I.B.E.W. Local 910 Welfare Fund
Health Care Benefits

FOR ACTIVE PARTICIPANTS

Effective Date: August 1, 2015

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I.B.E.W. Local 910 Welfare Fund
Health Care Benefit
for Active Participants

INTRODUCTION

This section of the booklet describes the Health Care Benefit for Active Participants of the I.B.E.W. Local 910 Welfare Fund provided by Excellus BCBS and should be used in conjunction with the Summary Plan Description booklet provided to you by the I.B.E.W. Local 910 Welfare Fund. We invite you to carefully review the Health Care Benefit provisions.

The Health Care Benefit for Active Participants is an Indemnity Plan, which means an active participant and their eligible dependents have the option to choose to receive health care services from a Provider who is a member of a Preferred Provider Network or from a Provider who is not a member of a Preferred Provider Network. Benefits payable under the Indemnity Program for in-network or out-of-network covered services will be subject to the applicable coinsurance, maximums and deductible amounts shown in the Schedule of Benefits. This Indemnity Plan does not require that you choose a primary care physician to coordinate and direct your care.

If a participant or their eligible dependent seeks care or treatment from a member of the Preferred Provider Network, the Plan will pay benefits directly to the Provider of services less any applicable coinsurance or deductible. A current listing of Preferred Providers is available at www.excellusbcbs.com/IBEW910 via the Internet.

If you have any questions relating to eligibility, classification or coverage under the Plan, submit them to the Fund Manager.

Statement of Grandfathered Health Plan Status: The Employer believes any Coverage Summary associated with this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (The Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on most benefits.

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

I.B.E.W. LOCAL 910 WELFARE FUND HEALTH CARE INSURANCE BENEFIT FOR ACTIVE PARTICIPANTS

SCHEDULE OF BENEFITS

Applies to: Active participants, COBRA beneficiaries, and their dependents.
Claims must be filed within 120 days after the claim is incurred or the claim will be denied. A detailed description of all Plan benefits, including the following benefits, can be found in the section entitled "Detailed Description of Benefits".

TYPE OF SERVICE	BASIC BENEFITS Benefits are limited to 365 days of care for each spell of Illness. The days of care may be for any combination of inpatient Hospital care, care in a skilled nursing or rehabilitation facility, home health care, or maternity care in a Hospital or birthing center, or inpatient treatment of Mental Illness or Substance Abuse. In and out-of-network benefits are combined.		MAJOR MEDICAL BENEFITS These benefits apply only after the Basic benefits, if any, have been paid or exhausted. All benefits are subject to the Major Medical deductible, except where noted. The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule or the Reasonable and Customary amount.
	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The deductible does not apply.	**OUT-OF-NETWORK PROVIDER** The Allowable Expense is limited to the Reasonable and Customary amount. The deductible does not apply.	
Hospital (also see Mental Illness, Substance Abuse, and maternity care for inpatient benefits)			
• **Inpatient**	100%	80%	80%
• **Outpatient Hospital**			
-Emergency room (Does not include Emergency room physician)	100%	80%	See Basic benefits
-Emergency room physician	See Major Medical benefits	See Major Medical benefits	80%
-Outpatient surgical center	100%	80%	See Basic benefits
-Clinic	See Major Medical benefits	See Major Medical benefits	80%
-Laboratory	See Major Medical benefits	See Major Medical benefits	80%
-X-rays	See Major Medical benefits	See Major Medical benefits	80%
-Diagnostic tests	See Major Medical benefits	See Major Medical benefits	80%
-Radiation	100%	80%	80%
-Chemotherapy	100%	80%	80%
-Respiratory therapy	100%	80%	See Basic benefits
-Physical/speech therapy	100% (1)	80% (1)	80%
-Occupational therapy	See Major Medical benefits	See Major Medical benefits	80%
-Dialysis or hemodialysis	100%	80%	80%
Freestanding Surgical Facility	100%	80%	See Basic benefits
Urgent Care Facility	See Major Medical benefits	See Major Medical benefits	80%
Ambulance	See Major Medical benefits	See Major Medical benefits	80%
Preadmission Testing	100%	80%	See Basic benefits
Convalescent/Skilled Nursing and Rehabilitation Facility			
-Inpatient	100%	80%	80%
-Outpatient	100%	80%	80%

(1) Limited to a maximum of 20 visits per participant or dependent per calendar year for physical therapy and 20 visits per participant or dependent per calendar year for speech therapy.

TYPE OF SERVICE	BASIC BENEFITS Benefits are limited to 365 days of care for each spell of Illness. The days of care may be for any combination of inpatient Hospital care, care in a skilled nursing or rehabilitation facility, home health care, or maternity care in a Hospital or birthing center, or inpatient treatment of Mental Illness or Substance Abuse. In and out-of-network benefits are combined.		MAJOR MEDICAL BENEFITS These benefits apply only after the Basic benefits, if any, have been paid or exhausted. All benefits are subject to the Major Medical deductible, except where noted. The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule or the Reasonable and Customary amount.
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Home Health Care	100%	80%	80%
Hospice Care [2] • Inpatient • Home	 100% 100%	 80% 80%	 80% 80%
Private Duty Nursing (not covered if the patient is receiving home health care services)	See Major Medical benefits	See Major Medical benefits	80%; up to 30 visits per calendar year
Mental Illness Services			
• Inpatient (Hospital or behavioral health care facility)	100%	80%	80%
• Outpatient (Hospital clinic, facility, office)	See Major Medical benefits	See Major Medical benefits	80%
• Emergency room treatment (Does not include Emergency room physician)	100%	80%	See Basic benefits
• Emergency room physician	See Major Medical benefits	See Major Medical benefits	80%
Substance Abuse Treatment			
• Inpatient (Hospital or behavioral health care facility).	100%	80%	80%
• Outpatient (Hospital clinic, facility, office)	100%	80%	80%
• Emergency room treatment (Does not include Emergency room physician)	100%	80%	See Basic benefits
• Emergency room physician	See Major Medical benefits	See Major Medical benefits	80%

(2) Limited to 210 days of treatment; in and out-of-network benefits combined; also includes coverage for five (5) bereavement counseling visits for the patient's family members.

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Maternity Care – Mother			
• Inpatient Hospital	100%	80%	80%
• Physician for prenatal care and delivery	100%	80%	80%
Newborn Care (Prior to discharge)			
• Hospital	100%	80%	See Basic benefits
• Physician	100%	80%	See Basic benefits
• Newborn circumcision	100%	80%	See Basic benefits
Physician (except for routine care and delivery, Emergency room physicians, or treatment of Mental Illness or Substance Abuse)			
• Inpatient visit	100%	80%	80%
• Office visit	See Major Medical benefits	See Major Medical benefits	80%
• Home visit	See Major Medical benefits	See Major Medical benefits	80%
• Consultation by a Specialist			
Inpatient	100%	80%	80%
Outpatient	See Major Medical benefits	See Major Medical benefits	80%
Office	See Major Medical benefits	See Major Medical benefits	80%
• Surgery			
Inpatient	100%	80%	See Basic benefits
Outpatient	100%	80%	See Basic benefits
Office	100%	80%	See Basic benefits
Assistant surgeon	100%	80%	See Basic benefits
• Second surgical opinion	100%	80%	See Basic benefits
• Second medical opinion	100%	80%	See Basic benefits
Anesthesia			
• Inpatient	100%	80%	See Basic benefits
• Outpatient	100%	80%	See Basic benefits
• Office	See Major Medical benefits	See Major Medical benefits	80%
Allergy Care			
• Treatment and serum	See Major Medical benefits	See Major Medical benefits	80%
• Testing - laboratory	100%	80%	See Basic benefits

