ELECTRICAL WORKERS GENERAL WELFARE FUND

(IBEW Local 701 Welfare Fund)

Summary Plan Description

Effective January 1, 2017

IMPORTANT CONTACT INFORMATION

Fund Office – 1-630-393-1701 #3

• IBEW Local 701 Welfare Fund • 28600 Bella Vista Parkway, Suite 1110 • Warrenville, IL 60555

Utilization Review Organization (Med-Care Management) – 1-800-367-1934 (24 hours)

- Pre-certify all inpatient hospitalizations, skilled nursing facility or residential treatment facility services, whether in or out of the PPO network
- Outpatient surgery, whether in or out of the PPO network.
- Other services requiring pre-certification are listed inside this booklet.
- There are penalties ($100) for failing to pre-certify

Prescription Drug Program (Sav-Rx) – 1-866-233-4239

• Sav-Rx • 224 North Park Avenue • Fremont, NE 68025 • www.savrx.com • Group / Plan No. IBEW701
• Sav-Rx also handles customer service for the retiree Medicare Part D plan.

Medical Preferred Provider Organization (PPO) – 1-800-810-BLUE

• Blue Cross Blue Shield of Illinois • www.bcbsil.com, select "Labor accounts," alpha prefix: IBW to find a participating provider

Special Fund (HRA) Program – 1-877-933-3539

• TASC DirectPay • www.tasconline.com

Dental PPO (DNoA) – 1-866-522-6758

- Dental Network of America (DNoA) (through Blue Cross Blue Shield of Illinois)
- www.dnoa.com (to find a participating provider), select the "Labor+" plan

Vision Plan (NVA) – 1-800-672-7723

• National Vision Administrators • P.O. Box 2187 • Clifton, NJ 07015 • Plan No. 10900001
• www.e-nva.com (to find a participating provider)

Members Assistance Program (MAP) – 1-630-393-1701 #6

• 1-630-791-2673 • Available 24/7 • Suite 1120 in the IBEW Local 701 building

Preferred Imaging Provider (Absolute Solutions, LLC) – 1-800-321-5040

- Call number above to schedule an MRI, CT scan or PET scan at a negotiated price

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You and your spouse must comply with the rules of the **Wellness Program** described on page 40 to avoid a reduction in benefits.

This Plan also has a **Working Spouse Rule**. For more information see page 24.

INTRODUCTION

To All Plan Participants and Their Eligible Dependents:

The Trustees of the Electrical Workers General Welfare Fund, usually referred to as the IBEW Local 701 Welfare Fund, are pleased to present you with this revised Summary Plan Description booklet which describes the eligibility rules and benefits available to you and your eligible dependents. This booklet is intended to give you an understandable summary of the benefits and provisions of the Plan Document which sets forth the Plan of Benefits adopted by the Trustees. If there is any discrepancy between the information in this summary and the provisions of the Plan Document, the Plan Document will take precedence.

We urge you to read this booklet carefully so that you will be aware of the benefits available to you. If you have any questions about the Plan or about your eligibility for benefits, please contact the Fund Office.

Sincerely,

Board of Trustees

To Contact the Board of Trustees

You can contact the Board of Trustees by writing to the Board of Trustees, c/o IBEW Local 701 Welfare Fund at the address below.

The names and addresses of the individual Trustees are shown on page 92.

Where to Get Help Understanding This Book

This booklet contains a summary in English of your Plan rights and the benefits available under the IBEW Local 701 Welfare Plan. If you have any difficulty understanding any part of this booklet, contact the Fund Office.

Donde Obtener Ayuda Para Entender Este Folleto

Este folleto contiene un resumen en Ingles de sus derechos y beneficios disponibles bajo el Plan de la IBEW Local 701 Welfare Plan. Si usted tiene alguna dificultad en entender cualquier parte de este folleto, por favor comuniquese con la Oficina del Fondo.

IBEW Local 701 Welfare Fund
28600 Bella Vista Parkway
Suite 1110
Warrenville, IL 60555
1-630-393-1701, #3

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PLAN A SCHEDULE OF BENEFITS

FOR ELIGIBLE ACTIVE AND RETIRED PARTICIPANTS, AND THEIR DEPENDENTS

(CLASSES 1, 3, 6 AND 7)

INSURANCE		
Life Insurance		
Active participant	$10,000	
Retiree (does not apply to Class 3)	$2,500	
Dependent(s) of eligible active participant (actives only)	$5,000	
Accidental Death and Dismemberment Insurance		
Active participant under age 70	$10,000	
WEEKLY LOSS OF TIME BENEFIT (Active Employees Only)		
Benefit amount		
Non-occupational disabilities	2.5% of last 12 months earnings up to a maximum of $400 per week	
Occupational disabilities	$45 for first week $15 for subsequent weeks	
Maximum weeks payable	26 weeks	
When benefits start	Accidents - 1st day Illnesses - 8th day if occupational, 4th day if non-occupational	
PREVENTIVE BENEFIT	**In-Network**	**Out-of-Network**
Plan payment percentage for covered preventive services (See list of preventive services starting on page 47.)	100%	70% after deductible
MAJOR MEDICAL BENEFIT		
Deductible per calendar year		
Per person	$400	
Per family	$800	
Utilization review noncompliance penalty (Inpatient confinements, including residential treatment facilities and skilled nursing facilities, and outpatient or inpatient surgery)	$100	
	In-Network	**Out-of-Network**
Plan payment percentages	90%	70%
Out-of-pocket limits		
Per person	$2,500	$5,000
Per family	$5,000	$10,000
(In- out-of-network limits must be met separately.)		

SPECIAL BENEFITS AND LIMITATIONS			
Chiropractic care	$1,000 per calendar year		
Congenitally missing teeth - maximum benefit for treatment and/or replacement of congenitally missing teeth	$5,000 per lifetime		
Emergency room (waived if visit meets definition of an emergency, or if admitted)	$200 deductible per occurrence; calendar year deductible and coinsurance also apply		
Foot orthotics	2 pairs every 3 calendar years		
Home health care	100 visits per calendar year		
Hospice care	180 days per lifetime		
	Absolute Solutions	**Blue Cross Blue Shield**	**Out-of-Network**
Imaging (MRIs, CT scans, PET scans)	100%	90%	70%
	no deductible	after deductible	
Infertility treatment - Maximum benefit for participant and spouse (only)	$10,000 per lifetime		
Office visit with in-network (PPO) physician (Deductible does not apply. Co-pay applies only to the charge for the visit itself. All other services are subject to deductible and coinsurance.)	100% after $25 copay		
Obesity (non-surgical treatment) - participant & spouse (only)	$1,000 per lifetime		
Out-of-network (non-PPO) surgical center	not covered		
Partial inpatient/intensive outpatient treatment for substance abuse and mental/nervous disorders (Additional visits may be covered if pre-certified by the review organization.)	12 visits for all related conditions		
Physical/occupational therapy (Additional visits may be covered if pre-certified by the review organization.)	12 visits for all related conditions		
Refractive surgery such as Lasik	$750 per eye per lifetime		
Residential treatment facility	45 days for all related confinements		
Skilled nursing facility	45 days for all related confinements		
Speech therapy for children under age 12	40 visits per calendar year		
PRESCRIPTION DRUG BENEFIT			
Retirees and dependents enrolled in this Plan's Medicare Part D plan generally have the same benefits as active participants (as shown below) – refer to page 55 for more information.	**Participant Pays**		
30-day retail			
Generic drugs	$5		
Preferred brands	20% with a min. of $20, to a max. $30		
Non-preferred brands	20% with a min. of $25, to a max. $45		
90-day retail			
Generic drugs	$15		
Preferred brands	$55		
Non-preferred brands	$85		

Mail-order		
Generic drugs	$10	
Preferred brands	$40	
Non-preferred brands	$55	
• Use of 30-day retail is mandatory for first two fills of a long-term or maintenance medication. • Mail-order or 90-day retail is mandatory for the 4th and all subsequent fills. • Patient pays difference in cost plus non-preferred brand co-pay if generic substitution is declined. • Additional requirements apply – see "Clinical Management Programs" starting on page 52.		
DENTAL BENEFIT		
Maximum benefit		
Per person	$1,500 per calendar year	
Per family	$5,000 per calendar year	
Annual maximum waived for preventive and routine services (those paid at 100%) for children under age 19.		
Plan payment percentages		
Preventive and routine	100%	
Minor restorative	80%	
Major restorative	50%	
Orthodontia (for children age 18 and under only)		
Plan payment percentage	50%	
Maximum benefit	$1,500 per lifetime	
VISION BENEFIT	**NVA Network**	**Out-of-Network**
Eye exam, one per calendar year	Provided in full	$50
Eyeglass lenses, one pair per year	Provided in full (plastic lenses)	
Single vision, per pair		$65
Bifocal or trifocal, per pair		$75
Frame, one every two calendar years	$50 wholesale allowance	$125
Contact lenses in lieu of eyeglasses, per calendar year	$100 allowance	$100
Safety glasses for active participants only, one per year	$100 allowance	$100
HEARING BENEFIT		
Exam	$75 every two calendar years	
Hearing aid device	$1,500 every three calendar years	

PLAN B SCHEDULE OF BENEFITS

LOW-OPTION SELF-PAY PLAN

(CLASS 1 PARTICIPANTS ONLY)

PREVENTIVE BENEFIT	In-Network	Out-of-Network
Plan payment percentage for covered preventive services (See list of preventive services starting on page 47.)	100%	50% after deductible
MAJOR MEDICAL BENEFIT		
Deductible per calendar year		
Per person	$900	
Per family	$1,800	
Utilization review noncompliance penalty (Inpatient confinements, including residential treatment facilities and skilled nursing facilities, and outpatient or inpatient surgery)	$100	
	In-Network	**Out-of-Network**
Plan payment percentages	70%	50%
Out-of-pocket limits		
Per person	$4,000	$8,000
Per family	$8,000	$16,000
(In- out-of-network limits must be met separately.)		
SPECIAL BENEFITS AND LIMITATIONS		
Chiropractic care	$1,000 per calendar year	
Congenitally missing teeth - maximum benefit for treatment and/or replacement of congenitally missing teeth	$5,000 per lifetime	
Emergency room (waived if visit meets definition of an "emergency," or if admitted)	$200 deductible per occurrence; calendar year deductible and coinsurance also apply	
Foot orthotics	2 pairs every 3 calendar years	
Home health care	100 visits per calendar year	
Hospice care	180 days per lifetime	
	Absolute Solutions	**Blue Cross Blue Shield**	**Out-of-Network**
Imaging (MRIs, CT scans, PET scans)	100% no deductible	70% after deductible	50%
Infertility treatment - Maximum benefit for participant and spouse (only)	$10,000 per lifetime		
Office visit with in-network (PPO) physician (Deductible does not apply. Co-pay applies only to the charge for the visit itself. All other services subject to deductible and coinsurance.)	100% after $25 copay		

