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Local Union No. 9, I.B.E.W.  
& Line Clearance Contractors  
Health and Welfare Benefit Fund

Summary Plan Description  
Benefits and Eligibility Rules

## **Notice**

This booklet contains a summary in English of your rights and benefits under the Local Union No. 9, I.B.E.W. & Line Clearance Contractors Health and Welfare Fund.

If you have difficulty understanding any part of this booklet, or difficulty understanding any information that you receive from the Local Union No. 9, I.B.E.W. & Line Clearance Contractors Health and Welfare Fund, you may receive assistance in Spanish by contacting the Fund Office between the hours of 7:30 a.m. and 5:30 p.m., Monday through Friday. The Fund Office is located at 6525 Centurion Drive, Lansing, Michigan 48917, and can be reached by telephone at (517) 321-7502 and toll free at (877) 423-9155.

Please pay attention to every letter and notice you receive from the Health and Welfare Fund about your health care coverage and respond immediately to any request for information and/or payment. A timely response and payment, when required, is essential to continue your health care coverage without interruption.

Please call the Fund Office if you have difficulty understanding any information that you receive from them.

## **Aviso**

Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo el Local Union No. 9, I.B.E.W. & Line Clearance Contractors Health and Welfare Fund.

Si usted tuviera dificultad para entender cualquier parte de este folleto, o dificultad para entender cualquier información que usted reciba de Local Union No. 9, I.B.E.W. & Line Clearance Contractors Health and Welfare Fund, usted puede recibir ayuda en español contactando a la Oficina del Fondo entre las horas de 7:30 a.m. y 5:30 p.m., de lunes a viernes. La Oficina del Fondo está ubicada en 6525 Centurion Drive, Lansing, Michigan 48917, y puede contactarse por teléfono en el (517) 321 -7502 y gratis en el (877) 423-9155.

Por favor preste atención a toda carta y aviso que reciba del Fondo de Salud y Bienestar sobre su cobertura de atención médica y responda inmediatamente a cualquier pedido de información y/o de pago. Una respuesta y un pago oportunos cuando se requiera, es esencial para continuar su cobertura de atención médica sin interrupción.

Por favor llame a La Oficina del Fondo si usted tuviera dificultad para entender cualquier información que usted reciba de ellos.

## **INTRODUCTION**

If You Move,  
Notify The Fund Office Immediately!

Most information about your plan is sent to you by mail. For you to receive this information, we must have a correct address on file at the Fund Office at all times. If you move, it's up to you to let us know your new address. Failure to do so may jeopardize your eligibility or benefits because we have no way to contact you about any changes in the eligibility rules or improvements in benefits.

So don't lose out! Remember: the responsibility for letting the Fund Office know your new address is yours.

The Fund Office will mail you forms upon request which you may use to notify the Fund Office about an address or designated beneficiary change. If you have access to the internet, the address change form is available on the Fund's website at [www.ibew9lctt.org](http://www.ibew9lctt.org). You may download the form, print it out and send it to the Fund Administrator.

Please send the completed forms to:

Local Union No. 9 IBEW & Line Clearance Contractors  
Health and Welfare Fund  
c/o TIC International Corporation  
6525 Centurion Drive  
Lansing, Michigan 48917-9275  
Telephone: TOLL FREE: (877) 423-9155  
Facsimile: (517) 321-7508  
Website: [www.ibew9lctt.org](http://www.ibew9lctt.org)

## **ABOUT YOUR PLAN**

Your Employer and the Union have created a Welfare Fund for you and your fellow workers. The Fund provides a specific, dependable plan of benefits. This Plan has been constantly improved in an effort to provide the best benefits possible consistent with sound financial management of the Plan. The Local Union No. 9, I.B.E.W. & Line Clearance Contractors Health and Welfare Benefit Fund is maintained as a result of a collective bargaining agreement, sometimes referred to as a labor contract, between your Employer and the Union.

Your Welfare Fund receives its money from Employer contributions, on dates and in amounts called for by the labor contract negotiated with the Employer by your Union. Money is not withheld from your paycheck in order to support the Fund.

Decisions on Plan operations and benefits are made by a Board of Trustees on which labor and management are equally represented.

Working together, the Board of Trustees establishes the eligibility rules, strives to maintain the schedule of benefits, supervises the investment of the Fund's money, and sees that the Fund is in compliance with all applicable Federal laws and regulations.

In carrying out these responsibilities, the Trustees are assisted by a team of professionals including:

The **Administrative Manager** who handles the day-to-day business activities of the Fund such as collecting employer contributions, keeping records of money received, crediting each participant's account with the correct number of hours worked, paying claims, and answering inquiries from participants about their eligibility and benefits.

The **Fund Attorney** advises the Trustees about what must be done to assure that all operations of the Fund comply with Federal and State laws.

The **Fund Investment Consultant** advises the Trustees about how to invest any reserves not needed to pay current Fund expenses.

The largest part of contributions the Fund receives is returned directly to participants in the form of benefits. Some of the contributions received are set aside for reserves. The Fund's reserves can be drawn on at times when the claims expenses exceed the income from Employer contributions.

As required by law, the Fund has an independent auditor examine the financial records each year and certifies them as to their accuracy, completeness and fairness. In addition, the Trustees are required to submit annual financial statements and other

reports to the U.S. Department of Labor and the Internal Revenue Service. These reports are available for inspection at the Fund Office during normal business hours.

This, then is a brief description of how your Fund was established, what its purpose is, and how it operates. This Summary Plan Description replaces and supersedes all previous Summary Plan Descriptions. This Summary Plan Description describes the benefits that were effective March 1, 2003.

## **YOUR RESPONSIBILITIES AS A PARTICIPANT**

There are certain responsibilities which you, as a participant, must assume. Failure to carry out these responsibilities could affect your eligibility for benefits payable on your behalf.

1. Take time to read this Summary Plan Description.
2. Complete and file a BlueCross/BlueShield of Illinois Enrollment Form.
3. Notify the Fund Office promptly, in writing, if you have:
  - a. a change of address; or
  - b. a change in marital status; or
  - c. a change in beneficiary; or
  - d. a change in dependents.
4. Fully complete a claim form each time you submit charges for any medical expense.
5. Make self-payments, if necessary, on time and in the correct amount.

A more detailed explanation of your responsibilities can be found in the appropriate section of the Plan Description. Please refer to the Table of Contents for page numbers.

## **HOW TO COLLECT BENEFITS**

Once you become eligible, this Fund has the responsibility for seeing that you receive all the benefits to which you are entitled. To receive these benefits, you must also assume some responsibility. Benefits are not paid automatically; you must file a claim to collect benefits.

Different types of claims may require you to complete different types of claim forms. Sometimes your medical provider will submit claims directly to the Fund for payment. You should ask your provider if they intend to submit a claim directly. If you need to

submit the claim, you may obtain the proper form from the Fund Office. If the claim form asks you to submit it to a different office for processing, you should follow the directions on the form.

Accidental Injury claims are handled a little bit differently. Please follow the steps listed below for **ALL** accidental injury claims:

1. Ask the Fund Office for a claim form. Different types of claims (medical, dental, short-term disability, etc.) require different claim forms.
2. Fill out **YOUR** portion of the claim form COMPLETELY.
3. Have the physician fill out his portion on the claim form.
  - a. Be sure the physician shows the diagnosis on the claim form.
  - b. If your physician provides his own claim form, you may attach that form to the Fund's claim form.
  - c. If you are applying for Short Term Disability (Loss of Time) Benefits, be sure that you, your physician, and your employer complete the appropriate areas on the claim form. If loss of time continues for an extended period, you will be asked to complete additional claim forms. Your physician must also certify, on his portion of the claim form, that you are still disabled.
4. Attach all itemized bills relating to the claim. Be sure all bills show:
  - a. the name of the patient;
  - b. the date of service;
  - c. the exact charge for each service provided and a description of the service(s); and,
  - d. the provider's name, address and telephone number.
5. Forward completed claim forms and related bills to the claims processing service provider shown on the claim form.

To receive benefits provided by the Fund, **all** members must comply with every applicable claim rule, and the Trustees reserve the right to deny benefits to any member who is, in their opinion, attempting to subvert the purpose of the Fund, or who does not, in their opinion, present a bona fide claim.

The Fund Office can provide you with the forms needed for filing a claim or a proof of loss. Additionally, the claim forms can be provided by the different service providers

who pay the various types of claims. For example, BlueCross/BlueShield of Illinois (BlueCross) pays the medical and prescription drug claims. BlueCross can provide you with these forms. The Guardian Life Insurance Company (Guardian) pays the Dental and Short-term Disability claims. Guardian can provide you with the forms for these types of claims. Vision Service Plans (VSP) pays the vision claims. VSP can provide you with vision claim forms. Finally, Hartford Life Insurance Company (Hartford) pays the life and accidental death and dismemberment claims and Hartford provides these claim forms. The various claim forms will instruct you on how to submit your claims for processing.

Although BlueCross, Guardian, VSP, and Hartford ("the Claims Paying Agents") all pay claims and although their names may appear on the claim forms, the benefits are controlled by the Board of Trustees and are paid out of the Trust Fund. Only the life and accidental death and dismemberment benefits paid by Hartford are insured. The Trustees purchased group insurance policies for these two types of benefits and the insurance policies will control payment of these claims. You may refer to the separate Hartford Life and Accidental Death and Dismemberment Insurance Booklet which provides further detail regarding these specific benefits. In addition, BlueCross, Guardian, and VSP also have specific booklets which provide further details regarding the specific claims for benefits which they process.

### **General Payment Provisions**

Upon submission of adequate proof and subject to any written direction of the Employee, all or a portion of any benefits provided by the Plan may, at the Trustees' option, be paid directly to the hospital or person rendering the services provided.

Written proof of Short-Term Disability benefits due to disability or hospital confinement must be furnished to the appropriate Claims Paying Agent within ninety (90) days after the termination of the period for which the claim is being made. Written proof of any other loss on which the claim may be based must be furnished to the Claims Paying Agent not later than ninety (90) days after the date of the loss. Failure to furnish notice or proof of claim within the time provided in the Plan will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time and proof is furnished as soon as reasonably possible. **However, in no event may any claim be submitted later than one (1) year from the date of loss.** The date of loss is the date the service was provided. In the case of hospital confinement, the date of loss is the first date of confinement. In the case of a short-term disability (a disability lasting no more than 26 weeks), the date of loss is the first date of the disability. In the event of a course of treatment, the date of loss is the first date of treatment within the course of treatment.

Benefits payable under the Plan for any loss other than Short-Term Disability will be paid as they accrue immediately upon receipt of due written proof of loss. Subject to

due written proof of loss, all accrued benefits for Short-Term Disability will be paid at the times set forth in the applicable benefit provision and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Death Benefits will be payable in accordance with the beneficiary designation form on file at the Fund Office and in accordance with the provisions with respect to such payments which are prescribed in the Hartford Insurance Booklet. The Hartford Insurance Booklet provides for a method of distribution if you do not complete a beneficiary designation card and it is as follows:

Payment will be made as follows if you name a beneficiary(-ies):

1. If more than one beneficiary is named, each will be paid an equal share.
2. If any named beneficiary dies before you, his share will be divided equally among the named surviving beneficiaries.

If no beneficiary is named, or if no named beneficiary survives you, the Fund may, at its option, pay:

1. up to \$2,000 of your life insurance to any party that the Fund deems is entitled because of their payment of burial expenses. The Fund and Hartford will be released from further liability for any amount so paid; and/or
2. the executors or administrators of your estate; or
3. Your surviving relatives in the following order:
  - a) all to your surviving spouse; or
  - b) if your spouse does not survive You, in equal shares to your surviving children; or
  - c) if no child survives you, in equal shares to your surviving parents.

Therefore, if you wish to have control over the distribution of this benefit, you should complete a beneficiary designation card and keep it current and on file at the Fund Office.

**Benefits under this plan will be paid only if the Board of Trustees decides in its discretion that the applicant is entitled to them. This provision applies to all benefits payable under the plan.**

## **ELIGIBILITY RULES**

All Employees working in Covered Employment shall be eligible to receive benefits after meeting the following eligibility requirements. Covered Employment means work performed for a Contributing Employer or Employers within the jurisdiction contained in the Collective Bargaining Agreement and for which the Employer is obligated to make contributions to the Fund.

### **Initial Eligibility**

An Employee (hereafter “you”) initially becomes eligible after he has worked at least 500 hours in covered employment. Specifically, you become eligible on the first day of the second month after the month in which you have completed the 500 hours of work. The Contributing Employer reports the hours worked and pays the contributions to the Fund on your behalf. The 500 hours must be worked in Covered Employment and at least within a period of four (4) consecutive calendar months. If you work 500 or more hours in three (3) consecutive calendar months then, you will become eligible on the first day of the month after that third month.

For example, if your employer contributed for 500 or more hours for you during the work months of January, February, March and April; your eligibility will begin effective June 1<sup>st</sup>.

However, if your employer contributed for 500 or more hours for you during the work months of January, February, and March; your eligibility will begin effective May 1<sup>st</sup>.

### **Continuing Eligibility**

You will remain eligible so long as your Employer continues to report at least one hundred twenty (120) hours worked in Covered Employment per month. In the event that your Employer fails to report at least one hundred twenty (120) hours worked in Covered Employment in a certain month, the Trustees may permit you to pay up to eighty (80) hours maximum within a calendar year at the self-pay rate determined by the Trustees. For further details about the self-payment procedures please refer to the section entitled **Self-payment of Contributions** which appears later in these **Eligibility Rules**. After you have exhausted the maximum self-payment hours, you may be eligible to continue your eligibility pursuant to the COBRA rules as reflected in this booklet.

Your eligibility ends on the last day of the second calendar month following the last work month for which your Employer made contributions on your behalf for at least one hundred (120) hours worked in Covered Employment. For example, if your employer last contributed 120 or more hours for your work in Covered Employment during the month of May, your eligibility will last be in effect on July 31<sup>st</sup>.

### **Continuation Of Coverage During Work Related Period of Disability**

If you become disabled while you are eligible under this Plan and you cannot work in Covered Employment, and your disability arose out of, or in the course of, your employment, your eligibility may be continued if your employer voluntarily makes contributions on your behalf or if your employer is obligated to make contributions on your behalf pursuant to a Workers Compensation or Occupational Disease Law.