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Chiropractor (3)	See Major Medical benefits	See Major Medical benefits	80%
Podiatrist			
• Visit	See Major Medical benefits	See Major Medical benefits	80%
• Orthotics	See Major Medical benefits	See Major Medical benefits	80%
• Surgery	100%	80%	See Basic benefits
Preventative/Well Care			
• GYN office visit (one per calendar year)	100%	80%	See Basic benefits
• Pap smear (one per calendar year)	100%	80%	See Basic benefits
• Mammogram (4)	100%	80%	See Basic benefits
• Well child care to age 19 (5)	100%	80%	See Basic benefits
• Routine adult physicals (for adults over age 50; one per calendar year)	100%	80%	See Basic benefits
• Routine PSA test (6)	See Major Medical benefits	See Major Medical benefits	80%
• Routine colonoscopy (7)	100%	80%	See Basic benefits
Pap Smear (Medically Necessary)	100%	80%	80%
Mammogram (Medically Necessary)	100%	80%	80%
Outpatient Diagnostic Tests			
• **Independent Laboratory** Laboratory/diagnostic tests, x-rays	See Major Medical benefits	See Major Medical benefits	80%
• **Physicians Office/ Freestanding Facility** Laboratory/diagnostic tests, x-rays	See Major Medical benefits	See Major Medical benefits	80%

(3) Limited to 40 visits per calendar year.
(4) Coverage for routine mammograms: a single baseline mammogram for women between ages of 35 and 39; one every calendar year for women between the ages of 40 and 49; one mammogram per calendar year for women age 50 and older. Mammograms are covered at any age for participants or dependents with a prior family history of breast cancer.
(5) The Plan will provide coverage for well child care visits in accordance with the schedule recommended by the American Academy of Pediatrics.
(6) Coverage for routine PSA tests: one diagnostic exam per calendar year for men over age 40 who have a family history of prostate cancer or who have other risk factors for prostate cancer; one exam per calendar year for men age 50 and older; standard diagnostic testing for men of any age will be covered if they have a prior history of prostate cancer.
(7) The Plan follows HCR guidelines.

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Outpatient Treatments			
• **Freestanding Facility**			
Chemotherapy	100%	80%	80%
Radiation therapy	100%	80%	80%
• **Physicians Office**			
Chemotherapy	See Major Medical benefits	See Major Medical benefits	80%
Radiation therapy	100%	80%	80%
Durable Medical Equipment, Prosthetics, Medical Supplies, and Oxygen	See Major Medical benefits	See Major Medical benefits	80%
Diabetic Treatment and Education	See Major Medical benefits	See Major Medical benefits	80%
Diabetic Supplies and Equipment (Includes Insulin and supplies used to control blood sugar)	See Major Medical benefits	See Major Medical benefits	100%; not subject to deductible
Outpatient Services & Therapy			
• **Freestanding Facility**			
Dialysis or hemodialysis	100%	80%	80%
Respiratory therapy	See Major Medical benefits	See Major Medical benefits	80%
Physical therapy[8]	See Major Medical benefits	See Major Medical benefits	80%
Occupational therapy[8]	See Major Medical benefits	See Major Medical benefits	80%
Speech therapy[8]	See Major Medical benefits	See Major Medical benefits	80%
Cardiac rehabilitation	See Major Medical benefits	See Major Medical benefits	80%
• **Physicians Office**			
Dialysis or hemodialysis	100%	80%	80%
Respiratory therapy	See Major Medical benefits	See Major Medical benefits	80%
Physical therapy[8]	See Major Medical benefits	See Major Medical benefits	80%
Occupational therapy[8]	See Major Medical benefits	See Major Medical benefits	80%
Speech therapy[8]	See Major Medical benefits	See Major Medical benefits	80%
Cardiac rehabilitation	See Major Medical benefits	See Major Medical benefits	80%
CALENDAR YEAR DEDUCTIBLE (Carryover applies Oct, Nov, Dec)	None	None	$250 Individual $500 Family
COINSURANCE MAXIMUM (Does not include deductible and/or copay)	None	None	$1,000 Individual
LIFETIME MAXIMUM	None	None	Unlimited

(8) Limited to a maximum of 20 visits per participant or dependent per calendar year per therapy.

DEFINITIONS

The terms defined in this section have been capitalized throughout this document.

ALLOWABLE EXPENSE means the maximum amount the Plan will pay to a Provider for the services or supplies covered under this Plan before any applicable deductible, Copayment and Coinsurance amounts are subtracted. The Covered Family Member's deductible, Copayment and Coinsurance amounts are based on the Allowable Expense, except as mentioned below. The Allowable Expense is determined as follows:

(1) The Allowable Expense for Covered Services received from a Facility (an institutional provider such as a Hospital, Skilled Nursing Facility, Urgent Care Facility, Home Health Care Facility, laboratory, etc.) is the amount set by State or Federal law. In the absence of State or Federal law:

- (A) The Allowable Expense for a Covered Service received from a Facility that is a Preferred Provider will be the amount that has been negotiated with the Facility.
- (B) The Allowable Expense for a Covered Service received from a Facility that is a non-Preferred Provider will be the lower of the amount that has been negotiated with the Facility or the Facility's billed charge; or

(2) The Allowable Expense for a Covered Service performed by a Provider is the fee schedule amount. The fee schedule amount is assigned to a service or procedure based upon a review of factors such as Medicare rates, provider specialty, geographic location, and network adequacy. In the absence of a set fee schedule amount, the Allowable Expense amount will be determined by taking into consideration the type of Covered Service, the provider specialty and the average fee schedule amount for similar Covered Services.

(1) The Allowable Expense for a Covered Service performed by a Preferred Provider will be the lower of:

- (i) The amount listed on the fee schedule; or
- (ii) The Provider's billed charge.

(2) The Allowable Expense for a Covered Service of a non-Preferred Provider will be the lower of:

- (i) The amount that has been negotiated with the Provider; or
- (ii) The 85th percentile the Reasonable and Customary charge as defined below; or
- (iii) The Provider's billed charge.

The Reasonable and Customary charge is a fee or charge the Plan determines based on provider charge data known as the Prevailing Healthcare Charges System (PHCS), which the Claim Administrator purchases from Ingenix, Inc, or provider charge data that the Claim Administrator purchases from a New York State-approved vendor of provider pricing data.

BEHAVIORAL HEALTH CARE FACILITY means a facility that specializes in the treatment of Substance Abuse or Mental Illness which meets any licensing or certification standards in the jurisdiction where it is located. For Covered Family Members who are entitled to Medicare, a Behavioral Health Care Facility must be a provider of services under Medicare.

DURABLE MEDICAL EQUIPMENT means medical equipment that satisfies all the following requirements:

(1) It is generally not useful in the absence of an Injury or a Sickness, and
(2) It is appropriate for use in the home, and
(3) It can withstand repeated use, and
(4) It is Medically Necessary, and
(5) It is not useful or convenient to other household members, and
(6) It is not a convenience item or an aid to daily living.

EMERGENCY means a condition manifesting itself with acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to pregnant women, the health of the woman's unborn Child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

ESSENTIAL HEALTH BENEFITS means benefits as defined by the Secretary of Health and Human Services. Such benefits will include at least the following general categories of benefits:

(1) Ambulatory patient services;
(2) Emergency services;
(3) Hospitalization;
(4) Maternity and newborn care;
(5) Mental health and substance use disorder services, including behavioral health treatment;
(6) Prescription drugs;
(7) Rehabilitative and habilitative services and devices;
(8) Laboratory services;
(9) Preventive and wellness services and chronic disease management; and
(10) Pediatric services, including oral and vision care.

