

ABOUT THIS EXPLANATION OF BENEFITS

If Your Claim Was Not Paid in Full-Claims are paid in accordance with the Schedule of Benefits in your Summary Plan Description (SPD) booklet. Your Explanation of Benefits (EOB) will indicate the reason that any submitted charges were not paid in full.

For example, medical benefits are subject to:

- * A calendar year deductible.
- * Reductions and exclusions if you do not precertify specified types of treatment.
- * Co-payment percentages. (You are usually required to pay a percentage of your covered expenses.)
- * PPO physician office visit copays.
- * Limitations on the benefits paid for certain specified types treatments. These treatments include but are not limited to: chiropractic, TMJ, smoking cessation, physical exams, home health care, weight control, refractive surgery, infertility, sterilization, skilled nursing facility, and hospice.

Co-payment percentages, and scheduled maximums also apply to dental, vision and hearing expenses.

Refer to your SPD and any related notices for more information about these Plan provisions.

If Additional Information Is Needed to Process Your Claim-If additional information is needed from you, your doctor or the provider, the necessary information or material was (or will be) requested in writing. It is your responsibility to see that the missing information is provided to the Fund Office. If you do not provide the missing information within 45 days, the Fund Office will make a decision on your claim without it, and your claim will be considered denied as a result.

CLAIM APPEAL PROCEDURES

How to Appeal the Denial of a Claim-If your claim has been denied in whole or in part, you may request a full and fair review (also called an appeal) by filing a written notice of appeal with the Plan.

1. A notice of appeal must be received at the Fund Office not more than 180 days after you receive the written notice of denial of the claim. Your appeal is considered to have been filed on the date the written notice of appeal is received at the Fund Office.

2. For post-service claims and disability claims, the Review Committee will be the Board of Trustees or a committee of the Board of Trustees. Mail your written request for review to the Board of Trustees, I.B.E.W. Local No. 701 Welfare Fund, Fringe Benefits Administration Office, 2900 Ogden Avenue, Suite 108, Lisle, IL 60532-1675.

3. For pre-service claims involving outpatient mental health treatment (treatment for mental/nervous disorders, chemical dependency or substance abuse), the Review Committee will be a professional with the Member Assistance Program (MAP). You may orally request a review of a denied urgent outpatient mental health claim by calling the MAP at (630) 416-2183, or you may submit your request in writing to Members Assistance Program, Fringe Benefits Administration Office, 2900 Ogden Avenue, Suite 107, Lisle, IL 60532-1675. The MAP may notify you of its decision by telephone or facsimile. If you are not satisfied with the appeal decision made by the MAP, you can request that the Board of Trustees conduct a second review of the claim.

4. For all other pre-service claims (including inpatient mental health claims), the Review Committee will be the Plan's review organization (Med-Care Management, Inc.). You may orally request a review of a denied urgent care claim by calling Med-Care at 1-800-423-7781, or you may submit your request in writing to Med-Care Management, Inc. at P.O. Box 20564, West Palm Beach, FL 33416-0564. Med-Care may notify you of its decision by telephone or facsimile. If you are not satisfied with the appeal decision made by Med-Care, you can request that the Board of Trustees conduct a second review of the claim.

Full and Fair Review-In deciding your appeal, the Review Committee will consider all comments and documents that you submit, regardless of whether that information was available when the claim was denied. The review will not defer to the initial denial, and will take into account all comments, documents and information submitted by you, without regard to whether they were previously submitted or relied upon in the initial determination. The Review Committee will not include the person, or a subordinate of the person, who made the original claim denial. If an appeal involves a medical judgment, such as whether treatment is medically necessary, the Review Committee will consult with a medical professional who is qualified to offer an opinion on the issue. The Review Committee will not consult with the same medical professional (or a subordinate of that person) in deciding your appeal. You may:

- * Have another person represent you in connection with an appeal. Call the Fund Office for the proper designation form and further instructions.
- * Request a personal appearance before the Review Committee, with or without your properly designated representative, but at your own expense.
- * Review or receive copies of pertinent documents on file at the Fund Office, at no charge to you.
- * Upon request, the names of any medical or vocational experts who provided opinions in connection with your claim.