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

FOR RETIREES
(MEDICARE SUPPLEMENT PLAN)

Effective: August 1, 2015

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INTRODUCTION

This booklet describes the Medicare Supplement Plan for Retirees under the Health Care Insurance Benefit for the I.B.E.W. Local 910 Welfare Fund 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 Insurance Benefit provisions. This booklet explains the benefits available to you and your family through the Health Care Insurance Benefit. This Plan helps to provide financial security for you and your family when you are faced with large health care expenses. We hope this booklet will serve not only as a guide but also as evidence of our concern for the welfare of you and your family.

The Medicare Supplement Plan for Retirees is intended to supplement Medicare benefits only. You must be enrolled for both Part A and Part B of Medicare in order to be eligible for benefits under the Medicare Supplement Plan for Retirees. Any service or supply that is not covered under Medicare is not covered under the Medicare Supplement Plan for Retirees.

If a retired participant or their eligible dependent seeks care or treatment from a member of the Preferred Provider Network, Excellus BCBS 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 Plan Administrator.

Adoption Date: August 1, 2015

I.B.E.W. LOCAL 910 WELFARE FUND HEALTH CARE BENEFIT FUND

SCHEDULE OF BENEFITS FOR RETIREES

Applies to: retirees, COBRA beneficiaries, and their dependents. Enrollment in Medicare Part A and Part B is required to receive benefits from this Plan.
Claims must be filed within 180 days after the claim is processed by Medicare or the claim will be denied. Any service that is not covered by Medicare will not be covered under this Medicare Supplement Plan for Retirees.
The following chart illustrates how the Plan fills the major benefit gaps in Medicare Parts A and B:

MEDICARE SUPPLEMENT PLAN FOR RETIREES				
SERVICE	**BENEFIT**	**MEDICARE PAYS**	**EXCELLUS BCBS PAYS**	**YOU PAY**
Part A Hospitalizations Semi-private room and board, general nursing, miscellaneous Hospital services and supplies, includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia, and rehabilitation services	First 60 days	All but Part A deductible	Part A deductible	Nothing
	61st – 90th day	All but Medicare copayment amount for each day	Medicare copayment amount for each day	Nothing
	91st – 150th day	All but Medicare copayment for each day	Medicare copayment amount for each day	Nothing
	Beyond 150 days	Nothing	365 lifetime reserve days	Nothing
Post-Hospital Skilled Nursing Care In a facility approved by Medicare, you must have been in a Hospital for at least three consecutive days and enter the facility within 30 days after the Hospital discharge	First 20 days	100% of cost	Nothing	Nothing
	Additional 80 days	All but Medicare copayment amount for each day	Medicare copayment amount for each day	Nothing
	Beyond 100 days	Nothing	Nothing	All
Blood		100% of costs except non-replacement fees (blood deductible) for first three pints in each benefit period	Reasonable cost of first three (3) pints in each calendar year	Nothing

Included in the chart below are examples of services covered under the Medicare Supplement Plan for Retirees. Under no circumstances will this Plan make any payments for the difference between the Medicare allowed amount and the actual charge for the service. Any service not covered by Medicare will not be covered under the Medicare Supplement Plan for Retirees.

MEDICARE SUPPLEMENT PLAN FOR RETIREES	
TYPE OF SERVICE	**BENEFIT** This Plan only pays benefits on the balance remaining after Medicare has already made its payment.
Hospital – Inpatient Care	
- Semi-private room & board (An additional 365 days are available provided there is a 90 day separation between date of discharge & date of readmission)	Paid in full
- Inpatient Mental Illness treatment	Paid in full
- Use of operating, recovery, intensive care, cystoscopic rooms & equipment	Paid in full
- X-ray & laboratory services – including all blood chemistry & pathological services	Paid in full
- Drugs and medications administered while inpatient	Paid in full
- Dressings, ordinary splints and plaster casts	Paid in full
Hospital – Outpatient Care (at the Hospital)	
- Emergency room medical/accidental Injury	Paid in full
- Minor surgical procedures	Paid in full
- Pre-admission testing	Paid in full
- X-rays, laboratory & other diagnostic tests	Paid in full
- Kidney dialysis	Paid in full
- Radiation therapy	Paid in full
- Physical therapy	Paid in full
- Speech therapy	Paid in full
Outpatient Care (other facility care)	
- Skilled nursing facility	Paid in full
- Home health care	Paid in full
- Inpatient Substance Abuse treatment	Paid in full
- Outpatient Substance Abuse treatment	Paid in full
- Hospice Care	Paid in full
Maternity Benefits	
- Delivery	Paid in full
- Routine nursery care (while mother is hospitalized)	Paid in full

