a period of six or more consecutive months, then you will be treated in the same manner as employees who have not been previously eligible for benefits. Accordingly, you will also earn eligibility for coverage if contributions are made on your behalf for two consecutive months with an average of at least 100 hours per month. Such eligibility begins on the first day of the Benefit Month that corresponds to the second month in which such contributions were made.

Termination of Coverage

Your eligibility for benefits will terminate on the earliest of:

(a) the last day of the Benefit Month that corresponds to the last Eligibility/Work Month during which contributions for the required number of hours were paid to the Plan on your behalf, as described above;

(b) the date that the Plan terminates; or

(c) the date you are no longer eligible for coverage by not being Available for Work or otherwise not satisfying any required conditions for coverage.

B. CWCE EMPLOYEES

The following eligibility rules apply to you if you are employed by an Employer under the terms of the IBEW Fifth District Recovery Addendum/Agreement in the job classifications of Construction Wireman or Construction Electrician, and your Employer is obligated to make contributions to the Trust Fund on your behalf. Such employees are described in this SPD as "CWCE Employees".

Available for Work

In order to maintain eligibility for benefits, you must either be working for an Employer who is obligated to make contributions to the Trust Fund on your behalf, or be Available for Work with such an Employer, as defined in the Glossary. This condition shall not apply to any CWCE Employee who cannot work due to illness, disability, or retirement. A CWCE Employee shall be presumed to be unavailable for full-time work with a contributing Employer if such person is employed full-time performing work in the trade for a non-signatory employer.

Plan Contributions

Your Employer will start to make contributions to the Plan on your behalf once you start working in a job classification under a CBA that requires health plan contributions. As explained further below, you will become eligible for benefits once contributions have been made to the Plan on your behalf for the minimum number of required hours.

Initial Eligibility

As a CWCE Employee you will first become eligible for benefits on the first day of the of the first month following the month in which contributions for at least 500 hours have been made on your behalf under the terms of a Collective Bargaining Agreement during any 6 consecutive calendar months.

Eligibility/Work Months and Benefit Months

After you have earned initial eligibility you may be eligible for continued eligibility during a "Benefit Month" based on contributions made to the Fund for your work during an "Eligibility/Work Month". The definitions of these terms are:

> ***Eligibility/Work Month:*** A period of one calendar month during which a CWCE Employee works under the terms of the applicable collective bargaining agreement and the hours are accumulated to determine if the CWCE Employee has met eligibility requirements for coverage in the corresponding Benefit Month.

Benefit Month: A period of one calendar month during which a CWCE Employee who has met eligibility requirements during the corresponding Eligibility/Work Month is eligible to receive benefits under the terms of the Plan.

The Eligibility/Work Months and Benefit Months are as follows:

CORRESPONDING ELIGIBILITY/WORK MONTHS AND BENEFIT MONTHS

Eligibility/Work Month	**Benefit Month**
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

Continued Eligibility

The minimum monthly hour requirement for CWCE Employees to continue coverage is 135 hours. As a CWCE Employee you are eligible for continued coverage for each subsequent Benefit Month for which at least 135 hours of contributions are made on your behalf for the corresponding Eligibility/Work Month.

Hours for Continued Eligibility

For purposes of maintaining continued eligibility, hours can be accumulated by using one or more of the following:

(a) Hours worked for which an Employer makes contributions to the Plan on your behalf;

(b) Reciprocity hours, pursuant to a reciprocal agreement approved by the Board of Trustees; or

(c) Disability credits, under applicable rules described below.

Disability Credits

A disabled CWCE Employee who was eligible for Plan benefits when his disability began may receive a credit of 135 hours for each calendar month of proven disability, up to a maximum of three (3) months in any twelve (12) month period.

For the purpose of continued coverage for a disabled CWCE Employee, a month of proven disability is any calendar month in which an employee can medically prove that he has been totally disabled for at least twenty consecutive days in the month.

Reinstatement

If your eligibility for benefits ends, and you continue working or return to work, your eligibility will be reinstated on the first day of the Benefit Month that corresponds to the Eligibility/Work Month during which contributions are made on your behalf for at least 135 hours, as long as it is within six months of the date when your coverage ended.

If you have been ineligible for benefits for a period of six or more consecutive months, then you will be treated in the same manner as employees who have not been previously eligible for benefits. Accordingly, you will earn eligibility for coverage if contributions are made on your behalf for at least 500 hours under the terms of a Collective Bargaining Agreement during any six consecutive calendar months.

Termination of Coverage

Your eligibility for benefits will terminate on the earliest of:

(a) the last day of the Benefit Month that corresponds to the last Eligibility/Work Month during which contributions for the required number of hours were paid to the Plan on your behalf, as described above;

(b) the date that the Plan terminates; or

(c) the date you are no longer eligible for coverage by not being Available for Work or otherwise not satisfying any required conditions for coverage.

C. NON BARGAINING UNIT EMPLOYEES

The following eligibility rules apply to you if you are not part of a bargaining unit and are instead covered under the terms of a Participation Agreement with the Trustees.

Eligible Employers

The Board of Trustees must enter into a Participation Agreement with an Employer in order for such Employer's Non Bargaining Unit Employees to become eligible for coverage. The following rules apply:

1. An Employer must be a signatory to a Collective Bargaining Agreement requiring contributions to the Fund on behalf of its bargaining unit employees in order for the Trustees to consider whether to enter into a Participation Agreement with such Employer for coverage of Non-Bargaining Unit Employees.

2. The Union and the Florida East Coast Electrical Joint Apprenticeship & Training Trust Fund are eligible employers.

3. The Board of Trustees has discretion to decide whether to enter into a Participation Agreement with a contributing Employer for coverage of Non-Bargaining Unit Employees. Employers do not have a right to or expectation of coverage for their Non-Bargaining Unit Employees under the Plan.

4. The Board of Trustees has discretion to decide whether to enter into a Participation Agreement for coverage of Non-Bargaining Unit Employees with any Employer or with the trustees of another trust fund.

Contribution Schedule

Contributions on behalf of Non-Bargaining Unit Employees must be paid at the rate determined by the Board of Trustees and following administrative rules and procedures as determined by the Board of Trustees and administered by the Third Party Administrator, or as otherwise agreed in a Participation Agreement.

Eligibility for Coverage

If you are covered under the terms of a Participation Agreement as a Non-Bargaining Unit Employee then you are eligible for benefits on the first day of the month for which contributions are paid to the Fund pursuant to the terms of the applicable Participation Agreement. Coverage continues thereafter on a monthly basis for each month for which such contributions are timely paid.

Dependent Eligibility

Unless otherwise agreed in a Participation Agreement, as a Non-Bargaining Unit Employee you are entitled to Dependent coverage under the same rules applicable to bargaining unit employees.

Hour Bank

As a Non-Bargaining Unit Employee you are eligible for an hour bank account under the same rules that apply to Journeyman Employees, as described above. Accordingly, any hours in excess of 140 paid on your behalf in a month will be credited to your hour bank account. The maximum accumulation in your hour bank account as a Non Bargaining Unit Employee is 840 hours.

Disability

Non-Bargaining Unit Employees are eligible for disability credits under the same rules that apply to Journeyman Employees, as described above.

Termination of Eligibility for Coverage

As a Non-Bargaining Unit Employee your eligibility for coverage terminates on the earliest of:

(a) the last day of the last month for which required contributions have been timely made to the Trust Fund on your behalf;

(b) the date that your Employer's bargaining unit employees are terminated from coverage for delinquent contributions;

(c) the date that your Employer's bargaining unit employees are terminated from coverage due to the termination of the applicable Collective Bargaining Agreement;

(d) the date the applicable Participation Agreement is cancelled;

(e) the date of your death;

(f) the date that the Plan terminates or is amended so that you are no longer eligible for benefits; or

(g) the date that there are insufficient assets left in the Trust Fund to pay benefits under the Plan.

D. DEPENDENTS

Eligibility for Coverage

The following eligibility rules apply for coverage of Dependents. The definition of Dependent is in the Glossary. Dependents include your legally married spouse and your children. **You must satisfy the definition of Dependent in order to be eligible for coverage as a Dependent.**

Because benefits are provided under an insured health care benefit policy the Plan offers extended dependent coverage for young adults, as required under Florida law. As set forth in detail in the Glossary, a dependent child may be eligible for coverage from the month in which such child reaches age 26 until the end of the year in which such child reaches age 30 if certain conditions are met. A Dependent is eligible for coverage as of the first day that he/she meets the definition of Dependent *and* the Covered Employee to whom he/she is dependent is both eligible for coverage and has met any requirements for dependent coverage. A Dependent is only eligible for coverage during time periods when the Covered Employee to whom he/she is dependent is eligible for coverage, or as otherwise provided herein.

CWCE Employees may need to meet additional requirements in order to become eligible for dependent coverage, such as making employee contributions.

Local 323 Retirees have limited dependent coverage as described later in this SPD. These Dependent coverage rules do not apply to Local 323 Retirees.

Dependent Enrollment

Dependents are eligible for coverage as of the date all eligibility conditions are met, as described above. **In order to receive benefits a Covered Employee must enroll his/her Dependents by submitting enrollment information to the Third Party Administrator.**

Continued Coverage for Dependents

If you have coverage as a Dependent you remain eligible for coverage during the time periods when you meet the definition of Dependent and the Covered Employee to whom you are dependent is eligible for coverage and continues to meet eligibility conditions, or as otherwise provided herein.

Coverage for Dependents of a deceased Employee will continue to the end of the month that the deceased Employee would have remained covered, taking into account all hours due to be reported, hour bank hours and/or self-contribution payments made by the Employee as of the date of death.

If a child between the ages of 26 and 30 is enrolled for health care coverage on the basis of being a full or part time student, and the child goes on a "medically necessary leave of absence", as defined in 29 U.S.C. § 1185c ("Michelle's Law"), and loses student status, the child's coverage will not be terminated before the date that is the earlier of (1) one year after the first day of the medically necessary leave of absence or (2) the date on which coverage would otherwise terminate under the terms of this Plan.

If a Dependent child is provided health care coverage under the Plan after the child reaches age twenty-six (26), and the coverage for the child is later terminated before the end of the calendar year in which the child turns age thirty (30), the child is ineligible to be covered again for health care benefits unless the child was continuously covered, by other creditable coverage, without a coverage gap of more than sixty-three (63) days.

Termination of Eligibility for Coverage

(a) A Dependent's eligibility for coverage terminates on the earliest of:

(1) the date upon which the Covered Employee to whom an individual is dependent is no longer eligible for benefits;

(2) the end of the month in which a Dependent ceases to be a Dependent of the Covered Employee;

(3) the date specified in a Qualified Medical Child Support Order (QMSCO);

(4) the date of a Dependent's death;

(5) the date that the Plan terminates or is amended so that a Dependent is no longer eligible for benefits; or

(6) the date that there are insufficient assets left in the Fund to pay benefits under the Plan.

(b) Upon a Covered Employee's death, his or her Dependents shall continue to be eligible for coverage up to the end of the period for which said deceased employee would have been eligible for coverage.

(c) If a Dependent child is provided health care coverage under the Plan after the child reaches age twenty-six (26), and the coverage for the child is later terminated before the end of the calendar year in which the child turns age thirty (30), the child is ineligible to be covered again for health care benefits unless the child was continuously covered, by other creditable coverage, without a coverage gap of more than sixty-three (63) days.

