

**SUMMARY PLAN
DESCRIPTION**

**FOR THE
IBEW LOCAL UNION NO. 306
SUPPLEMENTAL HEALTH
BENEFIT FUND**



EFFECTIVE JANUARY 1, 2005

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**SUMMARY PLAN DESCRIPTION FOR THE
INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS
LOCAL UNION 306 SUPPLEMENTAL HEALTH BENEFIT FUND**

Effective January 1, 2005

I. GENERAL DEFINITIONS

(A) "COVERED EMPLOYEE." The term "Covered Employee" as used herein shall mean:

(1) All Employees represented for the purpose of collective bargaining by the Union and who's Employers make contributions to the Trust Fund in accordance with the Collective Bargaining Agreement with the Union.

(2) The term "Covered Employees" may also include:

(a) Employees of other Employers who participate as otherwise permitted by the terms of this Plan and make contributions to the Trust Fund, including Employees of the Union and the Akron Area Electrical Joint Apprenticeship Committee.

(3) The term "Covered Employee" shall not include partners or self-employed persons no matter how designated; and such persons are expressly excluded from the benefits provided hereunder.

(4) A Covered Employee shall not be ineligible to participate in the benefits of the Fund because of his/her participation in a labor dispute or because of his/her absence from work due to such labor dispute or because of his/her being locked out by his/her Employer.

(B) "COVERED RETIREE" OR "ELIGIBLE RETIREE." The term "Covered Retiree" or "Eligible Retiree" shall mean any Covered Employee who is retired from active employment under the collective bargaining agreement and (1) is at least sixty (60) years of age; (2) during at least forty eight (48) of the sixty (60) months immediately prior to retirement has been eligible for benefits in the Fourth District IBEW Health Fund or successor Fund; and (3) is eligible for benefits in the Fourth District IBEW Health Fund in the month immediately preceding his/her month of retirement from active employment. A Covered Retiree shall also mean a disabled employee who meets the following conditions:

(1) Has received an award from the Social Security Administration for Disability Benefits; and

(2) On the date the award for Disability Benefits is received by the Covered Retiree from the Social Security Administration, the Covered Retiree was eligible for benefits in the Fourth District IBEW Health Fund. No retroactive eligibility is permitted.

The term "Covered Retiree" is used interchangeably in this document with the term "Eligible Retiree".

(C) "COVERED DEPENDENTS." Your spouse, provided you are not divorced, and each of your unmarried children, provided the child is less than twenty-four (24) years of age. Such a child who has attained nineteen (19) years of age is eligible as your Covered Dependent only if a full-time student in an accredited school and wholly dependent upon you for support. An individual who is eligible for benefits or who is a member of the country's armed forces is not eligible as your Covered Dependent.

The word "children" shall include your natural children and legally adopted children. Coverage for adopted children will commence at the beginning of the probationary period, regardless of whether the adoption becomes legally final. In addition, the word "children" shall also include stepchildren (if a child is not residing with you in a regular parent-child relationship, proof of dependent status must be furnished with any claim) or any child named in a Qualified Medical Child Support Order satisfying all conditions outlined in the Omnibus Budget Reconciliation Act (OBRA) of 1994. Grandchildren, nieces, nephews, etc. are not eligible unless they have been legally adopted by you and proof of same is provided to the Fourth District IBEW Health Fund and the IBEW Local Union 306 Supplemental Health Benefit Fund, even though the child may be wholly dependent upon your for support

While your dependent coverage is in effect, newly acquired Covered Dependents automatically become Covered Dependents subject to any provisions applicable to the effective date of coverage for benefits in the Fourth District IBEW Health Fund.

When the Covered Retiree dies, benefits for his/her Covered Dependents, shall be continued if permitted by the Fourth District IBEW Health Fund. Any subsidy for such coverage from the IBEW Local Union 306 Supplemental Health Benefit Fund shall cease in the month of the Covered Retiree's death.

(D) "COVERED SPOUSE". The term "Covered Spouse" shall mean the legal spouse of the Covered Retiree at the time of his/her retirement who continues to be married to the Covered Retiree during his/her retirement

(E) "EMPLOYER". The term "Employer" shall mean any individual, corporation or other business entity with whom the Union has a collective bargaining agreement.

(F) "ERISA". The term "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

(G) "FOURTH DISTRICT IBEW HEALTH FUND." The term "Fourth District IBEW Health Fund" shall mean the Trust established for benefits to Covered Employees, Covered Retirees and their Covered Dependents.