Included in the chart below are examples of services covered under the Medicare Supplement Plan for Retirees. Under no circumstances will this Plan make any payments for the difference between the Medicare allowed amount and the actual charge for the service. Any service not covered by Medicare will not be covered under the Medicare Supplement Plan for Retirees.

MEDICARE SUPPLEMENT PLAN FOR RETIREES	
TYPE OF SERVICE	**BENEFIT** This Plan only pays benefits on the balance remaining after Medicare has already made its payment.
Physician Services	
- Doctor's office visits	Paid in full
- Surgical procedures	Paid in full
- Assistant surgeon	Paid in full
- General anesthesia	Paid in full
- Inpatient Hospital medical visits	Paid in full
- Mental Illness care visits	Paid in full
- Inpatient Hospital consultations	Paid in full
- Maternity care	Paid in full
- Delivery of newborn	Paid in full
- Diagnostic x-rays – out of Hospital	Paid in full
- Radiation therapy – out of Hospital	Paid in full
- Electrocardiographic examinations	Paid in full
- Special examinations & procedures • Pap smears • Hemodialysis	 Paid in full Paid in full
- Second surgical opinions – board certified specialist, initial consultation, intermediate	Paid in full
Emergency Care in a Foreign Country	80% after a $250 calendar year deductible up to a $50,000 lifetime maximum. Emergency care must be Medically Necessary and begin within the first 60 consecutive days of the trip outside the United States.

DEFINITIONS

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

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.

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

(6) It is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

Additionally, the following institution will qualify under this definition:

(7) 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 by the Accreditation Association 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 services or supplies that are:

(1) Appropriate for the symptoms and diagnosis or treatment of the participant's or dependent's Injury or Sickness, and

(2) Provided for the diagnosis or the direct care and treatment of the participant's or dependent's Injury or Sickness, and

(3) Provided in accordance with standards of good medical practice, and

(4) Not primarily for the convenience of a participant, dependent, or the Provider, and

(5) The most appropriate supply or level of service that can safely be provided to the participant or dependent. When applied to an inpatient hospitalization for the treatment of Mental Illness, Substance Abuse, and admissions to a behavioral health care facility, a convalescent/skilled nursing facility or rehabilitation facility, this further means that the participant or dependent requires acute care as a bed patient due to the nature of the services provided or the participant's or dependent's condition, and the participant or dependent cannot receive safe or adequate care as an outpatient or in another less costly setting.

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.

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.

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.

DETAILED DESCRIPTION OF BENEFITS

The Medicare Supplement Plan for Retirees is intended to supplement Medicare benefits only. You must be enrolled for both Part A and Part B of Medicare in order to be eligible for benefits. Any service or supply that is not covered under Medicare is not covered under the Medicare Supplement Plan for Retirees.

The 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 Health Care Provider.

The Plan will pay benefits for Medically Necessary expenses subject to deductibles, coinsurance, maximums, and any limitations, as shown in the Schedule of Benefits for Retirees and elsewhere in this document. Under no circumstances will this Plan make any payments for the difference between the Medicare allowed amount and the actual charge for the service. Any service not covered by Medicare will not be covered under the Medicare Supplement Plan for Retirees, except where noted. Covered services include:

(1) **MEDICARE PART A DEDUCTIBLES AND COPAYMENTS**: When you have been hospitalized and have received benefits under Part A of Medicare for that hospitalization, this Plan will pay the following deductibles and copayments, which are left as balances after Medicare has made its payment:

(A) Medicare's Part A deductible in each benefit period;

(B) The copayment amount for the 61st through 90th day of each benefit period;

(C) The copayment amount for the Medicare 60 lifetime reserve Hospital days.