E. GRANDFATHERED LOCAL 323 RETIREE COVERAGE

Local 323 Retirees

This Plan does not provide retiree coverage. The Board of Trustees, however, has opted to continue to provide retiree health care benefits to former participants of the IBEW Local 323 Health and Welfare Plan who retired before January 1, 1996, and who met the eligibility requirements for retiree coverage that applied as of August 31, 1995 under the former Broward County Electricians Health and Welfare Plan, referred to as "Local 323 Retirees".

The Trustees have reserved the right to change or eliminate any and all aspects of benefits provided for Local 323 Retirees. The Trustees have the authority to amend or terminate such benefits and to increase self-payments for the coverage at any time. Such changes are effective when made.

Cost of Coverage, Due Date of Payment

The Board of Trustees shall determine, from time to time, the required monthly contribution amount that persons eligible for grandfathered retiree coverage must pay in order to maintain coverage. The required contribution amount is payable 15 days prior to the month of coverage. Coverage shall automatically terminate and no reinstatement shall be allowed if payment is late.

Termination of Eligibility for Local 323 Retirees

A Local 323 Retiree's eligibility for coverage terminates on the earliest of:

(1) The date a Local 323 Retiree again becomes eligible due to hours worked in the electrical trade, or becomes associated with any business as an officer, partner, or owner;

(2) the last day of the last month for which required contributions have been timely made to the Trust Fund by or on behalf of a Local 323 Retiree;

(3) the date of a Local 323 Retiree's death;

(4) the date that the Plan terminates or is amended so that a Local 323 Retiree is no longer eligible for benefits; or

(5) the date that there are insufficient assets left in the Fund to pay benefits under the Plan.

Eligibility Rules for Dependents of Local 323 Retirees

If you are a Local 323 Retiree eligible for coverage under this section then you are eligible for limited dependent coverage, as described below:

(1) A Local 323 Retiree's spouse is eligible for coverage as a Dependent under the same conditions that apply to spouses of Journeyman Employees.

(2) A Local 323 Retiree's Dependent spouse is eligible for coverage for as long as the Retiree to whom a person is dependent remains eligible for coverage, or as further described below.

(3) A Local 323 Retiree's Dependent spouse loses eligibility for coverage on the date that such person no longer satisfies the definition of a Dependent spouse.

(4) Upon a Local 323 Retiree's death, a Local 323 Retiree's Dependent spouse is eligible for coverage through the end of the coverage period that was paid by or on behalf of the Local 323 Retiree before his death.

II. AVAILABLE BENEFITS

A. MEDICAL AND PRESCRIPTION DRUG BENEFITS

The Board of Trustees has selected **United Healthcare** to provide the medical and prescription drug benefits under the Plan through a fully insured health care policy. **United Healthcare** administers medical and prescription drug benefits and serves as the Claims Administrator. **United Healthcare** has a broad network of doctors, hospitals and pharmacies that offer covered medical and prescription drug services. You can obtain information about your **United Healthcare** provider network by visiting myuhc.com.

United Healthcare will provide you with the following information:

(a) A description or summary of the benefits.

(b) A description of any cost-sharing provisions, including deductibles, coinsurance, and co-payment amounts for which participants are responsible.

(c) Exclusions or limits on benefits, including any annual or lifetime caps.

(d) Whether, and under what circumstances, existing and new drugs are covered under the plan.

(e) Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures.

(f) The extent to which preventive services are covered.

(g) Provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services.

(h) Any conditions or limits on the selection of primary care providers or providers of specialty medical care.

(i) Any conditions or limits applicable to obtaining emergency medical care.

(j) Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the plan.

(k) The listing of providers that are part of the provider network. You have also been given a Summary of Benefits and Coverage (SBC") and a Schedule of Benefits that list your medical and prescription drug benefits along with your related payment obligations. Please look at these documents for the description of your covered benefits. **There are different benefit schedules for Journeyman Employees and their Dependents; for CWCE Employees and their Dependents; for Non-Bargaining Unit Employees and their Dependents; and for Local 323 Retirees and their eligible Dependents. Your SBC and your Schedule of Benefits are incorporated into this Summary Plan Description.**

Medical and Prescription Drug benefits are offered under the terms and conditions set forth in materials provided by United Healthcare. This summary provides important information about your Medical and Prescription Drug benefits but does not provide all relevant information. Please consult materials provided by United Healthcare for the full description of your benefits.

ID Cards

You have also been issued a **United Healthcare** ID card. Please present your ID card when you obtain health care services. You can contact **United Healthcare** by using the phone number on the back of your ID card. You may also contact **United Healthcare** by visiting myuhc.com.

Network Benefits

United Healthcare offers a large network of providers. **Your plan does not provide out of network benefits (with limited exceptions).** Please be sure to check to make sure that you are going to Network providers before you schedule your health care services. When you receive services from an In-Network Provider, remind your provider to utilize in-network providers for x-rays, lab tests and other services to ensure the cost may be considered at the in-network level. You can obtain information about your **United Healthcare** provider network by visiting myuhc.com.

Selection of a Primary Care Provider

You must select a Primary Care Provider (PCP) under the **United Healthcare** policy. A Primary Care Provider serves an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. Please select a Primary Care Provider for yourself and your Dependents from the list provided by **United Healthcare**. You have the right to designate any Primary Care Provider who participates in the network and who is available to accept you or your family members. The Primary Care Provider you select for yourself may be different from the Primary Care Provider you select for each of your Dependents. For children, you may designate a pediatrician as the Primary Care Provider. For information on how to select a Primary Care

Provider, and for a list of the participating primary care providers, visit myuhc.com or contact customer service at the phone number listed on the back of your ID card.

Your Cost Sharing Obligations

Your SBC and your Schedule of Benefits lists what you have to pay for covered services. Some services require a co-pay amount, and some services are subject to your deductible and co-insurance. Your SBC and Schedule of Benefits explain in detail how much you will have to pay for different types of services. Deductibles, co-payments, and maximum amounts are applied separately for each Covered Person unless otherwise specified.

When you obtain health care from the doctors, hospitals, pharmacies and other providers in the Plan's Network they will submit claims to **United Healthcare** on your behalf. You may be required to pay your required share of the cost at the time that you receive services.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan. Coinsurance typically applies after any applicable Deductible has been satisfied.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the applicable Schedule of Benefits has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

Benefits Payable

Benefits are payable under the conditions listed in the applicable Schedule of Benefits and SBC, including your cost sharing obligations. You may be required to satisfy other conditions as well, such as pre-certification requirements. The total amount payable will not exceed any applicable Maximum Benefit set forth in the Schedules of Benefits.

Date of Charges Incurred

Covered Medical Charges are considered to be incurred on the date a Covered Person receives the services or supplies for which the charge is made.

Covered Medical and Prescription Drug Expenses

Covered Medical and Prescription Drug Expenses are expenses incurred by or on behalf of a Covered Person for medical or prescription drug charges on an applicable Schedule of Benefits. Covered charges include only charges and fees for services and supplies that: (a) are not excluded by other provisions of this Plan; (b) are Medically Necessary for the care and treatment of an Injury or Sickness; (c) are recommended by an attending Physician; and (d) are subject to the provisions and limits described in the applicable Schedule of Benefits or SBC.

Prescription Drug Lists and Tiers

United Healthcare may establish preferred drug lists, and prescription drug benefits may be limited to drugs on preferred drug lists. Pharmacies in **United Healthcare**'s network will use **United Healthcare**'s preferred drug lists.

Prescription drugs are provided under different tiers, and your cost sharing obligations will be different depending on the tier. Your benefits may vary depending on which of the prescription drug list tiers the prescription drug product is listed, or the pharmacy that provides the prescription drug product.

Exclusions and Limitations

Medical and prescription drug benefits are subject to certain exclusions and limitations, as set forth in the materials prepared by **United Healthcare**, including your Schedule of Benefits and SBC. .

Benefits Required under Federal Law

Covered medical benefits will always include all benefits required to be provided under ERISA, the Affordable Care Act, and any other applicable federal law, including the following:

Hospital Length of Stay after Childbirth

This Plan provides maternity benefits in compliance with Federal law. 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 caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). The hospital length of stay begins at the time of delivery of the newborn if delivery occurs in the hospital or at the time of admission to the hospital if delivery occurs outside a hospital.

Reconstructive Surgery after Mastectomy

As required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) this Plan provides coverage to any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, for: (a) All stages of reconstruction of the breast on which the mastectomy was performed; (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) Prostheses; and (d) Treatment of physical complications of mastectomy, including lymphedema. Coverage will be provided in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and Co-Insurance provisions as set forth herein, and as are consistent with those established for other benefits provided hereunder.

Parity for Mental Health and Substance Use Disorder Benefits

This Plan provides mental health benefits in compliance with Federal law. The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") requires that any group health plan that includes mental health and substance use disorder benefits along with standard medical and

surgical coverage must treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review. Your Plan is designed to comply with the requirements of this federal law.

Affordable Care Act Benefits

This Plan provides benefits in compliance with the Affordable Care Act ("ACA").

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in **United Healthcare**'s network who specializes in obstetrics or gynecology. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit myuhc.com or contact customer service at the phone number listed on the back of your ID card.

B. DENTAL BENEFITS

The Board of Trustees has selected **United Healthcare** to provide dental benefits under the Plan through a fully insured dental policy. **United Healthcare** administers dental benefits and serves as the Claims Administrator.

Dental benefits are not offered to all Covered Employees. CWCE Employees and their Dependents are not eligible for dental benefits.

Network of Participating Dentists **United Healthcare** has a broad network of participating dentists that offer covered services. While you can obtain services from both in and out of network providers, using network providers typically results in receiving greater value. You can obtain information about your **United Healthcare** provider network by visiting myuhc.com.

Dental benefits are offered under the terms and conditions set forth in materials provided by United Healthcare. You have been given a Schedule of Benefits that list your dental benefits along with your related payment obligations. Please look at these documents for the description of your covered benefits. Your Schedule of Benefits is an important part of this document and is incorporated into this Summary Plan Description.

United Healthcare will provide the following information:

(a) A description or summary of the benefits.

(b) A description of any cost-sharing provisions, including deductibles, coinsurance, and co-payment amounts for which participants are responsible.

(c) Exclusions or limits on benefits, including any annual or lifetime caps.

(d) Whether, and under what circumstances, existing and new drugs are covered under the plan.

(e) Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures.

(f) The extent to which preventive services are covered.

(g) Provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services.

(h) Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the plan.

(i) The listing of providers that are part of the provider network.

Benefits Payable and Cost Sharing Obligations

Benefits are payable under the conditions listed in the applicable Schedule of Benefits, including your cost sharing obligations. As noted in your Schedule of Benefits, dental benefits are subject to an annual maximum benefit, and vary according to the type of service received. You may be required to satisfy other conditions as well, such as pre-certification requirements. The total amount payable will not exceed any applicable Maximum Benefit set forth in the Schedules of Benefits.