### **Continuation Of Coverage During non-Work Related Period of Disability**

If you become disabled while you are eligible under this Plan and you cannot work in Covered Employment, and your disability did not arise out of, or in the course of, your employment, your eligibility may be continued by the Plan providing you with the required credits in the event that your employer does not voluntarily make contributions on your behalf. The Fund may credit up to 120 hours per month for up to 26 weeks for the duration of your disability. You will be required to file an application for short-term disability benefits to become eligible for these credits. You will be required to provide proof of your disability by providing appropriate documentation to the Fund Office. In the event you become disabled you should promptly notify the Fund Office.

### **Continuation Of Coverage During Leave of Absence**

If you take an unpaid Leave of Absence while you are eligible under this Plan and you do not work in Covered Employment your eligibility may be continued if your employer voluntarily makes contributions on your behalf or, if your employer is obligated to make contributions on your behalf, pursuant to any legal obligation.

### **Continuation of Coverage During Work Under a Different Collective Bargaining Agreement (Jurisdiction with Reciprocity)**

When you leave the jurisdiction of Local Union No. 9, IBEW to work at the trade in covered employment under another Collective Bargaining Agreement in the jurisdiction of another IBEW Local Union, the Employee's eligibility under this Plan is governed by the requirements of this section of the Eligibility Rules.

### **Termination of Coverage During Work Under a Different Collective Bargaining Agreement (Jurisdiction without Reciprocity)**

When you leave the jurisdiction of Local Union No.9 IBEW to work at the trade in Covered Employment under the jurisdiction of an IBEW Local Union that does not have a Reciprocal Agreement either through the International Brotherhood of Electrical Workers or directly with Local Union No. 9 IBEW, your eligibility (and that of any eligible Dependents) terminates on the earlier of:

1. The last day of the second calendar month following the last work month for which your Employer made contributions of at least one hundred twenty (120) hours worked in Covered Employment, or
2. The first day of the month in which you are covered, or become eligible for coverage, under any other group health care plan or program.

### **Return to Covered Employment (Reinstatement of Eligibility)**

When you return to covered employment within Local Union No. 9's jurisdiction, your eligibility may be reinstated in this Plan on the first day of the second month following the month in which you performed covered employment for an Employer required to contribute to this Fund. In this event, you may not be subject to the Initial Eligibility requirements and may only be subject to the Continuing Eligibility requirements. Please contact the Fund Administrator after you have returned to covered employment to determine if you can meet the Continuing Eligibility requirements to reinstate your eligibility.

Eligibility on and after the first day of the month following the reinstatement of your eligibility is governed by the normal "Continuing Eligibility" section.

If you fail to meet these requirements or, if you do meet the requirements but do not reestablish eligibility within six (6) months after your eligibility terminated, then you must meet the requirements under "Initial Eligibility" in these Rules to reinstate your eligibility.

### **Method of Calculating Contributions from a Jurisdiction with Reciprocity**

The Trustees of the Local Union No. 9 IBEW Health & Welfare Fund have entered into Reciprocal Agreements with the Trustees of similar IBEW Welfare Funds operating in the various jurisdictions of other IBEW Local Unions. Under these Reciprocal Agreements, contributions for hours worked at covered employment in the jurisdiction of another IBEW Local Union may be transferred to this Fund for use in continuing your eligibility.

The amounts to be transferred and the way in which those transfers are credited to your records is governed by the individual Reciprocity Agreement and by the administrative procedures adopted by this Fund's Trustees. You should inquire about the availability of Reciprocal transfers at the Fund Office before you leave the jurisdiction of Local Union No. 9, IBEW.

## **Electronic Reciprocal Transfer System (ERTS)**

The International Brotherhood of Electrical Workers ("the International Union") has implemented an Electronic Reciprocity Transfer System ("ERTS"). The system is designed to permit an IBEW member to register electronically one time and to designate one local Union as his "home local" for reciprocity purposes. Participation by the Fund in ERTS is mandatory.

To the extent that ERTS is operational, the rules established by the ERTS Reciprocal Administrator will control any contrary provisions of this document. If you plan to travel outside of Local Union No. 9's jurisdiction and to work in Covered Employment, you should contact the Fund Office and the appropriate IBEW Local Unions first to determine if the ERTS will apply to your situation.

## **Continuation of Eligibility For Dependents in the Event of an Employee's Death**

If you die while you are eligible under these Rules, your eligible dependents may continue to be eligible according to the following requirements. Eligibility for surviving dependents will continue automatically, without self-contribution, until the date on which your eligibility would have terminated had your death not occurred.

For example, if a participant, John, dies in March after having worked at least 120 hours in covered employment then, John's surviving dependents will continue coverage until the end of May.

Surviving dependents will have this continued eligibility so long as they continue to meet the definition of dependent under the terms of the Plan.

## **Continuing Eligibility under the Uniformed Services Employment and Reemployment Rights Act**

If you enter into military service as defined by the provisions of the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), you may be able to continue coverage under this Plan. If you qualify, USERRA provides that you may elect to continue coverage at a cost of not more than 102% of the actual cost of coverage in effect at the time of such eligibility. The Plan permits you to continue coverage at the self-pay rate as reflected in the section below entitled **Self-Payment of Contributions**. In the event that you are reemployed by a Contributing Employer and provided that USERRA applies, you will immediately receive eligibility upon your return to covered employment. The Board of Trustees shall determine the liability for any employer contributions due to the Plan in conformance with the provisions of USERRA.

Your dependent's eligibility will cease the day the dependent is inducted into the Armed Forces of the United States.

### **Reinstatement of Eligibility following a period of ineligibility**

#### Employees

If you once established eligibility under this Plan and lose that eligibility at a later date, you may be reinstated under **Continuation of Eligibility** in these Rules if you have been ineligible no more than six (6) consecutive months. If you remain ineligible for more than six (6) consecutive months, then you must meet the requirements under "Initial Eligibility" in these Rules to reinstate eligibility.

If you are not actively working due to disability on the day you would otherwise reinstate your eligibility, you will not become eligible for benefits until you return to active employment as described under **Initial Eligibility**.

#### Dependents

A dependent child who loses eligibility for reasons other than age (such as change of employment or residence) may have eligibility reinstated on the first day of the month after the month in which the child again meets all requirements of the dependent definition, provided the child has not remained ineligible for more than eighteen (18) consecutive months. You are responsible for notifying the Fund Office if your dependent child again meets all requirements for eligibility. If a dependent child remains ineligible more than eighteen (18) consecutive months, eligibility as a dependent cannot be reinstated.

### **Self-Payment of Contributions**

The Trustees have established self-pay rates, which may be partially subsidized by the Fund. These rates are modified, from time-to-time, by the Trustees. Please contact the Fund Office for the current rates.

The rate may vary depending on your coverage and your age and you have optional coverage available. Please contact the Fund Office for the current list of coverage availability.

Self-Payments must be received at the Fund Office within ten (10) days of the date the self-payment "Notice" is received by you. All "Notices" are sent by mail to the last known address on file at the Fund Office so it is important that any address changes are reported immediately. In any event, self-payments must be received within thirty (30) days of the date the self-payment Notice is sent to your last known address.

Self-Payments are required on a monthly basis in accordance with the eligibility requirements as defined by these Rules. A change in coverage circumstances (such as eligibility for Medicare) will result in the re-determination of the covered person's benefits class effective as of the first day of the calendar month coincident with, or next following, the date that the change in circumstances occurred.

Please contact the Fund Office at (877) 423-9155 if you are unsure of your coverage under the self-payment rules.

### **Change of Eligibility Rules**

The Trustees, in their discretion, are empowered to change or to amend these Eligibility Rules at any time.

### **GENERAL ELIGIBILITY PROVISIONS**

The Eligibility Rules are the requirements which must be met in order for you and your dependents to become and to remain eligible for benefits from this Plan. In the event the requirements are not satisfied, eligibility is lost and benefits are not payable. The Trustees reserve the right to deny benefits to any claimant who is, in their opinion, attempting to subvert the purpose of the Plan or who does not present a bona fide claim.

Remember: Changes in employment may have an effect on Employer contributions paid on your behalf. For example, Employer contributions stop if:

1. you change job classifications from covered to non-covered employment, even if that employment is with the same employer; or
2. you change employment from a participating to a non-participating Employer.

You and your dependents may obtain, upon written request to the Union Office, information as to the address of a particular Employer and whether that Employer is required to pay contributions to the Plan.

## **Effective Dates of Coverage**

### Employee

Your effective date of coverage as an Employee will normally be the date you satisfy the requirements of the Eligibility Rules. Your coverage is not delayed if you are disabled or confined in a Hospital on that date. However, if you are totally disabled or confined in a Hospital on the date your coverage would otherwise become effective, coverage for the charges related to the disability or confinement may not be eligible for benefits from this Plan. For example, if other coverage applies then, the Coordination of Benefits provision applies. Also, the Plan's pre-existing condition exclusion may apply subject to the prohibitions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please refer to the HIPAA section below for details.

### Dependents

Your effective date of coverage, as a Dependent, will normally be the date the Employee, who sponsors you, becomes eligible or the date you satisfy the definition of Dependent, whichever is later. Your coverage is not delayed if you or the Employee who sponsors you is disabled or confined in a Hospital on that date. However, if a Dependent is totally disabled or confined in a Hospital on the date his or her coverage would otherwise become effective, coverage for the charges related to the disability or confinement may not be eligible for benefits from this Plan. For example, if other coverage applies, then the Coordination of Benefits provision applies. Also, the Plan's pre-existing condition exclusion may apply subject to the prohibitions of HIPAA.

This provision does not apply to a newborn child. The newborn child of an Eligible Employee becomes eligible on the date of birth whether or not the child is confined in a Hospital due to injury or sickness.

## **Termination Dates of Coverage**

### Employee

Your coverage as an Employee under all benefit provisions of the Plan terminates or ends when any one of the following events first occurs:

1. you fail to meet the requirements for continuing eligibility as shown in the Eligibility Rules (this includes a failure to make any self-payments of contributions in a timely manner); or
2. the coverage classification under which you were continuing your eligibility terminates; or

3. the Plan itself is terminated.

### Dependents

Your coverage as a Dependent under all benefit provisions of the Plan terminates or ends when any one of the following events first occurs:

1. eligibility for the Employee who sponsors you is terminated (for reasons other than the receipt of a Maximum Amount Payable); or
2. you fail to meet the definition of Dependent (in this case, your coverage ends on the first of the month next following the date you fail to meet the definition of Dependent); or
3. you fail to meet the requirements for continuing eligibility as shown in the Eligibility Rules (this includes a failure to make any self-payments of contributions in a timely manner); or
4. the coverage classification under which you were continuing your eligibility terminates; or
5. the Plan itself is terminated.

### **Health Insurance Portability and Accountability Act**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you are covered. Under the law, a pre-existing condition exclusion generally may not be imposed for more than twelve (12) months (18 months for late enrollees). The twelve (12) month (or 18 month) exclusion period is reduced by the duration of your prior group health coverage. You are entitled to a certificate that will show evidence of the duration of your prior group health coverage.

If you subsequently buy health insurance other than through an employer group health plan or other source, a certificate of proof of coverage may help you obtain coverage without a pre-existing condition exclusion. If you have questions about your rights under ERISA or HIPAA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You have a right to receive a certificate of prior health coverage dating back to July 1, 1996. You may need to provide other documentation for earlier periods of health care

coverage. Check with your new Plan Administrator to see if your new Plan excludes coverage for pre-existing conditions and if you need to provide a certificate or documentation of your previous coverage. To receive a certificate, please contact the Fund Office.

### **Family and Medical Leave Act**

You may be eligible for up to 12 weeks of unpaid, job protected leave for certain family and medical reasons under the Family and Medical Leave Act of 1993. Generally, you are eligible under the Act if:

1. You are employed by an employer with at least 50 employees at your work site or with at least 50 employees within a 75 mile radius of your work site;
2. You have been employed by the employer for at least 12 months; and
3. You have worked at least 1,250 hours for the employer during the 12 months immediately before the requested leave.

Your employer determines whether you are eligible for family or medical leave under the Act, not this Plan or its Trustees.

Both you and your employer are required to notify the Fund Office if you take a family or medical leave and to provide certain other information as required by the Trustees. Your coverage under the Plan will continue during the period of your family or medical leave, provided your employer makes contributions to the Plan at the same rate and in the same amount as if you were continuously employed during the period of your leave and provided that your employer fully complies with all requirements established by the Trustees.

### **CONTINUING COVERAGE UNDER COBRA**

This section is intended to explain to you and your eligible dependents, in a summary fashion, about rights and obligations under the Continuation Coverage provisions of the Consolidated Omnibus Budget Reconciliation Act, or "COBRA." You, your spouse (if any), and your dependents (if any) should take time to read this section carefully.

Certain terms are used in this section and are defined as follows:

**Continuation Coverage** – the coverage available to you and your family in the event you lose eligibility due to a Qualifying Event. If you elect Continuation Coverage, the Plan must provide coverage which, as of the time such coverage is provided, is identical to the coverage provided for other similarly situated beneficiaries. However, short-term disability benefits are not provided.

**Qualified Beneficiary** – an individual who is covered under the Plan on the day before a Qualifying Event, as well as a newborn child or child placed for adoption with you during the period of Continuation Coverage. Qualified Beneficiaries are you, your spouse or your dependent child(ren).

**Qualifying Event** – an event that causes you and/or your family to lose coverage under the Plan. The specific events which are Qualifying Events for you, your spouse and/or your children are explained in detail in the following sections. Depending on the Qualifying Event, Continuation Coverage is available for 18, 29 or 36 months. In the case of a loss of coverage due to the end of employment (for reasons other than gross misconduct) or a reduction in the hours worked which results in loss of eligibility under the Plan, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

### **Employee Right to Elect Continuation Coverage**

You, as a Qualified Beneficiary, have the right to choose Continuation Coverage if you lose eligibility for coverage under the Plan due to a reduction in the amount of employer contributions remitted or termination of employment for any reason, unless termination is due to gross misconduct on your part. Either of those circumstances is what is known as a "Qualifying Event" for you, as an employee. These Qualifying Events entitle you and/or your family to elect 18 months of Continuation Coverage.