(H) "MEDICAL REIMBURSEMENT ACCOUNT." The term "Medical Reimbursement Account" shall mean the accounts established by the Trustees from contributions and ----- earnings for the use by Covered Employees and Covered Dependents for reimbursement of eligible medical expenses.

(I) "MEDICARE SUPPLEMENTAL POLICY". The term "Medicare Supplemental Policy" shall mean a policy purchased through the Fourth District IBEW Health Fund which provides, ,

according to its terms, supplemental benefits to policy holders after payment by Medicare or the same type of benefits which the Fourth District IBEW Health Fund elects to self insure.

(J) "PLAN YEAR". The term "Plan Year" shall mean the period beginning on June 1 and ending May 31 of the following calendar year.

(K) "RETIREE SUBSIDY". The term "Retiree Subsidy" shall mean the amount that the Trustees of the IBEW Local 306 Supplemental Health Benefit Fund subsidized the premiums for Covered Retirees and/or their Covered Dependents for coverage through the Fourth District IBEW Health Fund.

(L) "SUCCESSOR FUND." The term "Successor Fund" shall mean an employee health benefit plan established for Covered Employees, Covered Retirees and their Covered Dependents which succeeds the Fourth District IBEW Health Fund.

(M) "THIS FUND". The term "This Fund" shall mean the IBEW Local Union 306 Supplemental Health Benefit Fund.

(N) "UNION". The term "Union" shall mean the International Brotherhood of Electrical Workers Local 306.

II. ELIGIBILITY FOR RETIREE SUBSIDY

(A) Subject to the timely payment of premiums described hereinafter all Covered Retirees, Covered Spouses and Covered Dependents are eligible for benefits on the first day of the month following the date that he/she meets the eligibility requirements for participation as provided hereinafter.

(1) Covered Retiree Under Age 65. A Covered Retiree shall be eligible for coverage in the Fourth District IBEW Health Fund or a Successor Fund so long as those Funds provide benefits to such persons.

(2) Covered Retiree 65 and Over. A Covered Retiree shall be eligible for coverage through a Medicare Supplemental Policy provided by the Fourth District IBEW Health Fund or Successor Fund so long as those Funds provide such policies to such persons.

(3) Covered Spouse and Covered Dependents Under Age 65. The Covered Spouse and Covered Dependents of a Covered Retiree shall be eligible for coverage through the Fourth District IBEW Health Fund or Successor Fund so long as those Funds provide benefits to such persons.

(4) Covered Spouse 65 and Over. A Covered Spouse of a Covered Retiree who is 65 years or over, shall be eligible for coverage through a Medicare Supplemental Policy provided by the Outside Fourth District IBEW Health Fund or Successor Fund so long as those Funds provide such policies to such persons.

Conditions of Coverage

(1) **Covered Retiree Under Age 65.** The Covered Retiree may obtain coverage in the Fourth District IBEW Health Fund or Successor Fund through the payment of the premiums determined by the Trustees of the Fourth District IBEW Health Fund or the Successor Fund. The Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund may, from time to time at their discretion, subsidize a portion of said premium.

(2) **Covered Retirees 65 or Over.** The Covered Retiree may purchase a Medicare Supplemental Policy through the Fourth District IBEW Health Fund or Successor Fund through the payment of the premiums determined by the Trustees of the Fourth District IBEW Health Fund or the Successor Fund. The Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund may, from time to time at their discretion, subsidize a portion of said premium.

(3) **Covered Dependents Under Age 65.** In the event the Covered Retiree elects to cover his/her Covered Dependents through the Fourth District IBEW Health Fund or Successor Fund, the Covered Retiree shall pay the required premium to the appropriate Fund as determined by the Trustees of that Fund. The Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund may, from time to time at their discretion, subsidize a portion of said premium provided further that the Trustees shall not pay any portion of the premium for any Covered Dependent other than the Covered Spouse if the cost of that coverage is greater than the cost of coverage for Covered Spouse alone, and provided further, in the event the Trustees determine to subsidize any portion of the premium for the Covered Spouse or Covered Dependents, said subsidization shall not continue beyond the lifetime of the Covered Retiree.

(4) **Covered Spouse Age 65 and Over.** The cost of coverage for the purchase of Medicare Supplemental Policy provided by the Fourth District IBEW Health Fund or Successor Fund for the spouse of the Covered Retiree shall be determined by the Trustees of the Fourth District IBEW Health Fund or Successor Fund. The Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund may, from time to time, at their discretion, subsidize a portion of said premium of the Medicare Supplemental Policy for the spouse 65 or over provided further that, in no event, shall any subsidization of the premium for said Medicare Supplemental Policy by the IBEW Local Union 306 Supplemental Health Benefit Fund continue beyond the lifetime of the Covered Retiree.