Out-of-network (non-PPO) surgical center	not covered
Partial inpatient/intensive outpatient treatment for substance abuse and mental/nervous disorders (Additional visits may be covered if pre-certified by the review organization.)	12 visits for all related conditions
Physical/occupational therapy (Additional visits may be covered if pre-certified by the review organization.)	12 visits for all related conditions
Refractive surgery such as Lasik	$750 per eye per lifetime
Residential treatment facility	45 days for all related confinements
Skilled nursing facility	45 days for all related confinements
Speech therapy for children under age 12	40 visits per calendar year
PRESCRIPTION DRUG BENEFIT	**Participant Pays**
30-day retail	
Generic drugs	$5
Preferred brands	20%; with a min. of $30, to a max. of $55
Non-preferred brands	20%; with a min. of $35, to a max. $85
90-day retail	
Generic drugs	$15
Preferred brands	$105
Non-preferred brands	$165
Mail-order	
Generic drugs	$10
Preferred brands	$75
Non-preferred brands	$105
• Use of 30-day retail is mandatory for first two fills of a long-term or maintenance medication. • Mail-order or 90-day retail is mandatory for the 4th and all subsequent fills. • Patient pays difference in cost plus non-preferred brand co-pay if generic substitution is declined. • Additional requirements apply – see "Clinical Management Programs" starting on page 52.	
DENTAL BENEFIT	
Maximum benefit	
Per person	$750 per calendar year
Per family	$2,500 per calendar year
Annual maximum waived for preventive and routine services (those paid at 100%) for children under age 19.	
Plan payment percentages	
Preventive and routine	100%
Minor restorative	50%
Major restorative	50%

HEARING BENEFIT	
Exam	$75 every two calendar years
Hearing aid device	$1,500 every three calendar years

PLAN C SCHEDULE OF BENEFITS

FOR ELIGIBLE PLAN A PARTICIPANTS AND DEPENDENTS WHO ARE NOT COMPLIANT WITH THE WELLNESS PROGRAM

INSURANCE		
Life Insurance		
Active participant	$10,000	
Retiree	$2,500	
Dependent(s) of eligible active participant (actives only)	$5,000	
Accidental Death and Dismemberment Insurance		
Active participant under age 70	$10,000	
WEEKLY LOSS OF TIME BENEFIT (Active Employees Only)		
Benefit amount		
Non-occupational disabilities	2.5% of last 12 months earnings up to a maximum of $400 per week	
Occupational disabilities	$45 for first week $15 for subsequent weeks	
Maximum weeks payable	26 weeks	
When benefits start	Accidents - 1st day Illnesses - 8th day if occupational, 4th day if non-occupational	
PREVENTIVE BENEFIT	**In-Network**	**Out-of-Network**
Plan payment percentage for covered preventive services (See list of preventive services starting on page 47.)	100%	70% after deductible
MAJOR MEDICAL BENEFIT		
Deductible per calendar year		
Per person	$800	
Per family	$1,600	
Utilization review noncompliance penalty (Inpatient confinements, including residential treatment facilities and skilled nursing facilities, and outpatient or inpatient surgery)	$100	
	In-Network	**Out-of-Network**
Plan payment percentages	70%	50%
Out-of-pocket limits		
Per person	$4,000	$8,000
Per family	$8,000	$16,000
(In-network and out-of-network must be met separately.)		

SPECIAL BENEFITS AND LIMITATIONS			
Chiropractic care	$1,000 per calendar year		
Congenitally missing teeth - maximum benefit for treatment and/or replacement of congenitally missing teeth	$5,000 per lifetime		
Emergency room (waived if visit meets definition of an emergency, or if admitted)	$200 deductible per occurrence; calendar year deductible and coinsurance also apply		
Foot orthotics	2 pairs every 3 calendar years		
Home health care	100 visits per calendar year		
Hospice care	180 days per lifetime		
	Absolute Solutions	**Blue Cross Blue Shield**	**Out-of-Network**
Imaging (MRIs, CT scans, PET scans)	100%	70%	50%
	no deductible	after deductible	
Infertility treatment - Maximum benefit for participant and spouse (only)	$10,000 per lifetime		
Office visit with in-network (PPO) physician (Deductible does not apply. Co-pay applies only to the charge for the visit itself. All other services are subject to deductible and coinsurance.)	100% after $25 copay		
Obesity (non-surgical treatment) - participant & spouse (only)	$1,000 per lifetime		
Out-of-network (non-PPO) surgical center	not covered		
Partial inpatient/intensive outpatient treatment for substance abuse and mental/nervous disorders (Additional visits may be covered if pre-certified by the review organization.)	12 visits for all related conditions		
Physical/occupational therapy (Additional visits may be covered if pre-certified by the review organization.)	12 visits for all related conditions		
Refractive surgery such as Lasik	$750 per eye per lifetime		
Residential treatment facility	45 days for all related confinements		
Skilled nursing facility	45 days for all related confinements		
Speech therapy for children under age 12	40 visits per calendar year		
PRESCRIPTION DRUG BENEFIT	**Participant Pays**		
Retirees and dependents enrolled in this Plan's Medicare Part D plan generally have the same benefits as active participants (as shown below) – refer to page 55 for more information.			
30-day retail			
Generic drugs	$5		
Preferred brands	20% with a min. of $20, to a max. $30		
Non-preferred brands	20% with a min. of $25, to a max. $45		
90-day retail			
Generic drugs	$15		
Preferred brands	$55		
Non-preferred brands	$85		

Mail-order		
Generic drugs	$10	
Preferred brands	$40	
Non-preferred brands	$55	
• Use of 30-day retail is mandatory for first two fills of a long-term or maintenance medication. • Mail-order or 90-day retail is mandatory for the 4th and all subsequent fills. • Patient pays difference in cost plus non-preferred brand co-pay if generic substitution is declined. • Additional requirements apply – see "Clinical Management Programs" starting on page 52.		
DENTAL BENEFIT		
Maximum benefit		
Per person	$1,500 per calendar year	
Per family	$5,000 per calendar year	
Annual maximum waived for preventive and routine services (those paid at 100%) for children under age 19.		
Plan payment percentages		
Preventive and routine	100%	
Minor restorative	80%	
Major restorative	50%	
Orthodontia (for children age 18 and under only)		
Plan payment percentage	50%	
Maximum benefit	$1,500 per lifetime	
VISION BENEFIT	**NVA Network**	**Out-of-Network**
Eye exam, one per calendar year	Provided in full	$50
Eyeglass lenses, one pair per year	Provided in full (plastic lenses)	
Single vision, per pair		$65
Bifocal or trifocal, per pair		$75
Frame, one every two calendar years	$50 wholesale allowance	$125
Contact lenses in lieu of eyeglasses, per calendar year	$100 allowance	$100
Safety glasses for active participants only, one per year	$100 allowance	$100
HEARING BENEFIT		
Exam	$75 every two calendar years	
Hearing aid device	$1,500 every three calendar years	

PLAN 11 SCHEDULE OF BENEFITS

FOR ELIGIBLE CLASS 11 PARTICIPANTS AND THEIR DEPENDENTS

INSURANCE BENEFITS			
Life Insurance – Active participant	$10,000		
Accidental Death/Dismemberment Insurance – Active participant under age 70 only	$10,000		
PREVENTIVE BENEFIT	**In-Network**	**Out-of-Network**	
Plan payment percentage for covered preventive services (See list of preventive services starting on page 47.)	100%	70% after deductible	
MAJOR MEDICAL BENEFIT			
Deductible per calendar year			
Per person	$400		
Per family	$800		
Utilization review noncompliance penalty (Inpatient confinements, including residential treatment facilities and skilled nursing facilities, and outpatient or inpatient surgery)	$100		
	In-Network	**Out-of-Network**	
Plan payment percentages	90%	70%	
Out-of-pocket limits			
Per person	$2,500	$5,000	
Per family	$5,000	$10,000	
(In- out-of-network limits must be met separately.)			
SPECIAL BENEFITS AND LIMITATIONS			
Chiropractic care	$1,000 per calendar year		
Congenitally missing teeth - maximum benefit for treatment and/or replacement of congenitally missing teeth	$5,000 per lifetime		
Emergency room (waived if visit meets definition of an "emergency," or if admitted)	$200 deductible per occurrence; calendar year deductible and coinsurance also apply		
Foot orthotics	2 pairs every 3 calendar years		
Home health care	100 visits per calendar year		
Hospice care	180 days per lifetime		
	Absolute Solutions	**Blue Cross Blue Shield**	**Out-of-Network**
Imaging (MRIs, CT scans, PET scans)	100% no deductible	90% after deductible	70%
Infertility treatment - Maximum benefit for participant and spouse (only)	$10,000 per lifetime		
Obesity (non-surgical treatment) - participant & spouse (only)	$1,000 per lifetime		

Office visit with in-network (PPO) physician (Deductible does not apply. Co-pay applies only to the charge for the visit itself. All other services subject to deductible and coinsurance.)	100% after $25 copay
Out-of-network (non-PPO) surgical center	not covered
Partial inpatient/intensive outpatient treatment for substance abuse and mental/nervous disorders (Additional visits may be covered if pre-certified by the review organization.)	12 visits for all related conditions
Physical/occupational therapy (Additional visits may be covered if pre-certified by the review organization.)	12 visits for all related conditions
Refractive surgery such as Lasik	excluded
Residential treatment facility	45 days for all related confinements
Skilled nursing facility	45 days for all related confinements
Speech therapy for children under age 12	40 visits per calendar year
PRESCRIPTION DRUG BENEFIT	
	Participant Pays
30-day retail	
Generic drugs	lesser of 20% or $5
Preferred brands	20%
Non-preferred brands	20%
90-day retail	
Generic drugs	lesser of 20% or $15
Preferred brands	20%
Non-preferred brands	20%
Mail-order	
Generic drugs	lesser of 20% or $10
Preferred brands	20%
Non-preferred brands	20%
• Use of 30-day retail is mandatory for first two fills of a long-term or maintenance medication. • Mail-order or 90-day retail is mandatory for the 4th and all subsequent fills. • Patient pays difference in cost plus non-preferred brand co-pay if generic substitution is declined. • Additional requirements apply – see "Clinical Management Programs" starting on page 52.	
	Participant Co-Pay Limit
Out-of-pocket limit for prescription drug co-pays per calendar year	$4,600 per person $9,200 per family