The Trustees, through the Fund Office, determine when a Qualifying Event occurs as a result of a reduction of employer contributions or a termination of employment based on information contained on submitted employer contribution forms. The Fund Office will determine when the COBRA Qualifying Event has occurred within 120 days following receipt of the employer contribution form. The Fund Office will mail the COBRA election notice within 60 days after it has determined that you or a qualified beneficiary has lost eligibility for coverage. You have 60 days from the date you receive the election notice to elect to receive Continuation Coverage. If you do not make an election for coverage within 60 days, you no longer have a right to receive Continuation Coverage.

If you qualify for Continuation Coverage under COBRA but do not elect such coverage for your entire family, your spouse and/or dependent children are still entitled to independently elect Continuation Coverage for themselves.

### **Your Spouse's Right to Elect Continuation Coverage**

*Spouses of employees* covered under the Plan, as Qualified Beneficiaries, have the right to choose Continuation Coverage for themselves if they lose their group health care coverage under the Plan for any of the following reasons:

- Termination of your employment (for reasons other than gross misconduct), or a reduction in the hours worked by you which results in your losing eligibility under the Fund;
- Your death;
- Divorce or legal separation from you; or
- You become entitled to Medicare and are not eligible to continue coverage for your spouse under another portion of the Plan or choose not to continue such coverage.

These reasons are known as Qualifying Events for your spouse. In the case of losses of coverage due to your death, divorce or legal separation, or your becoming entitled to Medicare benefits, coverage may be continued for up to a total of 36 months. In the case of loss of coverage due to the first Qualifying Event (termination of your employment or a reduction in the hours worked by you which results in their loss of eligibility) your spouse can elect 18 months of Continuation Coverage. If a second Qualifying Event(s) occurs, it would entitle your spouse to elect up to a total of 36 months of Continuation Coverage.

### **Your Dependant Children's Right to Elect Continuation Coverage**

All of your dependent children covered under the Plan, as Qualified Beneficiaries, have the right to Continuation Coverage if they lose their eligibility for coverage under the Plan for any of the following five reasons:

- Termination your employment (for reasons other than gross misconduct) or a reduction in the hours worked by you which results in your losing eligibility under the Fund;
- Your death;
- Divorce or legal separation of their parents;
- You become entitled to Medicare and either are not eligible to continue coverage for the children or choose not to continue such coverage; or
- The child or children cease to satisfy the Plan's definition of a "dependent child."

These reasons are known as Qualifying Events for your dependent children. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. In the case of loss of coverage due to the first Qualifying Event (termination of your employment or a reduction in the hours worked by you which

results in their loss of eligibility) your dependent child(ren) can elect 18 months of Continuation Coverage. If a second Qualifying Event(s) occurs, it would entitle your dependent child(ren) to elect up to a total of 36 months of Continuation Coverage.

A newborn or adopted child will automatically be extended COBRA coverage if the parents already have COBRA coverage. This may involve an increase in the COBRA premium charged. A newborn child or an adopted child (or the child's custodian or guardian) has a right, separate from his or her parents to elect Continuation Coverage for 18 or 36 months, depending on the Qualifying Event, even if the child's parent(s) do not elect Continuation Coverage.

### **Continuation Coverage for Disabled Persons**

If you, as a covered employee, your spouse, or any dependent child, as Qualified Beneficiaries, qualify for Social Security disability benefits at the time of a Qualifying Event that entitles the Qualified Beneficiary to elect 18 months of Continuation Coverage (or any time during the first 60 days after you lose coverage due to a Qualifying Event), you may purchase up to an additional 11 months of Continuation Coverage (or a total of 29 months).

This additional Continuation Coverage may be purchased not only for the disabled person but also for other family members who are not disabled (subject to the applicable premium).

To obtain this additional Continuation Coverage, the Qualified Beneficiary must be determined eligible for Social Security disability benefits before the end of the 18-month Continuation Coverage period and must notify the Fund Office during the 18 month period and within 60 days after the Social Security Administration awards Social Security benefits to the disabled person.

The Fund is permitted to charge a higher premium (up to 150% of the regular COBRA premium) for the additional 11 months of Continuation Coverage available to disabled persons and their families. The higher premium applies to the disabled person and for other family members who opt for additional COBRA coverage.

Eligibility for extended Continuation Coverage because of disability ends the first day of the month that is more than 30 days after the date that the person is determined under the Social Security Administration to be no longer disabled. Federal law requires a disabled person to notify the Fund within 30 days of a final Social Security Administration determination that they no longer are disabled.

### **Employee Obligations to Notify the Fund Office of a Qualifying Event**

Under COBRA, you or a family member must notify the Fund Office immediately about a divorce, legal separation, or a child losing dependent status under the Plan. If such an event is not reported to the Fund Office within 60 days after it occurs, Continuation Coverage will not be permitted.

Your surviving spouse (or dependent child) should contact the Fund Office immediately after your death. This assures that Continuation Coverage is offered to your surviving spouse and children at the earliest possible date.

The law requires the COBRA election notice to be sent to the last known address on file at the Fund Office. If the election notice is sent to the wrong address due to your failure to notify the Fund Office about a change in address, the 60-day time limit will not be extended and you may lose the opportunity to elect COBRA.

You are also required to notify the Fund Office if you or any family members are covered under another group health care plan at the time you received a COBRA election notice (e.g., if you are covered as a dependent under your spouse's plan) or if you elect Continuation Coverage, at any time you or a family member later becomes covered under another group health care plan, including Medicare.

The Fund Office may require you to provide information about your coverage under another group health care plan. The Fund may seek reimbursement directly from you if medical expenses are paid by the Fund because you or your dependents do not notify the Fund of other health care coverage.

### **Second Qualifying Events**

The following rules concerning the occurrence of a second Qualifying Event only apply if the original Qualifying Event was termination of the employee's employment (for reasons other than gross misconduct) or reduction in the number of hours worked by the employee. If a second Qualifying Event should occur during the 18 months of coverage available as a result of the first Qualifying Event [or, 29 months if the 11 month extension due to disability applies], then you may purchase additional Continuation Coverage for up to a total of 36 months. An example of a second Qualifying Event would be:

- Death of the employee, if he or she is a covered employee under the Plan;
- Divorce or legal separation of the employee and his/her spouse;
- The employee, if a covered employee under the Plan, becomes enrolled in by Medicare (Part A, Part B, or both); or
- For dependant children, the dependant child ceases to satisfy the Plan's definition of a "dependent child." (The rules for second qualifying events also apply to newborn or adopted children.)

This 36 months total of Continuation Coverage available when a second Qualifying Event occurs includes the number of months you have already been covered under Continuation Coverage because the first Qualifying Event. The 36 month total is not in addition to any months of Continuation Coverage you have already had because of the first Qualifying Event. The Plan Administrator must be notified within 60 days of the second Qualifying Event or the additional extended coverage will not be allowed.

### **Proof of Insurability is Not Necessary to Elect Continuation Coverage**

You and your family members do not have to show that you are insurable to purchase Continuation Coverage. But, you must make the required self-payment(s) for such coverage in accordance with specific due dates. The amount(s) and the due date(s) will be shown on the COBRA election notice.

### **Procedure for Obtaining Continuation Coverage**

Once the Fund Office knows that an event has occurred which qualifies you or other family members for Continuation Coverage, the Fund Office will attempt to notify you or your family member of their rights to elect Continuation Coverage.

Once you receive this election notice, you will have 60 days after the date on the election notice within which to notify the Fund Office whether or not you want the Continuation Coverage. If you do not elect the coverage within the 60-day time period, your right to continue your group health care coverage will end.

### **Termination of Continuation Coverage**

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Although your Continuation Coverage may be canceled as soon as you are covered by Medicare, a spouse or dependent child receiving Continuation Coverage at that time may continue purchasing such coverage for up to 18 or 36 months minus any months of Continuation coverage received immediately prior to your coverage under Medicare. This option applies only if a spouse or dependent child is not also covered by Medicare.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability ACT (HIPPA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## SCHEDULE OF BENEFITS

**PLEASE NOTE: Comprehensive Major Medical Benefits and Prescription Drug Benefits are all paid by BlueCross/BlueShield of Illinois ("BC/BS"). The Plan has also contracted with BC/BS to use its Preferred Provider Organization Network. This booklet only provides you with a summary of those benefits. Please refer to the separate BC/BS Summary Plan Description Booklet which provides further detail regarding these specific benefits.**

### Comprehensive Major Medical Benefits

#### Deductible Amounts per calendar year:

Each Person .....	\$ 250.00
Family (Aggregate) .....	\$ 500.00

#### Co-payment rates:

In network, Plan pays .....	90%
Out of network, Plan pays .....	80%
Non-Administrator Provider, Plan pays .....	50%

"In network" means a Hospital or Physician that has an agreement with BlueCross/BlueShield of Illinois or a BlueCross Plan of another state to provide Hospital or Physician services to participants in the Participating Provider Option ("PPO") program.

"Out of network" means a Hospital or Physician that has an agreement with BlueCross/BlueShield of Illinois or a BlueCross Plan of another state to provide Hospital or Physician services to participants but, which does **not** participate in the Participating Provider Option ("PPO") program.

"Non-Administrator Provider" means a Hospital or Physician which does not have **any** written agreement with BlueCross/BlueShield of Illinois or a BlueCross Plan of another state to provide services to you at the time services are rendered to you.

When a member or beneficiary obtains services from a PPO network provider, the Plan pays 90% of the usual and customary charges above the deductible and the member is only responsible for 10% of those charges. The member is not responsible for any charges above the usual and customary limit. However, if a member or beneficiary obtains services from a provider outside of the PPO network (or from a Non-Administrator Provider) the Plan pays only 80% (or 50%) of the usual and customary charges above the deductible, the member is responsible for 20% (or 50%) of those charges, and the Plan cannot prevent the non-PPO provider from billing the member for the balance of the charges over the usual and customary limit.

Out-of-pocket maximum amounts per calendar year:

In network, Each Person .....	\$ 1,250.00
In network, Family (Aggregate) .....	\$ 2,500.00
Out of network, Each Person .....	\$ 2,250.00
Out of network, Family (Aggregate) .....	\$ 4,500.00
Non-Administrator Provider .....	No Limit

NOTE: The Out-of-pocket maximum figures above are **in addition to** your deductible. Charges for Prescription Drugs, Charges for treatment of mental illness (other than serious mental illness), Charges for treatment for Drug or Alcohol Dependency, and Doctor's Office Visit Member co-payments are not included within the Out-of-pocket maximums.

After you reach the out-of-pocket maximum for the year, the Plan pays at 100% of usual and customary charges.

Payment for Professional Services will be based upon a Schedule of Maximum Allowances. Please refer to the separate BlueCross/BlueShield of Illinois Summary Plan Description Booklet for details regarding the Schedule of Maximum Allowances.

Lifetime Maximum Benefit Amount Payable

Per Person .....	\$1,000,000.00
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**Doctor's Office Visit Charges\***

Deductible.....	None
Per office visit, In network and Out of network, Member pays .....	\$10.00
Balance of the Office Visit charge, In network, Plan pays .....	100%
Balance of the Office Visit charge, Out of network, Plan pays .....	80%
Balance of the Office Visit charge, Non-Administrator Provider, Plan pays .....	50%

The \$10.00 per Office Visit member co-payment is not applied towards either the individual or the family deductible. In addition, the Member's Office Visit co-payment does not count towards the out-of-pocket maximum amounts for the year.

Plan co-payments for the balance of the Office Visit charges are limited to usual and customary charges.

\*Please note that if the Doctor's office adds charges to an invoice in addition to the Office Visit charge, those charges are paid at the normal Major Medical rates and they are subject to the deductible and out-of-pocket maximums.

## **Prescription Drug Benefits**

The co-payment that the Plan pays for Prescription drugs is based upon which category it falls within. Prescription drugs will be grouped into three (3) categories:

- 1) Generic Drugs
- 2) Brand Name Formulary Drugs
- 3) Brand Name Non-Formulary Drugs

A "Formulary" is a list of drugs. The Formulary will list both a drug's Brand Name and its "Generic" name. The Plan will use a Pharmacy Benefit Manager that will publish the Formulary and you should consult the Formulary to determine how much you will pay for a certain prescription drug.

For prescriptions of Generic Drugs obtained at the pharmacy, the member's co-payment is \$10.00 for up to a 30 day supply. If you order your Generic Drugs from the mail order service, the co-payment is \$20.00 for up to a 90 day supply.

For prescriptions of Brand Name Formulary Drugs obtained at the pharmacy, the member's co-payment is \$20.00 for up to a 30 day supply. If you order your Brand Name Formulary Drugs from the mail order service, the co-payment is \$40.00 for up to a 90 day supply.

For prescriptions of Brand Name Non-Formulary Drugs obtained at the pharmacy, the member's co-payment is \$40.00 for up to a 30 day supply. If you order your Brand Name Non-Formulary Drugs from the mail order service, the co-payment is \$80.00 for up to a 90 day supply.

## **Benefits with Specific Limits and Co-payments**

### Emergency Hospital Care and Physician Charges

Deductible.....	None
In network, Out of network, or Non-Administrator, Plan Pays .....	100%

Note: Plan pays 100% of Eligible Charges of the Hospital and 100% of the Maximum Allowance of the Physician's charges.

### Routine Physical Examination Benefit

Deductible.....	None
In network or Out of network, Plan Pays .....	100%
Maximum Per Person Per Calendar Year .....	\$500.00

DOT required physicals are also covered (for members only). Women may have one routine gynecological exam per year in addition to routine physicals. The following

cancer screening exams are also included: mammograms, pap smears, prostate, digital rectal, and colorectal exams.

Well-Child Care Benefits

Deductible ..... None  
In network or Out of network, Plan Pays ..... 100%  
Maximum Per Child Per Calendar Year .....\$500.00

PLEASE NOTE: Immunizations and physical exams for dependent children are covered within the Well-Child Care Benefits.