C. LOSS OF TIME (DISABILITY) BENEFITS

The Plan offers Loss of Time benefits, paid from Fund assets, when participants become disabled, as described below. Loss of Time benefits are also referred to as Disability benefits. NEBA serves as the Claims Administrator for Loss of Time benefits. Journeymen Employees and Non-Bargaining Unit Employees eligible for Plan benefits are eligible for Loss of Time benefits. CWCE Employees, Local 323 Retirees, and Dependents are not eligible for this benefit.

Benefits Payable

Loss of Time benefits are payable to a Covered Employee if he becomes totally disabled while covered under the Plan, and subject to the conditions described herein.

Loss of Time benefits are listed on the applicable Schedule of Benefits.

An employee will be considered to be totally disabled if, as a result of non-occupational accidental bodily Injury or Illness, an employee is completely prevented from engaging in any occupation for which such employee is reasonably qualified by education, training or experience, and the employee is under the direct care of a physician.

An employee will not be eligible for Loss of Time benefits if he becomes disabled while he is making COBRA self-payments for Continuation Coverage.

Covered Loss of Time Benefits

(a) Benefit Amount: A Covered Employee is entitled to the weekly benefit amount indicated in the applicable Schedule of Benefits for disability due to a non-occupational Injury or Illness that renders a Covered Employee totally disabled.

(b) Required Physician Care: A Covered Employee must be under the regular care and attendance of a physician in order to receive and continue to receive weekly benefits.

(c) Start Date: The benefit will be paid beginning on the first day of disability due to an accidental Injury, and on the eighth day of disability due to Illness. Disabilities due to pregnancy-related conditions are treated as disabilities due to Illness. A disability will not be considered to have begun until the first day that the employee is actually examined or treated by a physician.

(d) Maximum Benefits: Loss of time benefits are payable for up to 13 weeks as long as a Covered Employee remains totally disabled. Loss of Time benefits are not available for more than 13 weeks for any one period of disability.

(e) Periods of Disability: Benefits will be paid for each separate and distinct period of continuous disability. Successive periods of disability due to injuries received in the same accident will be considered one period of disability. Two or more periods of disability due to the same or related causes are considered as one, unless between periods of disability a Covered Employee has returned to active full-time work or has become Available for Work, unless a subsequent disability is due to a cause or causes entirely unrelated to a previous disability.

(f) Prorated Benefits: If a Covered Employee is disabled for a part of a week, then he will receive one-seventh of his weekly benefit for each day of disability.

(g) Deductions: The Plan Administrator may deduct any taxes that are required by law and will pay the employer's portion of FICA taxes due on the subject amount.

Exclusions and Limitations:

(a) Loss of Time Benefits will not be payable for any period of disability that occurs:

1) prior to a Covered Employee seeking the services of a Physician;
2) while a Covered Employee is not under the direct care of a Physician;
3) prior to when a Covered Employee becomes eligible for Plan benefits;
4) after a Covered Employee is no longer eligible for Plan benefits; or
5) while an Employee is making COBRA self-payments for continuation coverage.

(b) Loss of Time Benefits will not be payable for any period of disability resulting from:

1) Sickness or Injury sustained while performing any act or duty pertaining to any occupation or employment for wages, remuneration for profit, or for which the employee is or may been entitled to receive benefits in whole or in part under any Workers' Compensation law, Occupational Diseases law or similar law; or
2) Self-inflicted injury.

Submitting a Claim

You must submit a claim to NEBA to obtain your Loss of Time benefits. Please contact NEBA at 1-800-822-5899 to obtain a copy of the required form to submit your claim. You must send your completed claim form to the claims address listed on the claim form.

Claims for benefits must be submitted within one year of the date that forms the basis for a claim.

D. DEATH AND ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

The Plan offers Death and Accidental Death or Dismemberment benefits, as described below. NEBA administers these benefits and serves as the Claims Administrator.

Journeymen Employees, CWCE Employees, and Non-Bargaining Unit Employees eligible for Plan benefits are eligible for Death benefits. Local 323 Retirees and all Dependents are not eligible for this benefit.

Your Schedule of Benefits describes available Death and Accidental Death or Dismemberment benefits and limits on the amount of such benefits. Your Schedule of Benefits is important and is attached to and incorporated into this Summary Plan Description.

Death benefits are payable to your designated Beneficiaries or as otherwise explained below.

Death Benefit Payable

The Death Benefit amount provided in the Schedule of Benefits shall be payable in the event of your death from any cause that occurs at any time while you are covered under the Plan, or within 31 days after your coverage terminates. Such amount shall be payable in a single lump sum to your designated Beneficiary or other appropriate recipient as provided below. The Death Benefit shall be payable only if written notice of death and proof of claim is received by the Board of Trustees. The Death Benefit is not assignable.

Accidental Death or Dismemberment Benefits Payable

An Accidental Death or Dismemberment benefit is payable for losses described below resulting from injuries sustained in an accident that occurred while you are eligible for benefits under the Plan. The loss must occur within 90 days of an accidental injury that occurs while you are eligible for AD&D benefits and must result solely from that injury.

The Accidental Death or Dismemberment benefit is a one-time payment in the amount set forth in the applicable Schedule of Benefits that is in effect on the date of your loss. The amount payable for all losses resulting from injuries sustained in any one accident cannot exceed this full amount. The Accidental Death benefit is in addition to any Death Benefit that may be payable. The Accidental Dismemberment benefit shall be payable to the Covered Employee. The Accidental Death benefit shall be payable to the Covered Employee's designated beneficiaries or other appropriate recipient as described below. The Accidental Death or Dismemberment Benefit shall be payable only if written notice and proof of claim is received by the Board of Trustees. This benefit may not be assigned.

Accidental Death or Dismemberment benefit is payable as follows:

For loss of:	*Amount Payable:*
Life	Full Amount in the Schedule of Benefits
One Hand and One Foot; One Hand and Sight of One Eye; One Foot and Sight of One Eye	Full Amount in the Schedule of Benefits
One Hand; One Foot; Sight of One Eye	One Half of Amount in the Schedule of Benefits

Loss of hand or foot means actual severance through or above the wrist or ankle joint. Loss of sight of an eye means the entire and irrecoverable loss of sight of such eye.

No Accidental Death or Dismemberment Benefit shall be payable if the Covered Employee's loss shall directly or wholly result from:

(1) intentionally self-inflicted injury;

(2) ptomaine or bacterial infections (except pyogenic infections occurring simultaneously with and in consequence of bodily injury for which accidental death or dismemberment benefits are payable);

(3) treatment or diagnosis of sickness or injury;

(4) the commission of or an attempt to commit an assault or felony;

(5) war, whether declared or undeclared, or insurrection;

(6) travel or flight as a pilot, crew member, or student pilot in any kind of aircraft; or

(7) travel, other than as a passenger, in any aircraft of a military, naval or air force;

(8) the use of illegal drugs, including but not limited to hallucinogens, heroin or other narcotics, amphetamines or other stimulants, barbiturates or other sedatives, meprobamate or other tranquilizers, except as prescribed by a doctor;

(9) acute ethanol intoxication.

Plan Beneficiaries

Death and Accidental Death Benefits are payable to the beneficiaries whom you have designated under the Plan. If you have not named a beneficiary with respect to these benefits, or if a named beneficiary is not living, the benefits will be paid as described below.

Designating Beneficiaries

NEBA has established rules, procedures, and forms for designating beneficiaries. NEBA, the Fund, and the Board of Trustees will rely on a beneficiary designation form submitted to and accepted by NEBA in paying Death and Accidental Death benefits. Payment to a designated beneficiary will release the Plan from all further liability to the extent of the payment made.

Designating Multiple Beneficiaries

You may designate more than one beneficiary and indicate how the benefit is to be shared among designated beneficiaries. If you designate more than one beneficiary but do not indicate how the benefit is to be shared, the benefit will be shared by designated beneficiaries equally. If your designated beneficiary is deceased at the time benefits would have been payable, the benefit that would have been paid to such deceased beneficiary will instead be payable equally to remaining designated beneficiaries, unless other instructions are provided.

Changing Beneficiaries

You may name a new beneficiary at any time by filing a written and signed request on a form satisfactory to the Board of Trustees. Beneficiary change forms can be obtained from NEBA and must be submitted to NEBA under NEBA's rules and procedures. A named beneficiary's consent is not required to change or add a person as a beneficiary.

Your request to change a beneficiary designation is effective upon receipt by NEBA as of the date the request was signed. NEBA, the Fund, and the Board of Trustees will rely on a beneficiary designation form submitted to and accepted by NEBA in making benefit payments. NEBA, the Fund, and the Board of Trustees will not be required to reverse or otherwise take any further action in connections with any payments made or any action taken or permitted by the Plan before receipt

of a request to change beneficiaries, regardless of the date on such change request form. A request to change beneficiaries submitted after a payment has already been made will not be effective as to such previously administered and paid benefits.

Lack of Designated Beneficiaries

If you failed to name a beneficiary prior to death with respect to any part of the payable benefit, or if a designated beneficiary is not living at the time of your death or cannot be located, the benefits shall be paid, in the discretion of the Board of Trustees, to any one of the following surviving relatives:

(1) spouse,
(2) child(ren) in equal shares,
(3) mother and/or father, in equal shares,
(4) sister(s) and/or brother(s), in equal shares, or
(5) the executors or administrators of the deceased's estate.

Payment to anyone described above will release the Plan from all further liability to the extent of the payment made.

Minor or Incompetent Beneficiaries

If, at the time of your death, a beneficiary is a minor, or, in the opinion of the Trustees, is incapable of giving valid receipt for any payment due, and if no request for payment has been made by a duly appointed guardian or committee of the beneficiary, the Board of Trustees may, at its option, make payment to any person or institution appearing to the Board of Trustees to have assumed the custody of and/or the principal support of the minor or incompetent beneficiary. Any such payment will release the Plan from all further liability to the extent of the payment made.

Equitable Beneficiaries

The Board of Trustees may, at its option, pay up to $3,000.00 of the Death Benefit to any person it determines to be equitably entitled to receive the payment by reason of having incurred funeral or other expenses incident to a deceased Covered Employee's last illness or death. Such payment shall be considered proper payment of the Death Benefit to the extent paid and your designated beneficiaries shall be entitled to receive only the remainder, if any, of the Death Benefit.

Submitting a Claim

You must submit a claim to NEBA to obtain Death and Accidental Death or Dismemberment benefits. Please contact NEBA at 1-800-822-5899 to obtain a copy of the required form to submit your claim. You must send your completed claim form to the claims address listed on the claim form. The Death Benefit shall be payable only if written notice of death and proof of claim is received by the Board of Trustees.

Claims for benefits must be submitted within one year of the date that forms the basis for a claim.

III. HEALTH REIMBURSEMENT ARRANGEMENT: (HRA Accounts)

The Board of Trustees has established a Health Reimbursement Arrangement (HRA) to allow Journeyman Employees and Non-Bargaining Unit Employees to obtain reimbursement, on a tax favored basis, of qualified medical expenses not otherwise covered under the Plan. CWCE Employees and Local 323 Retirees are not eligible for this benefit.

Under the Affordable Care Act (ACA) an HRA must be "integrated" with a health care benefit plan that complies with the ACA in order to preserve favorable tax treatment. This HRA is integrated with the health benefits offered under this Family Healthcare Plan.