EXPERIMENTAL or **INVESTIGATIVE** means services, supplies, care and treatment that do not constitute accepted medical practice. When determining whether or not a procedure is Experimental or Investigative, the Plan will take into consideration appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

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

(1) The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, except where the laws of the state mandate coverage for any drug not approved by the FDA but recognized as appropriate treatment for a particular type of cancer by an established reference such as the AMA Drug Evaluations, or
(2) The drug, device, medical treatment or procedure, or the patient informed consent document was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval, or

(3) Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, or

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

HOSPITAL means a licensed institution that meets all the following requirements:

(1) It primarily provides, for compensation from its patients and on an inpatient basis, all facilities necessary for medical and surgical treatments, and care of injured and sick persons by or under the supervision of a staff of physicians, and

(2) It continuously provides 24-hour-a-day nursing service by registered professional nurses, and

(3) It is not a primary place for rest, a place for the aged, or a nursing home, and

(4) It is not primarily a place providing convalescent/skilled nursing care, rehabilitation care, custodial care, hospice care, treatment of Mental Illness or Substance Abuse, a health resort or spa, a sanitarium, an infirmary at any school, college or camp, and

(5) It is a provider of services under Medicare with respect to participants or dependents who are entitled to Medicare, and

Additionally, the following institution will qualify under this definition:

(6) A licensed birthing center that:

(A) Provides care and treatment for patients during uncomplicated pregnancy, routine full-term delivery, and immediate postpartum care, and

(B) Provides full-time skilled nursing services, and

(C) Is staffed and equipped to give Emergency care, and

(D) Has a written arrangement with a local Hospital for Emergency care, and

(E) Is a provider of services under Medicare with respect to participants or dependents who are entitled to Medicare, and

(F) Is approved for its stated purpose for ambulatory care.

INJURY means an accidental loss, unforeseen impairment, or physical harm inflicted on the body by unexpected, external means.

MEDICALLY NECESSARY or **MEDICAL NECESSITY** means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

(1) In accordance with generally accepted standards of medical practice;

(2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

(3) Not primarily for the convenience of the patient, physician, or other health care provider, and

(4) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community when available. Physician Specialty Society recommendations, the views of prudent physicians practicing in relevant-clinical areas, and any other clinically relevant factors.

MENTAL ILLNESS means a mental or an emotional disorder as defined and classified by appropriate ICD-9 coding, regardless of cause, which is characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominating feature.

PLAN means the I.B.E.W. Local 910 Welfare Fund Health Care Benefit adopted and maintained pursuant to this document that sets forth the rights and obligations of the persons entitled to benefits under the Plan and the procedures by which Plan fiduciaries may be identified.

PREFERRED PROVIDER means a Health Care Provider who is a member of the Preferred Provider Network.

PREFERRED PROVIDER NETWORK means an organization of Health Care Providers who have entered into an agreement to provide covered services at a predetermined rate.

PREFERRED PROVIDER REIMBURSEMENT SCHEDULE means the schedule of Allowable Expenses payable for any covered services by an in-network Provider.

PROVIDER or **HEALTH CARE PROVIDER** means an individual who is operating within the scope of his license to provide Medically Necessary covered services. A physician operating within the scope of his license and who is licensed to prescribe medications, administer drugs, perform surgery or to provide Medically Necessary covered services is a Health Care Provider.

Provider will also include services of a certified nurse practitioner when services are performed directly under the supervision of a physician, and skilled nursing services rendered by a registered professional nurse or by a licensed practical nurse under the direction of a registered professional nurse. Provider will also include a certified nurse midwife for any covered service that is within the lawful scope of their practice regardless of their employment status by a physician. A certified nurse midwife need not act pursuant to a physician's orders. Provider will also include a licensed dentist, or a licensed practitioner who is practicing within the scope of his license and whose license is favorably accepted by the State or other jurisdiction in which the covered services are provided. The term Provider will also include a physician's assistant, podiatrist, osteopath, optometrist, psychiatrist, psychologist, chiropractor, speech therapist, occupational therapist, or licensed physical therapist acting within the scope of his license or certificate who is performing services that are covered by this Plan. When used in the treatment of Mental Illness, this term will also include a certified and registered social worker with at least six years of post-degree experience who has been qualified by the state in which they practice.

REASONABLE and CUSTOMARY means the smaller of:

(1) The charge usually made for the service by the Provider who furnishes it, or
(2) The prevailing charge made for the service, in the same geographic area, by Providers of similar professional standing, as determined by the Plan.

If the usual and prevailing charge for a service or supply cannot be easily determined because of the unusual nature of the service or supply, Excellus BCBS will determine to what extent the charge is a Reasonable and Customary charge, taking into account:

(1) The nature and severity of the condition, and
(2) The complexity involved, and
(3) The degree of professional skill required, and

(4) Any unusual circumstances which require additional time, skills or experience.

RECONSTRUCTIVE SURGERY means surgery necessary for the repair of a body part due to a non-occupational disease or non-occupational Injury. It will also include surgery required because of trauma, infection or disease and a congenital disease or anomaly of a covered child that results in a functional defect. If a participant or dependent requires Reconstructive Surgery to a breast following a covered mastectomy procedure, the term Reconstructive Surgery will also include surgery to the opposing breast to produce a symmetrical appearance.

SICKNESS or **ILLNESS** means an unhealthy condition of the body, a disease, a mental or physical disorder, or pregnancy. The term Sickness means all such Sicknesses due to the same or related causes, including all complications or recurrences. The term Sickness does not mean an Injury.

SUBSTANCE ABUSE means the chronic abuse of alcohol or other drugs as defined and classified by the appropriate ICD-9 coding characterized by impaired functioning, debilitating physical condition, the inability to keep from or reduce consumption of the substance, or the daily use of the substance in order to function. The term Substance Abuse includes addiction to alcohol or other drugs, but not caffeine, tobacco, or food.

URGENT CARE FACILITY means a medical facility that is open on an extended basis, is staffed by physicians to treat medical conditions not requiring inpatient or outpatient Hospital care, and which is not a physician's office.

UTILIZATION MANAGEMENT AND MEDICAL REVIEW

UTILIZATION MANAGEMENT: The Plan Administrator reserves the right to incorporate a utilization management program into the Plan's benefit provisions. If alternative services are recommended which are not specified in the Plan as Allowable Expenses, the Plan Administrator shall have the right to approve reimbursement of such services. Utilization Management means the systems, strategies, and mechanisms needed to manage appropriate, Medically Necessary and cost effective health care services.

Utilization Management is intended to:

(1) Assure high quality care and treatment, and
(2) Propose alternative treatments to avoid unnecessary or lengthy confinements and surgeries, and
(3) Promote cost-effective health care, and
(4) Monitor the treatment plan for participants or dependents with chronic Sickness or catastrophic Injury through medical case management.

When an alternate service involves care at home or is for rehabilitative purposes, the Plan may provide benefits for the alternate service as an Allowable Expense.

CASE MANAGEMENT AND CENTERS OF EXCELLENCE: In the event of a catastrophic Injury or Sickness, a participant or dependent may require long-term, perhaps lifetime care. Case Management monitors such patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. In certain cases, the case manager may recommend care and/or treatment at a Center of Excellence, a facility with proven expertise and success rates in the specific type of care and/or treatment needed. If the case manager's treatment plan is approved, the Plan Administrator may direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if the Plan would not normally pay those expenses.

DETAILED DESCRIPTION OF BENEFITS

This Plan only makes payment decisions based on the benefits provided. It is the responsibility of the patient and the attending physician to decide whether treatment should be rendered regardless if the services are totally or partially covered, or excluded from coverage under the Plan. The Plan does not and cannot make treatment decisions. The Plan does not select or take any responsibility for the proper or improper performance of any healthcare provided.

INDEMNITY PROGRAM

Under this Plan, a participant or dependent has the option to choose to receive health care services from either a Health Care Provider who is a member of a Preferred Provider Network or from a Health Care Provider who is not a member of a Preferred Provider Network. Benefits payable under the Indemnity Program for in-network and out-of-network treatment will be subject to the applicable coinsurance, maximums and deductible amounts, and any limitations as shown in the Schedule of Benefits.

If you or your covered dependent seeks care or treatment from a member of the Preferred Provider Network, medical expense benefits will be paid by the Plan according to the Preferred Provider Reimbursement Schedule. Excellus BCBS will pay benefits directly to the Provider for covered services less any applicable coinsurance and/or deductible.

A list of Preferred Providers is available at www.excellusbcbs.com/IBEW910.

