

# I.B.E.W. LOCAL NO. 701 WELFARE PLAN SCHEDULE OF BENEFITS

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## ACTIVE EMPLOYEES ONLY

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE\* .....\$10,000

## WEEKLY LOSS OF TIME BENEFIT\*

### Non-occupational

Benefit amount.....2.5% of the last 12  
months earnings up to a  
\$500 maximum per week

Maximum number of weeks payable ..... 52

Benefit starting date:

Disability due to an accident ..... First day

Disability due to an illness ..... Fourth day

### Occupational

Benefit amount:

First week ..... \$45

Subsequent weeks ..... \$15

Maximum number of weeks payable ..... 26

Benefit starting date:

Disability due to an accident ..... First day

Disability due to an illness ..... Eighth day

\* Items with an asterisk do not apply to Employees covered by the Maintenance D Collective Bargaining Agreement. Also please note that Maintenance D Benefits apply to Employees only and do not apply to their dependents.

# I.B.E.W. LOCAL NO. 701 WELFARE PLAN SCHEDULE OF BENEFITS

## ACTIVE EMPLOYEES AND THEIR DEPENDENTS

Certain conditions and limitations apply to these benefits. It is important to read the description of covered charges (pages 49-52) and general Plan exclusions and limitations (pages 70-73).

### ACTIVE EMPLOYEES

LIFE INSURANCE\* .....\$20,000

Spouse and Eligible dependent children

LIFE INSURANCE .....\$10,000

### COMPREHENSIVE MAJOR MEDICAL BENEFIT

Lifetime maximum benefit payable per person..... \$1,000,000

#### Calendar Year deductibles:

Per individual .....\$100

Per family .....\$200

The benefits normally payable on your claim will be reduced by \$100 if you do not precertify any inpatient or outpatient surgery, whether in or out of the PPO network. Any other inpatient Hospital confinement outside the PPO network must also be precertified or the benefits normally payable on your claim will be reduced by \$100. The Plan will pay no benefits for inpatient treatment of Mental or Nervous Disorders, chemical dependency, or substance abuse if you do not precertify the treatment. To precertify these types of treatment, call Med-Care Management at (800) 423-7781.

#### Plan copayment for the first \$10,000 of covered charges per Calendar Year after the satisfaction of the Calendar Year deductible:

PPO provider..... 90%

Non-PPO provider..... 80%

Plan payment for covered charges over \$10,000 during a Calendar Year after satisfaction of the Calendar Year deductible..... 100%

**PPO Physician office visit** .....\$10 copayment per visit;  
not subject to the deductible

**Skilled Nursing Facility**  
Maximum number of days ..... 45 days per confinement

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**Home Health Care**

Maximum number of visits ..... 100 visits per  
Calendar Year

**Hospice care**

Maximum benefits..... \$135 per day for  
up to six months

**Chiropractic care\***

Maximum number of visits per Calendar Year

Age 1 day to 3 years ..... 2-5 visits

Age 3 to 6 years ..... 5-8 visits

Age 7 to 10 years ..... 7-10 visits

Age 11 to 15 years ..... 9-12 visits

Age 16 years and older ..... 52 visits

Maximum benefit ..... \$2,600 per Calendar Year

**Voluntary sterilization** (Eligible Employee and spouse only)

Maximum benefit ..... \$1,000 per lifetime

**Infertility treatment and procedures** (Eligible Employee and spouse only)

Maximum benefit ..... \$10,000 per lifetime

**Weight control treatment** (Eligible Employee and spouse only)

Maximum benefit ..... \$1,000 per lifetime

Corrective refractive surgery\* ..... \$3,000 per eye  
per lifetime

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**Temporomandibular joint syndrome (TMJ)**

Maximum benefit:

Per Calendar Year .....\$1,000  
Per lifetime .....\$3,000

**Smoking cessation**, with Physician approval ..... \$75

**Podiatry**

Plan copayment after the Calendar Year deductible has been satisfied:

Tier 1 - AFAS network ..... 100%  
Tier 2 - BCBS network ..... 90%  
Tier 3 - Non-network ..... 80%

***The following items are not subject to the Comprehensive Major Medical Calendar Year deductible.***

**SUPPLEMENTAL ACCIDENT BENEFIT\***

Maximum benefit.....\$200 per accident

**PHYSICAL EXAMINATION EXPENSE BENEFIT\***

Maximum benefit per family ..... \$2,000 per  
Calendar Year

**DENTAL CARE EXPENSE BENEFIT\***

Coverage A (routine oral examination)..... 100% of covered charges  
Coverage B (basic dental care)..... 80% of covered charges  
Coverage C (gold restorations, crowns, prosthetics)..... 50% of covered charges

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Coverage D (orthodontic care)..... 50% of covered charges

Family Calendar Year maximum.....\$5,000

Coverage for loss or removal of teeth begins on the date of initial eligibility.

**VISION CARE EXPENSE BENEFIT\***

<b>Indemnity schedule:</b>	<b><u>Maximum benefit</u></b>
Examination .....	\$50
Single lens (pair) or contacts .....	\$65
Bifocal or trifocal (pair) .....	\$75
Frames.....	\$125
Contact lenses following cataract surgery.....	\$100
Safety glasses .....	\$100

**Cole Vision schedule:**

Eye examination once per Calendar Year .....	Provided
Uncoated plastic lenses once per Calendar Year .....	Provided
Frames once every two Calendar Years .....	Provided
Contact lenses.....	Up to \$100
Safety glasses (for Employees only) once per Calendar Year .....	Up to \$100

*Please call Cole Vision at (800) 334-7591 for the location of a provider near you.*

**HEARING CARE EXPENSE BENEFIT\***

Maximum benefit:	
Examination .....	\$75 every two Calendar Years
Hearing aid instrument per ear.....	\$750 every five consecutive years

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**MEMBERS ASSISTANCE PROGRAM BENEFIT\***

(No benefits will be payable if the treatment is not precertified or referred in accordance with the provisions on page 63.)

Plan copayment of covered charges, except prescription drugs ..... 80%

*Benefits will be reduced if you or your Dependent is receiving an inpatient or residential course of treatment or intensive outpatient program and you or your Dependent leaves against medical advice and MAP approval, even if the treatment has been precertified or referred.*

**PRESCRIPTION DRUG PROGRAM\***

**Drug Card Program (for short-term [acute] prescription drugs):**

Participant copay amount:

Generic drugs ..... \$0  
Brand name drug when the Physician does not authorize  
a generic substitution..... \$0  
Brand name drug when the participant declines a generic  
substitution .....\$12.50

**Mail Order Program (for long-term [maintenance] prescription drugs):**

Participant copay amount:

Generic drugs ..... \$0  
Brand name drug when the Physician does not authorize  
a generic substitution..... \$0  
Brand name drug when the participant declines a generic  
substitution .....\$12.50

**MEDICAL SAVINGS ALLOWANCE BENEFIT\***

Benefits determined annually.

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