United Healthcare is the designated Claims Administrator for HRA benefits. Please contact **United Healthcare** at the number on the back of your ID card for information on how to obtain HRA reimbursement benefits.

Eligibility and Establishment of HRA Accounts

Each Journeyman Employee and Non-Bargaining Unit Employee who is eligible for and enrolled for coverage in the Family Healthcare Plan is eligible for an HRA account. HRA accounts are automatically established as each eligible employee first becomes eligible and enrolled for coverage under the Family Healthcare Plan.

Credits to HRA Accounts

HRA accounts are credited using the rules set forth below for Journeyman Employees and for Non-Bargaining Unit Employees.

Journeyman Employees

HRA accounts for Journeyman Employees are credited based on the number of hours each Journeyman Employee works in covered employment. There are different rules for calculating amounts to be credited based on work performed by employees outside of IBEW Local 728's jurisdiction.

a) A Journeyman Employee's HRA account will be credited with an opening balance as of the date his account is established. The opening balance will be calculated by multiplying .10¢ by the total number of hours the employee worked in covered employment within IBEW Local 728's jurisdiction from September 1, 2013 through the last day of the month before the month in which the HRA account is established.

b) A Journeyman Employee's HRA account will be subsequently credited each month in which an employee is eligible and enrolled for coverage under the Family Healthcare Plan. The amount to be credited will be calculated by multiplying .10¢ by the total number of hours the employee worked in covered employment within IBEW Local 728's jurisdiction since the date that the employee's account was last credited.

c) A Journeyman Employee's HRA account will be credited based on work performed outside of IBEW Local 728's jurisdiction as follows:

    i. If the reciprocal amount paid to the Plan is equal to or higher than the contribution amount required to be paid to the Plan for work performed within IBEW Local 728's

jurisdiction: the amount to be credited will be calculated by first multiplying .10¢ by the total number of hours the employee worked in covered employment outside IBEW Local 728's jurisdiction;

ii. If the reciprocal amount paid to the Plan is higher than the contribution amount required to be paid to the Plan for work performed within IBEW Local 728's jurisdiction: the amount to be credited will also include the difference between the reciprocal amount paid and the amount required to be paid to the Plan for work performed within IBEW Local 728's jurisdiction;

iii. If the reciprocal amount paid to the Plan is lower than the contribution amount required to be paid to the Plan for work performed within IBEW Local 728's jurisdiction: there will be no credit to the employee's HRA account based on such work hours.

iv. If a Journeyman Employee performed work outside of IBEW Local 728's jurisdiction between September 1, 2013 and January 1, 2015: the amount to be credited to his account when it is first established will be calculated using these rules.

d) A Journeyman Employee's HRA account will only be credited in a month in which the employee is eligible for and enrolled for coverage under the Family Healthcare Plan.

e) There is no maximum amount that can be credited to a Journeyman Employee's HRA account.

Non-Bargaining Unit Employees

HRA accounts for Non-Bargaining Unit Employee are credited based on the terms of applicable Participation Agreements.

a) A Non-Bargaining Unit Employee's HRA account will be credited with an opening balance as of the date his account is established. Each Participation Agreement sets forth the terms on which an employer agrees to pay on behalf of covered Non-Bargaining Unit Employees for coverage under the Plan. The opening balance will be calculated by multiplying .10¢ by the total number of work hours paid to the Plan on behalf of each Non-Bargaining Unit Employee from September 1, 2013 through the last day of the month before the month in which the HRA account is established.

b) A Non-Bargaining Unit Employee's HRA account will be subsequently credited each month in which such Employee is eligible and enrolled for coverage under the Family Healthcare Plan. The amount to be credited will be calculated by multiplying .10¢ by the total number of work hours paid on behalf of each Employee under the terms of applicable Participation Agreements since the date that such Employee's account was last credited.

c) A Non-Bargaining Unit Employee's HRA account will only be credited in a month in which such Employee is eligible for and enrolled for coverage under the Family Healthcare Plan.

d) There is no maximum amount that can be credited to a Non-Bargaining Unit Employee's HRA account.

Eligibility for HRA Benefits

a) Eligibility for HRA Benefits: An employee is eligible for HRA benefits as long as there is a balance in his HRA account. Employees may obtain reimbursement of qualified medical

expenses, up to the balance in an HRA account, incurred by an employee, his spouse or his dependent children who are also eligible for and enrolled for coverage under the Family Healthcare Plan.

b) Continued Eligibility for HRA Benefits: An employee's HRA account balance carries forward year to year and such employee remains eligible for HRA benefits as long as there are amounts remaining in the HRA account to reimburse qualified medical expenses, subject to loss of HRA eligibility rules set forth below.

c) Regaining Eligibility for HRA Benefits: An employee who loses eligibility for HRA benefits may regain eligibility as follows:

   i. If an employee loses eligibility because his HRA account is reduced to zero, he will regain eligibility if amounts are subsequently credited to his account as described above.

   ii. If a Journeyman Employee loses HRA eligibility because he lost eligibility for coverage under the Family Healthcare Plan because he was not Available for Work, he will regain eligibility if he subsequently regains eligibility for coverage under the Family Healthcare Plan and amounts are credited to his account as described above.

   iii. If an employee elects to opt-out of eligibility for HRA benefits the employee will not be able to re-establish eligibility for HRA benefits.

HRA Benefits

Employees with balances in HRA accounts may obtain reimbursement of qualified medical expenses, up to the balance in an employee's HRA account, incurred by an employee, his spouse, or his dependent children who are also eligible for and enrolled for coverage under the Family Healthcare Plan.

The Board of Trustees has selected **United Healthcare** to facilitate the administration and delivery of HRA benefits. **United Healthcare** serves as the Claims Administrator for HRA benefit claims. Please contact **United Healthcare** using the phone number on the back of your ID card to obtain information on how to submit claims for HRA benefits.

United Healthcare is responsible for giving you the following information about your benefits:

- A description or summary of qualified medical expenses that may be reimbursed through an employee's HRA account.
- A description or summary of excluded medical expenses that may not be reimbursed through an employee's HRA account.
- Rules and procedures for submitting claims for reimbursement from an employee's HRA account and for appealing denials of claims.

All documents provided by **United Healthcare** are incorporated herein by reference.

Loss of Eligibility for HRA Benefits

Employees may lose eligibility for HRA benefits under the following circumstances:

a) The balance in an employee's HRA account is reduced to zero.

b) A Journeyman Employee loses eligibility for coverage under the Family Healthcare Plan because the employee is not Available for Work.

c) A retiree goes back to work in covered employment for an employer that is not obligated to make contributions to the Plan on behalf of covered employees, or is outside IBEW Local 728's jurisdiction and is not covered by a Reciprocal Agreement, as described in the definition of Available for Work.

d) No contributions have been made to an employee's HRA account during a period of three consecutive calendar years.

e) An employee elects to opt-out of eligibility for HRA benefits.

f) Upon an employee's death if the employee does not have eligible dependents.

Upon loss of eligibility for HRA benefits an employee's HRA account balance will be reduced to zero; any amounts remaining in an employee's HRA account are no longer available to reimburse medical expenses and are forfeited.

Accounts Not Vested; No Property Interest

Amounts credited to HRA accounts are not vested. Amounts credited to an employee's HRA account represent the total amount that an employee may request as reimbursement for qualified medical expenses under the rules established for the HRA. There is no direct monetary value, and the account is not the property of the employee on whose behalf it is established. Employees do not have a right to payment of amounts in an HRA account other than for reimbursement of qualified medical expenses. The Trustees retain the right to alter or amend HRA rules and procedures at any time and for any reason.

Death of Employee

If an employee has a balance in his HRA account at the time of his death, his eligible spouse or dependent children will be eligible to continue to receive reimbursement of qualified medical expenses up to the amount remaining in the deceased employee's HRA account.

COBRA Continuation Coverage

Benefits under an HRA are subject to COBRA continuation coverage rights if a Qualified Beneficiary loses eligibility for HRA benefits due to a Qualifying Event as described below.

Opting Out of Eligibility for HRA Benefits

Under the ACA employees eligible for HRA benefits must be permitted to permanently opt out of and waive eligibility for future reimbursements from the HRA annually and upon termination of employment.

An employee who elects to opt-out of eligibility for HRA benefits forfeits rights to reimbursement claims based on any amounts remaining in his HRA account and will not be permitted to re-establish eligibility to participate in the HRA based on subsequent employment.

IV. FEDERAL LAW RIGHTS FOR ENROLLMENT AND COVERAGE

A. Special Enrollment Rights under HIPAA

"Special Enrollment" rights are sometimes allowed under Federal law (HIPAA) to allow employees or dependents to enroll outside of the open enrollment period or after initial eligibility. This section describes when you may have special enrollment rights.

New Dependents: If you enroll in the Plan at the time you are first eligible and you remain eligible for coverage you can enroll a new dependent as a result of marriage, birth, adoption, placement for adoption, or legal guardianship by submitting a request for enrollment within 31 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

Limited "Special Enrollment" rights are also allowed under Federal law (HIPAA) if you decline or waive enrollment in the Plan and do not have other health insurance. Under these special enrollment rights you may request enrollment for yourself and/or your dependents outside of open enrollment if:

- You have a new dependent as a result of marriage, birth, adoption, placement for adoption, or legal guardianship and
- You request enrollment within 31 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

Loss of Other Coverage: If you decline or waive enrollment in the Plan because you have other health insurance coverage, you may be allowed "special enrollment" rights in the future if:

- You are covered under another group health plan or health insurance program at the time you waive coverage under the Plan;
- You lose eligibility for the health care coverage you had at the time of waiver, or the employer sponsoring the other coverage stops contributing towards such other coverage; and
- You make application for enrollment in the Plan within 30 days after your other coverage ends.

Loss of Medicaid or State Child Health Insurance Program: There are special rules for employees and dependents of employees who are eligible for Medicaid or a State Child Health Insurance Program. If an employee (or eligible dependent of such employee) experiences a loss of eligibility for Medicaid or a State Child Health Insurance Program, they have a Special Enrollment right to request enrollment in the Plan provided a request for enrollment is made within 60 days after the loss of eligibility.

Premium Assistance: If an employee (or eligible dependent of such employee) is determined to be eligible for premium assistance by Medicaid or a State Child Health Insurance Program (including under any waiver or demonstration project conducted under or in relation to such a program), such person has a Special Enrollment right to request enrollment in the Plan provided a request for enrollment is made within 60 days of the determination of assistance.

Employees who enroll in the Plan under these special circumstances will be offered the same benefit packages and payment options as those offered to similarly situated employees who enroll when first eligible.

B. Qualified Medical Child Support Orders (QMCSO)

Federal law requires that this Plan extend health care coverage directly to the children of a parent-employee who is divorced, separated, or never married when ordered to do so by state authorities. Generally, a State court or agency may require an ERISA-covered health plan to provide health benefits coverage to children by issuing a medical child support order. The group health plan must determine whether the medical child support order is "Qualified." Such an order is referred to as a Qualified Medical Child Support Order (QMCSO). Any judgment, decree, or order that is issued by a court of competent jurisdiction or an administrative agency authorized to issue child support orders under State law (such as a State child support enforcement agency) that provides for medical support of a child is a medical child support order. In addition, a State child support enforcement agency may obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified. A medical child support order must contain the following information in order to be Qualified:

- The name and last known mailing address of the participant and each alternate recipient. The order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined) ; and
- The period to which the order applies.