MEDICAL EXPENSE BENEFITS

The Plan will pay benefits for a Medically Necessary expense subject to coinsurance, maximums and deductibles, and any limitations, as shown in the Schedule of Benefits and elsewhere in this document. The benefit payment will be based on whether the participant or dependent chooses to receive care from an in-network Provider or an out-of-network Provider.

Any covered service that is described in this section will either be paid as a Basic benefit or as a Major Medical benefit, or both. If available, any Basic benefit will be paid first. Major Medical benefits will only be paid after all Basic benefits have been paid or exhausted. See the Schedule of Benefits for specific information regarding payment of benefits.

Covered services include the charges for the following Medically Necessary services and supplies. Similar health expenses identified by the Current Procedural Terminology (CPT) developed by the American Medical Association, the Common Procedure Coding System (HCPCS) developed by the Health Care Financing Administration, or the Hospital Revenue Code application will be covered unless they are excluded. Covered medical services may also be identified in the International Classification of Diseases, 9th edition (ICD-9). Covered services include:

(1) **Allergy Care**. The Plan covers allergy care treatment, to include but not limited to office visits, serum, scratch testing, and laboratory testing. Allergy serum that is covered under the Prescription Drug Benefit will not be covered under the medical expense benefit.

(2) **Ambulance or Paramedic Services**. The Plan covers Medically Necessary ambulance or paramedic services in connection with an inpatient confinement or outpatient Emergency treatment. Air ambulance transportation is covered if Medically Necessary and if no other mode of transportation is appropriate. Ambulance service used to transport a participant or dependent from a Hospital or other health care facility or to inpatient confinement at another Hospital or health care facility and home is also covered.

Ambulance Limitations: Transport is limited to Medically Necessary transportation to and from a local Hospital or the nearest Hospital where the appropriate treatment for an Injury or Sickness can be provided.

(3) **Anesthesia**.

(4) **Chemotherapy and Radiation Therapy**.

(5) **Chiropractic Care**. The Plan covers the Medically Necessary services of a chiropractor as described in the Schedule of Benefits. All chiropractic services will be reviewed to determine Medical Necessity.

Chiropractic Care Limitations: Maintenance therapy that seeks to prevent disease, promote health, prolong life, and enhance the quality of life is not covered.

(6) **Convalescent/Skilled Nursing Facility or Rehabilitation Facility**. The Plan covers convalescent/skilled nursing facility or a rehabilitation facility expenses for confinement in a semi-private room. A plan of treatment must be established by the attending physician and must demonstrate the Medical Necessity of the treatment, including the need for continuous care by a physician and 24 hour-a-day skilled nursing care. The physician must be qualified in the state of jurisdiction to prescribe the plan of treatment recommended, must remain available to visit the patient during the admission and provide the patient continuous care. The physician may not have any financial interest in the convalescent/skilled nursing facility or the rehabilitation facility.

The Plan covers the daily charge for room and board that does not exceed the semi-private rate. If the participant or dependent is confined in a private room, the Plan will pay an amount equal to the most common charge for a semi-private room. Outpatient care for physical, occupational, and speech therapy and other services shown in the Schedule of Benefits is covered.

Each day of care in a convalescent/skilled nursing facility or rehabilitation facility counts as one-half benefit day of care. For example, 20 days in a convalescent/skilled nursing facility or rehabilitation facility count as 10 benefit days of care toward the 365-day benefit maximum.

Convalescent/Skilled Nursing Facility or Rehabilitation Facility Limitations: Benefits in a convalescent/skilled nursing facility or in a rehabilitation facility are not provided under this Plan if the participant or dependent is eligible for reimbursement from Part A of Medicare.

(7) **Diabetic Education**. The Plan covers diabetic self-management education to ensure the participant or dependent is educated in the proper self-management and treatment of his diabetic condition.

Diabetic Education Limitations: Coverage is limited to visits for the diagnosis of diabetes, when a physician diagnoses a significant change in the participant's or dependent's symptoms or conditions which necessitates changes in the participant's or dependent's self-management, or where reeducation or refresher education is necessary. Coverage includes home visits when Medically Necessary.

(8) **Diabetic Supplies and Equipment**. The Plan covers the following equipment and supplies that are determined to be Medically Necessary for the treatment of diabetes: blood glucose monitors; blood glucose monitors for the legally blind; test strips for glucose monitors; visual reading and urine testing strips; injection aids; cartridges for

the legally blind; syringes; insulin pumps and accessories; insulin infusion devices; insulin; oral agents for controlling blood sugar; data management systems.
The diabetic education must be provided by a physician or other licensed Health Care Provider, or his staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian, upon the referral of a physician or other licensed Health Care Provider.

(9) **Diagnostic Tests**. The Plan covers diagnostic tests performed both inside and outside a Hospital including; diagnostic laboratory services, diagnostic x-ray tests, and diagnostic tests (EKG, EEG, etc.).

(10) **Dialysis and Hemodialysis**. The Plan covers dialysis and hemodialysis rendered by a licensed technician.

(11) **Durable Medical Equipment, Prosthetics, Medical Supplies, and Oxygen**. The Plan covers the following services, supplies, and equipment subject to review for Medical Necessity and the patient's condition:

(A) **Durable Medical Equipment**. The Plan covers the rental or, at the Plan's option, the purchase of Durable Medical Equipment. When the Plan covers the purchase of such equipment, the Plan also covers necessary maintenance and repairs. Maintenance and repairs can be paid on a per session basis or through an approved maintenance agreement. The Plan also covers the replacement of purchased equipment if the replacement is necessary due to a change in the patient's condition or is due to the growth of the patient.

Durable Medical Equipment Limitations: The Plan does not cover the cost of delivery of any Durable Medical Equipment, the set up of deluxe equipment when standard equipment is available and adequate, or the cost of materials used to manufacture equipment.

(B) **Prosthetic Devices**. The Plan covers the fitting and purchase of prosthetic devices that take the place of a natural internal or external part of a participant's or dependent's body (to include but not limited to breast prostheses following a covered mastectomy) or that are needed due to a functional defect of a covered dependent child. The prosthetic device must be ordered by a physician and must be Medically Necessary to relieve or correct a condition caused by an Injury or Illness. The Plan also covers the replacement of a purchased prosthetic device if the replacement is necessary due to a change in the patient's condition or is due to the growth of the patient. Implanted cataract lenses are covered when they perform the function of the human lens and are Medically Necessary because of intraocular surgery.

Prosthetic Devices Limitations: The Plan does not cover delivery charges or routine maintenance related to prosthetic devices. Eyeglasses are not considered prosthetic devices.

(C) **Medical Supplies**. The Plan covers medical supplies for use outside of a Hospital, convalescent/skilled nursing facility, or a rehabilitation facility ordered by a physician including, but not limited to, casts, splints, surgical dressings, ostomy bags and supplies, catheters, and oxygen.

(D) **Oxygen**. The Plan covers oxygen and the administration of oxygen. When the Plan covers the purchase of equipment used to administer oxygen, the

Plan also covers necessary maintenance and repairs. Maintenance and repairs can be paid on a per session basis or through an approved maintenance agreement.

(12) **Emergency Room Treatment**. The Plan covers treatment received in an Emergency room in connection with an Injury or Sickness

Emergency Room Treatment Limitations: Emergency treatment must be rendered within 72 hours of an Injury or within 12 hours of the onset of a sudden and serious Illness.

(13) **Freestanding Surgical Facility**.

(14) **Home Health Care**. The Plan covers home health care as shown in the Schedule of Benefits if a treatment plan is established at the time the physician certifies the Medical Necessity of the home health care services. The treatment plan must be filed with Excellus BCBS. The physician may not have any financial relationship with the home health care agency furnishing the services. The physician must be qualified under the law of the state to certify the need for home health care and the treatment plan. It is expected that the physician will see the patient although there is no specified time interval for those visits.

Each four hours of a home health care service is considered a visit. Each home health care visit counts as one-third benefit day of care. For example, 30 home health care visits count as 10 benefit days toward the 365-day benefit maximum.