Premiums for Coverage.

(1) Premiums for coverage paid for eligibility by the Covered Retiree must be received by the Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund no later than the first day of the month for each month of coverage. Premium payments received subsequent to that date are considered to be delinquent.

(2) If a premium payment is not received within fifteen (15) days after the date it is was due, the Fund will provide a notice to the Covered Retiree informing him/her of the delinquent premium and the Covered Retiree's right to pay all delinquencies in full

within thirty (30) days of said notice or eligibility to participant in the Plan will be terminated. In the event the Covered Retiree fails to pay the delinquent premium within thirty (30) days of said notice, eligibility for the Covered Retiree and Covered Dependents shall be terminated.

(3) Failure to timely remit premiums may affect coverage for benefits through the Fourth District IBEW Health Fund.

(D) Benefits for Covered Retirees and Their Covered Dependents and Other Conditions of Coverage. Please refer to the Summary Plan Description of the Fourth District IBEW Health Fund for the benefits provided to all Covered Retirees and their Covered Dependents. In addition, please refer to the Fourth District IBEW Health Fund for other conditions of coverage, including but not limited to, rights under the Health Insurance Portability and Accountability Act (HIPAA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Omnibus Budget Reconciliation Act of 1994 (OBRA).

III. MEDICAL REIMBURSEMENT ACCOUNTS

(A) Eligibility, Establishment and Maintenance of Medical Reimbursement Accounts.

(1) If contributions are made to the IBEW Local Union 306 Supplemental Health Benefit Fund under the collective bargaining agreement for Covered Employees, Medical Reimbursement Accounts will be established for Covered Employees for use for reimbursement of medical expenses of Covered Employees and their Covered Dependents.

(2) Medical expenses not covered elsewhere, if reimbursable, will be subtracted from the Covered Employee's Medical Reimbursement Account as provided herein.

(3) Covered Dependents of a deceased Covered Employee may continue to be reimbursed for medical care expenses up to an amount equal to the unused reimbursement amount remaining at the time of death of the Covered Employee.

(B) **What Medical Expenses Are Eligible.**

Reimbursable medical expenses are those medical expenses identified in Internal Revenue Code ("Code") §213 but which have not been paid under the Fourth District IBEW Health Fund or other qualified plan or arrangement. Unreimbursed medical expenses eligible for reimbursement under the Code include, but are not limited to:

- > Deductibles and co-payments applied to covered medical expenses under the Fourth District IBEW Health Fund or a qualified plan of a Covered Spouse;
- > Self-payments to maintain eligibility under the Fourth District IBEW Health Fund or other qualified plan or arrangement or premium or other payments required to maintain coverage under the Plan of Employee's Spouse;

- > Unreimbursed prescription medicines (prescribed by a doctor) and insulin, including co-pays;
- > Over the counter medicine bought without a prescription;
- > Unreimbursed medical services fees (from doctors, chiropractors, dentists, surgeons, registered nurses, specialists, and other medical practitioners);
- > Unreimbursed special items (artificial limbs, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.);
- > Unreimbursed treatment at a drug or alcohol center (includes meals and-lodging provided by the center);
- > Unreimbursed dental expenses;
- > Birth control pills;
- > Capital expenses for equipment or improvements to the Covered Employee's home needed for medical care;
- > Cost and care of guide dogs or other animals aiding the blind, deaf, and disabled;
- > Cost of lead-based paint removal;
- > Expenses of an organ donor;
- > Oxygen equipment and oxygen;
- > Part of life-care fee paid to retirement home designated for medical care;
- > Psychiatric care at a specially equipped medical center (includes meals and lodging);
- > Hospital services fees (lab work, therapy, nursing services, surgery, etc.);
- > Legal abortion;
- > Legal operation to prevent having children;
- > Meals and lodging provided by a hospital during medical treatment;
- > Special school or home for mentally or physically disabled persons;
- > Unreimbursed transportation for needed medical care;
- > Wages for nursing services; or
- > Any other medical expenses identified in the Internal Revenue **Code** Section 213.

(C) What Medical Expenses Are NOT Eligible?