A benefit period begins when you enter a Hospital. Successive stays in one or more Hospital or skilled nursing facility count as one benefit period unless 60 days or more elapse between the day of discharge and the next admission. When you enter a Hospital after 60 days have elapsed since the last discharge from the Hospital or skilled nursing facility, a new benefit period starts.

The Medicare Part A deductible amount usually increases each year. The Plan will pay the deductible even though it increases.

(2) **ADDITIONAL HOSPITAL DAYS**: During a benefit period, if you have used all your Medicare Hospital days, including your Medicare lifetime reserve days, then the Plan will pay for additional days of inpatient Hospital care in the same benefit period. The Plan will only pay for such additional days if, in the Plan's judgment, it is Medically Necessary for you to be hospitalized. The Plan will not pay for more than 365 of such additional days in your lifetime. The Plan's payment for each such additional day of inpatient care will be limited to:

(A) Those kind of expenses that would have been paid under Medicare, and

(B) Only when you are hospitalized in a short term acute care general Hospital that either qualifies under Medicare or is accredited by the Joint Commission on Accreditation of Health Care Organizations, and

(C) Only when Medicare would have made payment if you had not used all your Medicare days.

(3) **BLOOD DEDUCTIBLE UNDER MEDICARE**: The Plan will pay for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) under Part A or Part B of Medicare each year, unless the blood is replaced in accordance with federal regulations.

(4) **POST-HOSPITAL SKILLED NURSING FACILITY CARE**: When you are confined in a skilled nursing facility following hospitalization and you receive benefits under Part A of Medicare for that confinement, this Plan will pay the copayment amount from the 21st day through the 100th day in each benefit period.

The copayment amount for skilled nursing facility care under Part A of Medicare usually increases each year. The Plan will pay the copayment even though it increases.

(5) **PART B DEDUCTIBLE AND COINSURANCE**: When Medicare pays for a service covered under Part B of Medicare, the Plan will pay the deductible and coinsurance, if any, based on Medicare's allowed amount. If Medicare pays 100% of the allowed amount covered under Part B or Medicare pays nothing for any service, the service will not be reimbursed under this Plan. Under no circumstances will this Plan make any payments for the difference between the Medicare allowed amount and the actual charge for the service.

(6) **MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY**: The Plan will pay for Emergency care in a foreign country under the following terms and conditions:

(A) 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.

(B) After the eligible participant or dependent satisfies a $250 calendar year deductible, the Plan will pay 80% of billed charges for those expenses for Medically Necessary Emergency Hospital, physician and medical care in a foreign country which would have been covered under Medicare if the participant or dependent had received the care within the United States.

(C) The Emergency care must begin within the first 60 consecutive days of each trip outside the United States.

(D) Payments for Emergency care under this provision are subject to a lifetime maximum of $50,000.

(E) If Medicare pays for any service that is rendered outside the United States, this Plan will only base its payment on the balance left over after Medicare has made its payment.

SUBMITTING HEALTH CARE CLAIMS

All claims must be submitted to Medicare first. Once Medicare has made its payment, then the claim may be submitted to Excellus BCBS. Either the Provider or the participant or dependent must submit a claim form along with the "Explanation of Medicare Benefits" before reimbursement for an eligible expense can be paid. Claim forms are available at www.excellusbcbs.com/ibew910.

Claims must be submitted no later than 180 days after Medicare processes the claim. Claims that are not filed within this time period will be denied. When submitting a claim form, include:

(1) The participant's name, and

(2) The participant's Social Security Number or the participants 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) The "Explanation of Medicare Benefits" indicating what payment Medicare has made on the expenses, and

(6) 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.

(7) When a participant or dependent is covered under another health plan besides Medicare and this Plan, and medical coverage under that other plan 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