Nursing and therapy services authorized as part of a home health care plan and performed by a nurse or therapist affiliated with a home health care agency are also covered. Such services are limited to the home health care benefit maximums described in the Schedule of Benefits.

Home Health Care Limitations: Charges are not covered for any care or treatment not outlined by the physician in the treatment plan, or home health care incurred during any period when the participant or dependent is not under the care of a physician. No coverage will be provided for custodial care or for services by a relative of the Covered Family Member or a person who normally resides in the Covered Family Member's home.

Private duty nursing services authorized as part of a home health care plan and performed by a nurse affiliated with a Home Heath Care Agency are covered, but are subject to the home health care benefit maximum described in the Schedule of Benefits.

(15) **Hospice Care**. A participant or dependent diagnosed with a terminal Illness and a life expectancy of six months or less may receive care by a certified Hospice Care Agency up to the limit shown in the Schedule of Benefits. Hospice care consists of services and supplies, including prescription drugs, provided by the hospice to the extent they are otherwise covered by this Plan. Treatment may be furnished in a Hospice Facility or Hospital, or on an outpatient basis in the terminally ill participant's or dependent's home under a home care plan provided by a hospice care agency. Inpatient respite care need not meet the normal Medically Necessary criteria for admissions. Hospice care includes visits for bereavement counseling furnished to the family of the terminally ill family member as described in the Schedule of Benefits. Bereavement counseling may be provided before or after the participant's or dependent's death.

Hospice Care Limitations: The Plan does not cover:

(A) Charges for a physician employed by the Hospice.
(B) Any confinement not required for pain control or other acute or chronic system management.
(C) Services or supplies provided by volunteers or others who do not regularly charge for their services, including pastoral counseling.
(D) Funeral services or arrangements.
(E) Legal or financial counseling or services.
(F) Services, except bereavement counseling, supplied to other family members, other than the terminally ill participant or dependent.
(G) Bereavement counseling in excess of the number of visit maximum indicated in the Schedule of Benefits.
(H) Any expense incurred by a participant or dependent that is listed in the section of this booklet entitled "Plan Exclusions".

(16) **Infertility Treatment**. The Plan covers the treatment of the Sickness or Injury causing infertility. Treatment must be rendered on an outpatient basis and must be Medically Necessary.

Infertility Treatment Limitations: The Plan does not cover any service that provides assistance in achieving a pregnancy. The following procedures and similar procedures intended to achieve a pregnancy are excluded from coverage under this Plan's Medical Expense Benefit; artificial insemination, in-vitro fertilization, in-vivo fertilization, gamete inter-fallopian transfer (GIFT), zygote inter-fallopian transfer (ZIFT) or similar procedures to achieve a pregnancy.

(17) **Inpatient Hospital Admission**. The Plan covers inpatient Hospital expenses and semi-private room and board accommodations. See the Schedule of Benefits for information on coverage of a private room.

With respect to a confinement related to a dental procedure, the Plan does not cover Hospital expenses regardless of whether or not the actual dental procedure is covered.

(18) **Mammograms (Medically Necessary)**. As recommended by the attending physician.

(19) **Maternity Care**. The Plan covers charges in connection with prenatal care, delivery and postpartum care, including inpatient routine nursing care. Maternity care includes, but is not limited to, pre and post-natal office visits, associated diagnostic tests, laboratory tests and x-ray charges, semi-private room, general nursing care, Provider services, anesthesia if Medically Necessary, prescription drugs administered while inpatient, and ancillary services.

The provisions of the Newborns' and Mothers' Health Protection Act of 1996 provide for a minimum length of stay for the birth of a newborn. Benefits payable under this Plan for a maternity-related Hospital stay must not be restricted for the mother or the newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section unless a shorter stay is agreed to by both the mother and her attending physician.

(20) **Mental Illness Treatment**. The Plan covers inpatient confinement for Mental Illness in a Hospital or Behavioral Health Care Facility. Partial Hospitalization is covered when Medically Necessary.

The Plan also covers outpatient treatment, including Emergency visits. Outpatient treatment may be furnished in an outpatient department of a Hospital, including the Emergency room, in a Behavioral Health Care Facility, or in a physician's office.

The Plan covers Medically Necessary electro-shock therapy when provided in an outpatient department of a Hospital. Associated expenses for a Hospital operating room and for the anesthesiologist are covered as described in the Schedule of Benefits for those services.

Mental Illness Treatment Limitations: Treatment must be directly related to a Mental Illness (as defined). Benefits are not payable for care primarily directed at raising the level of consciousness, social enhancement, retraining, professional training, or counseling limited to everyday problems of living, marriage counseling, family situational counseling, sex therapy, or support groups. Under no circumstances will benefits be provided for therapy that includes the satisfaction of requirements for professional training.

(21) **Morbid Obesity Treatment**. The plan covers treatment of obesity as defined by the Excellus BCBS Medical Policy titled: Surgical Management of Obesity.

Morbid Obesity Treatment Limitations: Anything not included or not approved in the written treatment plan is not covered. Prescription appetite or weight control drugs will not be covered under the Health Care Insurance Benefit even when included as part of a written treatment plan. Non-prescription appetite or weight control drugs, dietary supplements, special foods or food supplements, health or weight control centers or resorts and health club memberships, subscriptions to books and exercise equipment also are not covered.

(22) **Newborn Care**. The Plan covers newborn care including nursery charges, charges for routine Provider examinations as described in the Schedule of Benefits, tests, and charges for routine procedures such as circumcision.

(23) **Occupational Therapy.** The Plan covers occupational therapy rendered by a licensed occupational therapist. The therapy must be Medically Necessary as outlined in a plan of treatment by the attending physician and expected to restore bodily functions within a reasonable period of time.

(24) **Organ and Tissue Transplants**. The plan will provide coverage for all of the benefits otherwise covered in this booklet for organ and bone marrow transplants subject to the following limits:

Care In Approved Transplant Centers. Certain types of organ transplant procedures must be performed in transplant centers certified or otherwise approved by the appropriate regulatory authority for the specific type of transplant procedure being performed. The types of organ transplants that must be performed in certified transplant centers are: bone marrow; liver; heart; lung; heart-lung; kidney and kidney-pancreas. You may contact Excellus BCBS if you wish to obtain a list of certified transplant centers.

No Coverage of Experimental Or Investigational Organ Transplants. The plan will not provide coverage for any benefits for an organ transplant we determine to be experimental or investigational. We maintain and revise from time to time a list of organ transplant procedures which we determine not to be experimental or investigational and therefore are covered by the plan. You may contact us if you have a question concerning whether a particular transplant procedure is covered.

Recipient Benefits. The Plan will provide coverage for a person covered under this plan for all of the benefits provided to the recipient of the organ transplant that are otherwise covered under the plan when they result from or are directly related to a covered organ or bone marrow transplant.

Coverage for Donor Searches Or Screenings. The Plan will not provide coverage for costs relating to searches or screenings for donors of organs.

Costs Of Organ Donor. The Plan will provide coverage for the medical services directly related to the donation of an organ for transplantation to a person covered under the plan. The Plan will not provide coverage if you are donating an organ for transplantation to a person not covered under the plan.

(25) **Outpatient Hospital Treatment**.

(26) **Pap Smears (Medically Necessary)**. As recommended by the attending physician.

(27) **Physical Therapy**. The Plan covers physical therapy rendered by a licensed physical therapist. The therapy must be Medically Necessary as outlined in a plan of treatment by the attending physician and expected to restore bodily functions within a reasonable period of time.

Physical Therapy Limitations: Therapy designed to prevent further deterioration is not covered.

(28) **Physician and Health Care Providers**. The Plan covers:

(A) **Office and Inpatient Visits**. The Plan covers non-surgical office and inpatient visit charges by a physician or other Provider for treatment of an Injury or Sickness as described in the Schedule of Benefits. Inpatient or outpatient Provider visits and office consultations by a specialist are also covered.

(B) **Surgery**. The Plan covers surgery, co-surgery, assistant surgery, and Reconstructive Surgery.

