

**IMPORTANT NOTICE
TO ALL ACTIVE AND RETIRED PLAN PARTICIPANTS
Benefit and Rule Changes**

June 2008

The Board of Trustees of the I.B.E.W. Local No. 701 Welfare Fund has made the following changes to the Plan of Benefits.

EFFECTIVE JANUARY 17, 2008:

1. **Nutritional counseling** is now covered under the medical plan for persons with diabetes, Crohn's Disease or celiac disease. The Plan will cover up to three individual (one-on-one) visits with a licensed nutritionist who is in the PPO network. The counseling must be recommended by the person's physician.
2. **Hearing aids** - The Plan's \$1,500 per ear hearing aid benefit is now payable every three years, instead of every five years.

EFFECTIVE MARCH, 1 2008:

1. **Additional covered providers** - The Plan's list of covered providers has been expanded to include:
 - Optometrists;
 - Nurse Practitioners if payment would have been made under this Plan to a physician for the same services; and
 - Physician's Assistants working under the direct supervision of a physician.
2. **Artificial stapes surgery (stapedectomy)** will be covered under the regular provisions of the Plan's medical benefit, instead of under the hearing benefit.
3. **Surgical assistants** - The allowable amount for an out-of-network surgical assistant will be 15% of the reasonable and customary fee for the primary surgeon.
4. **Obesity surgery** will only be covered if the following criteria are met:
 - The patient must have a Body Mass Index (BMI) of at least 40;

- The obesity must be a threat to the patient's life due to the existence of complicating health factors such as diabetes, heart trouble, hypertension, etc.;
- During the 24-month period prior to the proposed surgery, the patient must have a documented history of at least six continuous months of physician-assisted attempts to reduce weight by more conservative measures;
- The surgery must be performed in a PPO facility; and
- Before surgery is performed, the review organization (Med-Care Management) must approve the surgery based on a review of the medical history and treatment plan.

Obesity surgery will be covered only once in a patient's lifetime. No benefits are payable for obesity surgery performed on dependent children. The Plan will not cover any post-operative procedures to remove excess tissue or improve the person's appearance.

5. **Injuries to the jaw or teeth** - The time limit during which treatment of an injury to the jaw and/or natural teeth must be received in order to be covered under the medical plan is extended from six months to twelve months.
6. **Post-chemotherapy wigs** - The Plan will allow up to \$500 for one wig following chemotherapy.
7. **Erectile dysfunction drugs following prostatectomy** - The Plan will cover prescription erectile dysfunction drugs (such as Viagra) for a period of 12 months following a nerve-sparing radical prostatectomy.
8. **Special food products** - The Plan will now cover:
 - Physician-prescribed enteral or parenteral nutrition administered in accordance with a treatment plan that has been approved and is being managed by the review organization. Enteral/parenteral nutrition will only be covered when it is the primary source of nutrition for a patient who is unable to take oral nutrition as the result of sickness or accidental bodily injury.
 - In certain cases, and when pre-approved by the review organization, the Plan will also cover specialized infant formula for a child with an inborn error of metabolism. (Inborn errors of metabolism are specific rare inherited conditions, such as PKU, that can be diagnosed with standard diagnostic tests.) The Plan does not consider maldigestion or intolerance to lactose, gluten, fat, soy or protein to be inborn errors of metabolism. If the Plan's criteria are met, coverage will be provided for up to 12 months at a payment percentage of 70%.
9. **Loss of Time (Disability) Benefits:**
 - Loss of Time Benefits are not payable for, and disability hours will not be credited for, a disability that begins during a quarter for which the employee made a full self-payment, unless the employee was available for work and eligible for SUB Fund benefits.
 - Loss of Time Benefits are not payable unless a physician who is an M.D., D.O. or D.P.M. is treating the patient and certifying the disability.
 - As before, the weekly benefit amount payable by the Plan will be equal to 2.5% of the employee's or apprentice's reported earnings for the 12 consecutive months preceding the month in which the total disability begins, up to a maximum of \$400. The Trustees have now adopted an amendment that defines the term "reported earnings" to mean wages paid by a contributing employer (whether or not contributions were made to this Fund). No other earnings will be counted, even if the result is a lower weekly benefit because the participant has fewer than 12 months of reported earnings.

10. **“Felony” exclusion added** - An exclusion has been added to the Plan for treatment of injuries sustained while committing (or in the act of committing) a crime punishable as a Class X, 1 or 2 felony.
11. **Dental Benefits:**
 - Coverage for two periodontal prophylaxis has been added for the treatment of periodontal disease. Charges are payable under Coverage A (preventive) services in addition to the two regular cleanings allowed per year.
 - Full mouth x-rays will be allowed every three years instead of once every year.
12. **Covered dependent children** - The Plan will no longer cover foster children, but will cover any child for whom you (the employee or retiree) are the legal guardian. In addition, the Plan will no longer require your federal income tax return in order to establish that a child is your dependent.
13. **Survivor coverage:**
 - *Active employees* - If an eligible employee dies, his or her dependents will remain eligible while the employee’s accumulated eligibility is run out, or until the end of the month during which the employee died, whichever is longer. The previous rule extended coverage only through the end of the month.
 - *Retirees* - The surviving spouse of a deceased retiree may postpone or suspend this Plan’s retiree coverage if he/she is eligible to enroll in another group health plan. In such case, the spouse’s (and/or child’s) Retiree Benefits may be reinstated when the other group coverage ends, provided the Fund Office is notified within 30 days after the termination date. There cannot be a break between the two coverages.

EFFECTIVE JUNE 1, 2008:

1. **Routine colonoscopies covered at 100% in-network** - Colonoscopies for colon and rectal cancer screening will be covered at 100% (no deductible) when you use PPO providers. Reasonable and customary charges by out-of-network providers will continue to be subject to the \$250 calendar year deductible and paid at the 70% non-PPO rate.
2. **No precertification is required** for routine colonoscopies.

EFFECTIVE JULY 1, 2008:

AFAS podiatry network terminated - The Plan will no longer pay 100% for podiatry performed through the Associated Foot and Ankle Specialists (AFAS) network. Covered podiatry will be paid at the same rates as other covered medical expenses (90% for BCBS PPO doctors; 70% non-PPO doctors; calendar year deductible applies).