All requests for enrollment and/or claims for benefits pursuant to a medical child support order shall be submitted, in writing, to the Third Party Administrator along with a copy of the medical child support order. The Third Party Administrator can be reached at: National Employee Benefits Administrators, Inc., 2010 N.W. 150th Avenue, Suite 100, Pembroke Pines, Florida 33028, 1-800-822-5899.

Upon receipt of a medical child support order the Third Party Administrator shall notify the Employee and each Alternate Recipient named in the order that the medical child support order was received and shall provide each with a written copy of the procedures for determining whether the order is Qualified. Notices shall be sent to the addresses shown in the medical child support order. Alternate Recipients may designate an attorney or other representative to receive copies of notices and communications sent to them relating to a medical child support order by submitting a written and signed authorization to the Third Party Administrator.

The Board of Trustees shall consult with legal counsel and shall determine whether an order is a Qualified Medical Child Support Order no later than the date of the Board of Trustees' meeting that immediately follows the Plan's receipt of the medical child support order, unless it is submitted within 30 days preceding the date of such meeting. If a medical child support order is submitted less than 30 days before the next meeting, the Board of Trustees shall determine whether it is a QMCSO no later than the date of the second meeting following the Plan's receipt of the order. If special circumstances require a further extension of time, the Board of Trustees shall make the determination not later than the date of the third meeting following the Plan's receipt of the order.

The Trustees will provide notice of their decision to the Employee and to the Alternate Recipient as soon as possible, but not later than 5 days after the determination is made. The Trustees will notify the Employee and each Alternate Recipient of a denial of benefits based on a determination that a medical child support order is not qualified following the procedures established under this

Plan for notification of benefit claim denials. The decision can be appealed by filing a notice of appeal within sixty (60) days after receipt of the Trustees' decision.

If the Third Party Administrator receives an appropriately completed National Medical Support Notice that meets the requirements for a QMCSO set forth above, the Notice shall be deemed to be a QMCSO.

Pending a decision by the Board of Trustees as to whether a medical child support order is a QMCSO any amount which would be payable for benefits on behalf of such Alternate Recipient may be withheld.

C. Continuation Coverage under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Covered Employees and/or their Dependents may be entitled to temporarily extend their coverage under this Plan by electing COBRA continuation coverage after their eligibility for coverage under the Plan has terminated.

The following sets forth important information about your right to COBRA continuation coverage. It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

What is COBRA Continuation Coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

A dependent child will become a qualified beneficiary if he/she loses coverage under the Plan because any of the following qualifying events happens:

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

An employer filing a proceeding in bankruptcy under title 11 of the United States Code can also be a qualifying event for retired employees with Plan coverage. If a proceeding in bankruptcy is filed with respect to a participating employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary as a result of the bankruptcy, if the bankruptcy results in loss of coverage under the Plan. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if the employer's bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

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

- The end of employment or reduction of hours of employment;
- The commencement of bankruptcy proceedings;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, a dependent child's losing eligibility for coverage as a dependent child, or the occurrence of an event that qualifies as a Second Qualifying Event that entitles you to an extension of your COBRA coverage), you must notify the Third Party Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Third Party Administrator at:

National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, Florida 33028
1-800-822-5899

How is COBRA Coverage Provided?

Once the Third Party Administrator receives notice that a qualifying event has occurred, the TPA will notify you or your Dependent of the right to elect continuation coverage. The Third Party Administrator will also tell you how much such coverage will cost, and will provide an election form and instructions for electing the coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. To elect continuation coverage, you or your Dependent must complete the election form and timely submit it to the Third Party Administrator.

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

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

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Third Party Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

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

Paying for COBRA continuation coverage

A person who elects continuation coverage must pay the required premium in order to remain covered. The COBRA notice will provide all necessary information regarding the premium and required due dates for payment. The Board of Trustees annually determines the monthly premium amount due for COBRA continuation coverage. It cannot be more than 102% of the cost of coverage provided to similarly situated Participants and Dependents unless a higher charge is permitted by law.

When does COBRA Coverage End?

COBRA coverage ends on the first to occur of the following:

- The end of the maximum continuation period;
- The date on which all coverage offered by the Plan terminates;
- The date on which you or your Dependent becomes covered by another group health plan provided this occurs on a date after COBRA continuation coverage is elected;
- The date you or your Dependent become entitled to Medicare coverage, provided this occurs on a date after COBRA continuation coverage is elected; or
- The last day of the month preceding the month for which the COBRA premium was not timely.

Are there other coverage options besides COBRA Continuation Coverage?

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Third Party Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Third Party Administrator.

Plan Contact Information

IBEW Local 728 Family Healthcare Plan
c/o National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, Florida 33028
1-800-822-5899

D. Continuation Coverage under USERRA

The right to continuation coverage when you leave work to perform military service is provided under a federal law called the Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"). If you leave your employment to perform services in the uniformed services you may elect to continue coverage under the Plan for yourself and your dependents up to a maximum period of time that is the lesser of:

(a) the 24-month period beginning on the date on which the absence for the purpose of performing military service begins; or

(b) the period beginning on the date upon which the absence for the purpose of performing military service begins and ending on the day after the date on which the Covered Employee fails to apply for or return to a position of employment, as defined in USERRA.

If your service in the uniformed services continues for fewer than 31 days you will not be required to pay more than any regular employee share for continuing health plan coverage.

If your service in the uniformed services continues for more than 31 days and you elect continuation coverage you may be required to pay no more than 102 percent of the full premium under the Plan, representing the employer's share plus the employee's share plus 2% for administrative costs.

If you enter military service lasting more than 31 days; your eligibility is based on your reserve account; you elect continuation coverage; and you have a positive balance in your reserve account at the time you leave employment, you may either:

(a) use your reserve account balance instead of paying for continuation coverage, with the opportunity to continue coverage by paying no more than 102% of the full premium under the Plan if your reserve account balance is depleted; or

(b) pay for continuation coverage as provided above in order to maintain your reserve account balance intact as of the beginning date of your military service.

If you leave employment for military service without giving advance notice or with notice but without electing continuation coverage then your coverage may be terminated under the terms of the Plan. Depending on the circumstances you may be eligible for retroactive reinstatement of coverage. You may also lose coverage if you fail to make required payments.

If your coverage is terminated as a result of your service in the uniformed services your coverage under the Plan will be re-instated immediately upon re-employment after military service. You will not be subject to any exclusions or waiting periods if exclusions or waiting periods would not have been imposed if your coverage had not been terminated as a result of military service, unless you have an injury or illness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

If your eligibility for coverage is based on maintaining required numbers of hours or weeks in a reserve account your coverage will be re-instated immediately, even if you do not have sufficient hours or weeks in your reserve account to establish coverage. The Plan may require that you pay the cost of coverage until the time that your reserve account contains sufficient hours or weeks to sustain coverage.

E. FMLA Authorized Leave

Employees receiving benefits under this Plan may be eligible to take Authorized Leave under the Family and Medical Leave Act ("FMLA") if an Employee is granted Authorized Leave under FMLA by his or her Employer.

An Employee's Employer has all responsibilities and obligations under FMLA to determine whether and when an Employee is eligible for Authorized Leave under FMLA. The Trustees have no responsibilities or obligations relating to such determination, except to the extent that the Plan is the Employer of any Employees receiving benefits.

An Employer who grants Authorized Leave under FMLA to an Employee is required to notify the Third Party Administrator at the time the Authorized Leave period begins and provide all relevant information regarding the Employee's Authorized Leave.

FMLA Authorized Leave

Pursuant to FMLA, Authorized Leave may be granted to an Employee by an Employer for a period of up to 12 workweeks during a 12 month period, or, in the case of Authorized Leave to care for a servicemember, up to 26 workweeks during a 12 month period.

Pursuant to FMLA, Authorized Leave means leave from employment granted for the following specified reasons:

(a) For the birth of an Employee's child, and to care for such child;

(b) For the placement with the Employee of a child for adoption or foster care;

(c) To care for the Employee's spouse, child or parent with a serious health condition;

(d) Because of a serious health condition that makes the Employee unable to perform the function of the Employee's job;

(e) Because of a qualifying exigency arising out of the fact that an Employee's spouse, child or parent is on active duty in the Armed Forces in support of a contingency operation; or

(f) To care for the Employee's spouse, child, parent or next of kin who is a covered service member, as defined in the Family and Medical Leave Act.

Employer Obligations during FMLA Authorized Leave

Pursuant to FMLA, an Employer who grants FMLA Authorized Leave to an Employee is required to maintain group health insurance coverage for the Employee during the period of Authorized Leave on the same conditions as if the Employee had been continuously employed. An Employer must therefore continue to make contributions to the Plan in the amount and manner as would otherwise be required if the Employee was not on Authorized Leave.

An Employer is required to maintain group coverage for an Employee on Authorized FMLA Leave until:

(a) the Employee's FMLA Leave entitlement is exhausted;

(b) the Employer can show that the Employee would have been laid off and the employment relationship terminated; or

(c) the Employee provides unequivocal notice of intent not to return to work.

Employee Rights and Obligations during FMLA Authorized Leave

An Employee may not be required to use any hours in his reserve account during a period of FMLA Authorized Leave, and may not be required to pay a greater premium than the Employee would have been required to pay if the Employee had been continuously employed.

An Employee remains obligated to make payment of any copayments or other financial obligations which are due to be paid by the Employee in order to maintain continuing coverage during the period of Authorized Leave.

Failure by Employee to Make Required Contributions

The Plan will not terminate an Employee's eligibility for failure to make required contributions during a period of FMLA leave until and unless the Plan receives certification from the Employer that notice was properly given to the Employee that coverage would be terminated if payment was not received, as required under 29 CFR §825.212(a)(1). Nothing in this section shall be construed to prohibit an Employer from making payment of any co-contributions on behalf of an Employee.

If an Employee's eligibility for coverage during Authorized FMLA Leave is terminated due to the Employee's failure to make required contributions, then the Employer's contribution obligation may be suspended for the duration of the Employee's Authorized Leave.

Reinstatement after FMLA Authorized Leave

If an Employee's coverage during FMLA Authorized Leave lapses for failure to make required contributions, and the Employee returns to employment after FMLA Authorized Leave, the Employee's eligibility for coverage shall be restored upon re-employment under the same conditions as if the Employee had been continuously employed, and without being required to meet any qualification requirements, including pre-existing condition waiting periods.

If an Employee on Authorized FMLA Leave chooses not to retain coverage under the Plan during the period of leave, and returns to employment after FMLA Authorized Leave, the Employee is entitled to be reinstated upon re-employment on the same terms as prior to taking the leave, and without being required to meet any qualification requirements, including pre-existing condition waiting periods.

FMLA Authorized Leave and COBRA Continuation Coverage

Authorized Leave granted to an Employee by an Employer pursuant to FMLA is not a Qualifying Event for the purpose of eligibility for COBRA continuation coverage. If an Employee fails to return to work at the end of a period of Authorized Leave, however, such failure to return to work terminates an Employer's obligation to continue coverage and may constitute a Qualifying Event for the purpose of eligibility for COBRA continuation coverage.