DENTAL BENEFIT		
Maximum benefit		
Per person	$750 per calendar year	
Annual maximum waived for preventive and routine services (those paid at 100%) for children under age 19.		
Plan payment percentages		
Preventive and routine	100%	
Minor restorative	80%	
Major restorative	50%	
Orthodontia (for children age 18 and under only)		
Plan payment percentage	50%	
Maximum benefit	applies to $750 annual maximum shown above	
VISION BENEFIT		
	NVA Network	**Out-of-Network**
Eye exam, one per calendar year	Provided in full	$35
Eyeglass lenses, one pair per year	Provided in full (plastic lenses)	
Single vision, per pair		$50
Bifocal or trifocal, per pair		$65
Frame, one every two calendar years	$50 wholesale allowance	$35
Contact lenses in lieu of eyeglasses, per calendar year	$100 allowance	$90
Safety glasses for active participants only, one per year	$100 allowance	$100
HEARING BENEFIT		
Exam	$75 every two calendar years	
Hearing aid device	$750 every three calendar years	

PLAN 11-C SCHEDULE OF BENEFITS

FOR ELIGIBLE PLAN 11 PARTICIPANTS AND DEPENDENTS WHO ARE NOT COMPLIANT WITH THE WELLNESS PROGRAM

INSURANCE BENEFITS			
Life Insurance - Active participant	$10,000		
Accidental Death/Dismemberment Insurance - Active participant under age 70	$10,000		
PREVENTIVE BENEFIT	**In-Network**	**Out-of-Network**	
Plan payment percentage for covered preventive services (See list of preventive services starting on page 47.)	100%	50% after deductible	
MAJOR MEDICAL BENEFIT			
Deductible per calendar year			
Per person	$800		
Per family	$1,600		
Utilization review noncompliance penalty (Inpatient confinements, including residential treatment facilities and skilled nursing facilities, and outpatient or inpatient surgery)	$100		
	In-Network	**Out-of-Network**	
Plan payment percentages	70%	50%	
Out-of-pocket limits			
Per person	$4,000	$8,000	
Per family	$8,000	$16,000	
(In- out-of-network limits must be met separately.)			
SPECIAL BENEFITS AND LIMITATIONS			
Chiropractic care	$1,000 per calendar year		
Congenitally missing teeth - maximum benefit for treatment and/or replacement of congenitally missing teeth	$5,000 per lifetime		
Emergency room (waived if visit meets definition of an "emergency," or if admitted)	$200 deductible per occurrence; calendar year deductible and coinsurance also apply		
Foot orthotics	2 pairs every 3 calendar years		
Home health care	100 visits per calendar year		
Hospice care	180 days per lifetime		
	Absolute Solutions	**Blue Cross Blue Shield**	**Out-of-Network**
Imaging (MRIs, CT scans, PET scans)	100%	70%	50%
	no deductible	after deductible	
Infertility treatment - Maximum benefit for participant and spouse (only)	$10,000 per lifetime		
Obesity (non-surgical treatment) - participant & spouse (only)	$1,000 per lifetime		

Office visit with in-network (PPO) physician (Deductible does not apply. Co-pay applies only to the charge for the visit itself. All other services subject to deductible and coinsurance.)	100% after $25 copay
Out-of-network (non-PPO) surgical center	not covered
Partial inpatient/intensive outpatient treatment for substance abuse and mental/nervous disorders (Additional visits may be covered if pre-certified by the review organization.)	12 visits per disability
Physical/occupational therapy (Additional visits may be covered if pre-certified by the review organization.)	12 visits per disability
Refractive surgery such as Lasik	not covered
Residential treatment facility	45 days for all related confinements
Skilled nursing facility	45 days for all related confinements
Speech therapy for children under age 12	40 visits per calendar year
PRESCRIPTION DRUG BENEFIT	
The following benefits do not apply to retirees and dependents enrolled in this Plan's Medicare Part D plan. Participants in that plan will receive benefits information from UHC and Sav-Rx.	**Participant Pays**
30-day retail	
Generic drugs	lesser of 20% or $5
Preferred brands	20%
Non-preferred brands	20%
90-day retail	
Generic drugs	lesser of 20% or $15
Preferred brands	20%
Non-preferred brands	20%
Mail-order	
Generic drugs	lesser of 20% or $10
Preferred brands	20%
Non-preferred brands	20%
• Use of 30-day retail is mandatory for first two fills of a long-term or maintenance medication. • Mail-order or 90-day retail is mandatory for the 4th and all subsequent fills. • Patient pays difference in cost plus non-preferred brand co-pay if generic substitution is declined. • Additional requirements apply – see "Clinical Management Programs" starting on page 52.	
Out-of-pocket limit for prescription drug co-pays per calendar year (participant co-pay maximum)	$4,600 per person $9,200 per family

DENTAL BENEFIT		
Maximum benefit		
Per person	$750 per calendar year	
Annual maximum waived for preventive and routine services (those paid at 100%) for children under age 19.		
Plan payment percentages		
Preventive and routine	100%	
Minor restorative	80%	
Major restorative	50%	
Orthodontia (for children age 18 and under only)		
Plan payment percentage	50%	
Maximum benefit	applies to $750 annual maximum shown above	
VISION BENEFIT		
	NVA Network	**Out-of-Network**
Eye exam, one per calendar year	Provided in full	$35
Eyeglass lenses, one pair per year	Provided in full (plastic lenses)	
Single vision, per pair		$50
Bifocal or trifocal, per pair		$65
Frame, one every two calendar years	$50 wholesale allowance	$35
Contact lenses in lieu of eyeglasses, per calendar year	$100 allowance	$90
Safety glasses for active participants only, one per year	$100 allowance	$100
HEARING BENEFIT		
Exam	$75 every two calendar years	
Hearing aid device	$750 every three calendar years	

ELIGIBILITY FOR ACTIVE PARTICIPANTS

ABOUT ELIGIBILITY CLASSES

The following table shows the eligibility categories (classes) covered by this Plan. Your class is determined by the collective bargaining agreement between your employer and Local 701 or, if you are not part of the bargaining unit, by the participation agreement between your employer and the Plan.

Eligibility Classes and Benefit Plans for Active Employees

Eligibility Category	Brief Description	Applicable Benefit Schedule
Class 1	Bargained-for employees whose employers contribute for each hour worked	Plan A or Plan C (wellness non-compliance) or Plan B (optional self-pay plan)
Class 3	Non-bargained for employees of contributing employers	Plan A or Plan C (wellness non-compliance)
Class 6	Owners-in-fact	Plan A or Plan C (wellness non-compliance) or Plan B (optional self-pay plan)
Class 7	Non-bargained-for employees of Local 701, the JATC, the Fund Office, and Power Forward DuPage	Plan A or Plan C (wellness non-compliance) or
Class 11	Factory sign employees	Plan 11 or Plan 11-C (wellness non-compliance)

ELIGIBILITY RULES FOR CLASS 1 BARGAINING UNIT EMPLOYEES

Class 1 employees are bargained-for employees for whom employers make contributions for each hour worked.

Class 1 employees who are eligible for benefits because they have satisfied the eligibility rules described below normally will be covered under the Plan A Schedule of Benefits. When you are eligible for Plan A benefits, your dependents will also be eligible for Plan A benefits.

Definition of "Credited Hour"

The eligibility of a Class 1 participant is based on credited hours. A "credited hour" means work performed under the jurisdiction of IBEW Local 701 for which a contributing employer makes the required hourly contribution to the Fund on behalf of the participant performing the work.

Hours for which you make a short-hours self-payment are also considered credited hours, but only for continuing (not initial) eligibility. You do not get credited hours for COBRA self-payments.

Disability hours granted by the Fund during a period of total disability also count as credited hours.

Establishing Initial Eligibility

New Apprentices in JATC Program and Participants who Previously Lost Eligibility Under This Plan

If you are not currently eligible for benefits, you will become eligible on:

- The first day of the month following the month in which at least 300 credited hours are paid on your behalf by one or more contributing employers during any contribution quarter;

OR

- The first day of the month following the month in which one of the following requirements is met:
  - ~ 600 credited hours are paid on your behalf by one or more contributing employers during any six-consecutive-month period; or
  - ~ 1,000 credited hours are paid on your behalf by one or more contributing employers during any nine-consecutive-month period; or
  - ~ 1,300 credited hours are paid on your behalf by one or more contributing employers during any twelve-consecutive-month period.

If your eligibility terminates, it will be reinstated on the first day of the coverage quarter for which you have at least 300 credited hours during the corresponding contribution quarter.

New Participants Not in the JATC Program and Participants Who Have Never Been Eligible Under This Plan

If you are a new participant who is not in the JATC program and have never been eligible under this Plan, you will become initially eligible on the first day of the month following the month that one of the following requirements is met:

- 800 credited hours are paid on your behalf by one or more contributing employers during any six-consecutive-month period; or
- 1,200 credited hours are paid on your behalf by one or more contributing employers during any nine-consecutive-month period; or
- 1,500 credited hours are paid on your behalf by one or more contributing employers during any twelve-consecutive-month period.

If You Are Disabled on Your Effective Date

If you are not actively at work due to disability on the date your benefits would have become effective, you will be eligible for all benefits beginning on that date except the Weekly Loss of Time Benefit. Loss of Time Benefits will become effective when you return to active work.

How Eligibility Continues

Eligibility due to Work Hours

After you meet the initial eligibility requirements, you will remain eligible for benefits until the end of the three-month coverage quarter, or the remaining part of the coverage quarter, during which you became initially eligible.

You will remain eligible for each successive coverage quarter if your employer(s) contribute sufficient credited hours on your behalf. There are **two ways** to maintain your eligibility during a coverage quarter due to worked hours.

Continuing Eligibility

	You need EITHER of the following:	
For eligibility during this coverage quarter:	**300 credited hours in this contribution quarter:**	**1,200 credited hours in this 12-month period (lookback rule):**
January, February, March	August, September, October	November 1 - October 31
April, May, June	November, December, January	February 1 - January 31
July, August, September	February, March, April	May - April 30
October, November, December	May, June July	August - July 31

Note that there are two administrative lag months between a contribution quarter and its related coverage quarter.

Eligibility due to Self-Payments for Short Hours

If you fall short of the continuing eligibility requirement of 300 credited hours in a contribution quarter, or 1,200 credited hours during the previous twelve-month period, you may make self-payments without losing eligibility and having to meet the initial eligibility requirement again.