Surgery (including multiple surgery or multiple surgical procedures) is defined by the American Medical Association's Current Procedural Terminology (CPT) and by the Healthcare Common Procedure Coding System (HCPCS). All surgical procedures, including multiple surgical procedures, are subject to clinical edits and must fall within standards of practice as defined by the American Medical Association, are subject to review for Medical Necessity, and approval by the appropriate governmental agency. Surgery will include physical complications in all stages of covered surgeries, to include, but not limited to mastectomies, including lymphedemas. Surgery also includes voluntary termination of pregnancy.

(C) **Treatment of an Injury to the Teeth**. The Plan covers Medically Necessary treatment of an Injury to sound, natural teeth. The Injury must not be caused, directly or indirectly, by biting or chewing, and all treatment must be performed within 12 months of the date of the Injury. Treatment includes replacing natural teeth lost due to such Injury. A sound natural tooth is any tooth that has adequate bone structure, healthy periodontium, and healthy support tissue. A tooth may have been restored in any manner including fillings or a crown but will still be considered a sound and natural tooth as long as the "support" of the tooth remains intact. The above dental services

will be covered if they can be identified in the Current Dental Terminology (CDT) developed by the American Dental Association.

(D) **Second Medical Opinions**. The Plan allows coverage for an office visit in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. The Plan also allows coverage for a second medical opinion concerning any recommendation of a course of treatment for cancer. If a participant or dependent receives a written referral from a participating doctor to a non-participating specialist, in-network benefits will apply.

(29) **Podiatrist**. The Plan covers charges by a podiatrist for treatment of an Injury, Sickness, or deformity of the feet. The Plan covers the initial fitting and purchase of custom made orthotics if determined to be Medically Necessary for the relief or correction of any condition caused by an Injury or Sickness. Replacements are covered only if necessary due to growth or a change in health.

(30) **Preadmission Testing**. The Plan covers preadmission testing prior to surgery. Tests must be performed within seven days of the planned admission and must be accepted by the Hospital in place of the same post-admission tests. Tests repeated after admission or before surgery are not covered, unless the admission or surgery is deferred solely due to a change in the health of the participant or dependent.

(31) **Preventative Care and Well Care**. The Plan covers:

(A) **Preventative Care for a Child**. The Plan covers routine preventative/well-care visits up to age 19 for a dependent child as described in the Schedule of Benefits.

The Plan will provide coverage for well child care visits in accordance with the schedule recommended by the American Academy of Pediatrics.

(B) **Preventative Care for an Adult**. The Plan covers routine preventative care for an adult over age 50 as recommended by the attending physician. Benefits are limited to the maximums described in the Schedule of Benefits.

(C) **Routine Pap Smear Tests and Pelvic Exams**. The Plan covers charges for routine pap smear test(s) and pelvic exam(s) as described in the Schedule of Benefits.

(D) **Routine Mammography Screening**. The Plan covers charges for routine mammography screenings as recommended by the attending physician as described in the Schedule of Benefits.

(E) **Routine PSA Tests**. The Plan covers charges for routine PSA tests as recommended by the attending physician as described in the Schedule of Benefits.

(F) **Colon Cancer Screening**. The Plan covers a routine screening colonoscopy for Covered Family Members age 50 and over, and every 10 years after a normal colonoscopy. Routine screening colonoscopy may start at an age 10 years younger than a first degree relative with colon cancer (e.g., your father is diagnosed with colon cancer at age 55, colonoscopy could start at age 45).

(32) **Private Duty Nursing**. The Plan covers the services of a private duty registered nurse or licensed practical nurse when the participant or dependent is confined in a Hospital as described in the Schedule of Benefits. The Hospital must not have available the level of nursing care necessary to care for the patient's condition. The Plan will also cover private duty nursing services outside the Hospital, however, the nurse may not be a relative or a person living in the participant's or dependent's home and the Plan will not cover private duty nursing services if the patient is receiving home health care services.

Private Duty Nursing Limitations: Private duty nursing services, both inpatient and outpatient, must be ordered by a physician and the Plan will determine if the private duty nursing services are Medically Necessary for treatment of the medical condition. The nature of the Illness must show that nursing care can only be provided by a person with the education and skills of a nurse. The Plan will not pay for services that consist mainly of providing assistance with the activities of daily living.

(33) **Respiratory Therapy**. The Plan covers respiratory therapy rendered by a licensed respiratory therapist.

(34) **Speech Therapy**. The Plan covers speech therapy rendered by a licensed speech therapist when needed by a participant or dependent due to Injury or Sickness. Speech therapy must be performed to restore speech that was lost due to an Injury or Sickness, be an active treatment for a medical condition resulting in functional defect or be for the correction of a speech impairment resulting from said Injury or Sickness, including previous therapeutic processes.

Speech Therapy Limitations: This Plan does not cover speech therapy services that are educational in any part, or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders. Therapy designed to prevent further deterioration is not covered.

(35) **Substance Abuse Treatment**. The Plan covers inpatient confinement for Substance Abuse in a Hospital or in a Behavioral Health Care Facility. Partial Hospitalization is covered when Medically Necessary.

The Plan also covers outpatient treatment, including Emergency visits. A portion of these visits may be used by other Covered Family Members even if the Covered Family Member in need of Substance Abuse treatment is not receiving it. Outpatient treatment, including outpatient Emergency visits, may be furnished in an outpatient department of a Hospital, including the Emergency room, in a Behavioral Health Care Facility, or in a physician's office.

(36) **Urgent Care Facility**.

MEDICAL EXPENSE BENEFITS
SPECIAL CONDITIONS

APPLICATION OF THE DEDUCTIBLE: The deductible as outlined in the Schedule of Benefits applies when benefits are being reimbursed under the Major Medical Benefits section of the Plan only. No deductible applies to the Basic Benefit section of the Plan. Any applicable Basic benefit will be paid by the Plan first. Major Medical expenses will apply only after all Basic benefits have been paid or exhausted.

The deductible applies to all Major Medical services regardless of whether the participant or dependent chooses to go to an in-network Provider or an out-of-network Provider, except where noted in the Schedule of Benefits. Each participant or dependent must have eligible charges that exceed the deductible before the Plan pays Major Medical expenses for that person. Once a participant or dependent meets the deductible, the Plan pays benefits for Allowable Expenses incurred by the participant or dependent less any applicable coinsurance for the rest of the calendar year. A separate deductible applies to each participant or dependent regardless of the number of his or her disabilities. When any part of a calendar year's deductible is applied against expenses arising during October, November and December, the following calendar year's deductible will be reduced by the same amount.

FAMILY LIMIT ON DEDUCTIBLES: When Major Medical expense deductible amounts for all participant or dependents total the family deductible amount indicated in the Schedule of Benefits, no further deductible will be applied to the family's covered expenses for the rest of that calendar year.

COMMON ACCIDENT DEDUCTIBLE: If two or more family members incur charges as a result of the same accident, only one deductible will be applied to all resulting Injuries of all family members involved in the accident during that calendar year.

COINSURANCE MAXIMUM: During a calendar year, when the coinsurance payable by a participant or dependent equals the coinsurance maximum shown in the Schedule of Benefits, benefits for covered Major Medical expenses will be payable at 100% of the Reasonable and Customary charge or 100% of the Preferred Provider Reimbursement Schedule for the remainder of that calendar year. The deductible will not be applied to the coinsurance maximum.

LIMITATIONS AND EXCLUSIONS: No benefits are payable under the Health Care Insurance Benefit for any expenses incurred that result from circumstances outlined in the section of this booklet entitled "Plan Exclusions".

PLAN EXCLUSIONS

The following general exclusions apply to all sections of this Plan. Specific Limitations and Exclusions for individual Plan benefits are also described in the Schedule of Benefits or with that benefit in the Detailed Description of Benefits. No payment will be made under this Plan for expenses incurred by a participant or dependent for:

(1) **Acupuncture**

(2) **Any Other Employment** The Plan does not cover charges for or in connection with a Sickness, Injury, occupational disease or condition arising out of, or in the course of, any employment for wage, profit, intent of profit, or self-employment, or for which the participant or dependent is or was entitled to receive workers' compensation benefits. This exclusion applies even if the participant's or dependent's right to workers' compensation has been waived, qualified, or not asserted.