Chiropractic Treatment

Per office visit, Member pays ..... \$10.00

In Network

Plan Deductible Applies  
Plan pays .....90%

Out of network

Plan Deductible Applies  
Plan pays .....80%

Per Visit (one per day) Maximum Amount Allowable..... \$50.00

Maximum Allowable Visits (per person, per calendar year)..... 13

Elective Sterilization Benefit

Eligible Member or Spouse Only (Once Per Lifetime)

Deductible ..... None

In network or Out of network, Plan Pays ..... 100%

Lifetime Maximum for All Expenses:

Vasectomy .....\$500.00

Tubal Ligation .....\$750.00

Private Duty Nursing

Benefit Maximum ..... \$2,000.00 per month

Physical Therapy

Benefit Maximum ..... \$2,000.00 per calendar year

Occupational Therapy

Benefit Maximum ..... \$2,000.00 per calendar year

Speech Therapy

Benefit Maximum ..... \$2,000.00 per calendar year

Temporomandibular Joint Dysfunction and Related Disorders  
 Lifetime Maximum.....\$1,000.00

NOTE: Organ Transplant Benefits are not covered.

**Weekly Loss of Time Benefits (For Employees Only)**

**PLEASE NOTE: Weekly Loss of Time Benefits (or, Short-term Disability Benefits) are paid by The Guardian Life Insurance Company (“Guardian”). This booklet only provides you with a summary of those benefits. Please refer to the separate Guardian Summary Plan Description Booklet which provides further details regarding these specific benefits.**

Non-occupational Benefits

- Payment Begins - for Accident or Hospital Confinement ..... 1st Day
- Payment Begins - for Sickness..... 8th Day
- Weekly Benefit .....\$200.00
- Maximum Payment Period..... 26 Weeks

Occupational Benefits (work related).....NOT COVERED

**Dental Benefits**

**PLEASE NOTE: Dental Benefits are paid by The Guardian Life Insurance Company (“Guardian”). This booklet only provides you with a summary of those benefits. Please refer to the separate Guardian Summary Plan Description Booklet which provides further details regarding these specific benefits.**

Plan Co-Payment Rates and Deductibles

- Preventative Services (no deductible).....100%
- Basic Services (\$25.00 deductible for each person).....80%
- Major Services (\$25.00 deductible for each person) .....50%
- Orthodontic Services .....50%

Maximum Allowable Benefit Per Calendar Year

For Non-Orthodontic Services ..... up to \$1,200.00

Maximum Allowable Lifetime Benefit

For Orthodontic Services ..... up to \$1,200.00

**Death Benefits and Accidental Death and Dismemberment Benefits**

**PLEASE NOTE: Death Benefits and Accidental Death and Dismemberment Benefits are insured and paid by The Hartford Life Insurance Company (“Hartford”). This booklet only provides you with a summary of those benefits. Please refer to the separate Hartford Life and Accidental Death and Dismemberment Insurance Booklet which provides further details regarding these specific benefits.**

Death Benefits

Employee Only .....\$10,000.00

Accidental Death and Dismemberment Benefits

Employee Only .....\$5,000.00

**Vision Benefits**

**PLEASE NOTE: Vision Benefits are paid by Vision Service Plans, Inc. (“VSP”). VSP also has a Preferred Provider Organization Network. This booklet only provides you with a summary of those benefits. Please refer to the separate VSP Summary Plan Description Booklet which provides further details regarding these specific benefits.**

Vision Care Services (Eye Examination)

Co-payment rates:

In network, Plan pays ..... 100%  
Out of network, Plan pays ..... up to \$25.00

Vision Care Materials (Lenses and Frames)

Co-payment rates:

In network, Plan pays ..... 100%  
Out of network, Plan pays ..... up to \$130.00

Contact Lenses (Professional Fees and Materials\*)

Co-payment rates:

In network, Plan pays ..... 100%  
Out of network, Plan pays ..... up to \$130.00

\*Allowance is for contact lens evaluation fee, fitting costs, and materials.

## **Mental or Nervous Disorder Treatment**

**The Member Assistance Plan is provided by Integrated Behavioral Health through the Plan's contract with Guardian. You should contact Integrated Behavioral Health by calling (800) 386-7055 before you seek treatment for mental or nervous disorder treatment.**

Note: Mental and Nervous Disorders are considered mental illnesses and the term **Mental Illness** is divided into two categories: **Serious Mental Illness** and **Other Than Serious Mental Illness**. The definitions are defined as follows:

**Mental Illness** means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"Serious Mental Illness" means the following mental disorders as classified in the current Diagnostic and Statistical Manual published by the American Psychiatric Association:

- (i) schizophrenia;
- (ii) paranoid and other psychotic disorders;
- (iii) bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) major depressive disorders (single episode or recurrent);
- (v) schizoaffective disorders (bipolar or depressive);
- (vi) pervasive developmental disorders;
- (vii) obsessive-compulsive disorders;
- (viii) depression in childhood and adolescence; and
- (ix) panic disorder.

Mental Illness is also defined in the separate BlueCross/BlueShield of Illinois Summary Plan Description Booklet. You should refer to that booklet as well if you have questions about coverage for this type of illness.

### **Serious Mental Illness – Hospital and Physician Charges (Must Pre-authorize Through Member Assistance Program "MAP")**

In Network (After deductible) Plan pays .....	90%
Out of Network (After deductible) Plan Pays .....	80%
Inpatient Maximum .....	45 Days Per Calendar Year
Outpatient Maximum .....	35 Visits Per Calendar Year

### **Other Than Serious Mental Illness – Hospital and Physician Charges (Must Pre-authorize Through MAP)**

In Network (After deductible) Plan pays .....	90%
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Out of Network (After deductible) Plan Pays.....	80%
Inpatient .....	12 Days Lifetime Maximum
Outpatient Maximum .....	24 Visits Per Calendar Year

Payment for Professional Services related to Mental or Nervous Disorder Treatment will be based upon a Schedule of Maximum Allowances. Please refer to the separate BlueCross/BlueShield of Illinois Summary Plan Description Booklet for details regarding the Schedule of Maximum Allowances.

**Alcoholism or Substance Abuse Treatment (Member and Spouse only)**

**Although the Member Assistance Plan is provided by Integrated Behavioral Health (“IBH”), the Plan has contracted separately with Employee Resource Systems (“ERS”) for assistance to employees who test positive for drug or alcohol use pursuant to United States Department of Transportation (“US DOT”) testing requirements. Coverage for assistance with treatment consistent with US DOT regulations must be obtained through ERS and not IBH. This benefit is available to employees only. Employees should contact ERS by calling (800) 292-2780 before seeking treatment for alcohol or substance abuse treatment in a US DOT context. Employees and Dependent Spouses may contact IBH for non-DOT related Alcoholism or Substance Abuse Treatment.**

**Alcoholism or Substance Abuse (non-US DOT related only) In or Out-Patient Treatment (Must Pre-authorize Through MAP)**

In network, Plan pays .....	90%
Out of network, Plan pays .....	80%
Non-Administrator Provider, Plan pays .....	50%

Combined Inpatient and Outpatient Lifetime Maximums for all charges

Member .....	\$ 6,000.00
Spouse .....	\$ 6,000.00

Payment for Professional Services related to Alcoholism or Substance Abuse Treatment will be based upon a Schedule of Maximum Allowances. Please refer to the separate BlueCross/BlueShield of Illinois Summary Plan Description Booklet for details regarding the Schedule of Maximum Allowances.

## **GENERAL DEFINITIONS**

### **Accident**

An Accident must contain some degree of unexpected violence, such as a fall, blow, laceration, contusion, or abrasion.

### **Accidental Bodily Injury and Sickness**

Accidental Bodily Injury and Sickness means an injury or sickness which is the result of an Accident.

However, Accidental Bodily Injury and Sickness does not include an accidental bodily injury or sickness which arises out of, or in the course of, employment. This exclusion from the definition shall not apply to the Death Benefit and to the Accidental Death & Dismemberment Benefit.

### **Ambulatory Surgical Center**

An Ambulatory Surgical Center is a free standing facility, which is wholly owned and operated by a Hospital on the same basis as the outpatient department of its main facility or, a separate legal entity which meets all of the following requirements:

1. It is established, equipped, and operated primarily for the purpose of performing surgical procedures.
2. It operates under the supervision of one or more physicians as defined by the Plan.
3. It is equipped with at least two operating rooms, at least one post-anesthesia recovery room, and has the ability to perform diagnostic X-ray and laboratory procedures as required in conjunction with the surgery to be performed.
4. It continually provides nursing services by registered nurses for patient care in the operating rooms and the post-anesthesia recovery room(s).
5. It is licensed by the appropriate State agency and is recognized by the local medical society.

## **Covered Employment**

Covered Employment is that employment for an Employer for which the Employer is obligated to contribute to the Fund.

## **Custodial Care**

Custodial Care means care, services or supplies, which are furnished mainly to train or to assist in personal hygiene or other activities of daily living, rather than to provide therapeutic treatment. Care, services or supplies will also be considered "custodial" if they can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider.

## **Dental Hygienist**

Dental Hygienist means a person who is currently licensed (if licensing is required in the State) to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of dental hygiene and who works under the supervision of a Dentist.

## **Dentist**

Dentist means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

## **Diagnosis**

Diagnosis refers to the statement of the medical condition requiring the care of a physician.

## **Educational Institution**

Educational Institution means a trade school, college or university or other organization whose primary purpose is training and which regularly charges tuition for such training.

Educational Institution does not include "work-study" or other training programs during which the trainee receives compensation.

## **Elective or Voluntary Sterilization**

Elective Sterilization is sterilization not medically required but requested by the patient and will include among others, vas ligation, vasectomy, salpingectomy, and tubal ligation.

## Eligibility Rules

The Eligibility Rules are defined in the section entitled **Eligibility Rules** and such rules shall apply to all Employees and their Dependents, and to all Self-Pay Employees and their Dependents.

## Eligible Dependents

Eligible Dependents are the following:

1. The legal spouse of the eligible Employee;
2. Any unmarried, natural child of the eligible Employee and the legal spouse provided:
  - a. the child is less than nineteen (19) years old, excluding a person who would otherwise be entitled to benefits under this Plan as an Employee;
  - b. the child is less than twenty-three (23) years of age provided that such child is enrolled in an accredited educational institution (see definition) and is considered a full-time student (12 or more credit hours per semester) at that institution and is dependent on the Employee for the major portion of his or her financial support (written proof of full time enrollment must be submitted); or,
  - c. the child is over nineteen (19) years of age and he/she is totally and permanently disabled because of a qualifying physical handicap or mental retardation. To qualify as a physical handicap or mental retardation under this section, the handicap or retardation must:
    - 1) occur before the child reaches age nineteen (19);
    - 2) be certified by a Physician; and,
    - 3) render the child incapable of self-sustaining employment so as to make the child dependent upon his or her parents for financial support and maintenance.

Initial proof of such disability and financial dependency must be furnished to the Trustees within 60 days of the child's reaching nineteen (19) years of age. Subsequent proof may be required by the Trustees after the child reaches twenty-one (21), but not more frequently than annually.

3. Any unmarried, natural child of the Employee (provided the child's surname is the same as the eligible employee); any step child, foster child, or legally adopted child of the Employee (including the legally required trial period prior to the approval of the adoption by a court).

In order to qualify under the definition of an eligible dependent the following conditions must be met:

- a. the child must be living with the Eligible Employee in a regular parent-child relationship, except in the case of divorce;
- b. the Employee contributes more than 50% toward the maintenance and support of the child; and
- c. legal documentation is presented, upon request, supporting the Dependent's status.

It is understood that coverage of a dependent child may also be established in those cases where the Welfare Fund has received a "Qualified Medical Child Support Order" (QMCSO) entered by an appropriate court as defined under applicable federal law. Normally, such an order will be issued in a divorce or other family law action, which recognizes the child's right to health benefits under the Plan.

The term Eligible Dependent does not include a child fathered by a Dependent child.

In the event that a participant has a child during his eligibility, the natural child of the participant is covered as a dependent; however, the eligibility of the mother is conditioned upon independently satisfying the dependent eligibility requirements.

In the event that the legal spouse of the eligible Employee has a child that is not the natural child of the eligible Employee, the eligibility of the child is conditioned upon independently satisfying the dependent eligibility requirements.

### **Eligible Member**

An Eligible Member means any person who is working in Covered Employment and, who is eligible for benefits as set forth in the Eligibility Rules.

## **Eligible Person**

An Eligible Person means either the eligible Employee or the eligible Employee's Dependents.

## **Employee**

An Employee means a person, actively employed by an Employer, on whose behalf Employer contributions are required to be made.

## **Employer**

Employer or Contributing Employer means any association or individual employer who has duly executed a collective bargaining agreement with the Union and is thereby required to make contributions to this Fund on behalf of its Employees. Any employer not presently party to such collective bargaining agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement is also included within this definition.

## **Expense Incurred**

Expense Incurred includes only those charges made for services and supplies, which are reasonably priced and medically necessary for treatment of the injury or sickness.

## **Health Insurance Portability and Accountability Act**

A Law which limits the circumstances under which coverage may be excluded for medical conditions before your enroll.

## **Hospital**

A Hospital is any legally constituted institution, which meets all the following requirements:

1. Maintains permanent and full time facilities for bed care of five (5) or more resident patients; and
2. Has a doctor in regular attendance; and
3. Continually provides a twenty-four (24) hour-a-day nursing service by registered nurses; and
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other

than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics; and

5. Is operating lawfully in the jurisdiction where it is located.

### **In-patient**

In-patient means a person who is a resident patient using and being charged for the room and board facilities of the hospital.

### **Intensive Care Unit**

Intensive Care Unit means a special area of a hospital, exclusively reserved for critically ill patients requiring constant observation, which in its normal course of operation provides:

1. Personal care by specialized registered professional nurses and other nursing care on a twenty-four (24) hour per day basis;
2. Special equipment and supplies which are immediately available on a stand-by basis; and
3. Care required, but not rendered, in the general surgical or medical nursing units of the hospital. The term "Intensive Care Unit" shall also include an area of the hospital designated and operated exclusively as a Coronary Care Unit or as a Cardiac Care Unit.