The following expenses are not eligible for reimbursement:

- > Expenses for which the Covered Employee claimed or will claim a medical expense deduction on the Covered Employee's tax returns;
- > Expenses incurred before the Covered Employee became initially eligible for medical benefits under this Plan, unless permitted by Internal Revenue Code Section 213;
- > Expenses incurred after termination of employment and eligibility, unless permitted by Internal Revenue Code Section 213;
- > Bottled water;
- > Diaper service;
- > Expenses for general health (even if following doctor's advice) such as—
 - Health club dues;
 - Household help (even if recommended by a doctor);
 - Social activities, such as dancing or swimming lessons;
 - Trip for general health improvement.
 - Non-legend drugs for smoking cessation;
- > Funeral, burial or cremation expenses;
- > Illegal operation or treatment;
- > Life insurance or income protection policies or policies providing payment for loss of life, limb, sight, etc.
- > Maternity clothes;
- > Medical insurance included in a car insurance policy covering all persons injured in or by the Covered Employee's car,
- > Nursing care for a healthy baby;
- > Surgery for purely cosmetic reasons;
- > Toothpaste, toiletries, cosmetics;
- > Medical services in a U.S. Government Hospital;

- > Medical services provided at no cost through any public program;
- > Medical expenses for which reimbursement is available under another plan or program; or
- > Expenses related to cosmetic surgery.

Medical Expenses will be reimbursed only to the extent that reimbursement for such Medical Expenses is not available to the Covered Employee under any health insurance policy or plan provided through any employer of the Covered Employee. If there is such a policy or plan in effect, providing for reimbursement or payment in whole or in part, then to the extent of the coverage under such other policy or plan, the Plan shall be relieved of any liability hereunder.

(D) How to Obtain Reimbursement.

(1) **Submission of Claim.** When a Covered Employee or Covered Dependent has unreimbursed medical expenses and a balance in the Covered Employee's Medical Reimbursement Account, the Covered Employee should submit proof of such out-of-pocket expenses on forms available from Compensation Programs of Ohio, Inc. (Administrative Manager), 33 Fitch Boulevard, Austintown, Ohio 44515; 800-435-2388. Separate bills may be itemized on the same claim form. Forms (samples attached) must be accompanied by receipt for bills.

(2) **Reimbursement Payment.** The Administrative Manager will send reimbursement checks quarterly (example: expenses submitted in January, February and March will be reimbursed in April and so on) or sooner if premium payments are necessary to maintain eligibility under the Fourth District IBEW Health Fund or other qualified plan or arrangement or premium or other payment required to maintain coverage of Employee's spouse.

(3) **Limitations.** Claims for medical expense reimbursement must be filed no later than eighteen (18) months following the end of the Plan Year in which the claims were incurred.

(4) **Administrative Fee.** The Plan may assess a monthly administrative fee against the Covered Employee's Medical Reimbursement Account for any account activity (i.e. contributions received or claims paid).

(5) **Carry Over.** Any unused balances in the Covered Employee's Medical Reimbursement Account will be carried over to the next Plan Year, subject to provisions below about "Cancellation of Account" and "Changes."

(E) Earnings

Periodically, the Trustees shall credit interest or other earnings, less administrative expenses, to Covered Employees Medical Expense Reimbursement Accounts.

(F) Cancellation of Account

If the Covered Employee's Medical Reimbursement Account has no activity for a period of two (2) years (i.e., no contributions received to the account or claims made from the account), such account will be canceled, and any remaining account balance will revert to the Plan's subtrust for medical reimbursements.

(G) Changes

This Medical Reimbursement Account Program is based on existing law, as currently interpreted. If there are legislative changes, governmental announcements or financial considerations which affect this Program, the Trustees reserve the right to change or cancel the Program, including cancellation of existing Medical Reimbursement Accounts. If the Program is to be discontinued or changed, the Trustees will provide Covered Employees with as much written notice as possible.

IV. CLAIMS AND APPEALS PROCEDURE

Determination of Eligibility and Claims

The Administrative Manager shall initially determine the eligibility of Covered Employees and/or their Covered Dependents for coverage in the program for Retiree Subsidy and the program for establishment and maintenance of Medical Reimbursement Accounts. In addition, the Administrative Manager will initially determine whether claims for medical expenses are reimbursable and/or payable from the Medical Reimbursement Account of Covered Employees or Covered Dependents.

(A) Eligibility for Retiree Subsidy. Determinations concerning eligibility for coverage or payment of Retiree Subsidies shall be made within thirty (30) days after the request for coverage is submitted.

(B) Eligibility for Determination for Payment of Medical Reimbursement. Eligibility for medical reimbursement of claims shall be made within thirty (30) days following the end of each calendar quarter in which the claim is submitted.