- Your self-payment will be an amount equal to the difference between 300 credited hours in a contribution quarter and the actual contribution hours for the most recent contribution quarter, or the difference between 1,200 credited hours and the actual contribution hours for the most recent twelve-month period, whichever is less.
- You must make self-payments for consecutive coverage quarters so that there is no break in your eligibility and so your eligibility remains continuous. In the event that your eligibility terminates because you fail to make your self-payment on time, you will lose the right to make future short-hours self-payments until you return to work and subsequently reinstate your eligibility by meeting the requirements outlined under the "Establishing Initial Eligibility" provisions on page 17.
- Self-payments for short hours must be received by the Fund Office prior to the first day of the month for which coverage is being paid. Payments received after this date will be returned to you and your coverage will end. You will have to meet the initial eligibility requirements to become covered again.
- Under no circumstances will you be allowed to make self-payments toward the establishment of initial eligibility.
- You may not make more than four full consecutive self-payments of 300 hours. You can make an unlimited number of partial self-payments.

- Self-payments for short hours are in lieu of COBRA coverage. This means that your maximum 18-month COBRA period begins with the first day of the quarter for which you make a short-hours self-payment.

Self-Payments for Plan B

Normally when you make a self-payment for short hours, you pay the full hourly contribution rate for regular (Plan A) benefits. However, if you are eligible to self-pay, you will also be offered the option of self-paying at a lower rate for a lesser benefit schedule called Plan B. (The Plan B schedule starts on page 4.)

- Plan B is only available for active (not retired) Class 1 and Class 6 employees who are eligible to make short hours self-payments. Plan B is not available for participants whose employers make flat rate or monthly contributions, or for retirees or survivors.
- If you initially elect to make self-payments for Plan A, you are permitted to drop down to Plan B during the same self-payment period, but you cannot go up from Plan B to Plan A until you re-establish eligibility based on hours worked.
- If you are eligible during a coverage quarter because of a Plan B self-payment, you will be covered under Plan B during the entire quarter. This rule applies even if your Plan B payment was only for one hour.
- Amounts applied toward deductibles, out-of-pocket limits and maximums while you were covered under Plan A will carry forward to your Plan B benefits, and vice versa.
- All the rules governing Plan A short hours self-payments apply to Plan B self-payments, including the four-quarter limit on the number of consecutive full self-payments you can make.
- If your maximum self-pay period ends while you are covered under Plan B, you will be eligible to elect COBRA coverage for Plan B benefits. (Your maximum 18-month COBRA period begins with the first day of the quarter for which you make a short-hours self-payment.)

Eligibility During Temporary Disability

If you are unable to perform work because of a certified disability that starts while you are eligible, you will be credited with 25 disability hours for each full week of disability for the purpose of maintaining eligibility. A “certified disability” is one for which you are receiving Weekly Loss of Time Benefits from the Fund.

If you remain totally disabled for more than the 26-week period for which Loss of Time Benefits are payable, the Fund will continue granting you disability hours for up to another 26 weeks if proof of total disability is submitted.

You will not be entitled to disability hours if your disability begins during a coverage quarter for which you made a full 300-hour self-payment, unless you were available for work, not turning down calls, and eligible for SUB Fund benefits, or would be eligible for SUB Fund benefits had you not already received the maximum state unemployment benefits available.

Your eligibility for disability hours will end if:

1. You recover from your total disability and/or return to work;
2. You lose eligibility for Loss of Time benefits before receiving 26 weeks of benefits; or
3. You fail to provide evidence of disability, such as a doctor's statement.

Eligibility During Permanent and Total Disability

If you continue to be totally disabled beyond 52 weeks, you can continue receiving disability hours for up to 30 months following the initial date of your disability, provided that you are receiving or applying for a Social Security Disability award.

You are not entitled to this extension if you elect COBRA coverage.

Your benefits will terminate on the last day of the month through which the 30 months of disability hours extended your eligibility, unless you qualify for Retiree Benefits. Your coverage will end sooner if your disability ceases or you fail to provide evidence of disability, such as a copy of your application for a Social Security Disability award.

If you recover from your total disability and/or return to work, then your eligibility will be based on the requirements for continued eligibility and not based on the initial eligibility requirements for new participants.

It is your sole responsibility to provide initial and continuing evidence of your disability in a timely manner. Any correspondence sent from the Fund Office is a courtesy. Receipt or non-receipt of such correspondence does not in any way obligate the Fund, the Trustees or the Administrator.

Reciprocity

The I.B.E.W. uses the Electronic Reciprocal Transfer System (ERTS) for reciprocity transfers. If you want this Fund to be your home fund when you travel outside its jurisdiction, you should register with ERTS. You can register online at any I.B.E.W. Local Union office. You cannot be given proper credit for your reciprocity hours until you register with ERTS.

When Eligibility Ends

Your eligibility will end:

1. At the end of the coverage quarter for which you do not have the required credited hours, unless you make a correct and timely short-hours self-payment or COBRA self-payment. Coverage quarters end on March 31, June 30, September 30 and December 31.
2. If you are eligible due to short-hours self-payments, at the end of the last coverage quarter corresponding to the contribution quarter for which you made self-payments, or were permitted to make self-payments. (You can make full self-payments for a maximum of four successive quarters.)
3. If you are eligible under the rules governing extended eligibility due to temporary disability or permanent and total disability, the end of the coverage quarter corresponding to the contribution quarter for

which you had sufficient credited hours (disability hours plus hours for which an employer made contributions) to satisfy the eligibility requirements.

4. The date you enter the armed forces, unless you are entitled to make and do make self-payments for continued coverage.
5. The date the Trustees terminate the benefits provided by this Plan.
6. If you are making COBRA self-payments, at the end of the last day of the applicable maximum coverage period to which you were entitled and for which correct and on-time self-payments have been made or, on the date of occurrence of any of the events stated in "Termination of COBRA Coverage" on page 28, whichever occurs first.

How Eligibility Can Be Reinstated

If you lose eligibility for benefits because you do not have the required credited hours or you have not made the required self-payment, you may again become eligible as a new participant as described beginning on page 17. In no event will your eligibility be reinstated prior to the beginning of the next coverage quarter following your loss of coverage.

ELIGIBILITY FOR CLASS 3 (NON-BARGAINED-FOR) PARTICIPANTS

The eligibility rules for Class 3 (non-bargained-for) participants are governed by participation agreements between the Trustees and the employers that require contributions on a month-to-month basis.

- A participant covered by such an agreement will become initially eligible on the first day of his or her first full calendar month of employment for which the employer makes a contribution to the Fund. For example, if the employee starts work on January 15th, his or her coverage will begin on February 1. The employee will remain eligible through the end of the last month in which his or her employment terminates and for which the employer has made continuous contributions.
- Eligible Class 3 participants and their dependents will be covered under the Plan A benefit schedule, the same schedule provided for Class 1 employees and dependents. And, like Class 1, Class 3 participants are subject to the Wellness Program requirements. Failure of a Class 3 employee and spouse to comply with those requirements will result in coverage under Plan C, the non-compliance schedule, for the following year.
- The provisions governing short-hours self-payments, eligibility during disability, and retiree coverage do NOT apply to Class 3 employees. Class 3 participants and dependents can, however, make COBRA self-payments if coverage terminates due a COBRA qualifying event.

ELIGIBILITY FOR CLASS 6 (OWNERS IN FACT)

The eligibility rules for Class 6 participants (owners in fact) are governed by a collective bargaining agreement between the Union and the company. Contributions are required to be made for a specified amount for each hour worked.

- Eligibility is based on hours in the same manner as bargaining unit employees (Class 1), except that 437.5 hours are needed per quarter and the lookback rule does not apply.

- Eligible Class 6 participants and their dependents will be covered under the Plan A benefit schedule, the same schedule provided for Class 1 employees and dependents. The Wellness Program requirements apply to Class 6 – failure of a Class 6 participant and spouse to comply with those requirements will result in coverage under Plan C, the non-compliance schedule, for the following year.
- Class 6 participants CAN make self-payments for short hours under the Class 1 rules except that 437.5 hours are required instead of 300 hours.
- The Class 1 eligibility during disability and COBRA provisions, and retiree coverage do apply to Class 6 participants. However, a Class 6 participant or dependent will generally not be eligible for COBRA based upon a "reduction in hours" because 437.5 hours are required to be paid for a Class 6 participant regardless of the number of hours worked.

ELIGIBILITY FOR CLASS 7 (STAFF)

Class 7 participants are non-bargained-for employees who work in the Welfare Fund Office, or in the offices of Local 701 and its affiliated entities. Coverage for Class 7 participants is governed by participation agreements with the Trustees that require contributions on a month-to-month basis.

- Initial coverage for Class 7 participants begins on the first day of the month following one full month of employment. For example, if the employee starts work on January 15th, his or her coverage will begin on March 1. Coverage will remain in effect until the last day of the month following the month in which employment terminates. For example, if employment terminates September 15th, coverage under the Fund will terminate October 31.
- The Wellness Program requirements apply to Class 7 – failure of a Class 7 employee and spouse to comply with the requirements will result in coverage under Plan C, the non-compliance schedule, for the following year.
- The provisions governing short-hours self-payments, eligibility during disability do NOT apply to Class 7 participants, but Class 7 participants and dependents can make COBRA self-payments if coverage terminates due a COBRA qualifying event.

ELIGIBILITY FOR CLASS 11 (FACTORY SIGN) PARTICIPANTS

The eligibility rules for Class 11 (factory sign) employees are governed by a collective bargaining agreement requiring employer contributions for a specified amount on a month-to-month basis.

- An employee covered by such an agreement will become initially eligible on the first day of the month for which a monthly contribution is made, and will remain eligible through the end of the last month for which the contributions are continuously made.
- Eligible Class 11 employees and their dependents will be covered under the Plan 11 benefit schedule. Failure of a Class 11 employee and spouse to comply with the Wellness Program requirements will result in coverage under Plan 11-C, the non-compliance schedule, for the following year.
- The provisions governing short-hours self-payments, eligibility during disability and retiree coverage do NOT apply to Class 11 employees. However, Class 11 employees and dependents can make COBRA self-payments if coverage terminates due a COBRA qualifying event.

ELIGIBILITY PROVISIONS APPLICABLE TO ALL PARTICIPANTS

Family and Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) requires certain employers (but not all) to grant unpaid leave. In general, affected employers must grant you a short-term leave for specific reasons, such as the birth of a child or a serious family illness. Eligibility for this unpaid leave is determined by the employer, not by the Trustees of this Fund.

If you are granted a FMLA leave, your employer must provide the necessary documentation and make contributions to the Fund on your behalf. Failure of your employer to submit contributions on a timely basis will result in loss of coverage under this Plan.

The Fund does not determine whether or not you are entitled to a family medical leave, or whether or not your employer must make contributions during a FMLA leave.

Coverage During Military Service

Eligibility Freeze - If you are a Class 1 participant and leave employment with a contributing employer to enter active duty in the uniformed services of the United States for at least 30 days, any hours you have accumulated will be frozen during your period of active duty. If you are in one of the other eligibility classes, your coverage will be suspended during any period of active duty for which your employer is not required to continue making contributions.