### **Medical Equipment**

Medical Equipment means equipment, which meets all of the following requirements:

1. Is primarily and customarily used to serve a medical purpose; and
2. Is generally not useful to a person in the absence of illness or injury; and
3. Is necessary and reasonable for the treatment of an illness or injury, which is covered by the terms of this Plan.

To be considered "medical equipment," a device must make a meaningful contribution to the treatment of a patient's illness or injury or to the improved functioning of a malformed or damaged body member. Equipment, which primarily serves a comfort or convenience function for the patient or the patient's caretaker (such as a wheelchair ramp or a vehicle lift device), is not considered "medical equipment."

## **Medicare**

Medicare means the program established by Title XVIII of the Social Security Act.

## **Medicare Secondary Payer or MSP**

Medicare Secondary Payer or MSP means those provisions of the Social Security Act and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, their spouses and, in some cases, dependent children.

## **Optician, Optometrist, and Ophthalmologist**

Optician, Optometrist, and Ophthalmologist means any person who is qualified and currently licensed (if licensing is required in the State) to practice each such profession by the appropriate government agency or authority having jurisdiction over the licensing and practice of such a profession, and who is acting within the usual scope of his practice.

## **Out-patient**

Out-patient means a person who receives hospital services and treatments, but is not an in-patient.

## **Period of Disability Confinement**

Successive periods of disability or hospital confinement are considered one continuous disability and period of confinement for the purpose of determining maximum benefits payable unless:

1. The later treatment period is due to causes entirely unrelated to the causes of the prior treatment; or
2. The periods of treatment are separated by ninety (90) calendar days; or
3. For an Employee, a return to covered employment for at least two (2) weeks.

## **Physician, Doctor, or Surgeon**

Physician, Doctor, or Surgeon includes Osteopaths, Dentists, and Podiatrists or Chiropractors when practicing within the scope of their respective licenses.

A Chiropractor is **not** considered to be a Physician for most benefits under this Plan.

A Naprapath is **not** considered to be a Physician for benefits under this Plan.

## **Pregnancy**

Pregnancy includes resulting childbirth, miscarriage, and any complications of pregnancy. Pregnancy shall be treated as any other sickness.

## **Reasonable and Customary Charge**

Reasonable and Customary Charge (or, a Usual and Customary Charge) is determined by uniform reference standards as adopted by the Board of Trustees. To be considered reasonable and customary, the charge by any provider for a service must be similar to the charges generally incurred for cases of comparable nature and severity by a physician of similar training and experience in that geographical area. Area means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of providers rendering such service or furnishing such supplies.

With respect to medical equipment, a charge will be considered "reasonable" only if the following requirements are met:

1. The expense of the equipment must be clearly proportionate to the therapeutic benefits ordinarily derived from its use; and
2. The equipment may not be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and
3. The equipment may not serve essentially the same purpose as equipment already available to the patient.

## **Routine Physical Examination**

A Routine Physical Examination is an examination done by a physician for screening purposes. If there is no diagnosis or symptoms presented on a claim form or itemized bill by the physician, the care will be considered routine.

## **Sickness**

Sickness means a deviation from a healthy condition which:

1. Alters the state of the body; and
2. Interrupts or disturbs the performance of vital functions; and
3. Tends to undermine or weaken the constitution.

Sickness does not include a limitation on or a loss of body function or a temporary indisposition, which does not progressively undermine or weaken the constitution. Sickness caused or contributed by self-abuse, such as alcoholism or intentional overdose of drugs, are generally subject to special limitations and may be excluded from coverage entirely.

### **Skilled Nursing Care Facility**

Skilled nursing care facility means an institution or that part of any institution, which operates to provide convalescent or nursing care and:

1. Is primarily engaged in providing to inpatients:
  - a. skilled nursing care and related services for patients who require medical or nursing care; or
  - b. rehabilitation services for the rehabilitation of injured, disabled or sick persons; and
2. Has a requirement that the health care of every patient be under the supervision of a physician; and
3. Has a physician available to furnish necessary medical care in case of emergency; and
4. Has policies, which are developed with the advice (and with provision for review of such policies from time to time) by a group of professional personnel, including one (1) or more physicians and one (1) or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides; and
5. Has a physician, a registered professional nurse or a medical staff responsible for the execution of such policies; and
6. Maintains clinical records on all patients; and
7. Provides twenty-four hour nursing services which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph 2, and has at least one (1) registered professional nurse employed full time; and
8. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals; and

9. In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature:
  - a. is licensed pursuant to such law; or
  - b. is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and
10. Meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof.

### **Surgical Procedure**

Surgical procedure means certain invasive procedures, as well as reduction of fractures or dislocations, in addition to recognized cutting procedures.

### **Total Disability**

Total Disability, unless otherwise specifically defined, refers to a disability resulting solely from a sickness or bodily injury which prevents an Employee from engaging in any occupation or employment for compensation or profit or which prevents a Dependent from engaging in substantially all of the normal activities of a person of like age and sex in good health. The Board of Trustees shall determine if an individual is totally disabled in its sole discretion. The person must also be eligible for Social Security Disability Benefits. A copy of the Social Security Administration Award Letter is required for proof of total disability.

### **Trust Agreement**

Trust Agreement means the Agreement and Declaration of Trust establishing the Line Clearance Benefit Fund and that instrument as it may be amended from time to time.

### **Trust Fund**

Trust Fund or Fund means the Line Clearance Benefit Fund.

**Trustees**

Trustee means the Employer Trustees and the Union Trustees, collectively, as selected under the Trust Agreement, and as constituted from time to time in accordance with the provisions of the Trust Agreement.

**Union**

Union means those Unions, which have executed a Collective Bargaining Agreement (CBA) with an Employer who, in accordance with such CBA, participates in and contributes to the Local Union No. 9, IBEW & Line Clearance Contractors Health and Welfare Trust Fund.

## **GENERAL PLAN PROVISIONS**

### **Physical or Dental Examination and Autopsy**

The Board of Trustees has the right and shall have the opportunity to examine the person of any individual whose injury or sickness is the basis of a claim. Such examination shall be at the Board's expense and shall be performed when and as often as it may reasonably require if a claim has been filed under the Plan. In addition, the Board shall have the option to make an autopsy in case of death, where it is not forbidden by law.

### **Free Choice of Physician**

The covered person has free choice of any physician and the physician-patient relationship will be maintained.

### **Workers' Compensation Not Affected**

The Plan is not in lieu of and does not affect any requirement for coverage of Workers' Compensation insurance or coverage.

### **No Right to Employment**

The Plan and this SPD shall not be construed to give you any right to be retained in the Company's employ nor any right or claim to a benefit unless the right to such benefit is in accordance with the Plan's terms.

### **Circumstances That May Result in Loss of Eligibility or Benefits**

Throughout this booklet the Trustees have tried to bring to your attention those circumstances, which might lead to a loss of eligibility and to describe any limitations, exclusions, or restrictions applicable to specified benefits.

The Trustees urge you to familiarize yourself with this information, especially as it relates to the requirements that must be met in order to maintain your eligibility for benefits.

Remember, you must work the required number of hours or make timely self-payments in order to maintain your eligibility.

If at any time you are uncertain about how specific circumstances might affect your eligibility or benefit coverage, please contact the Fund Office and, if possible, try to do so before those circumstances arise.

## **Coordination of Benefits with Other Group Plans**

To alleviate the problem of duplicate coverage, which needlessly increases the costs of protection, all of "This Plan's" benefits will be coordinated with the following types of "plans." For purposes of Coordination of Benefits only, it is important to distinguish between "This Plan" and other "Plans." "This Plan" will refer to the Local Union No. 9, I.B.E.W. & Line Clearance Contractors Health and Welfare Plan. However, in this section only for purposes of Coordination of Benefits ("COB"), "Plan" will mean any of the following:

1. Group Insurance or group-type insurance (for example individually underwritten group insurance), whether insured or uninsured (self-funded), blanket, franchise, general liability, and common carrier insurance coverage;
2. Hospital or medical service organizations, group practice, individual practice, and other pre-payment coverage;
3. Labor-management trust plans, union welfare plans, employer organization plans, and Employee benefit organization plans; and,
4. Government plans or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301 et seq.), as amended from time to time).

Benefits will be reduced under certain circumstances when an individual is covered under this Plan and under one or more other plans or types of coverage, but it is intended that the individual will be fully reimbursed for allowable expenses under the various plans to the extent combined benefits equal one hundred (100%) percent of the total allowable expenses.

## **Order of Benefit Determination**

As stated above, the Plan will coordinate benefits with all plans providing coverage to the Employee or his dependent for all claims.

1. When the other plan does not have a provision for Coordination of Benefits, they must be considered the primary carrier and This Plan will be secondary to such coverage. Such other plan must make payment first before This Plan will consider payment.
2. When the other plan does have a provision for Coordination of Benefits, the order of benefit payments will be determined as follows:

The eligible person must claim benefits due from the "primary" plan determined by these rules for its share of eligible expenses, including benefits or services available from prepayment coverage programs such as Health Maintenance Organizations. When This Plan is "secondary" according to the established order of benefit determination, the term "benefits payable under another plan" will include the benefits that would have been paid if the eligible person had made a proper claim on that plan or used its services. This Plan's liability and its benefit payments will not increase simply because the eligible person elects not to use the "primary" coverage.

### **Order of Benefit Determination Rules**

This Plan determines its order of benefits using the first of the following rules which applies:

Rule 1: Employee/Dependent rule. The plan which covers the person as an employee, member, or subscriber (that is, other than as a dependent) are primary to those of the plan which covers the person as a dependent. Except, if the person is also a Medicare beneficiary, then Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent.

Rule 2a: Dependent Child rule. This rule applies only if the dependent child's Parents are not Separated or Divorced. If the child's parents are separated or divorced, please refer to Rules 2b and 2c and to the section below entitled Qualified Medical Child Support Orders.

The benefits of the plan of the parent whose birthday falls earlier in a year are primary to those of the plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the plan which covered the parent longer are primary to those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in Rule 2 immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

Rule 2b: Dependent Child rule. This rule applies if the dependent child's Parents are Separated or Divorced, no Qualified Medical Child Support Order exists, and there is no Joint Custody as defined in Rule 2c below. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

First, the plan of the parent with custody of the child;

Second, the plan of the spouse of the parent with the custody of the child; and

Finally, the plan of the parent not having custody of the child.

Rule 2c: Dependent Child Rule. This rule applies if the dependent child's Parents are Separated or Divorced, no Qualified Medical Child Support Order exists, and there is Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, the plans covering the child shall follow the order of benefit determination rules outlined in Rule 2a above.

### **Qualified Medical Child Support Orders**

In the event of a divorce and/or remarriage, the financial and medical responsibility for dependent medical coverage may be addressed by court order. However, unless the court order is a Qualified Medical Child Support Order, which means it has been "qualified" by the Plan Administrator, it may not be enforceable. Employees are required to submit certain legal documents requested by the Fund Office in such an event so that the order of benefit determination can be established. Please contact the Fund Office for further information.

Rule 3: Active Employee rule. The benefits of the plan which covers a person who is an active employee, who is neither laid off nor retired (or as that employee's dependent), are determined before those of the plan which covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule is ignored.

Rule 4: Continuation Coverage rule. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

First, the benefits of the plan covering the person as an employee, member, or subscriber (or as that person's dependent);

Second, the benefits of the plan covering the person under the continuation coverage.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule is ignored.

Rule 5: Longer Length of Coverage rule. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber

longer are determined before those of the Plan which covered that person for the shorter term.

### **Effect on the Benefits of This Plan**

When This Plan is *secondary* pursuant to the "Order of Benefit Determination Rules" or "Coordination of Benefits Rules" outlined above, the benefits paid by This Plan may be reduced according to the terms of this section. Such other plan or plans are referred to as "the other plans" below.

The reduction in This Plan's benefits: The benefits of This Plan will be reduced when the sum of (1) and (2) below exceeds the Allowable Expenses in a Claim Determination Period.

- (1) The benefits that would have been payable as an Allowable Expense under This Plan in the absence of this COB provision.
- (2) The benefits that would be payable as Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

### **Right to Receive and Release Needed Information**

Certain facts are needed to apply these Coordination of Benefits Rules ("COB rules"). The Board of Trustees has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Board of Trustees need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Board of Trustees any facts it needs to pay the claim.

### **Facility of Payment**

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, the Board of Trustees may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Board of Trustees will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

## **Right of Recovery**

If the amount of the payments made by the Board of Trustees is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- A. The persons it has paid or for whom it has paid;
- B. Insurance companies; or
- C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## **BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS**

This section describes the benefits which will be provided for Employees (Employees means persons actively employed by an Employer as defined by this document in the Definitions section) that are also Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this Summary Plan Description booklet (see provisions entitled "Medicare Eligible Covered Persons" below.)

The benefits and provisions described throughout this booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Plan.

When you have a claim, you must send the Claims Paying Agent a copy of your Explanation of Medicare Benefits ("EOMB") in order for your claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

## **Medicare Eligible Covered Persons**

If you meet the eligibility requirements as stated in the ELIGIBILITY section above and you are eligible for Medicare and not affected by the "Medicare Secondary Payer" (MSP) laws as described below, the benefits described in the section of the this Summary Plan Description booklet entitled "Benefits for Medicare Eligible Covered Persons" will apply to

you and to your spouse and to your covered dependent children (if he or she is also eligible for Medicare and not affected by the Medicare Secondary Payer laws).

A series of federal laws collectively referred to as the "Medicare Secondary Payer" (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for Medicare Secondary Payor coverage vary depending on the basis for Medicare and the employer's group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the group health plan coverage. In general, Medicare pays secondary to the following:

1. Group Health Plans that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."
2. In the case of individuals age 65 or over, group health plans of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." This Plan is a multi-employer plan therefore, if it has at least one contributing or participating employer that employs 20 or more employees, the Medicare Secondary Payor rules apply even with respect to those employers of fewer than 20 employees. This Plan has not elected the small employer exception under the statute.
3. In the case of disabled individuals under age 65, group health plans of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." This Plan is a multi-employer plan therefore, if it has at least one contributing or participating employer that employs 100 or more employees, the Medicare Secondary Payor rules apply even with respect to employers of fewer than 100 employees.