(3) **Artificial Insemination** The Plan does not cover expenses related to artificial insemination, in-vitro fertilization, sperm washing, and for a surrogate mother. However, the expenses for the birth of a child as the result of artificial insemination, in-vitro fertilization, or other approved methods of conception, and the expenses of the child of a surrogate mother if the child has been placed for adoption with the covered participant will be covered. "Placed" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

(4) **Automobile Insurance, Ineligibility** The Plan does not cover charges for which the participant or dependent is eligible to receive benefits through mandatory no fault or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. Excellus BCBS will take into consideration any adjustment option chosen under such part by the participant or dependent. If a participant or dependent is ineligible to receive benefits through mandatory no-fault insurance or uninsured motorist insurance law due to his operation of a motor vehicle while he is intoxicated (DWI), while his ability is impaired (DWAI), or while under the influence (DUI) as defined by applicable state law, or other diagnostic tests indicating the impermissible presence of drugs or alcohol, regardless of whether or not charges are filed, no payment will be made under this plan for charges incurred by that participant or dependent in connection with the resulting Injury.

(5) **Biofeedback**

(6) **Blood Products** The Plan will not provide coverage for the cost of blood, blood plasma, other blood products or blood processing or storage charges, when they are available free of charge in the local area, except the plan will provide coverage for blood required for the treatment of hemophilia when billed by a Facility. When not free in the local area, the plan will cover blood charges, even if you donate or store your own blood, if billed by a Facility, ambulatory surgery center, or a certified blood bank.

(7) **Civil and Criminal Misconduct** The Plan does not cover charges for, or in connection with, any Injury or Sickness that arises while committing or attempting to commit an assault, felony, participating in a riot or civil disorder, or any other illegal act. This includes any Injury or Sickness directly related to substance abuse or incurred while under the influence of alcohol, drugs, or narcotics, including while operating a vehicle.

(8) **Clothing, Orthopedic Shoes** The Plan does not cover charges for special clothing, including orthopedic shoes, except for Medically Necessary burn garments or lymphedema sleeves.

(9) **Cosmetic Surgery** The Plan does not cover cosmetic surgery, unless it qualifies as Reconstructive Surgery as defined.

(10) **Court Mandated Services** The Plan does not cover charges related to court mandated non-Medically Necessary services for therapy or treatment for Mental Illness, Substance Abuse or any other health services. The Plan will retain the right to cover such services if they are deemed to be Medically Necessary.

(11) **Custodial Care** The Plan does not cover charges for or in connection with custodial care (except as specifically covered under the hospice benefit or elsewhere in the Plan) sanitariums or rest care.

(12) **Dental Care** The Plan does not cover for or in connection with treatment of the teeth or periodontium, unless such expenses are incurred for charges made for, or in connection with, dental work due to an Injury to sound, natural teeth. Treatment must be rendered within 12 months of the accident. All the conditions for payment that apply to covered services under the Plan apply to the above covered expenses. Injuries to the teeth and soft tissue as a result of chewing or biting are not considered Injuries.

(13) **Dental Implants**

(14) **Diagnostic Studies and Therapy** The Plan does not pay for any Hospital stay, or any portion of a Hospital stay, that is primarily for diagnostic purposes or therapy. This includes, but is not limited to, a Hospital stay, or a portion of a Hospital stay, during which the services are primarily for diagnostic x-rays, laboratory tests, other types of diagnostic studies, or medical evaluation or therapy.

(15) **Disallowed Benefits or Penalties** The Plan does not cover charges for penalties or disallowed benefits determined by a primary health plan as determined by this Plan's Coordination of Benefits section, Medicare, an HMO or other managed care plan due to failure of the covered person to obtain the proper pre-certification, second opinion, or any other reason including failure to comply with the requirements of the primary care physician network established by the HMO or managed care plan or by voluntarily obtaining services outside the established provider network thereby incurring a reduction or denial of benefits. For any penalty imposed due to failure to adhere to the conditions of the section entitled "Utilization Management and Medical Review".

(16) **Educational and Recreational Therapy** The Plan does not cover charges for recreational or educational therapy, forms of self care or self help training, or marital, family or other counseling or training services unless specifically covered elsewhere under the Plan.

(17) **Employment, School, or Camp Physical Exams** The Plan does not cover routine exams for the sole purpose of employment, school extracurricular activities, and summer camp physical examinations.

(18) **Excessive Charges** For charges made which are in excess of Reasonable and Customary charges or the Preferred Provider's Reimbursement Schedule.

(19) **Excluded Treatments** The Plan does not cover charges incurred for treatment of Sickness or Injury that results directly or indirectly from a treatment, procedure or therapy that is excluded from coverage under this Plan. This exclusion does not apply

to charges incurred for maternity or newborn care arising from a non-covered service.

(20) **Experimental or Investigative Drugs** The Plan does not cover Experimental or Investigative drugs or substances not approved by the Food and Drug Administration or for drugs labeled "Caution - limited by Federal Law to investigational use," including any drug or substance which is Experimental or Investigative.

(21) **Experimental or Investigative Services or Procedures** The Plan does not cover any and all charges resulting from Experimental or Investigative services and procedures, as defined in the Plan, including, but not limited to, all Experimental organ transplants and Experimental organ implants.

(22) **Eye Examinations and Vision Therapy** The Plan does not cover eye examinations, contact lenses or glasses (except for aphakic patients and cataract patients who do not receive implants), and soft lens or sclera shells intended for use in the treatment of Sickness or Injury. However, expenses for eye examinations and glasses are covered under the Plan when necessitated by accidental Injury. The Plan will not cover corrective lenses, eye refractions or any other services to determine the need for and/or proper adjustment of corrective lenses. This includes, but is not limited to: astigmatism, modifying or correcting myopia, hyperopia or stigmatic error, and other eye refractions including surgery performed to eliminate the need for corrective lenses. The Plan does not cover vision training for dyslexia and similar procedures, perceptual training and learning disability training. Coverage will only be provided when necessitated by damage to the natural eye as a result of an Injury as stated above, or a Sickness that results in similar damage. Services must restore or rehabilitate any resulting loss of vision.

(23) **Eye/Refractive Surgery**

(24) **Genetically Engineered Treatment**

(25) **Government Hospitals** The Plan does not cover services rendered in a Hospital owned or operated by the United States Government or any other government unless there is a legal obligation to pay such charges without regard to the existence of any coverage.

(26) **Hazardous Hobbies for Cash or Prize Money** The Plan does not cover charges incurred for the treatment of a Sickness or Injury that is the result of engaging in a hazardous hobby for cash compensation or prize money. A hobby is considered hazardous if it is an unusual activity characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies include but are not limited to automobile, bicycle and motorcycle racing, skydiving, hang gliding, ATV operation, jet skiing, snowmobiling, skateboarding, or bungee jumping.

(27) **Hearing Aids and Examinations** The Plan does not cover hearing aids, hearing examinations, or the prescription or fitting of hearing aids.

(28) **Herbal and Homeopathic Remedies**

(29) **Hypnosis**

(30) **Inpatient Routine Physical Examinations/Services** The Plan does not cover routine exams and services rendered in a Hospital during an inpatient confinement (except charges for routine nursery care of newborn child), unless otherwise specified in the Plan.

(31) **Interns and Residents** The Plan does not cover services rendered and billed by a

resident physician or intern while serving in that capacity.

(32) **Licensing** The Plan does not cover charges for care, services, or supplies rendered which are not within the scope of the professional license of the person providing them.

(33) **Massage Therapy** The Plan does not cover massage therapy unless it is performed by a licensed Provider, such as a physical therapist or a chiropractor, and is an integral part of a therapy treatment plan that has been approved by the Plan.