After your release from active duty under circumstances entitling you to reemployment under federal law, your eligibility and accumulated hours will be reinstated on the date you return to work with a contributing employer, provided your return to work is within the time prescribed by federal law.

Self-Payments - You may also choose to make self-payments for continued coverage for up to 24 months, regardless of any coverage provided by the military or government. You will not need this coverage for yourself, but you may want to maintain coverage under this Fund for your dependents. You are only entitled to make these self-payments if you are covered under the Plan but leave covered employment for active duty in the U.S. military for at least 30 days. The payment amounts, rules and provisions for continued coverage during military leave are very similar to COBRA coverage.

Upon your return, if your frozen eligibility is insufficient to re-establish your eligibility under the regular rules, you can continue making self-payments until you re-establish eligibility under the regular rules (assuming you haven't previously reached the 24-month limit).

For Additional Information - For more information about your self-payment rights during military service, contact the Fund Office. More information about the re-employment rights of persons returning to work from the uniformed services of the United States is available from the Veterans' Employment and Training Administration of the United States Department of Labor.

ELIGIBILITY FOR DEPENDENTS OF ACTIVE PARTICIPANTS

If you meet the eligibility requirements, your dependents will be eligible for benefits under this Plan if they meet the definition of "dependent" found on page 74 of this booklet. Dependents are always covered under the same benefit plan as the participant.

Your dependents will be eligible for benefits as long as your eligibility is maintained in accordance with the participant eligibility rules and any applicable continuation of coverage rules explained in the Plan.

New Dependents

If you acquire a dependent while eligible for benefit coverage, that dependent will automatically and immediately be eligible for benefits. Adopted children are covered from the time they are placed in your home for adoption. Contact the Fund Office for the forms needed to add a new dependent to your coverage. You will be asked to send written documentation to demonstrate that the person meets the Plan's definition of a dependent. For example, you are required to submit your marriage certificate, your family's birth certificates, plus all relevant court orders.

If Both Parents Are Covered as Participants

If both you and your spouse are eligible participants under this Plan, your children are covered as dependents of both of you, and the coordination of benefits rules apply. Those rules start on page 68.

Working Spouse Rule

If your spouse works and is eligible for coverage through his or her employer (a plan in which the employer contributes some or all of the premiums), then that plan is primary and this Plan will be secondary for all your spouse's medical claims. The Plan will be secondary under these circumstances even if your spouse does not elect the employer's coverage. In such a case, the primary plan's benefit level will be deemed to be 80% of this Plan's allowable charges, and the 20% balance will be the maximum payable by this Plan.

Hardship Exemption

The 20% Plan payment rule will not apply if your spouse:

1. Has gross annual wages of less than $20,000; or
2. Has gross annual wages greater than or equal to $20,000 but less than $30,000, and must pay more than $100 per month toward the cost of the least expensive health plan offered by his or her employer.

You are responsible for demonstrating your entitlement to a hardship exemption by submitting a letter attesting to wages and cost of coverage from the employer on company letterhead. The Fund Office will determine whether a spouse with variable wages qualifies for the hardship exemption by looking at the spouse's average wages over the past 12 months.

Additional Provisions and Exceptions to the 20% Payment Rule:

1. The 20% rule only applies to your spouse's claims, not to claims incurred by your children.
2. It applies to retirees as well as active employees, but only if the retiree's spouse is still actively employed.
3. It does not apply to COBRA coverage, meaning that if your spouse terminates employment and declines COBRA, this Plan will pay its normal benefits (instead of 20%).
4. The rule only applies to medical and drug expenses. Enrollment in the employer's dental and/or vision plan is not required. (However, if your spouse does enroll in the employer's dental and/or vision programs, this Plan will coordinate benefits and pay secondary to the employer's plan.)

5. The rule applies without regard to whether or not your spouse's employer requires its employees to pay for part of the premium, whether or not the employer offers an incentive to induce employees not to enroll, and whether or not the employer offers a single-only coverage option. It also applies if the employer only offers medical coverage as an option under a cafeteria plan.
6. If this Plan pays 20% of your spouse's claims because of this rule, his or her coinsurance shares will not apply to the Plan's out-of-pocket limits, nor will the claim be paid at 100% if the applicable out-of-pocket limit was previously met by other charges.
7. No reductions will apply to a particular claim if you can demonstrate that your spouse's claim would have been denied under the employer's plan.
8. The requirement to enroll in the employer's plan will not apply if the only health plan offered by your spouse's employer is an HMO plan, and your residence is more than 25 miles outside the HMO service area.
9. If your spouse is covered under his or her employer's plan, then your spouse must receive his or her medical care in accordance with that plan's rules. This Plan will not cover the amount of the other plan's noncompliance penalties, or any charges incurred because of failure to follow the other plan's rules, including failure to use HMO providers or follow the HMO's referral procedures. (This also applies to claims for your children when your spouse's plan is primary).
10. You are required to provide accurate and timely information to the Fund about your spouse's employment status and benefit entitlement, and the Fund Office may require verification of this information from your spouse's employer.

When Dependent Eligibility Ends

The eligibility of a dependent will end on the earliest of any of the following dates:

1. The date your eligibility under the Plan ends (unless the dependent makes a correct and timely self-payment for COBRA coverage);
2. The end of the calendar month during which the person no longer meets the definition of a "dependent" as described on page 74; or
3. In the event of your death, after any accumulated eligibility has been run out. After that, your surviving spouse may make COBRA self-payments to continue coverage for himself or herself and any dependent children.

   If, upon your death, you met the eligibility requirements for retiree coverage (as described on page 30), and your surviving spouse is eligible for preretirement survivor benefits from the Electrical Workers General Pension Fund, your spouse will be able to elect and self-pay for retiree benefits after your accumulated active employee eligibility has been exhausted. If you have no surviving spouse, your eligible children who are eligible for preretirement survivor benefits from the Pension Fund can elect to make the self-payments until they no longer meet the definition of a "dependent."

COBRA CONTINUATION COVERAGE

You may elect continuation coverage as required under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") as an alternative to any other self-payment provisions provided under this Plan. If you choose COBRA Continuation Coverage (COBRA coverage), you cannot elect any other self-pay option under this Plan. If you were making short-hours self-payments, you can elect COBRA coverage at the end of your self-pay period, provided however that your maximum coverage period of 18 months will begin in the month in which you first made a short-hours self-payment.

Qualifying Event/Maximum Coverage Period

You or your dependents may continue health coverage for up to 18 months after Plan coverage would otherwise terminate due to one of the following events (called a "qualifying event"):

1. A reduction in the number of your work hours; or
2. Termination of employment for any reason other than gross misconduct.

If you or any of your dependents are disabled as defined by Social Security for the purpose of Social Security Disability benefits on the date of one of the qualifying events listed above, or if you or any of your dependents becomes so disabled within 60 days after an 18-month COBRA period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. The COBRA self-payment is higher for the extra 11 months of coverage.

Your dependent may continue health coverage for up to 36 months after Plan coverage would otherwise terminate due to one of the following "qualifying events":

1. Divorce or legal separation from you;
2. Your death; or
3. Your child's loss of dependent status by failing to meet the definition of a "dependent."

Multiple Qualifying Events

If your dependents are covered under an 18-month COBRA period due to termination of your employment or a reduction in hours, their COBRA coverage period may be extended as explained below if a second qualifying event (any of the following qualifying events) occurs during that 18-month period: your death, a child's failure to meet the definition of a "dependent," or your divorce or legal separation from your spouse.

If any of these events occur, your spouse and children (or the child) are entitled to elect COBRA coverage for up to a maximum of 36 months minus the number of months of COBRA coverage already received under the 18-month continuation.

Only a person (spouse or child) who was your dependent on the day before the occurrence of the first qualifying event (termination of your employment or a reduction in hours) is entitled to make an election for this extended coverage when a second qualifying event occurs except as follows: if a child is born to you (the eligible participant), adopted by you or placed with you for adoption during the first 18-month continuation period, that child will have the same election rights when a second qualifying event occurs as those of a person who was your dependent on the day before the first qualifying event.

It is the affected dependent's responsibility to notify the Fund Office within 60 days after a second qualifying event occurs. If the Fund Office is not notified within 60 days, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.

Special Medicare Entitlement Rule

A special rule for dependents provides that if a covered employee becomes entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of hours, the period of coverage for the employee's spouse and dependent children ends with the later of the 36-month period that begins on the date the covered employee became entitled to Medicare, or the 18- or 29-month period (whichever applies) that begins on the date of the employee's termination of employment or reduction of employment hours.

Your Notification Responsibilities

If a child loses dependent status or if you get divorced from your spouse, you or your dependent must notify the Fund Office within 60 days of any of these events or within 60 days of the date coverage for the affected persons would terminate, whichever date is later. If written notification is not provided within these time limits, your spouse or child will not be entitled to COBRA coverage.

It is your employer's responsibility to notify the Fund Office of any other qualifying events that could cause loss of coverage. However, to make sure you are sent notification of your election rights as soon as possible, you or your dependent should notify the Fund Office any time any type of qualifying event occurs.

So that the Fund Office can give proper notification when coverage terminates, please be sure they always have the current mailing address for you and all your covered dependents.

Electing COBRA Coverage

When the Fund Office is notified of a qualifying event, an election notice and election form will be sent to you and/or your dependents who would lose coverage due to the event. The election notice tells you about your right to elect COBRA coverage, the due dates, the amount of the self-payments, etc. The election form is the form you or your dependent fills in and returns to the Fund Office if you want to elect COBRA coverage.

The person electing COBRA coverage has 60 days after he is sent the election notice or 60 days after his/her coverage would terminate, whichever is later, to return the completed election form. An election of COBRA coverage is considered to be made on the date the election form is personally delivered or mailed back to the Fund. The postmark will govern the date of the mailing.

If the election form is not returned to the Fund Office within the allowable period, you and/or your dependents will be considered to have waived your right to COBRA coverage.

Benefits Provided Under COBRA Coverage

The benefits provided under COBRA coverage are the same health care benefits for that which you or your dependents were eligible on the day before the qualifying event, except that you will not be eligible for Life Insurance, Accidental Death and Dismemberment Insurance or Weekly Loss of Time Benefits. You have the option of omitting dental and vision coverage for a lesser payment amount.

You or your dependent who is losing coverage will be required to pay the full monthly cost of health coverage as established by the Trustees. You or your dependent will have the option to continue medical benefits only or to continue medical, dental and vision benefits.

Class 1 and Class 6 participants eligible for regular (Plan A) COBRA will be given the option of electing Plan B COBRA instead, but the person's coverage option cannot be changed during his or her COBRA coverage period.