**PLEASE NOTE: SEE YOUR EMPLOYER OR THE PLAN ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE END STAGE RENAL DISEASE PRIMARY PERIOD OR OTHER PROVISIONS OF MEDICARE SECONDARY PAYOR LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.**

### **Your MSP Responsibilities**

In order to assist your Employer in complying with Medicare Secondary Payor laws, it is very important that you promptly and accurately complete any requests for information from the Fund Office regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your Employer or the Fund Administrator promptly to ensure that your claims are processed in accordance with applicable Medicare Secondary Payor laws.

## **GENERAL PLAN EXCLUSIONS AND LIMITATIONS**

The following exclusions and limitations apply to all benefits provided by the Fund.

### **Routine Care and Elective Procedures**

Benefits under this Plan are for the treatment of sickness or accidental bodily injury when rendered by hospitals and physicians. Routine care, cosmetic surgery\*, and diet medication or supplements (which are not medically necessary to correct a condition that threatens the health of an Eligible Person) are not eligible for Benefits from this Plan. The Trustees reserve the right to have an Eligible Person examined by a physician of the Trustees choice and at the Trustees expense in order to assist them in making a determination regarding a claim for benefits or for eligibility under the Plan.

Treatment designed to merely improve bodily functions is not considered medically necessary or an eligible expense for benefits. Examples of treatment considered not covered (by way of illustration and not limitation) include: radial keratotomy (to improve sight), treatment to improve sexual dysfunctions or inadequacies (including penile prosthesis to treat impotence), treatment to improve fertility (including, but not limited to, drug/hormone therapy, surgical procedures, artificial insemination, in vitro fertilization, embryo transfer procedures and related diagnostic testing of all types).

\* Note: The cosmetic surgery exclusion does not apply to coverage mandated by the Women's Health and Cancer Rights Act. Under that Act if a mastectomy is performed, the plan will cover reconstructive surgery, including surgery to produce a symmetrical appearance, a prostheses, and treatment for lymphedema.

### **Medical Necessity**

Benefits under this Plan are payable only for services and supplies which are considered by the Trustees to be medically necessary considering the patient's condition and diagnosis. For example, (by way of illustration and not limitation) non-emergency hospital admission and confinement over a weekend will be presumed not medically necessary and not an eligible expense incurred. Hospital admission for surgery which is generally performed on an out-patient basis will not be considered eligible for benefits unless such admission is medically necessary due, for example, to a coexisting medical condition.

However, since this plan offers maternity and newborn coverage, you are advised that under federal law, this plan may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. Also, by law, the Plan may not require authorization from the plan administrator for prescribing a length of stay not in excess of the above

periods. However, federal law does not prohibit a mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

### **Work Related Disabilities**

Payment will not be made by the Plan for expenses incurred because of disease, defect, or accidental injury which occurs during, or arises out of, any occupation for wage or profit. If the Eligible Person's claim under Workers' Compensation or any Occupational Disease Law is rejected, the illness or injury may not be considered work-related and payment may be made. However, the Trustees reserve the right to determine, in their sole discretion, if a claim is work related.

A claim under Workers' Compensation or under any Occupational Disease Law will be considered to have been rejected under the following circumstances:

- a. when, after a hearing by the Illinois Workers' Compensation Commission (or the corresponding agency in another state), there has been a final administrative determination that the claim is not work related and the time limit for filing a court review of the decision has been exceeded; or
- b. after a decision has been rendered by the Illinois Workers' Compensation Commission (or corresponding agency in another state) that the claim is not work related, a party has sought court review of the decision, and a final court determination has been made affirming that the claim is not work related.

### **Self-Inflicted Injury or Substance Abuse**

Payment will not be made for self-inflicted injury such as attempted suicide (whether sane or insane) or substance abuse to the extent such exclusion is permitted by law.

### **Reasonable and Customary Charges**

Payment will not be made by this Plan for any expense incurred, or charge made, which the Trustees determine in their sole discretion, is not reasonable or customary.

### **Treatment Sponsored by Governmental Units**

Payment **will not** be made by the Plan for expenses incurred:

1. While confined in a hospital owned or operated by the Federal Government or any other government unit; or

2. For treatment by a physician employed by the Federal Government or any other governmental unit; or
3. For services or supplies furnished by, or at the request or direction of, the Federal Government, any of its agencies, or any other government unit unless the Eligible Person is legally required to pay for such supplies or services.

This exclusion will not prevent the coordination of benefits with a plan specifically established by a governmental unit for its own civilian employees and their dependents. In addition, if Federal Law prohibits this plan from being secondary to any Veteran's Administration benefits then, this exclusion will not apply to the extent that Federal Law prohibits that coordination of benefits.

### **Treatment without Charge**

Payment will not be made for charges by any service provider when the service provider makes no charge that the Eligible Person is legally required to pay. In addition, payment will not be made for charges by any service provider when, in the absence of these benefits, the service provider would make no charge to the Eligible Person.

### **Illegal Occupation or Commission of Felony**

The Trustees will not pay any claims for any loss to which a contributing cause was the commission of, or attempt to commit, a criminal act or acts initiated by the Eligible Person whose injury or sickness is the basis the of claim. In addition, the Trustees will not pay any claims for any loss to which a contributing cause was the engagement in, or attempted engagement of, an illegal occupation by the Eligible Person whose injury or sickness is the basis the of claim. Criminal acts shall include, but not be limited to, acts defined as criminal under any Federal or State law, penal code, or motor vehicle code. Specifically, driving under the influence of alcohol or drugs shall be considered criminal for purposes of this definition. Determinations of coverage shall not be dependent upon a conviction by the governmental authority. Injury or injuries sustained by a Eligible Person resulting from assault and/or battery committed by that Eligible Person shall also be excluded from coverage.

Payment will not be made for confinement in any hospital or treatment by any provider otherwise eligible under this Plan when such treatment is ordered as a part of any litigation, court-ordered judgment or penalty including, but not limited to, psychiatric evaluation or counseling and confinement, evaluation, or other treatment related to alcoholism or substance abuse (to the extent permitted by applicable law).

### **Experimental or Investigational Treatment or Procedures**

“Experimental or Investigational Treatment or Procedures” means treatment, procedures, drugs, devices, services, and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency, and effectiveness; and/or, (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to the Eligible Person; and, (3) specifically with regard to drugs, a combination of drugs and/or devices, which is not finally approved by the Federal Drug Administration at the time used by or administered to the Eligible Person.

Treatment (medicines, surgery, techniques, devices, and procedures) which is not generally recognized by professional medical peer groups, such as the American Medical Association, may be considered experimental or investigational. Recognized treatment that is used in a non-routine manner, such as frequency or dosage, may be considered experimental or investigational. If a particular form of medical treatment has been subject to a multiple phase set of clinical trials, such as developing cancer treatment, completion and publication of the results of the last phase of the clinical trials must occur before a treatment may be considered to be non-experimental or non-investigational.

The Board of Trustees will use its sole discretion to determine if a particular procedure, drug, device, service, and/or supplies are experimental or investigational based upon the Board’s review of the substantial evidence presented. The Board reserves the right to consult independent experts from outside sources in an effort to aid it in reaching a determination.

### **Other Types of Liability Insurance for Accidental Injuries**

Benefits under this Plan are considered secondary to, and may be excess to, other insurance coverage, including but not limited to, automobile insurance, common carrier insurance or liability, general commercial liability, “umbrella” liability, and real property insurance. No payment shall be made until proof is submitted to, and accepted by, the Trustees that a proper claim has been made for any other applicable coverage. Plan benefits may be denied in full, or coordinated with, any other applicable insurance coverage.

## **Other Plan Exclusions and Limitations**

Benefits of this Plan ***do not cover*** any loss caused by, incurred for, or resulting from:

1. Declared or undeclared war, or any act thereof, or as the result of military (however, if Federal Law prohibits this plan from being secondary to any Veteran's Administration benefits then, this exclusion will not apply to the extent that Federal Law prohibits that coordination of benefits);
2. Services, treatment or supplies received from a dental or medical department maintained by a mutual benefit association of this or any other employee benefit plan or labor union;
3. Services, treatment, or supplies, which are payable or furnished under any policy of insurance or other medical benefit plan or service plan for which the Trustees shall, directly or indirectly, have paid for all or a portion of the cost;
4. Services or treatment rendered or supplies furnished primarily for cosmetic purposes;

Note: This exclusion does not apply to coverage mandated by the Women's Health and Cancer Rights Act. Under that Act if a mastectomy is performed, the plan will cover reconstructive surgery, including surgery to produce a symmetrical appearance, a prosthesis, and treatment for lymphedema.

5. Expenses incurred for services performed or supplies furnished by other than a physician;
6. Services, treatment, or supplies rendered or furnished:
  - a. Before the individual concerned became an Eligible Person; or
  - b. Without the recommendation and approval of a legally qualified physician;
7. Services related to obesity, diet or weight control, including but not limited to: exercise programs, surgery, special diet or diet supplements, pre-natal vitamins, smoking cessation, amphetamines, or any form of diet medication whether or not recommended or supervised by a physician, including dietary or nutritional counseling, books, pamphlets or classes;
8. Mental counseling, physical therapy, supplies or prosthesis for sexual dysfunction or inadequacies;

9. Implantation within the human body of artificial or mechanical devices to replace human organs (other than pacemakers or similar such devices which merely assist rather than replace the function of the organ);
10. Ambulance service or transportation between cities or states in excess of one hundred (100) miles (such as by ambulance, air ambulance, railroad or bus) unless judged by the Trustees as essential for treatment of a life-threatening illness or injury;
11. Expenses incurred for services performed and supplies furnished by other than a physician;
12. Growth hormones;
13. Programs or prescription medications for the purposes of smoking cessation;
14. Expenses incurred for the purpose of reversing tubal ligations, vasectomies or other sterilization procedures;
15. Special home construction to accommodate a disabled person;
16. Education, special education, job training or work hardening whether or not given in a facility that also provides medical or psychiatric treatment beyond the first medically necessary visit. Education, special education, or like services, regardless of: the type of education, the purpose of the education, their recommendation of the attending physician, or the qualification of the individual rendering the educational services;
17. Rest cures or custodial care;
18. Speech therapy, other than charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) while eligible in the Plan and as the result of a disease or accidental injury. Speech therapy to improve speech in the absence of disease or accidental injury (such as for a learning disability or speech delay) is considered special education and is not covered;
19. Supplies or equipment for personal hygiene, comfort or convenience;
20. Services, treatment or care rendered by a member of the Eligible Person's family;

21. Treatment or services for or in connection with financial counseling;
22. Treatment or services for: primal therapy, massage therapy (such as Rolfing), psychodrama, megavitamin therapy, bio-energetic therapy, vision perception training, or carbon dioxide therapy;
23. Cosmetic or reconstructive surgery which:
  - a. is not necessary for the prompt repair of accidental bodily injury, sickness or disease which occurs while the patient is not eligible; and,
  - b. is not performed within two (2) years from the date of a covered loss.

Note: This exclusion does not apply to coverage mandated by the Women's Health and Cancer Rights Act. Under that Act if a mastectomy is performed, the plan will cover reconstructive surgery, including surgery to produce a symmetrical appearance, a prosthesis, and treatment for lymphedema;

24. Dietary or nutritional counseling, books, pamphlets or classes;
25. Charges incurred for any abortion procedure performed on a Dependent child except where the pregnancy is the result of rape as evidenced by a police report;
26. Charges incurred for travel, whether or not recommended by a physician;
27. Artificial insemination, in-vitro fertilization, or embryo transfer process;
28. Birth Control;
29. Organ Transplants; and,
30. Accidental Injuries For Which a Third Party May Be Liable

No benefits will be paid to an Eligible Person for expenses incurred due to an accidental injury for which a third party may be liable unless you and/or your Eligible Dependent sign a Subrogation/reimbursement agreement on a form approved by the Trustees. Under the terms of the subrogation/reimbursement agreement you and/or your Eligible Dependent, must agree that if you recover any amount from a third party relating to your

accidental injury, you will repay the Fund the benefits which had been paid, without deduction for any expenses or attorney's fees.

Under the provisions of the subrogation/reimbursement agreement, if you and/or your Eligible Dependent do not pursue or prosecute a claim against the third party to recover for your injuries, then you and/or your Eligible Dependent must agree to authorize the Fund to bring a claim, at its option, in your name and/or in the name of you and/or your Eligible Dependent against the third party, including the authority to file a lawsuit in court. You and/or your Eligible Dependent must agree to cooperate fully with the Fund in any action which the Fund may take. After a loss for which the Fund has paid benefits, neither you nor your Eligible Dependent must do anything which impairs the Fund's right to recover the benefits paid on your behalf.

If you and/or your Eligible Dependent accept any settlement, or receive any award for future medical expenses related to any injury or illness that had been caused by a third party, any such future medical expenses are not eligible expenses under this Plan.

For more details on this exclusion please refer to the section below entitled "Subrogation and Reimbursement."

### **Subrogation and Reimbursement**

The Trustees of the Welfare Fund may elect to use their right of Subrogation if you and/or your Eligible Dependent (hereafter "you") are paid benefits by the Plan due to any accidental injury or sickness for which someone else may be liable. Subrogation means that the Trustees can regain, by legal action if necessary, benefits paid on your behalf by the Fund from the person who caused the injury or from that person's insurance company. The Trustees believe that subrogation will result in savings for the Fund for the benefit of all Eligible Persons because the cost of treatment for such accidental injuries or sickness properly should be the responsibility of the person (or other legal entity) who caused or contributed to your injury, sickness, or to the accident which resulted in your injury or sickness.

If the Trustees enter into a Subrogation and Reimbursement Agreement with you, your claims and benefit payments will normally continue to be processed in the same way as claims that are not related to subrogation. However, you retain certain responsibilities to the Fund after you file a subrogation claim. An Eligible Person who receives benefits from the Fund under these circumstances must sign and deliver all related papers and forms to the Fund Office and must do whatever else is necessary to help the Fund enforce the Fund's right of subrogation pursuant to the terms of this provision and the Subrogation and Reimbursement Agreement. An Eligible Person must not do anything

or sign any document, which may impair the Fund's right to recover the benefits paid which are related to the loss.