(C) In the event that an adverse determination is made by the Administrative Manager, in whole or in part, the Covered Employee, Covered Retiree or Covered Dependent, where applicable, will receive a written notice which shall include the following:

- The specific reason for the denial;
- The sections of the Plan and/or SPD upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

A notice of your right to a written explanation of any exclusion which affects your claim, if applicable;

A notice of your right to file an appeal to the Benefits Committee of the IBEW Local Union 306 Supplemental Health Benefit Fund as outlined below.

Appeal Procedure

(A) Appeal to the Benefits Committee of the IBEW Local Union 306 Supplemental Health Benefit Fund.

You or your authorized representative may appeal the decision of the Administrative Manager denying any eligibility or claim in whole or in part. An "authorized representative" must be designated in writing to act on your behalf and to the extent of the person's authority must be clearly indicated in the authorization.

You may file a written notice of appeal to the Benefits Committee at any time within one hundred eighty (180) days after the mailing of the Notice of Adverse Benefit Determination by the Administrative Manager. The written notice only needs to state your name, address, social security number and the fact that you are appealing from the decision of the Fund Office, giving the date of the Notice. The Appeal should be addressed as follows:

**Benefits Committee
IBEW Local Union 306 Supplemental Health Benefit Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515**

During the appeals process, you will also be afforded with access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Benefits Committee shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Benefits Committee will consider your appeal of a claim at its next regularly scheduled quarterly meeting. If your appeal is received less than thirty (30) days prior to the next regularly scheduled quarterly meeting, it will be reviewed at the second quarterly meeting following the receipt of the appeal. You will be notified of the decision of the Benefits Committee as soon as possible after the meeting, but in no case later than fifteen (15) days after the decision is made.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;**

- The sections of the Plan and/or SPD upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable;
- A notice of your right to file a voluntary appeal to the Board of Trustees as outlined below; and
- A notice of your right to file suit under ERISA Section 502(a).

The decision of the Benefits Committee is final and binding.

(B) Voluntary Appeal to the Board of Trustees.

Once you have filed your appeal through the Benefits Committee as detailed above, you have the right to file a lawsuit in federal court. However, you can also file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within sixty (60) days of the mailing Notice of Final Decision by the Benefits Committee.

The Appeal should be addressed as follows:

Board of Trustees
 IBEW Local Union 306 Supplement Health Benefit Fund
 c/o Compensation Programs of Ohio, Inc.
 33 Fitch Boulevard
 Austintown, Ohio 44515

The Board of Trustees will consider your appeal of a claim at its next regularly scheduled quarterly meeting. If your appeal is received less than thirty (30) days prior to the next regularly scheduled quarterly meeting, it will be reviewed at the second quarterly meeting following the receipt of the appeal. You will be notified of the decision of the Board of Trustees as soon as possible after the meeting, but in no case later than fifteen (15) days after the decision is made.

In the event that you file a voluntary appeal with the Board of Trustees:

1. The Fund will not assert a failure to exhaust administrative remedies;
2. The Fund agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;
3. The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);

4. You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:

- A statement that using this procedure will have no effect on your right to receive other benefits under this Fund
- A statement that you have the right to have a personal representative with regard to your claim;
- A notice of any circumstances which may impair the impartiality of the Board of Trustees;

The Fund will not impose any fees or costs on you as part of this voluntary appeal process.

The Plan's Claim Procedure is furnished automatically, without charge, as a separate document, upon the request of a Participant or Beneficiary.

V. TRUSTEE DISCRETIONARY AUTHORITY OF PLAN INTERPRETATION

The decisions of the Trustees in all matters pertaining to the administration of the Trust shall be final. The Board of Trustees, as the administrator of the Trust, shall have complete control of the administration of the Trust, subject to the provisions hereof, with all powers necessary to enable it to properly carry out its duties in that respect. Not in limitation, but in amplification of the foregoing, the Trustees shall have full authority and discretion to construe, interpret and apply all provisions of the Trust and to determine all questions that may rise hereunder, including all questions relating to the eligibility of Covered Employees and Covered Dependents to participate in the Plan, the amount of any benefit to which any Covered Employee or Covered Dependent may become entitled hereunder and to determine all appeals subsequent to any application for eligibility or benefits. Specifically, the Trustees shall have full and complete authority and discretion to make any determinations or findings of fact regarding any claims and appeals of any benefit determinations. Its decision upon all matters within the scope of its authority shall be final.