A change in the benefits provided by the Plan or the cost of coverage will apply to you or your dependent the same way it would if you were covered under the regular provisions of the Plan.

COBRA Self-Payment Rules

1. COBRA self-payments must be made monthly.
2. The amount of the monthly self-payments are determined by the Trustees based on federal regulations. The amounts are subject to change.
3. A person electing COBRA coverage has 45 days after the signed election form is returned to the Fund Office to make the initial (first) self-payment for coverage provided between the date coverage would have terminated and the date of the payment. (If a person waits 45 days to make the initial payment, one or more monthly payments may also fall due within that period and must also be paid at that time.)
4. The due date for each following monthly self-payment is the first day of the month for which payment is made. A monthly self-payment will be considered on time if it is received within 30 days of the due date.
5. If a self-payment is not made within the time allowed, COBRA coverage for all affected family members will terminate. You may not make up the payment or reinstate coverage by making future payments.

Additional COBRA Coverage Rules

1. COBRA coverage may not be elected by anyone who was not covered under the Plan on the day before the occurrence of a qualifying event.
2. Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage. However, if you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents.
3. If coverage is going to terminate due to your termination of employment or reduction in hours and you don't elect COBRA coverage for your dependents when they were entitled to the coverage, your dependent spouse has the right to elect COBRA coverage for up to 18-months for himself or herself and any children within the time period that you could have elected COBRA coverage.
4. You do not have to show proof that you and/or your dependents are insurable in order to be entitled to COBRA coverage.

Termination of COBRA Coverage

Normally COBRA coverage for a covered person will terminate at the end of the last month of the applicable maximum coverage period to which the person was entitled and for which correct and on-time self-

payments were made. However, COBRA coverage for a covered person will terminate before the end of the applicable maximum coverage period when the first of the following events occurs:

1. A correct and on-time payment is not made to the Fund;
2. The IBEW Local 701 Welfare Fund no longer provides group health care coverage to any participants;
3. If the person has been receiving extended COBRA coverage for up to an additional 11 months due to his/her or another family member's disability, and Social Security has determined that he or the other family member is no longer disabled;
4. The person becomes covered under another group health plan as a participant or otherwise after his/her COBRA election date; or
5. The person becomes entitled to Medicare after his or her COBRA election date.

Alternatives for Coverage Other than COBRA

There may be other coverage options for you and your family. You are now able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

ELIGIBILITY FOR RETIREE COVERAGE

QUALIFYING FOR THE RETIREE PLAN

You must meet the following requirements in order to qualify for post-retirement benefits from the IBEW Local 701 Welfare Fund:

1. You must be receiving an Early, Regular or Disability Pension from the Electrical Workers General Pension Fund (the "Local 701 Pension Fund");
2. You must have been eligible for benefits from this Plan for a minimum of ten years; and
3. You must have been eligible for benefits from this Plan for at least three years out of the last five years immediately preceding your retirement.

If you meet these requirements and later become eligible as an active employee, then your eligibility as a retiree will end. Your retiree coverage will be reinstated when your active coverage ends, assuming you still meet the above requirements, not including No. 3.

PAYING FOR RETIREE PLAN BENEFITS

Although retiree coverage is subsidized by the Welfare Fund, you are required to help pay for your coverage. The amount a person must pay is based on the following components:

1. The HCP benefit from the Local 701 Pension Fund. If you are receiving an HCP benefit, you must sign over the benefit to receive coverage.

PLUS

2. A base amount under the 45,000-hour rule. Your monthly cost under the 45,000-hour rule is based on the number of lifetime hours contributed for you. If you have 45,000 or more lifetime hours, your payment under this rule is $0. If you have fewer than 45,000 hours, your monthly cost is determined as follows: *Base Amount x [1 - (Number of lifetime hours worked / 45,000)]*

   The base amount in the above formula is currently $300 per retiree, and $600 for a retiree and dependent spouse.

PLUS

3. A supplemental age rate based on your current age:

Supplemental Age Rates (Subject to Change)

Retiree's Current Age	Retiree Only	Retiree & Spouse
55	$200	$400
56	180	360
57	160	320
58	140	280

Supplemental Age Rates (Subject to Change)

Retiree's Current Age	Retiree Only	Retiree & Spouse
59	$120	$240
60 - 64	100	200
65 & over	20	40
Disability pensioner	0	0
Survivor	0	n/a

- The age 55-64 rates apply to all participants who retired on or after January 1, 2002. The 65 and over rates apply to all retirees.
- Your rates will change as you age. Rate changes are effective on the first day of the month in which your birthday occurs.
- If your spouse is covered by another employer-sponsored plan, then you do not have to make the self-payment listed in this table for your spouse. (Note: employed spouses are subject to the Working Spouse Rule – see page 24.)

PLUS

4. $160 per month to cover each child. You can cover any of your children who meet the Plan's definition of a dependent child, provided you elect coverage for them when you first elect retiree coverage. You must maintain continuous coverage for your child(ren). If coverage is dropped, it cannot be reinstated. A child's coverage will terminate when the child no longer meets the Plan's definition of a dependent, for example, on the first day of the month after the child's 26th birthday.

Summary - Each Month a Retiree Pays:

HCP
+ Base amount (45,000-hour rule)
+ Supplemental age rate (see table above)
+ $160 per child

All self-payment amounts and rates will be reviewed annually and increased as necessary to keep pace with the cost of providing the coverage.

Examples

1. Dan retires at age 65 with over 45,000 lifetime hours. Dan will turn over his HCP benefit to the Fund, and because he has more than 45,000 hours, he will not have to pay any portion of the base amount. However, because Dan has a 63-year old spouse, he will be required to pay $40 per month for his retiree benefits (see chart above).

2. Henry retires at age 55 with 30,000 lifetime hours. He has a spouse but no dependent children. In addition to signing over his HCP, Henry will be required to pay:

Base amount (45,000 hour rule):
$600 x [1 - (30,000/45,000)] = $200

Supplemental age rate:
Retiree age 55 and spouse = $400

Henry's TOTAL monthly self-payment = $600

Applying for Retiree Coverage

You must apply to the Fund Office no later than 30 days after the date of your retirement. You will become covered as a retiree on the later of the first day of the month following your retirement or the first day of the month after your application for retiree coverage has been filed.

Self-Payment Due Date

Retiree self-payments are due by the first day of the coverage month. Your payment will be deducted from your monthly pension check to insure that your coverage will not be terminated due to a late or forgotten payment.

BENEFITS PROVIDED TO RETIREES

Benefits for retirees are the same medical, dental, vision and hearing benefits as Plan A, the benefit schedule covering most active participants. A $2,500 retiree Life Insurance benefit is included. Weekly Loss of Time Benefits are not provided.

With respect to **prescription drug benefits**:

- **Pre-Medicare -** Before a retiree or the dependent of a retiree becomes eligible for Medicare, his or her prescription drug benefits will be the same as benefits provided under Plan A for active participants.
- **Post-Medicare -** Once a retiree or the dependent of a retiree becomes eligible for Medicare, his or her prescription drug benefits will be provided through the Fund's insured Medicare Part D prescription drug plan. See "Medicare Part D Prescription Drug Plan (PDP) for Retirees" on page 55 for more information.

> When a retiree or a dependent of retiree becomes eligible for Medicare, they MUST start using the Medicare Part D (PDP) plan. Call the Fund Office immediately if you need the applicable I.D. cards, and be sure to give your two new cards to your pharmacist.

DEPENDENT ELIGIBILITY FOR RETIREE PLAN BENEFITS

You can include your spouse and children in your retiree coverage if they meet the Plan's definition of a dependent and you make the required self-payments for their coverage.

If you marry after you become eligible for retiree coverage, you may add and self-pay for your new spouse effective the first day of the third calendar month after the date of your marriage, provided you notify the Fund Office of your remarriage within 90 days of the marriage. If the first day of the third month is more than 90 days after your marriage, your new spouse's effective date will be the first day of the second calendar month following your marriage.

You may NOT add your new stepchildren to your retiree coverage.

In the Event of Your Death

If your surviving spouse is covered under the Plan when your death occurs, your spouse may continue to self-pay for retiree coverage for your spouse and any eligible surviving children until your spouse remarries.

TERMINATION OF RETIREE COVERAGE

Your eligibility for retiree coverage will end on the first to occur of the following events:

1. On the day you reestablish eligibility as an active participant;
2. Six months after you return to active employment; or
3. On the last day of the last month that the Fund Office received your correct and timely self-payment.

Your dependent's retiree coverage will end on the first to occur of the following events:

1. On the day your coverage ends;
2. On the last day of the month that he or she no longer meets the definition of a "dependent" described on page 74;
3. On the last day of the last month for which he or she fails to make a correct and timely self-payment to the Fund Office;
4. On the last day of the month in which your death occurs, unless your surviving spouse is eligible to continue making self-payments for continued retiree coverage;

   Your surviving spouse and/or child may postpone or suspend this Plan's retiree coverage if he or she is eligible to enroll in another group health plan. In such case, that person's retiree coverage 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 coverages;
5. If your surviving spouse is making self-payments to continue retiree coverage after your death, on the last day of the month that he or she remarries; or
6. On the last day of the month in which your child, including your surviving child whose coverage is being continued after your death, fails to meet the definition of a dependent, or, if earlier, when your surviving spouse's coverage terminates (for example, if she remarries).

COBRA Coverage for Divorced and Surviving Spouses and Terminated Dependent Children

If a divorce or legal separation from your spouse occurs while your spouse is eligible for retiree coverage, or in the event of your death, he or she is entitled to elect COBRA coverage for a maximum coverage period of up to 36 months after the date coverage would otherwise terminate due to the divorce or legal separation. The same applies to a child who loses coverage because he or she no longer meets the Plan's definition of a dependent (at age 26 for example).

The dependent's maximum COBRA period starts with the date of the divorce, loss of dependent status or your death, whichever is applicable. Any coverage granted under the Plan's regular provisions for survivors of retirees will offset the person's 36-month COBRA period. A surviving spouse whose retiree coverage terminates early due to remarriage can continue coverage under COBRA if the remarriage occurs before he or she has had 36 months of regular survivor coverage.

COBRA coverage provides the same class of benefits that the person was eligible for when the COBRA qualifying event occurred. Eligibility for Medicare or another group plan does not affect a person's initial

entitlement to elect COBRA. However, if the eligibility for that coverage occurs after COBRA coverage starts, then COBRA coverage will terminate.

It is the responsibility of the affected dependent spouse to notify the Fund Office of the date of the divorce, legal separation, birthday, death or remarriage within 60 days of the event, or within 60 days after Plan coverage would otherwise terminate, whichever date is later. Failure to provide notification within the time limits will result in the denial of COBRA coverage.