If you becomes sick or are injured and a third party is liable, you may recover money damages or reimbursement for expenses you have incurred as a result of that liable third party's action or inaction. You may recover directly from that third party, from some insurer or other self-insured plan, from your Worker's Compensation coverage through your employer, or from some other source as a result of that other third party liability. If you do obtain such a recovery, the Trustees have the right to require you to repay the Fund for any applicable benefits you received from this Plan. The Trustees may, at their own discretion pursue a claim against any third party, including the filing of a claim in court.

If you or an Eligible Dependent accept a settlement or receive an award, future medical expenses for any injury or illness caused by the responsible third party are not eligible expenses under this Plan.

The Fund's right of subrogation is from the first dollar you receive and takes effect before the whole debt is paid to the you by the liable third party.

The Plan does not pay for, nor is it responsible for, your attorney's fees for subrogation claims. Attorney's fees are to be paid solely your responsibility or the responsibility of your Eligible Dependent.

## **CLAIMS PROCEDURE**

UNLESS PROHIBITED BY LAW THE CLAIMS PROCEDURES IN THIS SECTION MUST BE USED BEFORE YOU CAN FILE A LAWSUIT RELATED TO THIS PLAN.

You as a Participant or Beneficiary may file a claim with any of the Fund's Claims Paying Agents for benefits. The claim must be in writing and must contain the following information:

- (i) a description of the claim;
- (ii) the facts supporting the claim;
- (iii) the amount claimed; and
- (iv) the name and address of the person filing the claim.

**Pre-service Claims.** If you fail to follow the pre-approval procedures for pre-service claims, you will be notified of the failure and of the proper procedures for filing these claims not later than 5 days (24 hours in the case of a failure to file a claim for urgent care) following the failure if your communication is received by the organizational unit that normally handles these claims and if the communication names a specific claimant, a specific medical condition, and a specific product or treatment for which approval is requested. You may request written notification.

### **Timing of Benefit Determinations**

The timing of benefit determinations for the following types of claims and decisions is as follows:

**Urgent Care Claims.** The Fund's Claims Paying Agent will designate a representative to answer urgent care claims as soon as possible (taking into account medical exigencies) but no later than 72 hours after receipt of the claim if sufficient information is provided so that a determination may be made as to the extent benefits are covered under the Plan. If you fail to provide sufficient information, you shall (1) be notified as soon as possible (and not later than 24 hours after the receipt of the claim by the plan) of the specific information needed to complete the claim and (2) given a reasonable amount of time (and not less than 48 hours) to provide such information. For purposes of these claims procedures the term "urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—(1) Could seriously jeopardize your life or health or your ability to regain maximum function, or, (2) In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The Fund's Claims Paying Agent will notify you of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

- (i) the Plan's receipt of the specified information, or
- (ii) the end of the period afforded you to provide the specified additional information.

If your claim is denied, you may request orally or in writing an expedited review of the claim. If such review occurs, all necessary information shall be transmitted by telefax or telephone or another equivalent method.

**Concurrent Care Decisions.** If the plan has approved an ongoing course of treatment over a specified time or for a specified number of treatments, any reduction or termination by the plan of such course of treatment before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Fund's Claims Paying Agent will notify you of the adverse benefit determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. For claims involving urgent care, if you request to extend the course of treatment beyond the period of time or number of treatments then your request will be decided as soon as possible, taking into account the medical exigencies. The Fund's Claims Paying Agent will notify you of the benefit determination within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

**Pre-service claims.** The Fund's Claims Paying Agent will notify you of the plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the Fund's Claims Paying Agent both determines that such an extension is necessary due to matters beyond the control of the plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, you will be afforded at least 45 days from receipt of the notice within which to provide the specified information, and the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

**Post-service claims.** The Fund's Claims Paying Agent will notify you of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan Fund's Claims Paying Agent both determines that such an extension is necessary due to matters beyond the control of the plan and notifies you prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information, and the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

### **Notification of Benefit Determinations**

If the claim results in an adverse benefits decision, you will be provided with a written or electronic notice containing:

- (i) the specific reasons for the denial;
- (ii) references to the specific provisions in the Plan document on which the denial is based;
- (iii) a description of any additional information needed to perfect the claim and an explanation of why the additional information is needed; and
- (iv) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA section 502(a).
- (v) if applicable, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- (vi) if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(vii) in the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

For urgent care claims, the above information may be provided to you orally provided that a written or electronic notification containing this information is furnished to you not later than 3 days after the oral notification.

### **Appeals of Adverse Benefit Decisions**

If you are not satisfied with the action taken on your claim, you have the right to appeal to the Board of Trustees through the **Appeals Procedure** as outlined in this section below. Remember, the Board of Trustees is the Plan Administrator even though another Claims Paying Agent may perform certain administrative duties. The procedures for appeals are set forth below in detail.

In reviewing your claim every effort will be made by the Trustees to handle interpretations of the Plan and claims disputes in a consistent and equitable manner. The Trustees have full discretionary authority to determine eligibility for benefits under the Plan and to interpret the Plan, all Plan documents, Plan rules, and procedures, and the terms of the Trust Agreement. Their decisions and interpretations will be given the maximum deference permitted by law for the exercise of such full discretionary authority and will be binding upon all persons involved. In other words, to summarize: "Benefits under this plan will be paid only if the Board of Trustees decides in its discretion that the applicant is entitled to them."

### **Your Right to Request Review of an Adverse Benefit Determination**

The Employee Retirement Income Security Act of 1974, as amended (ERISA) claims procedure regulations protect you by providing you the opportunity to request review of an adverse benefit determination.

An adverse benefit determination is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on your eligibility to participate in your employer's health plan. You may request review of an adverse benefit determination on a pre-service claim, an urgent care claim, or a post-service claim.

"Pre-service claim" means a claim for a benefit where your plan conditions receipt of the benefit, in whole or in part, on obtaining approval in advance of receiving medical care.

"Urgent care claim" means a claim for medical care or treatment where applying the time periods for non-urgent determinations could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician who knows

your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

A claim will be found to be one involving urgent care in one of two ways. If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, we will treat it as such. Absent a determination by your physician, we will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

“Post-service claim” means all other claims that are not “pre-service claims” or “urgent care claims”.

To obtain review of an adverse benefit determination, you must follow the review procedures below. These procedures vary, depending on whether you are asking for review of a decision on a pre-service, a post-service, or an urgent care claim.

With the exception of requests for review of adverse benefit determinations involving urgent care claims, which may be made orally, all requests for review must be in writing. Normally, for all three types of claims, you must exhaust our internal review procedure before you can initiate a civil action under section 502(a) of ERISA to obtain benefits.

## **Appeal Procedure**

The appeal procedure which applies to your particular claim denial will vary depending upon the type of claim you filed which was denied. For appeal procedure purposes, a claim is classified as either: a Post-service claim, a Pre-service claim, or an urgent care claim.

### **A. Appeal Procedure – Post-service claims**

Under the appeal procedure for post-service claims, you are entitled to a two-level review process. The Fund’s Claims Paying Agent which denied your claim: BlueCross/BlueShield of Illinois (“BC/BS IL”), The Guardian Life Insurance Company (“Guardian”), The Hartford Life Insurance Company (“Hartford”), or Vision Service Plans (“VSP”) (hereafter “THE FUND’S CLAIMS PAYING AGENT”) must provide you with a written determination within 30 calendar days or receipt of your written requests for review at each level. However, that 30-day timeframe may be suspended if THE FUND’S CLAIMS PAYING AGENT has not received information they have requested in writing from you or from your health care provider, for example your doctor or hospital.

1. The appeal procedure for post-service claims provides two levels of review: To initiate review level 1 review, you or your authorized representative must send THE FUND’S CLAIMS PAYING AGENT a written statement explaining why you disagree with

the determination. Please include in your request all documentation, records or comments you believe support your position. You must request review no later than 180 calendar days after you receive our decision on your claim for benefits. Mail your written request for review to the address found in the top right hand corner of the first page of your Explanation of Benefits statement, or to the address contained in the letter THE FUND'S CLAIMS PAYING AGENT sends you to notify you that THE FUND'S CLAIMS PAYING AGENT has not approved a benefit or service you are requesting. THE FUND'S CLAIMS PAYING AGENT will respond to your request for review in writing within 30 days, unless they have notified you in writing that they need additional information to complete the review. If you agree with their response, it becomes their final determination and the review ends.

2. If you disagree with the THE FUND'S CLAIMS PAYING AGENT response to your request for review at level 1, you may then proceed to level 2. You must request review at level 2 in writing no later than 30 calendar days after you receive the THE FUND'S CLAIMS PAYING AGENT determination at level 1.

Mail your request for a level 2 appeal to the Board of Trustees care of the Fund's Administrative Manager. Address your appeal to the Board of Trustees as follows:

Board of Trustees,  
Local Union No. 9 IBEW & Line Clearance Contractors  
Health and Welfare Fund  
c/o TIC International Corporation  
6525 Centurion Drive  
Lansing, Michigan 48917-9275

Again, please provide all documentation, records, and comments, that you feel support your position. You will receive a written determination within 30 days of receipt of your request for review at level 2, unless you are notified in writing that additional information is needed to complete the review. The written determination at level 2 will be the final determination regarding your request for review.

3. If you disagree with the final determination, or if the determination at each level is not issued within the 30 day time frame or the review procedures for level 1 and level 2 are otherwise not complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

## **B. Appeal Procedure – Pre-service claims**

1. The appeal procedure for pre-service claims is identical to the review procedure for post-service claims, except that THE FUND'S CLAIMS PAYING AGENT must provide you

with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a two-step process. A determination will be issued within 15 calendar days of receipt of your request for a level 1 review, and within 15 calendar days of your request for a level 2 appeal. You still have 30 days after receipt of the level 1 determination to file your level 2 appeal.

2. If you disagree with the final determination, or if the determination at each level is not issued within the 15 day time frame or the review procedures for level 1 and level 2 are otherwise not complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

### **C. Appeal Procedure – Urgent care claims**

The appeal procedure for urgent care claims is as follows:

1. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call: BlueCross/BlueShield of Illinois for urgent medical care claims at (800) 367-8309.

2. THE FUND'S CLAIMS PAYING AGENT must provide you with their decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review. All necessary information, including the THE FUND'S CLAIMS PAYING AGENT decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile, or other available similarly expeditious method. If the THE FUND'S CLAIMS PAYING AGENT decision is communicated orally, they must provide you or your authorized representative with written confirmation of their decision within 2 business days.

3. If you disagree with the THE FUND'S CLAIMS PAYING AGENT final determination or if they fail to issue the determination within 72 hours, or otherwise fail to comply with the review procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits.

In addition to the information found above, the following requirements apply to the appeal of all types of claims (pre-service, post-service, and urgent care claims).

- a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal review procedure.
- b. No fees or costs may be imposed as a condition to requesting review.

- c. Although there are set timeframes within which you must receive the final determination on all three types of claims, you have the right to allow additional time if you wish.
- d. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claims for benefits.
- e. You may submit written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination.
- f. The person who reviews your adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The determination on review will be a new determination; the initial determination on your claim will not be afforded deference on review.
- g. If you request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.
- h. Upon request, the medical experts whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination.
- i. On review, you will be advised of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.
- j. If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion free of charge upon request.
- k. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be advised and provided an explanation of the scientific or clinical judgment free of charge upon request.
- l. If your health plan provides for any voluntary appeal procedures beyond the level 2 review, you will be advised of those procedures in the level 2 response.

**Expedited review process.** For claims involving urgent care you may submit a request for an expedited review of an adverse benefit determination. If the Board of Trustees concurs with the request, your appeal may be submitted orally or in writing and all necessary information, including the plan's benefit determination on review, shall be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

The Board of Trustees has the discretion to determine eligibility for benefits and the amount of benefits payable, both initially and on review, make factual determinations and construe the terms of the Plan. Such determinations and constructions shall be conclusive and binding on all persons and entities.

Any decision rendered by the Board of Trustees, after compliance with the foregoing conditions and appeal procedures, shall be final and binding on all parties concerned.

**Benefits under this plan will be paid only if the Board of Trustees decides in its discretion that the applicant is entitled to them. This provision applies to all benefits payable under the plan.**

## **STATEMENT OF PARTICIPANT'S RIGHTS**

### **Information Required by the Employee Retirement Income Security Act (ERISA)**

#### **Introduction**

You have probably heard about 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 benefits plans including the Local Union No. 9 & Line Clearance Contractors Health & Welfare Fund. The Trustees of your Fund, in consultation with their professional advisors, have reviewed these standards carefully and have taken the 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. This information follows:

**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.

### **Your Rights as a Participant**

As a participant in the Local Union No. 9 & Line Clearance Contractors Health & Welfare Plan:

1. You will automatically receive a Summary Plan Description (this booklet). The purpose of this booklet is to describe all pertinent information about the Plan.
2. If any substantial changes are made in the Plan, you will be notified within the time limits required by ERISA.
3. Each year you will automatically receive a summary of the Plan's latest annual financial report. A copy of the full report is also available upon written request.
4. You may examine, without charge, all documents relating to this Plan. These documents include: the legal Plan Document, collective bargaining agreements, and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as annual reports and Plan descriptions. Such documents may be examined at the Fund Office (or at other required locations such as work sites or union halls) during normal business hours.

To assure that your request is handled promptly and that you have given the information you want, the Trustees have adopted certain procedures which you should follow:

- Your request should be in writing;
- It should specify what materials you wish to look at; and
- It should be received at the Fund Office at least three days before you want to review the materials at the Fund Office.

Although all pertinent Plan documents are on file at the Fund Office, arrangements can be made upon written request to make the documents you

want available at any work site or union location at which 50 or more participants report to work. Allow ten days for delivery.

5. You may obtain copies of any Plan document upon written request to the Trustees, addressed to the Fund Office. ERISA provides that the Trustees may make a reasonable charge for the actual cost of reproducing any documents you request.

You are entitled to know, however, what the charge will be in advance. Just ask the Fund Office.