V. CLAIMS PROCEDURES

The Plan is required by law to follow certain procedures in processing, reviewing and paying claims. The following procedures apply for the filing and processing of benefit claims; the notification of benefit determinations; and the appeal of adverse benefit determinations.

These rules incorporate and mirror the standards set forth in 29 CFR §2560.503-1 and 29 CFR §2590.715-2719. If there are any inconsistencies between these rules and applicable federal regulations then the applicable federal regulations apply. All modifications to the federal

regulations are incorporated herein by reference. All terms used in this section, including "urgent care" (in all applicable uses), "pre-service claim", "post-service claim", "notice", "notification", and "health care professional" shall have the meaning set forth at 29 C.F.R. §2560.503-1(m).

The Board of Trustees has delegated responsibility for deciding claims to a Claims Administrator for each type of benefit claim. United Healthcare is the Claims Administrator for Medical, Prescription Drug, and Dental benefits. NEBA is the Claims Administrator for Loss of Time, Death, and Accidental Death or Dismemberment benefits. Please see above in the section describing benefits for information regarding submitting your claims for benefits.

Time for Filing Claims

Please note and follow any time limits for filing claims or appealing adverse benefit determinations for each Claims Administrator. Claims for benefits for which United Healthcare acts as the Claims Administrator must be filed under United Healthcare's rules and procedures, including time limits. Claims for benefits may be made by a medical care service provider, such as a doctor, hospital, pharmacy or clinic, on your behalf at or near the time services were provided under **United Healthcare**'s rules and procedures.

Claims for benefits for which NEBA acts as Claims Administrator must be submitted within one year of the date a service was provided or the date of an event that forms the basis for a claim, following NEBA's rules and procedures. Please see above in the section describing benefits for information regarding submitting your claims for benefits.

Claims Determination Procedures

Once a benefit claim is filed, the appropriate Claims Administrator follows set procedures to evaluate the claim and determine the benefits available under the Plan. The time periods for benefit claim determinations are different depending on the type of claim, as described below. All benefit claim determinations are made following governing plan documents and will be applied consistently with respect to similarly situated claimants.

Time Periods for Claims Determinations

All benefit claim determinations will be made within the time periods specified herein. The applicable time period begins at the time you file a claim under the procedures provided, whether or not you have provided all of the information necessary to make a benefit determination.

If you fail to submit information necessary to decide a claim, however, the Claims Administrator will need more time before making a determination. If the time period for making a determination is extended for any of the reasons described below, then the period for making the benefit determination is frozen from the date on which you are notified of the need for an extension of time until the date on which you respond to the request for additional information.

Time Period for Determination of Medical, Prescription Drug, and Dental Claims

The Claims Administrator will process claims for Medical, Prescription Drug, or Dental benefits upon receipt of each claim and will subsequently notify you of the benefit determination.

Dental claims are processed under the rules for post-service claims. Medical and Prescription Drug claims will be processed based on procedures and within the time period allowed for each type of claim, as follows:

Urgent Care Claims

An "Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—(A) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (B) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim is to be made by a person acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any claim that a physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim.

If you submit an Urgent Care Claim then the Claims Administrator will notify you of the Plan's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless you failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If you failed to provide sufficient information, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Following such notification the Claims Administrator will notify you of the benefit determination as soon as possible, but in no case later than 48 hours after (i) the Plan receives the specified information, or (ii) the end of the period afforded to provide the specified additional information, whichever is earlier.

Concurrent Care Claims

A Concurrent Care Claim is a claim for benefits for an approved ongoing course of treatment to be provided over a period of time or number of treatments.

It will be considered as an "adverse benefit determination" if, after approval of a course of treatment, there is a reduction or termination of the benefits (other than by plan amendment or termination) before the end of the approved time period or number of treatments. The Claims Administrator shall notify you of such a change in benefits at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

A request to extend an approved ongoing course of treatment beyond the approved time period or number of treatments may also be an Urgent Care Claim depending on the circumstances. An Urgent Care Claim for extension of an approved ongoing course of treatment shall be decided as soon as possible, taking into account the medical exigencies. If such a claim is made to the Claims Administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the Claims Administrator shall notify the Participant of the benefit determination within 24 hours after receipt of the claim.

Pre-Service Claims

A "Pre-Service Claim" is any claim for a benefit that requires, in whole or in part, approval of the benefit in advance of obtaining medical care. ***Some benefits under the Plan require pre-approval before the benefit is provided, and you must be sure to submit a Pre-Service Claim in order to obtain coverage for such benefits.***

The Claims Administrator will notify you that your Pre-Service Claim has been approved or denied within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan.

This time period may be extended once by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because you failed to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice to provide the specified information.

If you or your authorized representative fail to follow the Plan's procedures for filing a Pre-Service Claim, then you or your authorized representative will be notified of the failure and of the proper procedures to be followed, provided that the failure to follow procedures is a communication as described in 29 C.F.R. §2560.503-1(c) (1)(ii). This notification shall be made as soon as possible, but no later than 24 hours following a failure to properly file a Pre-Service Claim involving Urgent Care, or 5 days following a failure to properly file any other type of Pre-Service Claim. This notification may be made orally, unless you or your authorized representative requests written notification.

Post-Service Claims

A "Post-Service Claim" is a claim for a benefit that is filed after the services have been provided. The Claims Administrator shall notify you of an adverse benefit determination of a Post-Service Claim within a reasonable period of time, but not later than 30 days after receipt of the claim.

This period may be extended one time by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because you failed to submit the information necessary to decide the claim, then the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

Time Period for Determination of Loss of Time Claims

Loss of Time benefits are also referred to as Disability benefits. This benefit provides you with defined income for a defined period of time if you are unable to work due to a disability.

The Claims Administrator will process a claim for Disability benefits and notify you of the determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan.

This period may be extended by the Claims Administrator, for up to 30 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision.

In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you shall have at least 45 days within which to provide the specified information.

Time Period for Determination of Death, Accidental Death or Dismemberment Claims

After you submit a claim for Death, Accidental Death or Dismemberment Benefits, the Claims Administrator will process the claim and notify you of its determination within a reasonable period of time not exceeding 90 days. The Claims Administrator may extend the 90-day limitation if special circumstances so require.

Adverse Benefit Determinations

An "adverse benefit determination" is any decision on a claim that is a denial, reduction, or termination of benefits. More specifically, the term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

A rescission of coverage is also an 'adverse benefit determination" for this purpose, whether or not there is an adverse effect on any particular benefit at the time of the rescission, including any rescission of disability (Loss of Time) coverage. For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is

attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Time Period for Notification of Adverse Benefit Determinations

Except as otherwise described below, if a claim is wholly or partially denied, the Claims Administrator shall notify you of the adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim.

If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 90 day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the benefit determination.

Manner and Content of Notification of Adverse Benefit Determinations

Except as otherwise described below, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination.

In the case of an adverse benefit determination on an Urgent Care Claim, notification may be given orally within the time frame described above, provided that a written or electronic notification is furnished not later than 3 days following the date of oral notification.

The notification of an adverse benefit determination relating to any benefits offered under this Plan shall set forth, in a manner calculated to be understood by the claimant, the following information:

(1) The specific reason or reasons for the adverse determination;

(2) For Medical and Prescription Drug claims, information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis code, the treatment code and the meanings of any such codes.

(3) For Medical and Prescription Drug claims, the specific reason or reasons for the adverse determination, including the denial code and its meaning and a description of the standard that was used in denying the claim;

(4) Reference to the specific plan provisions on which the determination is based;

(5) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(6) A description of the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal;

(7) A statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

(8) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar

criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

(9) In the case of an adverse benefit determination of Medical or Prescription Drug claims —

a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

b. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(10) In the case of an adverse benefit determination concerning a claim involving urgent care—

a. A description of the expedited review process applicable to such claims.

b. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(11) In the case of an adverse benefit determination with respect to disability benefits—

a. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

b. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

c. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or,

alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

d. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section; and

e. The notification shall be provided in a culturally and linguistically appropriate manner.

(12) For Medical and Prescription Drug claims, contact information for any office of health insurance consumer assistance available to assist individuals with the internal claims and appeals process and applicable external review processes.

Appeals of Adverse Benefit Determinations

You have a right to appeal an adverse benefit determination relating to any claim for benefits under this Plan to an appropriate named fiduciary of the Plan for a full and fair review of the claim and the adverse benefit determination. The Claims Administrator for Medical, Prescription Drug, and Dental claims is authorized to administer and determine appeals. The Board of Trustees will determine appeals when the Third Party Administrator acts as the initial Claims Administrator.

Time Period for Appeal

Unless otherwise provided herein, you will have *at least 60 days* following receipt of an adverse benefit determination to appeal the determination. Appeals of adverse benefit determinations must be brought by you or by your authorized representative. The Plan will provide continued coverage pending the outcome of an appeal and will comply with required notice provisions before reducing or terminating an ongoing course of treatment.

Opportunity to Review and Submit Material Relevant to Your Claim

You will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The Claims Administrator will provide, free of charge and upon request, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

A document, record, or other information shall be considered “relevant” to your claim for benefits if such document, record, or other information, (i) was relied upon in making the benefit determination, (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination, (iii) demonstrates compliance with the administrative processes and safeguards required pursuant to this section in making the benefit determination, or (iv) in the case of disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The review shall take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Additional Time Period and Procedures for Appeals of Claims for Medical, Prescription Drug, and Disability Benefits

Appeals of adverse benefit determinations of claims for Medical, Prescription Drug, and Disability benefits must be submitted in writing within 180 days of your receipt of an adverse benefit determination.

The Claims Administrator or the Board of Trustees, as applicable, will consider and decide all appeals of adverse benefit determinations for claims for Medical, Prescription Drug, and Disability benefits, taking into account all comments, documents, records and other information submitted by the claimant relating to the claims, without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator or the Board of Trustees will also provide, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan or at the direction of the Plan in connection with your claim. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided, so that you have a reasonable opportunity to respond prior to that date.

The Claims Administrator or Board of Trustees will not issue a final internal adverse benefit determination based on a new or additional rationale before first providing the rationale to you, free of charge, as soon as possible, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided, so that you have a reasonable opportunity to respond prior to that date.

The Claims Administrator or the Board of Trustees will not afford deference to the initial adverse benefit determination, and the review will be conducted by a fiduciary who did not make the initial adverse benefit determination and who is not a subordinate of the person who did.

If an adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board of Trustees or the Claims Administrator, as applicable, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The professional so consulted will not be a person who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and will not be a subordinate of any expert consulted in connection with the adverse determination under appeal.

If medical or vocational experts were consulted on behalf of the Plan in connection with an adverse benefit determination, such experts will be identified, whether or not the advice obtained was relied upon in making the benefit determination.

Appeals of adverse benefit determinations of claims for Medical or Prescription Drug benefits involving urgent care will include an expedited review process. Under the expedited review process a request for an expedited appeal may be submitted orally or in writing by the claimant, and all necessary information, including the plan's benefit determination on review, shall be

transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

The Trustees strive to ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly the Claims Administrator will not make any personnel decisions, including hiring, compensation, termination, promotion or other similar actions, based upon the likelihood that the persons involved in the claims review procedure will support the denial of benefits.