INSURANCE COVERAGE

LIFE INSURANCE

Life Insurance benefits are governed by an insurance policy through Union Labor Life Insurance Company. This section is a summary of the policy provisions. If there is any discrepancy between the policy and this summary, the policy will govern.

Life Insurance benefits are provided for active eligible participants, their eligible dependents, and eligible retirees. These benefits are not payable for employees who are making self-payments for Plan B, or for employees and retirees who are making self-payments for COBRA coverage. Dependent Life Insurance is not provided for Class 11 participants.

Life Insurance for Employees and Retirees

If you die from any cause, your designated beneficiary or beneficiaries will receive the amount of the Life Insurance benefit specified in your Schedule of Benefits.

Designating a Beneficiary

In order to designate your beneficiary or beneficiaries, you must file a written "Designation of Beneficiary" form supplied by the Fund Office. You can change your beneficiary or beneficiaries at any time, unless you make an irrevocable designation of beneficiary. Beneficiary designations will be effective on the date you sign the form. The Fund Office is not responsible for any benefit payments made before a new beneficiary designation is received.

If you don't designate a beneficiary or beneficiaries, or if none of your designated beneficiaries outlive you, your Life Insurance benefit will be paid equally to the members of the first appropriate class, in the following order:

Your spouse;
Your children, including legally adopted children;
Your parents;
Your brothers and sisters; or
Your estate.

In the event of your death, your beneficiary must provide the Fund Office with proof of your death **within 90 days**.

Dependent Life Insurance (Active Participants Only)

In the event of the death of your eligible spouse or child, the amount of Dependent Life Insurance stated in your Schedule of Benefits will be paid to you, the active participant. You should provide proof of your loss to the Fund Office within 90 days of your dependent's death.

If a dependent other than a newborn is hospitalized on the date the dependent would otherwise become insured for this benefit, the effective date of that person's Dependent Life Insurance coverage will be postponed until the hospital discharge date.

Note: Dependent Life Insurance is not provided under Class 11.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (ACTIVE PARTICIPANTS ONLY)

Accidental Death and Dismemberment (AD&D) Insurance is provided for active employees only. It is not provided to employees who are making self-payments for Plan B or COBRA.

If you accidentally die or suffer the loss of sight in both your eyes, or the loss of two limbs, or the loss of one limb and sight of one eye, the benefit is payable as shown in your Schedule of Benefits. If you accidentally suffer the loss of one hand or foot or the sight of one eye, the benefit payable will be one-half of the amount shown in your Schedule of Benefits.

The amount paid for accidental death (loss of life) is in addition to the amount of your Life Insurance benefit. If you suffer any combination of the losses as the result of one accident, only one amount (the largest) is payable for all losses. The amount payable for all losses resulting from any one accident cannot be more than the amount shown in your Schedule of Benefits.

The loss must occur within 90 days of an accidental injury which occurs while you are covered under the Plan and must result solely from that injury.

Your beneficiary for loss of life under this benefit is the same beneficiary as for your Life Insurance. If you change your beneficiary for your Life Insurance, you automatically change your beneficiary for this benefit.

AD&D claims must be submitted to the Fund Office within 90 days of your loss.

Exclusions and Limitations

1. Benefits are not payable if you are 70 years of age or older.
2. No payments will be made under this benefit for any loss which results directly or wholly from:
    a. Intentionally self-inflicted injury or suicide or attempted suicide, while sane or insane;
    b. Bodily or mental infirmity, ptomaines, bacterial infections, (except pyogenic infections occurring simultaneously with or through an accidental cut or wound) or any other disease;
    c. Committing an assault or a crime punishable as a felony; or
    d. Bodily injury or sickness caused by: war or any act of war, whether war is declared or undeclared; or participation in, or the result of participation in, a riot or insurrection or a civil commotion.

WEEKLY LOSS OF TIME BENEFIT

Eligibility for Loss of Time Benefits

Weekly Loss of Time Benefits are disability benefits for active employees covered under Plan A or Plan C (only). Benefits are not provided for employees in Plan 11, or for employees who are making self-payments for Plan B or COBRA. Retirees and dependents are not eligible for Loss of Time Benefits.

If your total disability starts before your effective date of eligibility, your Loss of Time Benefits will not begin until after your initial eligibility date. Benefits are also not payable if your disability begins during a coverage quarter for which you made a full 300-hour self-payment, unless you were available for work, not turning down calls and eligible for SUB Fund benefits.

Definition of Totally Disabled - Benefits are payable if you are "totally disabled," which means you are wholly and continuously disabled by an accidental bodily injury or an illness which prevents you from working at your occupation, and which requires the regular care and attendance of a legally qualified physician. The disability must begin while you are eligible for benefits as an active participant.

Non-Occupational Disabilities

If your disability is due to a non-occupational cause, benefits will begin on the first day of a disability due to accidental bodily injury and on the fourth day of a disability due to an illness.

The benefit amount will be equal to 2.5% of your reported earnings for the twelve (12) consecutive months preceding the month in which your disability begins, up to the maximum shown in your Schedule of Benefits. "Reported earnings" are wages paid by a contributing employer (whether or not contributions were made to the Fund). No other earnings will be counted, even if the result is a lower weekly benefit because you have fewer than 12 months of reported earnings.

Occupational Disabilities

If your disability is due to occupational causes, benefits will begin on the first day of a disability due to an accidental bodily injury and the eighth day of a disability due to an illness. Loss of Time Benefits for occupational causes is payable up to the maximum shown in your Schedule of Benefits.

Length of the Loss of Time Benefit

The maximum number of weeks payable for any one period of disability is 26 weeks.

Successive periods of disability resulting from or contributed to by the same or related causes will be considered one continuous period of disability unless the second period of disability starts after you have returned to active full-time employment for at least 30 days.

If the second period of disability is due to an injury or illness entirely unrelated to the cause of the first disability and begins after you have returned to work for a contributing employer for one full day of active full-time employment, then the second disability will begin a new period of disability.

If you have two or more disabilities at the same time while receiving disability benefits, the benefits payable for all of the disabilities will be limited to a maximum of 26 weeks. Successive periods of disability due to injuries received in one accident will be considered one period of disability.

How Benefits Are Paid

Loss or Time benefit checks are issued every two weeks, and are made payable to you, the disabled participant.

Benefits will be paid at a daily rate of one-fifth of the weekly benefit during partial weeks of disability. As required by federal law, your share of the applicable taxes will be deducted from each disability benefit check. You may also elect to have federal income taxes withheld from your check beginning with the fifth week of disability.

Exclusions and Limitations

Loss of Time Benefits are not payable for any disability during which you are not under the direct care of a legally qualified physician. You are required to provide the Fund Office with updated certification of the continuation of your disability upon request. You may also be required to submit to an independent medical examination.

Loss of Time Benefits are not payable for any period of time:

- After you retire;
- During which you are actively working for any employer; or
- For which you are receiving state unemployment benefits.

Longer Periods of Disability

If you continue to be disabled beyond 26 weeks, your Loss of Time Benefits will cease, but you could continue receiving disability hours for up to 30 months following your original disability date. Your disability hours will count the same as worked hours for the purposes of maintaining your eligibility while you are disabled. Refer to the rules starting on page 19 for additional information.

MEDICAL BENEFITS

Your medical benefits cover most reasonable health care expenses (with certain deductibles, co-payments and limitations) that you and your family may have, whether treatment, services and supplies are received in or out of the hospital. The following sections describe these benefits and explain how they work.

MAJOR MEDICAL BENEFIT

The Major Medical Benefit pays the majority of medical expenses that you or your dependent may have for a non-occupational illness or injury up to the reasonable and customary charge.

Preferred Provider Organization (PPO)

The Plan's hospital and physician preferred provider organization (PPO) is the Blue Cross Blue Shield of Illinois Labor Account. The national Blue Card network is for out-of-state services. If you use an in-network (PPO) provider you can save significant out-of-pocket expenses. You can obtain up-to-date information about PPO providers by either calling Blue Cross Blue Shield of Illinois at 1 800-810-BLUE or going to www.bcbsil.com and clicking on "Labor Accounts."

Pre-Certification and Utilization Review (UR)

- **Inpatient Hospitalization -** If your physician recommends an inpatient hospital stay, you must call the Plan's utilization review (UR) organization for pre-certification before hospitalization begins.

  Maternity stays do not require pre-authorization unless they exceed 48 hours following a normal delivery and 96 hours following a Cesarean section.

  In the case of an emergency admission, the Plan's UR organization must be contacted within 2 business days.

  The pre-certification requirement also applies to residential treatment facility and skilled nursing facility care.

  > If you do not call the Plan's utilization review (UR) organization at 1-800-367-1934 for pre-certification of inpatient care, residential treatment facility care, skilled nursing facility care, or inpatient or outpatient surgery, the benefits normally payable on your claim will be reduced by $100. The facility or provider will usually make the call for you, but it is ultimately your responsibility to see that the UR organization is contacted for pre-certification.

- **Surgery -** Any time you have any surgery, whether inpatient or outpatient, and whether provided in or out of the PPO network, you must call the Plan's UR organization for pre-certification. If you do not, the benefits normally payable on your claim will be reduced by $100.

  You do not have to pre-certify a routine (screening) colonoscopy.

  > Note: The Plan does not cover charges for outpatient surgery performed in surgical centers that are not in the PPO network.

- **Physical and Occupational Therapy -** Physical or occupational therapies which exceed 12 visits (for all related conditions) require pre-authorization through the Plan's UR organization.
- **Mental Health/Substance Abuse -** Partial hospitalization and intensive outpatient programs that exceed 12 visits (for all related conditions) also require pre-authorization through the Plan's UR organization.
- **Other Medical Services -** The Fund Office may submit other types of claims to the UR organization in order to obtain qualified professional medical opinions concerning the medical necessity or appropriateness of the treatment.

> If you are unsure about whether a proposed service will be covered, ask your provider to have it pre-certified. You can also call the Fund Office and ask for more information.

Wellness Program

The Fund wants to promote wellness and healthy lifestyles, and to encourage participants to obtain regular medical exams and screenings. Therefore, each year you and your spouse will be asked to submit written verification from your doctor that you had comprehensive lab screenings. If you and your spouse do not submit timely verification of your lab screenings, your family's medical benefits will be subject to the lower level of benefits shown in the Plan C Schedule of Benefits. (Persons normally covered under Plan 11 will be covered under Plan 11-C if the participant and spouse fail to comply.)

All participants will receive a notice outlining the types of lab tests required and the due date for submitting their doctor's verification. The Fund does not need your lab results!