(34) **Medicare** The Plan does not cover charges to the extent that the participant or dependent is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by Medicare. Any individual who, at any time, was entitled to enroll in all or any portion of the Medicare program but who did not so enroll, will be considered to be entitled to reimbursement in an amount equal to the amount to which he would have been entitled, if any, if he were so enrolled.

(35) **No Coverage** The Plan does not cover charges that are incurred before a participant or dependent becomes covered by the Plan, after the participant's or dependent's coverage ended, or the Plan has terminated.

(36) **Non-Acute Hospital Care** The Plan does not pay for a Hospital stay or any portion of a Hospital stay where the participant or dependent received non-acute care. This includes, but is not limited to, a Hospital stay, or a portion of a Hospital stay, in connection with physical checkups, convalescent or custodial care, rest cures, or sanitarium type care.

(37) **Non-Durable Medical Equipment** The Plan does not cover equipment that does not meet the definition of Durable Medical Equipment, including but not limited to: air conditioners, humidifiers, exercise equipment, etc., and for wigs and artificial hair pieces, human or artificial hair transplants or any drug, prescription or otherwise, used to eliminate baldness.

(38) **Not Legally Required to Pay** The Plan does not cover charges which would not have been made if no coverage had existed or for which the participant or dependent is not legally required to pay, or payment is unlawful in the jurisdiction where the person resides at the time the expenses are incurred.

(39) **Not Medically Necessary** The Plan does not cover charges that are not Medically Necessary, except as specifically provided for in this Plan, or are not recommended and approved by an attending physician.

(40) **Not Physically Present** The Plan does not cover charges incurred for room and board for a participant or dependent in any Hospital or facility for any period of time during which that individual was not physically present.

(41) **Nutritional Counseling** The Plan does not cover nutritional, except for diabetic education.

(42) **Nutritional Supplements**

(43) **Oral Surgery** The Plan does not cover oral surgery, except for oral surgery needed due to an accidental Injury to sound, natural teeth if the services are performed within 12 months of the accident.

(44) **Outdated Claims** The Plan does not cover bills submitted to the Plan after the timely filing limit indicated in the section of this booklet entitled "Submitting Health Care Claims".

(45) **Over the Counter Medical Drugs and Medical Supplies** The Plan does not cover any items that can be obtained without a prescription, except for diabetic supplies.

(46) **Patient Charges and Penalties** The Plan does not cover charges for telephone consultations, charges for failure to keep a scheduled visit, or charges for the completion of claim forms, new patient processing, and late payment, penalty or interest charges caused by the patient's action or inaction.

(47) **Physicals** The Plan does not cover physicals required as a condition of employment.

(48) **Prescription Drugs** The Medical Expense Benefit section of the Plan does not cover Prescription drugs (except where noted elsewhere in the Plan). Please refer to the section entitled "Prescription Drug Benefit" in the Summary Plan Description booklet provided to you by the I.B.E.W. Local 910 Welfare Fund for information regarding prescription coverage.

(49) **Private Duty Nursing Care at Home** The Plan does not cover private duty nursing services rendered when the patient is receiving home health care services.

(50) **Reimbursements** The Plan does not cover charges to the extent that the participant or dependent is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public or government program or applicable law, other than the program of Medical Assistance for Needy Persons (Medicaid).

(51) **Reversal of Sterilization Procedures**

(52) **Routine Care** The Plan does not cover any service in connection with routine or periodic physicals or routine screening examinations, except for routine services covered as described in the subsection entitled "Medical Expense Benefits.

(53) **Routine Foot Care** The Plan does not cover routine or palliative foot care such as treatment of corns, calluses, toenails, flat feet, fallen arches, chronic foot strain, reduction of nails, or symptomatic complaints of the feet, except if necessitated due to metabolic conditions such as diabetes.

(54) **Sales taxes**

(55) **Self-Destruction, Self-Inflicted Injury** The Plan does not cover any intentionally self-inflicted Sickness or Injury, except for treatment resulting from a medical condition (including behavioral health disorders). The Plan also does not cover charges resulting from insurrection, participation in a riot or in consequence of having participated in an illegal act.

(56) **Services Maintained by the Employer** The Plan does not cover any service or care furnished by a medical department, clinic, or other similar service maintained by the employer or any participating employer.

(57) **Services of a Relative** The Plan does not cover services provided by your immediate family (the patient's Spouse, children, brother, sister, parent of Spouse or other person residing with the patient).

(58) **Services by an Institutional Employee** The Plan will not cover any service by any health care professional including, but not limited to, a physician or a nurse if the person is an employee of a Hospital, skilled nursing/convalescent facility, home health care agency, hospice organization, Substance Abuse treatment facility, or other health

care facility where the participant or dependent receives care.

(59) **Sex Therapy** The Plan does not cover therapy, supplies, or counseling for transsexuals, sexual dysfunction or other related inadequacies.

(60) **Surrogate Pregnancy** The Plan does not cover services or supplies related to surrogate's maternity care, including but not limited to, those needed to start the pregnancy, prenatal care, delivery or other obstetrical procedures, and postnatal care. The newborn is covered separately when meeting Plan eligibility and enrollment requirements as a dependent child.

(61) **Temporomandibular Joint Dysfunction (TMJ) Disorder** The Plan does not cover for or in connection with dental treatment of the teeth or periodontium, related to Temporomandibular Joint Dysfunction (TMJ). This includes but is not limited to: treatment for clicking or grinding of the temporomandibular joint, soreness of the jaw muscle, stiffness of the jaw, and spasms of the muscles. Hospital and anesthesia charges incurred as a result of dental treatment are not covered.

(62) **Third Party Liability** The Plan does not cover charges with respect to any Injury or Sickness for which a third party may be legally responsible or liable unless the participant or dependent fully complies with subrogation provisions described in the Summary Plan Description booklet supplied to you by the I.B.E.W. Local 910 Welfare Fund.

(63) **Training** The Plan does not cover expenses incurred for education or training (except as specifically covered in the Plan).

(64) **Travel** The Plan does not cover charges incurred for travel, (other than transportation via Medically Necessary ambulance).

(65) **Veteran's Benefits** The Plan does not cover services or supplies furnished to the participant or dependent by the Veteran's Administration for which there is no charge.

(66) **War** The Plan does not cover expenses related to War or any act of war (declared or undeclared) including armed aggression, or military or naval service of any country.

(67) **Weight Reduction** The Plan does not cover charges for weight reduction, diet programs (Weight Watchers, Nutrisystem, etc.) or diet supplements. The Plan will not pay for any surgical procedures intended for weight loss, except in cases of morbid obesity. (See the subsection entitled "Morbid Obesity Treatment" in the section entitled "Medical Expense Benefits" for information on coverage available for the treatment of morbid obesity.)

(68) **Wigs and Hairpieces**

SUBMITTING HEALTH CARE CLAIMS

Either the Provider or the participant or dependent must submit a claim form before reimbursement for an eligible expense can be paid. Claim forms are available from the Fund Office or at www.excellusbcbs.com/IBEW910.

Claims must be submitted no later than **120 days** after the date the claim is incurred. Claims that are not filed within this time period will be denied. When submitting a claim form, include:

(1) The employee's name, and

(2) The employee's Social Security Number or the employee's Alternative Identification Number, and

(3) The full name of the participant or dependent receiving treatment, and

(4) An itemized bill reflecting a diagnosis, and

(5) When the claim is the result of an accident, note the time and date of the accident and include a one or two sentence description of the circumstances.

(6) When a participant or dependent is covered under more than one health plan, and medical coverage under the other plan is, or could be, primary, submit the claim to the other plan first. Then, submit a copy of the "explanation of benefits" from the other plan when submitting the claim to Excellus BCBS.

Payment for services provided by an In-Network Provider will be made directly to the provider. If you receive services from an Out-of-Network Provider, Excellus BCBS reserves the right to pay either you or the provider. Submit claim forms to Excellus BCBS at:

Excellus BCBS
P.O. Box 22999
Rochester, NY 14692

WORD USAGE: Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine or neuter form.