Time for Determination and Notification of Decision after Appeal

All appeals of adverse benefit claim determinations will be made within the time periods described below. The applicable time period begins at the time a request for an appeal is received by the Plan in accordance with the procedures for filing appeals, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. *If you fail to submit information necessary to decide a claim, and an applicable time period is extended as permitted herein, the period for making the benefit determination shall be frozen from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.*

Except for appeals of certain types of health care claims, if the Board of Trustees is considering an appeal the Board shall make a benefit determination no later than the date of the Board of Trustees' meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. If a request for review is filed less than 30 days before the next meeting, the Board shall make a determination no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the date of the third meeting following the Plan's receipt of the request for review.

If an extension of time for review is required because of special circumstances, the Plan Administrator shall provide written notice of the extension, prior to the commencement of the extension, describing the special circumstances and the date as of which the benefit determination will be made.

The Plan Administrator shall notify you of a benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

Time for Determination and Notification of Decision after Appeal of Certain Types of Health Care Claims

Urgent Care Claims

If you appealed an adverse benefit determination of an Urgent Care Claim you will be notified of the Plan's decision on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

Pre-Service Claims

If you appealed an adverse benefit determination of a Pre-Service Claim you will be notified of the Plan's decision on appeal within a reasonable period of time appropriate to the medical

circumstances, but not later than 30 days after receipt of the claimant's request for review of an adverse benefit determination.

Manner and Content of Notification of Decision after Appeal

The Plan Administrator shall provide written or electronic notification to the claimant of the Board's decision on a claim after appeal and review.

In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant, the following information—

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code and the meanings of any such codes.

(2) The specific reason or reasons for the adverse determination, including the denial code and its meaning, a description of the standard that was used in denying the claim, and a discussion of the reasons supporting the decision;

(3) Reference to the specific plan provisions on which the benefit determination is based;

(4) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(5) A description of the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal;

(6) A statement of the claimant's right to bring an action under section 502(a) of ERISA;

(7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(8) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(9) In the case of an adverse benefit decision with respect to disability benefits—

a. Any applicable contractual limitations period that applies to the claimant's right to bring an action under section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim.

b. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

i. The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

ii. The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

iii. A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

c. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request; and

d. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

(10) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency"; and

(11) Contact information for any office of health insurance consumer assistance available to assist individuals with the internal claims and appeals process and applicable external review processes.

External Review Procedures

The following standards only apply to Medical and Prescription Drug claims.

If you appealed an adverse benefit determination of a Medical or Prescription Drug claim, and your appeal was denied, you may request an external review of the Plan's decision by an Independent Review Organization ("IRO"). The following describes your rights and responsibilities in connection with an external review of the Plan's adverse benefit determination.

Depending on the circumstances you may request either a Standard external review or an Expedited external review. An Expedited external review is available when the time frame to complete a standard external review would seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or if the claim involves care related to emergency services received by the claimant and the claimant has not been discharged from a facility.

You must request an external review of a final adverse benefit determination under procedures established by the network provider through which your benefits were provided. External review procedures are provided through **United Healthcare** and must comply with the federal law guidelines described below.

Standard External Review

(a) ***Request for external review.*** You may file a request for an external review within four months after the date of receipt of a notice of an adverse benefit determination or final

internal adverse benefit determination. If that date falls on a weekend or holiday you have until the next business day.

(b) ***Preliminary review.*** Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

1. The claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care service was provided;
2. The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the eligibility requirements under the terms of the Plan;
3. The claimant has exhausted the plan's internal appeals process, unless the claimant is not required to do so under the applicable regulations; and
4. The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan must issue a written notification to the claimant. If the request is complete but not eligible for external review, such written notification must include the reasons the claim is ineligible and contact information for the DOL's Employee Benefits Security Administration. If the request is not complete, the written notification must describe the information needed to complete the request, and the claimant must be permitted to perfect the request within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

(c) ***Referral to Independent Review Organization (IRO).*** If the request for review is complete and is eligible for external review then the Claims Administrator will assign an Independent Review Organization (IRO) that is accredited under the appropriate regulations and federal guidance to conduct the external review. In order to prevent against bias and ensure independence, the Plan or the network providers have established or will establish contracts with at least three (3) IROs for assignments and will rotate claims assignments among them (or will incorporate other independent, unbiased methods for selection of IROs, such as random selection). The IROs are prohibited from receiving any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(d) ***Procedures for IRO External Review:*** The assigned IRO will conduct the external review following applicable federal guidelines, as described in its contract, and using legal experts as necessary. The IRO assigned to review the claim will let the claimant know in writing that it will be conducting the external review and will give the claimant a notice stating that the claimant may submit, in writing, within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO may also consider information provided by the claimant after the 10 day window but is not required to do so. Upon receipt of any information from the claimant the IRO will promptly forward the information to the Plan within one business day, and the Plan may reconsider it decision to deny the claim. If the Plan were

to reconsider its decision and allow the claim then the external review will be terminated upon receipt of notice of the Plan's decision.

The Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination within 5 business days after the date of assignment.

The IRO will review all of the information and documents timely received and will review the claim without deferring to any decisions or conclusions reach during the plan's appeal process. The IRO may also consider, if the IRO thinks it is appropriate, the following:

1. The claimant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or the claimant's treating provider;
4. The terms of the plan to ensure that the IRO's decision is not contrary to them, as long as the terms are consistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards or associations;
6. Any applicable clinical review criteria developed and used by the Plan; and
7. The opinion of the IRO's clinical reviewer after considering the information described in the notice, as long as the documents are available and the clinical review considers them appropriate.

(e) ***Written notice:*** The assigned IRO will provide written notice of the final external review decision to the Plan and to the claimant within 45 days after the IRO receives the request for the external review. The IRO's decision notice will include the following:

1. A general description of the reason for the request for external review, the reason for the previous denial and information sufficient to identify the claim, the diagnosis code, treatment code, and explanations of the codes;
2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards considered in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standard that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to the claimant;
6. A statement that judicial review may be available to the claimant; and

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the new federal health care reform law.

(f) ***Reversal of plan's decision.*** The IRO could determine after external review that the adverse benefit determination should be reversed. Upon receipt of a notice of a final external review decision that reverses the adverse benefit determination or final internal adverse benefit determination, the Plan is required to immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

(g) ***Records to be maintained:*** After a final external review decision the IRO must maintain record of all claims and notices associated with the external review process for six years. The IRO must make such records available for examination by the claimant, the Plan, or state or federal oversight agencies upon request, unless prohibited by law.

Expedited External Review

(a) ***Request for expedited external review.*** You may make a request for an expedited external review when you receive:

1. An adverse benefit determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or
2. A final internal adverse benefit determination and the claimant has a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

(b) ***Preliminary Review.*** Upon receipt of a request for an expedited external review the Claims Administrator will immediately determine whether the request meets the standards described above for standard external review. The plan will send a notice regarding its preliminary review as soon as possible notifying the claimant of its eligibility determination.

(c) ***Referral to Independent Review Organization (IRO).*** Upon determination that a request is eligible for external review the Claims Administrator will assign an Independent Review Organization following the procedures described above for standard external reviews. The Plan will provide all necessary documents and information considered in making the adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO will consider the documents and information provided under the standards and procedures described above for standard external reviews. In reaching a

decision the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(d) ***Notice of final external review decision.*** The IRO will provide notice of the final external review decision following the requirements and procedures described above for standard external review decisions as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

VI. OTHER IMPORTANT INFORMATION ABOUT YOUR BENEFITS

A. Circumstances That Could Affect Your Receipt of Benefits

Fraud or Misrepresentation: The Plan shall have the right to recover whatever benefits are paid on behalf of any person when the basis of such claim is misrepresented or fraudulently presented to the Plan, whether by a Participant or by any medical service provider(s). If fraud or misrepresentation is established the Plan shall have the right to recover all benefits paid by either: (1) a direct recovery from the Participant and/or the medical service provider(s) responsible for the fraud or misrepresentation; or (2) by reducing or off-setting all subsequent benefits for such Participant and members of the Participant's family eligible for benefits until such time as the Plan has made full recovery of the misrepresented or fraudulent amounts. Such recovery may also include medical investigation charges, auditors' fees and attorney fees, as necessary.

Coordination of Benefits: If you are enrolled in more than one group health plan, insurance program or government program, benefit payments may be coordinated between providers that provided Plan benefits and the other source of benefit payments. Coordination of Benefits ("COB") ensures that the combined payments of all coverage will not exceed the expense incurred for the services provided. You are required to provide **United Healthcare** with updated information regarding your other coverage. The rules governing Coordination of Benefits are set forth in the materials provided by **United Healthcare**. Contact **United Healthcare** at the number on the back of your ID card for more information.

Reimbursement and Subrogation: **United Healthcare** has independent reimbursement and subrogation rights under the insured policy issued to the Plan. Providers hired to provide benefits under this Plan have also been delegated the authority to manage reimbursement and subrogation claims on behalf of the Plan, to the extent of any amounts paid by the Plan. If you receive benefits under the Plan for injuries or illness caused by a third party, **United Healthcare** has the right through subrogation and/or assignment to seek repayment in the event that you recover any portion of the benefits it paid by court action, settlement or otherwise. **United Healthcare** has rules and procedures that apply to managing reimbursement and subrogation rights, including requirements for executing subrogation and reimbursement agreements. **United Healthcare's** subrogation and reimbursement rules are incorporated herein by reference.

To the extent that the Plan has made any benefit payments, by accepting benefits under the Plan, you agree for yourself and any minor children that the Plan shall be subrogated and succeed to the

rights of recovery that you have against any third party or insurer relating to your injury, accident, or illness that resulted from the act or omission of any third party. You agree to cooperate with the Plan, provide all requested information, and enter into agreements as necessary to protect the Plan's subrogation and reimbursement rights.

The Plan may withhold payment of claims in the event you refuse to sign a subrogation agreement or otherwise cooperate as required.

By accepting benefits under the Plan, you authorize the Plan to claim the right of first reimbursement even if you or your minor child is not made whole.

The Plan shall automatically have a lien upon the proceeds of any recovery to the extent of any benefits paid under the Plan.

If you or your minor child is represented by an attorney in a claim or potential claim against a third party, then your attorney may be required to execute an agreement that all funds received on your behalf will first be applied to satisfy the subrogation lien, and that, in the event of a dispute over the amount required to discharge the lien, any amounts received will be held in escrow by your attorney until the dispute is resolved.

In the event you receive any funds as settlement of claims made for personal injuries for which the Plan paid benefits, and payment is not made to the Plan to discharge or reduce the Plan's rights to subrogation and reimbursement, then the Trustees may deny or withhold payment of claims until the Plan's rights have been discharged or reduced to the extent of the funds received.

Plan's Right to Recover Excess Payments: Whenever payments have been made by the Plan in excess of the maximum amount of payment allowed under the Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator shall determine: (a) any persons to whom, for whom or with respect to whom such payments were made or (b) any insurance companies, service plans or any other organizations to whom such payments were made.