VI. NOTICE OF PRIVACY PRACTICES

This Notice describes:

- How medical information about you may be used and disclosed; and
- How you may obtain access to this information.

1. Purpose of this Notice and effective date

Effective Date. The effective date of this Notice is December 15, 2004.

This Notice is required by law. The IBEW Local Union 306 Supplemental Health Benefit Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI).
- Your rights to privacy with respect to your PHI.
- The Fund's duties with respect to your PHI.
- Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services, and
- The person or office you should contact for further information about the Fund's privacy practices.

2. Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Fund in oral, written, electronic or any other form.

When the Fund May Disclose Your PHI

The Fund Sponsor has amended its Fund Documents to protect your PHI as required by federal law. Under the law, the Fund may disclose your PHI without your consent or authorization in the following cases:

- *At your request.* If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.
- *As required by an agency of the government* The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.
- *For treatment, payment or health care operations.* The Fund and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out: treatment, payment, or health care operations.

PHI refers to your health information held by the Fund.

The Fund does not need your consent or authorization to release your PHI when:

- * you request it, a governmental agency requires it, or the Fund uses it for treatment, payment or health care operations.

Definitions of Treatment, Payment or Health Care Operations

Treatment is health care. Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example: The Fund may disclose to a treating physical therapist the name of your treating physician so that the physical therapist may ask for your x-rays from the treating physician.

Payment is paying claims for health care and related activities. Payment includes, but is not limited to, making coverage determination payment. These actions include billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization.

For example: The Fund tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.

Health Care Operations keep the Fund operating soundly. Health care operations, include but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business funding and development, business management and general administrative activities.

For example: The Fund uses information about your medical claims to project future benefit costs or to audit the accuracy of claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

The Fund must generally obtain your written authorization before it will use or disclose psychotherapy notes about you from your psychotherapist. However the Fund may use and disclose such notes when needed to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if.

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and

- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required

The Fund is allowed under federal law to use and disclose your PHI without your consent, authorization or request under the following circumstances:

- **When required by law.**
- **Public health purposes.** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- **Domestic violence or abuse situations.** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- **Health oversight activities.** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensures or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- **Legal proceedings.** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
- **Law enforcement health purposes.** When required for law enforcement purposes (for example, to report certain types of wounds).
- **Law enforcement emergency purposes.** For law enforcement purposes including:
 - a. Identifying or locating a suspect, fugitive, material witness or missing person, and
 - b. Disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.
- **Determining cause of death or organ donation.** When required to be given to a coroner or medical examiner to identify a deceased person to determine a cause of

death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

- **Funeral purposes.** When required to be given to funeral directors to carry out their duties with respect to the decedent.
- **Health or safety threats.** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- **Workers¹ compensation programs.** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

Other Uses or Disclosures

The Fund may contact you to provide you information about treatment alternatives or other health related benefits and services that may be of interest to you.

The Fund may disclose protected health information to the sponsor of the Fund for reviewing your appeal of a benefit claim or for other reasons regarding the administration of the Fund. The "Plan Sponsor" of this Fund is the IBEW Local Union 306 Supplemental Health Benefit Fund Board of Trustees.

3. Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

- Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
- Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request if the Fund Administrator or Privacy Official determines it to be unreasonable.

In addition, the Fund will accommodate an individual's reasonable request to receive communication of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI.

The Fund must provide the requested information within thirty (30) days if the information is maintained on site or within sixty (60) days if the information is maintained offsite. A single thirty (30) day extension is allowed if the Fund is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend Policy for a list of exceptions.

The Fund has sixty (60) days after receiving your request to act on it. The Fund is allowed a single thirty (30) day extension if the Fund is unable to comply with the sixty (60) day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI.

If you disagree with the record of your PHI, you may amend it.

If the Fund denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI.

Forms are available for these purposes,

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of disclosures by the Fund of your PHI. This accounting period starts as of January 1, 2005 and allows you to request an accounting for up to six (6) years of disclosures after that date. The maximum period of time you can request is six (6) year. Please contact the Fund Office for a complete listing of

the contents of an accounting. You should request a copy of the Fund's Accounting for Disclosure Policy.

The Fund has sixty (60) days to provide the accounting. The Fund is allowed an additional thirty (30) days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a twelve (12) month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider spouse's covered under the Fund as the personal representative for each other. Additionally, the Fund will consider a covered parent, guardian, or other person acting *in loco parentis* as the personal representative of any Covered Dependent covered by the Fund unless applicable law requires otherwise. A parent may act on an individual's behalf, including requesting access to their PHI. Covered Dependents, including your spouse may, however, request that the Fund restrict information that goes to family members as described above at the beginning of Section 3 of this Notice. Additionally, the Fund will automatically consider any person designated under a Power of Attorney which is on file with the Fund as a personal representative.