6. No one may take any action which would prevent you from obtaining a benefit to which you may be entitled or from exercising any of your rights under ERISA.
7. In accordance with Section 503 of ERISA and related regulations, the Trustee have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim.
8. These procedures appear in the Appeal section of this booklet. Basically they provide that:

- If your claim for a welfare benefit is denied in whole or in part, you will receive a written explanation of the reason(s) for the denial.
- Then, if you are still not satisfied with the action on your claim, you have the right to have the Plan review and reconsider your claim in accordance with the Plan's claims review procedures.
- These procedures are designed to give you a full and fair review and to provide maximum opportunity for all of the pertinent facts to be presented on your behalf.

9. In addition to creating rights for Plan participants, ERISA also defines the obligations of those people involved in operating employee benefit plans.

These persons are known as "fiduciaries." They have the duty to operate your Plan with reasonable care and with your best interests in mind as a participant under the Plan.

Be assured that the Trustees of this Plan will do their best to know what is required of them as "fiduciaries" and to take whatever actions are necessary to assure full compliance with all state and federal laws applicable to the Plan.

10. Under ERISA, you may take certain actions to enforce the rights listed above.

- a. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trustees.

Of course, before taking such action, you will no doubt want to check again with the Fund Office to make sure that:

- (1) the request was actually received, and
- (2) the material was mailed to the right address, or
- (3) the failure to send the material was not due to circumstances beyond the Trustees' control.

If you are still not able to get the information you want, you may wish to take legal action. The Court may require the Trustees to provide the materials promptly or pay you a fine until you actually receive the materials (unless the delay was caused by reasons beyond the Trustees' control).

- b. Although the Trustees will make every effort to settle any disputed claims with participants fairly and promptly, in accordance with the Fund's rules, there is always the possibility that differences can not be resolved to everyone's satisfaction.

For this reason, you may file suit in a state or federal court if you feel that you have been improperly denied a benefit.

Before exercising this right, however, you will normally find it advisable to exhaust all the claim review procedures available under your Plan and then proceed only upon the advice of your attorney.

- c. If it should happen that Plan fiduciaries misuse the Plan's money or discriminate against you 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 the court finds your claim is frivolous, you may be required to pay court costs and legal fees.

We hope this Summary Plan Description has provided you with most important information about your Plan and your rights under ERISA.

If you have any questions about your Plan, you should contact the Trustees by writing to: Local Union No. 9, IBEW & Line Clearance Contractors Health and Welfare Fund, 6525 Centurion Drive, Lansing, Michigan, 48917-9275 or by calling the Fund Office: (517) 321-7502.

If you have any questions about this Statement or about your rights under ERISA which have not been answered in this Summary Plan Description or by the Fund Office, you should contact the nearest Area Office of the U.S. Department of Labor. The Fund Office will be glad to furnish the address.

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. Participants will be notified of any plan changes pursuant to all legal requirements.

## **HIPAA PRIVACY INFORMATION**

The Fund is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Plan may disclose protected health information (the "information") as defined by HIPAA to the Board of Trustees (which is the plan sponsor) since the Board of Trustees has certified that the plan documents have been amended to incorporate the following provisions. In addition, the Board of Trustees has agreed to do the following:

(A) to not use or further disclose the information other than as permitted or required by the plan documents or as required by law;

(B) to ensure that any agents, including any subcontractors, to whom it provides protected health information received from the group health plan, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information;

(C) to not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees;

(D) to report to the group health plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for by HIPAA and in accordance with the provisions of the applicable HIPAA regulations;

(E) to make available protected health information in accordance with the provisions of the applicable HIPAA regulations;

(F) to make available protected health information for amendment and to incorporate any amendments to the protected health information in accordance with the provisions of the applicable HIPAA regulations;

(G) to make available the information required to provide an accounting of disclosures in accordance with the provisions of the applicable HIPAA regulations;

(H) to make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plan available to the Secretary of Labor for purposes of determining compliance by the group health plan with the provisions of the applicable HIPAA regulations;

(I) to return or, if feasible, to destroy all protected health information received from the group health plan that the Board still maintains in any form and to retain no copies of such information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and,

(J) to ensure that the adequate separation required in the provisions of the applicable HIPAA regulations is established.

Furthermore, the Plan Document provides for adequate separation between the group health plan and the plan sponsor. Specifically, the Plan Document:

(A) describes those employees or classes of employees or other persons under the control of the plan sponsor to be given access to the protected health information to be disclosed, provided that any employee or person who receives protected health information relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of

business must be included in such description;

(B) restricts the access to and use by such employees and other persons described in the provisions of the applicable HIPAA regulations to the plan administration functions that the plan sponsor performs for the group health plan; and,

(C) provides an effective mechanism for resolving any issues of noncompliance by persons described in the provisions of the applicable HIPAA regulations.

## **OTHER IMPORTANT INFORMATION**

### **The Trustees Interpret the Plan**

Under the terms of the Trust Agreement that created the Fund, and under the terms of this Plan, the Board of Trustees has the sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan and any administrative rules adopted by the Trustees. The Trustees have full discretionary authority to interpret and construe the Plan, all Plan Documents, the Trust Agreement, this Summary Plan Description, and all Plan rules and procedures. The Trustees' interpretation will be given the maximum deference permitted by law for the exercise of such full discretionary authority. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties to the Plan, and the Welfare Plan provides that, such decision is to be upheld unless it is determined to be arbitrary or capricious. In other words, to summarize: "Benefits under this plan will be paid only if the Board of Trustees decides in its discretion that the applicant is entitled to them."

Any interpretation of the Plan's provisions rests with the Board of Trustees. No employer, union, representative of any employer, representative of any union, or any other individual or entity is authorized to interpret this Plan on behalf of the Board of Trustees. No employer, union, representative of any employer, representative of any union, or any other individual or entity can act as agent of the Board of Trustees unless given actual authority by the Board of Trustees.

Although, the Board of Trustees has authorized the Administrative Manager and the Fund Office staff to handle routine requests from participants regarding eligibility rules, benefits, and claims procedures, if there are any questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for a final determination.

## **The Plan Can Be Changed**

The Trustees have the legal right to change the Plan, subject to any collective bargaining agreement that applies to it.

Although the Trustees hope to maintain the present level of benefits and to improve upon them if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. To do so may require Plan changes from time to time.

Changes in the Plan may also be required in order to preserve the Fund's tax exempt status under Internal Revenue Service rules and regulations. These rules and regulations may change and as a result, the Trustees may find it necessary to change Plan provisions so that the Trust does not lose its tax exempt status.

## **Your Plan is Tax Exempt**

Your Welfare Plan is classified by the Internal Revenue Service as a 501(c)(9) Trust Fund. This means that the employers contributions to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefits paid on your behalf are not taxable as personal income. Also, investment earnings on Plan assets are excluded as taxable income of the Trust since they are specifically set aside for the purpose of providing benefits to participants.

Obviously, such tax exemption works to the benefit of both employer and employee. In effect, it means that money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses.

The Trustees are well aware of these advantages and will take whatever steps are necessary to keep your Plan "Qualified" and to maintain it as a tax exempt Trust under Internal Revenue Code, ERISA and under the rules and regulations of the Internal revenue Service and of the Department of Labor.

## **Right to Receive and Release Necessary Information**

To determine the applicability of, and to implement the terms of, this Plan or the similar terms of any other plan, the Fund may, without consent or notice to any covered person, release to, or obtain from, any insurance company or other organization or individual, any information with respect to any covered person which the Fund deems to be necessary for such purposes. Any covered person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

## **Right of Recovery**

Whenever payments have been made by the Fund with respect to allowable expenses in excess of the maximum amount of payment necessary at the time to satisfy its provisions, the Fund shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Fund shall determine:

1. Any individual to whom, or from whom, such payments were made; or
2. Any insurance company, hospital, physician, or any other organization.

The Fund may also recover such excess payments by reducing future benefit payments, if any, which become due a Participant, Dependent or Beneficiary.

## **Payment of Claims**

Indemnity for loss of life will be payable in accordance with the beneficiary designation form on file at the Fund Office and in accordance with the provisions with respect to such payments which are prescribed in the Hartford Insurance Booklet. The Hartford Insurance Booklet provides for a method of distribution if a beneficiary designation card is not on file or if those named on the card predecease the participant.

## **Name of the Plan**

The name of Plan is the Local Union No. 9, IBEW & Line Clearance Contractors Health and Welfare Benefit Fund. The Plan is a successor plan to a plan that was called the Line Clearance Benefit Fund.

## **Type of Plan**

This Plan provides health care benefits for expenses incurred due to hospitalization, surgical treatment, medical treatment, vision treatment, or dental treatment. This Plan also provides benefits for Death, Accidental Death and Dismemberment, and Weekly Accident and Sickness (also known as Short-term Disability or Loss of Time Benefits).

## **Type of Plan Administration**

Every Plan has a Plan Sponsor. The Board of Trustees is your Plan's Sponsor. The address for the Board of Trustees is:

Board of Trustees, Local Union No. 9, IBEW & Line Clearance Contractors  
Health & Welfare Fund c/o  
TIC International Corporation  
6525 Centurion Drive  
Lansing, MI 48917-9275  
Telephone: (517) 321-7502 or Toll Free: (877) 423-9155  
Facsimile: (517) 321-7508

The Plan is administered and maintained by the Board of Trustees. The Trustees have selected a professional employee benefits administrative firm as the Administrative Manager of the Plan. The Administrative Manager maintains the Fund Office and is responsible for carrying out the Trustees' policy decisions, record keeping and accounting. The Trustees have entered into contracts with other Claims Paying Agents to pay benefits subject to the Plan Document.

## **Name and Address of Administrative Manager**

The Administrative Manager selected by the Trustees is:

James E. Schreiber, Administrative Manager  
TIC International Corporation  
6525 Centurion Drive  
Lansing, MI 48917-9275  
Telephone: (517) 321-7502 or Toll Free: (877) 423-9155  
Facsimile: (517) 321-7508

## **Name and Address of Investment Consultant**

Ted L. Disabato  
Clark Strategic Advisors, Inc.  
500 W. Madison St., Suite 2740  
Chicago, IL 60661  
(312) 798-3222  
(312) 902-1984 FAX

## **Name and Title of Each Trustee**

The Trustees of this Fund are:

### **Management Trustees**

Larry Gauger, Secretary  
Phil Heinz  
Mark Sanders (Alternate)  
Dennis Nelson (Alternate)

### **Union Trustees**

Bob Pierson, Chairman  
John Burkard  
Timothy E. Ladwein  
Craig Nolan  
Robert Spychalski  
Marty Clevenger  
Bill Niesman (Alternate)

## **Parties to the Collective Bargaining Agreement**

The Fund is established and maintained under the terms of a collective bargaining agreement. This agreement sets forth the conditions under which participating Employers are required to contribute to your Fund.

The current parties to applicable collective bargaining agreements are:

Local Union No. 9, International Brotherhood of Electrical Workers, AFL-CIO

Asplundh Tree Expert Company  
Wright Tree Service, Inc.

In addition, those Employers which execute a letter of assent to a collective bargaining agreement with the Local Union may become Contributing Employers. Upon written request to the Administrative Manager, Participants and Beneficiaries may obtain information as to the address of a particular Employer and whether that Employer is required to pay contributions to this Plan.

## **Internal Revenue Service Employer and Plan Identification Numbers**

The Employer Identification Number (EIN) issued to the Board of Trustees is 36-3332983 the Plan Number is 501.

## **Agent for Service of Legal Process**

Robert E. Fitzgerald, III, P.C.  
714 West Burlington Avenue  
La Grange, IL 60525  
Service of legal process may also be made upon any Plan Trustee.

## **Eligibility Requirements**

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules in the Eligibility Section of this Document. Circumstances which may cause you to lose eligibility are explained in the Eligibility Rules in the Eligibility Section of this Document.

## **Sources of Trust Fund Income**

Sources of Trust Fund income include Employer contributions, Employee self-payment of contributions and investment earnings. All Employer contributions are paid to the Trust Fund subject to provisions in the applicable collective bargaining agreement or non-bargaining participation agreements between the Union and an Employer Association or those Employers who are not members of or represented by an Association but who execute an individual collective bargaining agreement with the Local Union.

The agreements specify the amount of contributions, due date of Employer contributions, type of work for which contributions are payable and the geographic area covered by the labor contract.

## **Method of Funding Benefits**

Benefits payable under this Plan are self-funded and paid directly from the accumulated assets of the Trust Fund. Except for Life and Accidental Death & Dismemberment benefits for which the Trust Fund has purchased a group insurance policy insured by Hartford Life and Accident Insurance Company, Policy number GL-674708. The Fund has also purchased Stop-Loss Insurance policies from BlueCross/BlueShield of Illinois for specific claims which exceed \$100,000 and for any claim or claims that exceed a certain aggregate amount. The Stop-Loss Insurance Policies do not insure individual participants or beneficiaries rather, it is for the Fund's protection from large claims which could cause it significant financial damage.

## **Fiscal Year of the Plan**

The financial records of this Plan are based on a fiscal year which begins July 1<sup>st</sup> and ends June 30<sup>th</sup>.

## **The Plan May be Amended or Terminated**

The Trust Fund Documents gives the Trustees the authority to amend the Plan if they determine that such amendment is necessary or desirable to further the purposes of the Trust Fund. You will be provided with notice of amendments when necessary in conformity with all legal requirements. Although the Trustees do not foresee that the

Plan will be terminated, the Trust Agreement provides that termination may occur when:

1. The Trustees determine that the Trust Fund assets are not adequate to carry out the purpose for which the Welfare Fund is intended; or
2. There is no longer a collective bargaining agreement or other written agreement in effect that requires Employer contributions to be made to the Trust Fund and negotiations for extension thereof have ceased.

The Trustees are obligated to use the Trust Assets for payment of expenses incurred up to the date of termination and expenses related to the termination as their first priority. Remaining assets, if any, must be disbursed pursuant to the applicable provisions of the Trust Agreement.

Upon written request, you may examine the agreement at the Administration Office or other specified locations. Or you may request of a copy of the agreement which will be provided for a reasonable charge.