B. Other Important Information

Assignment of Claims: Benefits which are not based on expenses incurred may not be assigned. Benefits payable for expenses incurred in connection with a specified period of disability, hospital care or surgical or medical treatment resulting from one injury or illness may be assigned only to the institution or individual furnishing the respective services or supplies for which such benefits are payable. The Plan assumes no responsibility for the validity of any assignment, nor will it be liable under assignment until and unless satisfactory proof of assignment is submitted to the Plan prior to payment of the assigned benefits. Any payment made by the Plan prior to receipt of satisfactory proof of assignment will completely discharge the Plan's obligations to the extent of such payments and the Plan will not be required to see to the application of the payment.

Time Limitations for Actions Brought in Court: No action may be brought under ERISA in court prior to exhaustion of the administrative remedies described in the Claims Procedures section. Each insurance company providing benefits through this Plan under insurance policies may have additional limits on filing legal actions. Please refer to materials provided by each insurance company. Any action brought in court relating to benefits for which the Third Party Administrator acts as Claims Administrator must be initiated within two years of the date that a claim was denied after exhaustion of all administrative remedies.

Applicable Law: This Plan is created and accepted in the State of Florida. All questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Florida except as to matters governed by federal law.

VII. STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, *all documents governing the plan,* including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Benefit from reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. Information can also be obtained at the DOL's website, www.dol.gov.

VIII. GLOSSARY

The Board of Trustees may contract from time to time with one or more Preferred Provider Organization(s) (PPO), Pharmacy Benefit Manager(s) (PBM), insurance companies, or other managed care network providers in order to facilitate the delivery of the benefits under this Plan. Each such provider has relevant definitions and related rules and procedures that apply to the services that each provides to the Plan and its Participants, including the delivery of medical, prescription drug and dental benefits. All such definitions, rules and procedures are incorporated herein by reference.

The Board of Trustees has selected **United Healthcare** to provide Medical, Prescription Drug and Dental benefits under this Plan. **United Healthcare**'s relevant definitions and related rules and procedures are incorporated herein by reference.

In addition, the following definitions apply:

1. Apprentice – An Employee enrolled in the Florida East Coast Electrical Joint Apprenticeship & Training Trust Fund program and employed by an Employer under the terms of a Collective Bargaining Agreement in an apprentice job classification.

2. Available for Work - Being registered on the out-of-work list with the Union's hiring hall and otherwise being unemployed. An Employee shall not be considered Available For Work if: (i) he is working for an employer that is located within the geographic jurisdiction of the Plan, but is not obligated to make contributions to the Fund on the employee's behalf; or (ii) he is working for an employer that is located outside of the geographic jurisdiction covered by the Plan, but is not covered by a Reciprocal Agreement.

3. Board of Trustees -The Board of Trustees of the IBEW Local 728 Family Healthcare Fund.

4. Claims Administrator - The person or entity designated by the Board of Trustees to adjudicate benefit claims on behalf of the Plan.

5. Collective Bargaining Agreement – An agreement between an Employer and a Union under which the Employer has agreed to make contributions to the Trust Fund on behalf of its Employees under its terms. Also referred to as a "CBA".

6. Covered Employee - An Employee who is eligible for and covered for benefits under this Plan.

7. Covered Person - An Employee, a Local 323 Retiree and/or a Dependent covered for benefits under this Plan. Also referred to as a Participant.

8. CWCE Employee – An Employee employed by an Employer under the terms of the IBEW Fifth District Recovery Addendum/Agreement in the job classifications of Construction Wireman or Construction Electrician, and on whose behalf an Employer is obligated to make contributions to the Trust Fund.

9. Dependent -

   The term "Dependent" means:

   (a) An Employee's married spouse while not divorced or legally separated from the Employee.

   (b) Each child of an Employee, until the end of the month in which a child attains age 26, and as described below.

      (i) For the purpose of this section, the term "child" means a Covered Employee's natural child, adopted child, stepchild and/or foster child, as described in Section 152(f)(1) of the Internal Revenue Code.

      (ii) A Dependent also means a child for whom there is a Qualified Medical Child Support Order which states that health care coverage must be maintained by an Employee.

      (iii) A child who (a) otherwise qualifies as a Dependent, (b) would lose eligibility because of age, (c) is unmarried, (d) is incapable of self sustaining employment by reason of mental or physical handicap, as determined by the Office of Rehabilitation Services in the State Department of Education, and (e) remains dependent chiefly upon

an Employee, is a Dependent during the continuation of such incapacity, subject to the right of the Plan Administrator to require proof of incapacity. Proof of such incapacity must be furnished to the Board of Trustees no later than 31 days after the date that such child would otherwise lose eligibility for coverage because of age, and thereafter as requested by the Board of Trustees, but not more frequently than annually after the two year period following the date that such child would otherwise have lost coverage. Coverage hereunder shall terminate automatically on the date the child ceases to be incapacitated and dependent upon the employee as stated above, or on the date such Coverage would otherwise terminate in the absence of this Subsection. A child eligible for coverage on the basis of incapacity must have become incapacitated while covered as a Dependent and is eligible for coverage only during the continuation of such incapacity.

(c) Each child of a Covered Employee from the end of the month in which such child attains age 26 until the end of the calendar year in which the child attains age 30, if all of the following requirements are met:

(i) The Covered Employee has exercised his/her option to have said child insured, and

(ii) The child is unmarried and does not have a dependent of his/her own, and

(iii) The child is a resident of Florida or is a full-time or part-time student, and

(iv) The child is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, franchise or individual health benefit plan, and

(v) The child is not entitled to benefits under Title XVIII of the Social Security Act.

10. Employee–Each person who is employed by an Employer and on whose behalf the Employer is required to make contributions to the Trust Fund under the terms of a Collective Bargaining Agreement, Participation Agreement, or other agreement.

11. Employer –

(a) An employer who is bound by a Collective Bargaining Agreement with a Union, by a Participation Agreement with the Trustees, or by any other agreement, to make payments to the Trust Fund with respect to its Employees covered by said Collective Bargaining Agreement, Participation Agreement, or other agreement.

(b) A Union required to contribute to the Trust Fund on behalf of its employees, as agreed to by the Trustees and as set forth in a Participation Agreement.

(c). The Florida East Coast Electrical Joint Apprenticeship & Training Trust Fund, as agreed to by the Trustees and as set forth in a Participation Agreement.

(d) The Trustees of the Trust Fund who contribute on behalf of Trust Fund employees, as set forth in a Participation Agreement.

(e) The trustees of any other trust fund established pursuant to a collective bargaining agreement who contribute on behalf of trust fund employees or trust fund participants, as agreed to by the Trustees and as set forth in a Participation Agreement.

12. Illness - A disease, disorder, or condition which requires treatment by a Physician. Illness also includes pregnancy, childbirth, miscarriages, abortion, or any related condition. Also referred to as Sickness.

13. Injury - A bodily injury sustained accidentally.

14. Journeyman Employee - An Employee employed by an Employer under the terms of a Collective Bargaining Agreement in the job classifications of Journeyman, Foreman, or General Foreman.

15. Local 323 Retiree - Former participants of the IBEW Local 323 Health and Welfare Plan who retired before January 1, 1996, and who met the eligibility requirements for retiree coverage that applied as of August 31, 1995 under the former Broward County Electricians Health and Welfare Plan.

16. Medically Necessary - means that the service received is required to identify or treat the Illness or Injury which a Physician has diagnosed or reasonably suspects. The service must be:

    (a) consistent with the diagnosis and treatment of the condition;
    (b) in accordance with standards of good medical practice;
    (c) required for reasons other than the Employee's convenience or his Physician's; and
    (d) performed in the least costly setting required by the condition.

    The fact that a service is prescribed by a Physician does not necessarily mean that such service is Medically Necessary.

17. Non-Bargaining Unit Employee – An employee of the Union, of the Florida East Coast Electrical Joint Apprenticeship & Training Trust Fund, of a trust fund accepted by the Trustees for participation, or of an Employer accepted by the Trustees for participation, who is a full-time salaried employee, officer or director, and upon whose behalf the Trustees have agreed to accept contributions pursuant to a written Participation Agreement.

18. Physician – a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. The term also includes any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

    (a) operating within the scope of his license; and
    (b) performing a service for which benefits are provided under this plan when performed by a Physician.

19. Participant - A Covered Employee, Local 323 Retiree, and/or a covered Dependent. Also referred to as a Covered Person.

20. Participation Agreement –

    (a) An agreement between the Board of Trustees and an Employer obligated to make contributions to the Trust Fund on behalf of its Employees covered under the terms of a Collective Bargaining Agreement, under which such Employer agrees to also make contributions to the Trust Fund on behalf of the Employer’s Non-Bargaining Unit Employees.

(b) An agreement between the Board of Trustees and the Union, the trustees of the Florida East Coast Electrical Joint Apprenticeship & Training Trust Fund, or the trustees of a trust fund accepted by the Trustees for participation, under which the Union or trustees agree to make contributions to the Trust Fund on behalf of their Non-Bargaining Unit Employees.

21. Plan – The IBEW Local 728 Family Healthcare Plan.

22. Plan Administrator – The Board of Trustees of the Plan.

23. Plan Year - The twelve (12) month period beginning on January 1st and ending on December 31st of each year.

24. Schedule of Benefits – A Schedule that sets forth the levels of benefits and cost sharing requirements, including Co-payments, Co-Insurance, Deductible amounts and maximum benefit and payment limitations. There are different Schedules of Benefits for different types of benefits and for different benefit options.

25. Sickness - A disease, disorder, or condition which requires treatment by a Physician. Sickness also includes pregnancy, childbirth, miscarriages, abortion, or any related condition. Also referred to as Illness.

26. Third Party Administrator – The person or entity designated by the Board of Trustees to perform plan administration functions for the Plan.

27. Trust Fund or Fund -The entire trust estate of the IBEW Local 728 Family Healthcare Fund, as it may from time to time be constituted, including but not limited to, all funds received in the form of contributions, together with all contracts (including dividends, interest, refunds, and other sums payable to the Trustees on account of such contracts), earnings and profits therefrom, and any and all other property or funds received and held by the Trustees.

28. Union – The International Brotherhood of Electrical Workers (IBEW) Local 728, as well as such other labor organizations as may from time to time be accepted for participation under such terms and conditions as may be established by the Trustees.

Schedule of Benefits

IBEW Local No 728 Family Healthcare Plan

Disability Benefit

Short Term Disability Benefit	
Maximum Disability Period (CREDITS ONLY)	6 Consecutive Calendar Months (26 weeks)
Maximum Disability Period (PAYMENT ONLY)	13 weeks
A - Accident (AC Type used to calculate credits)	$75 per week - No Waiting Period
I - Illness (IC Type usedd to calculate credits)	$75 per week - 7 day Waiting Period
For the purpose of maintaining continued eligibility only, bargaining unit employees will be credited with 130 disability hours for each calendar month of proven Disability up to a maximum of 6 months in any 12 month period. A month of proven Disability is any calendar month in which the employee can medically prove that he has been totally disabled for a minimum of twenty (20) consecutive days. Disability credit shall also be granted if you are eligible but disabled during an annual termination measurement period on the basis of 1/12 of the total minimum hours to remain eligible for each month of proven disability during the prior 12 month period, up to a maximum of 6 months in a 12 month period. If you die while covered, our dependents shall remain eligible for the balance of your eligibility including any unused disability hours as if you had not died.	

Life Insurance (Employee Only Benefit)

Life Insurance Benefit	$1,500
Accidental Death and Dismemberment Benefit	$1,500