You or your spouse may elect not to have one another as your personal representative. You or your spouse must fill out an Opt-Out of Personal Representation Form and submit the form to the Privacy Official. Your Covered Dependent children also have the right to submit an Opt-Out Form if they do not wish to have one or both of their parents as their deemed personal representative. All requests are reviewed by the Privacy Official who may deny the requests, especially those based upon State law restrictions.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative.

You may designate a personal representative by completing a form that is available from the Fund Office.

For information on or to exercise your Individual Privacy Rights, contact:

Privacy Official
Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44446
(800)435-2388

Designated Record Set includes your medical records and billing records that are maintained in paper form or electronically by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health fund or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analysis and not used to make decisions about your is not included.

4. The Fund's Duties

The Fund is required by law to maintain the privacy of your PHI and to provide you and your Covered Dependents with notice of its legal duties and privacy practices.

This notice is effective beginning on December 15, 2004 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. This revised notice will be mailed to the Covered Employee and Covered Dependents.

Any revised version of this notice will be distributed within sixty (60) days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,

- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA.

5. Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund Privacy Official at the address provided in Section 3.

You may also file a complaint with:

Secretary of the U.S. Department of Health and
Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Fund will not retaliate against you for filing a complaint.

6. If You Need More Information

if you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the address provided in Section 3.

7. Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal*

Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

VII. ADDITIONAL INFORMATION REQUIRED BY ERISA

Name of Plan

I.B.E.W. Local 306 Supplemental Health Benefit Fund

Plan Established and Maintained by

Board of Trustees

I.B.E.W. Local 306 Supplemental Health Benefit Fund
c/o Compensation Programs of Ohio, Inc. 33 Fitch
Boulevard Austintown, Ohio 44515 Phone: (800)435-2388

Employer Identification Number: 34-1409929

Participating Employers

Upon written request to the Fund Office, you may receive information as to whether a particular employer is a sponsor of the Plan. If the employer does participate, the Fund Office will furnish the address.

Plan Year/Fiscal Year

The Plan Year is the same as the Fiscal Year and begins June 1 of each year.

Type of Administration of the Plan

Although this Plan technically is administered and maintained by the joint Board of Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund, the Trustees have delegated certain administrative functions to a professional Administrative Manager, Compensation Programs of Ohio, Inc.

Address all communications with the Board of Trustees to: Board of Trustees, IBEW Local Union 306 Supplemental Health Benefit Plan, 33 Fitch Boulevard, Austintown, Ohio 44515, Phone: (800) 435-2388.

Agent for Service of Legal Process

Board of Trustees, IBEW Local Union 306 Supplemental Health Benefit Fund, 33 Fitch Boulevard, Austintown, Ohio 44515, Phone: (800) 435-2388.

Service of legal process may also be made upon any individual Trustee.

Name, Title and Address Principal Place of Business of Each Trustee

Management Trustees

Don Bourn

Novatny Electric 955
Evans Avenue Akron,
Ohio 44305

Tony K. Sasala, Jr.

S & E Electric, Inc. 1521
Highland Road Twinsburg, Ohio
44087-2254

Christeen A. Parsons
Speelman Electric 358
Commerce Street
Tallmadge, Ohio 44278

Union Trustees

David Moran
IBEW Local 306
2650 South Main Street, Suite 200
Akron, Ohio 44319

Al Sutter
1264 Walton Drive
Akron, Ohio 44313

Bob Beltz
3578 Tallmadge Road
Kent, Ohio 44240

Collective Bargaining Agreement

This Plan is maintained pursuant to a Collective Bargaining Agreement between the International Brotherhood of Electrical Workers Local Union No. 306 and the National Electrical Contractors Association and various other Participating Employers. You may obtain a copy of the Collective Bargaining Agreement from the Fund Office, the Union, or you may examine the Agreement at either of these locations.

Funding Medium for the Accumulation of Plan Assets

Assets are accumulated and subsidies for premiums required by the Fourth District IBEW Health Fund is paid for Covered Retirees. Such assets are invested at the

discretion of the Board of Trustees. Assets are also accumulated for medical reimbursement in individual accounts which are invested by the Board of Trustees.

Type of Plan

This Plan is maintained for the purpose of providing a subsidy for premiums required to be paid by Covered Retirees who are covered by the IBEW Local Union 306 Supplemental Health Benefit Plan who are eligible to participate in the Fourth District IBEW Health Fund or its successor.

The benefits to be provided to the Covered Retirees and their Covered Dependents shall be determined exclusively by the Fourth District IBEW Health Fund.

This Plan is also established for the purpose of establishing and maintaining Medical Reimbursements Accounts for Covered Employees for the payment of eligible medical expenses for the Covered Employees and their Covered Dependents.

VIII. STATEMENT OF YOUR RIGHTS UNDER ERISA

ERISA stands for the Employee Retirement Income Security Act which was signed into law in 1974.

This federal law establishes certain minimum standards for the operation of employee benefit plans, including the I.B.E.W. Local Union 306 Supplemental Health Benefit Fund. The Trustees of your Plan, in consultation with their professional advisors, have reviewed these standards carefully and have taken steps necessary to assure full compliance with ERISA.

ERISA requires that Plan Participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits and the procedures to follow when filing a claim for benefits. This information has already been presented in the preceding pages of this Summary Plan Description.

ERISA also requires that Participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan.

READ THIS SECTION CAREFULLY. Only by doing so can you be sure that you have the information you need to protect your rights and your best interests under this Plan.

(A) ERISA provides that all Plan Participants shall be entitled to:

(1) Examine, without charge, at the Fund Office and at other specific locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the public disclosure room of the Pension and Welfare Benefit Administration.

(2) Obtain, upon written request to the Administrative Manager or Board of Trustees, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrative Manager may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each Participant with a copy of this Summary Annual Report.

(4) Obtain a complete list of employers sponsoring the Plan upon written request to the Administrative Manager which list is available for examination by Participants and Beneficiaries.

(5) In addition, Participants and Beneficiaries may obtain from the Administrative Manager, upon written request, information as to whether a particular employer or employee organization is a sponsor to the Plan and if the employer or employee organization is a plan sponsor, the sponsor's address.

(B) In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries.

(C) No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit to which you may be entitled, or exercising your rights under ERISA.

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

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

have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

(F) If you have any questions about your Plan, you should contact the Plan Administrative Manager or the Board of Trustees. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trustees, you should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor or the Pension and Welfare Benefits Administration, whose offices are located at:

1730 K Street
Suite 556
Washington, DC 2006
Tel: (202)254-7013

Or

1885 Dixie Highway
Suite 210
Ft. Wright, Kentucky 41011-2664
Tel: (606)578-4680

Or

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor 200 Constitution
Avenue, N.W. Washington, D.C. 20210

I.B.E.W. LOCAL UNION 306
Supplemental Health Benefit Fund

33 FITCH BOULEVARD

AUSTINTOWN, OHIO 44515

1-800-589-8041

**AUTHORIZATION FOR DISBURSEMENT FROM
MEDICAL REIMBURSEMENT ACCOUNT**

REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

EMPLOYEE NAME _____

ADDRESS _____

PHONE NO. _____

SOCIAL SECURITY NUMBER _____

I am requesting payment for the following charges for which I have not been reimbursed, and for which I have not and will not be claiming a federal income tax deduction:

AMOUNT OF DEDUCTIBLE \$ _____

AMOUNT OF CO-INSURANCE \$ _____

VISION CARE (attach receipts) \$ _____

DENTAL CARE (attach receipts) \$ _____

OTHER MEDICAL EXPENSES (attach receipts) \$ _____
(not covered by the Health & Welfare Fund)

SELF PAYMENT BILLING (attach copy of billing) \$ _____

Check here if you elect to have your self-payment remitted directly to your health fund

Please complete the above, attach a copy of your EOB (Explanation of Benefits) from the Health & Welfare Plan where applicable, and receipts showing payments were made for expenses not covered by the Health & Welfare Plan, sign and return this form to:

**I.B.E.W. LOCAL UNION 306
SUPPLEMENTAL HEALTH BENEFIT FUND
33 Fitch Boulevard
Austintown, Ohio 44515**

All expenses submitted for a quarter (other than self-payments) will be reimbursed in the months of October, January, April, and July. For example, claims received during the months of July, August and September will be reimbursed in October. Please call first to check the status of your account before filing large dollar claims and PLEASE MAKE A COPY FOR YOURSELF OF ALL CHARGES SUBMITTED IN THE EVENT OF LOSS.

EMPLOYEE SIGNATURE _____ **DATE** _____

◆◆Not valid unless signed and dated by Employee'