Spouses who have their own health care coverage through their employers do not have to comply with the wellness requirements. Persons for whom Medicare is the primary plan are also exempt.

Your Out-of-Pocket Costs

Annual Deductible

- **Individual Deductible -** The individual deductible is the amount of covered charges that you or your dependents must pay each calendar year before the Plan pays its percentage share. The amount of the deductible is stated in your Schedule of Benefits.

  Any expenses applied against your individual deductible in the last three months of a calendar year will also be carried over and applied against your deductible for the next calendar year. Carryover only applies to individual deductibles – there is no carryover for the family deductible.

- **Family Deductible -** The Plan provides a maximum family limit on deductibles as stated in your Schedule of Benefits. After amounts totaling the maximum family deductible have been deducted from covered charges of two or more members of the same family toward satisfaction of their individual deductibles during a year, no further amounts will be deducted from any of that family's covered charges for the rest of that year.

Emergency Room Deductible

A $200 emergency room (ER) deductible will apply to each incident of emergency room treatment at an in-network or out-of-network hospital. The ER deductible will be waived if the patient is admitted to the hospital as an inpatient directly from the emergency room, or if the condition treated meets the Plan's definition of an emergency (see page 75). ER deductibles apply in addition to the calendar year deductibles.

The emergency room deductible is not a penalty – it is a cost-sharing provision. Participants are required to share an additional portion of the cost of ER treatment because it is much more costly than an office visit.

PPO Office Visit Co-Payments

The Plan pays 100% for the cost of office visits with in-network (PPO) physicians after you pay a $25 co-payment per visit. The annual deductible does not apply. The same $25 co-pay applies to visits with primary care doctors and specialists. The co-pay applies only to the charge for the office visit itself, not to any additional services or procedures. All additional services are subject to the deductible and in-network coinsurance percentage.

Coinsurance

For most other medical expenses, the Plan pays a percentage after your deductible is satisfied. You pay the remaining percentage (called your "coinsurance") until your out-of-pocket limit is met. The payment percentages and out-of-pocket limits that apply to you are listed in the Schedule of Benefits for your benefit class.

Out-of-Pocket Limits

If the amounts of your deductible, co-pays (PPO office visits and prescription drugs) and coinsurance together total the amount of your out-of-pocket limit for a calendar year, the Plan will pay 100% of the covered charges you incur during the remainder of that calendar year. There are separate out-of-pocket limits for in-network and out-of-network charges. The amounts of your out-of-pocket limits are listed in your Schedule of Benefits. Amounts that are applied to the in-network out-of-pocket limit do NOT apply to the out-of-network limit, or vice versa.

The following charges do NOT apply toward your out-of-pocket limits:

- Charges over the allowable or reasonable and customary charge, or, in the case of out-of-network professional providers, charges in excess of 120% of Medicare's allowable amount;
- Non-covered charges, including amounts in excess of a Plan limit or dollar maximum;
- Penalty amounts for not obtaining the required pre-authorization; or
- With respect to prescription drugs, the difference in cost between the brand and generic drug when the mandatory-generic rule applies.

Once you reach the in-network out-of-pocket limit in a calendar year, the Plan will pay 100% of covered in-network medical and prescription expenses you incur during the rest of the year. Similarly, covered out-of-network medical expenses will be paid at 100% if you reach your out-of-network out-of-pocket limit in a calendar year. Note that charges in excess of the allowable or reasonable and customary charge will NOT be paid at 100% if your out-of-pocket limit is met.

Benefit Maximums and Limitations

Some types of medical services are subject to limitations and maximum benefits. These limitations are shown in your Schedule of Benefits.

Balance Billed Out-of-Network Charges

Because out-of-network providers do not have fee arrangements with the Fund or Blue Cross Blue Shield, they may bill you for amounts in excess of the Plan's allowable charge limit. For out-of-network professional fees, the Plan's allowable charge is 120% of Medicare's allowable charge. Billing the patient for charges over the allowable charge is called "balance billing."

Covered Medical Expenses

Covered charges under the Major Medical Benefit are the reasonable and customary charges for the following medically necessary services and supplies received for the treatment of a non-occupational illness or injury:

1. **Ambulance** services as follows:

   a. *Local ambulance* transportation to a hospital, including medically necessary inter-facility transfers.

   b. *Air ambulance* by a licensed air ambulance from the location of a sudden illness or injury to the nearest hospital where emergency treatment can be provided, but only if the following requirements are satisfied:

   - The patient requires immediate medical attention; and
   - The patient's condition is such that no other mode of transportation could be used without endangering the patient's life or seriously endangering the patient's health.

   If air ambulance charges do not meet all of the above criteria, benefits will be limited to what the Plan would have paid for transportation by ground ambulance.

2. **Anesthesia** and its administration, blood, blood plasma, oxygen and rental of equipment for its administration.

3. **Chiropractic** services billed by a chiropractic practitioner, *including physical therapy, x-rays and diagnostic imaging*, up to the annual maximum shown in your Schedule of Benefits.

4. **Clinical trials -** The patient costs for a covered person enrolled in an approved clinical trial. An "approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition that is federally funded or approved; or conducted under an investigational new drug application reviewed by the Food and Drug Administration; or a drug trial that is exempt from having such an investigational new drug application.

   A "life-threatening condition" is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

   "Routine patient costs" include all services and supplies that are typically covered by the Plan for persons not enrolled in clinical trials. Routine patient costs do NOT include the investigational item, device or service itself; services that are provided solely to satisfy data collection and analysis needs, or services that are clearly inconsistent with the widely accepted and established standards of care.

5. **Corrective refractive surgery, such as Lasik** and other procedures to correct refraction (vision) up to the maximum shown in your Schedule of Benefits. (These procedures are not covered under the Plan 11 and 11-C Schedules of Benefits.)

6. **Dental-related services -** Services of a dentist or dental surgeon for:
   a. The *repair of damage to the jaw and sound natural teeth*, including replacement of such teeth, that is the direct result of an accident, provided such treatment is rendered within twelve months of the accident;
   b. Surgical removal of partially or completely *bony impacted teeth*; or
   c. Treatment and/or replacement of *congenitally missing teeth*, including dental implants, up to the per-person lifetime maximum for all such services specified in your Schedule of Benefits.
7. **Diagnostic tests,** including x-rays, laboratory examinations and diagnostic scans. Note that covered expenses for MRIs, CT scans and PET scans are paid at 100% if you use Absolute Solutions, the Plan's preferred imaging provider. See the inside front cover of this booklet for contact information.
8. **Durable medical equipment -** Rental up to purchase price, or purchase if the purchase cost is expected to be less than the cost of renting, of physician-prescribed equipment that meets the Plan's definition of durable medical equipment (page 75). The equipment must be prescribed and used to improve the functions of a malformed part of the body or to prevent or slow further decline of the patient's medical condition. The physician must certify in writing the medical necessity for the equipment, and state the length of time the equipment will be required. The Plan may require proof at any time of the continuing medical necessity of any item. You should pre-certify durable medical equipment with the utilization review organization to ensure that the equipment and duration of use meets the Plan's medical necessity criteria.
9. **Foot orthotics** that are custom-made and prescribed by a physician or podiatrist, up to two pairs every three calendar years if medically necessary. You should pre-certify orthotics with the utilization review organization to ensure that they meet the Plan's medical necessity criteria.
10. **Home health care** services when ordered by the patient's physician and provided by a home health agency in lieu of an inpatient hospitalization, up to the maximum number of visits shown in your Schedule of Benefits. The Plan covers the following services:
    a. Part-time or intermittent home nursing care from or supervised by a registered nurse;
    b. Part-time or intermittent home health aide services;
    c. Physical therapy and occupational therapy, subject to Plan limitations for these services;
    d. Speech therapy, if necessary as result of a stroke or traumatic brain injury, subject to Plan limitations; and
    e. Medical supplies, drugs and medications prescribed by a physician, and laboratory services, but only to the extent that they would have been covered in a hospital or skilled nursing facility.

    Each visit of four hours or less from a member of a home health agency team is considered one visit.

    You should pre-certify home health care with the utilization review organization to ensure that it meets the Plan's medical necessity criteria.
11. **Hospice** care furnished by a hospice agency to a terminally ill patient for a maximum period of 180 days. A terminally ill patient is a patient who has been diagnosed by a physician as having a life expectancy of six months or less. Hospice care will only be covered if the care is being case managed by the Plan's review organization.

12. **Hospital** services and supplies as follows:

    a. *Room and board* charges up to the hospital's regular daily semi-private rate, or for confinement in an intensive care unit, up to the hospital's average charge for daily intensive care. Private rooms are covered if the hospital is a private-room-only facility, or if a private room is certified as medically necessary by the attending physician for isolation of a communicable disease.

    b. *Ancillary inpatient hospital services and supplies*, including drugs and medicines that are required for treatment of the covered person.

    c. *Newborn nursery room and board*, miscellaneous services and supplies, and doctors' services for healthy newborn infants during the initial hospital confinement after birth.

    d. *Emergency treatment* provided in a hospital outpatient or emergency department.

    e. *Outpatient* services and treatment.

    You should pre-certify inpatient care and outpatient surgery with the review organization.

13. **Infertility -** Tests and examinations to identify the cause or causes of infertility, and infertility treatments, up to the maximum benefit shown in your Schedule of Benefits. (Donor, storage and surrogacy services are excluded, as is pre-implantation testing of embryos for in vitro fertilization.) Infertility-related expenses are not covered for children of any age.

14. **Intensive outpatient or partial inpatient therapy** performed by licensed mental health or substance abuse clinicians with Masters' degrees or higher. Pre-certification is required after 12 combined visits or days (for all related medical conditions).

15. **Medical supplies** including surgical dressings, casts, splints, braces and crutches when provided or prescribed by a physician. Prescription back braces are covered up to a maximum of two every twelve months. You should pre-certify back braces with the utilization review organization to ensure that they meet the Plan's medical necessity criteria.

16. **Nutrition counseling -** Three individual (one-on-one) visits with a licensed nutritionist who is in the PPO network, when recommended by a physician for a person with diabetes, Crohn's Disease or celiac disease. (Note that one diet counseling visits for an adult at risk for cardiovascular disease is covered under the Preventive Benefit.)

17. **Obesity** treatment as follows:

    a. *Physician-supervised medical treatment* for obesity, including office visits, related laboratory tests, nutritional counseling by a licensed nutritionist, and FDA-approved prescription weight loss medications, up to the maximum benefit shown in your Schedule of Benefits. Exercise and/or diet programs, and food products and nutritional supplements of any kind are not covered. (Note: The Plan also provides benefits for certain obesity management programs under the Preventive Benefit.)

    b. *Surgical treatment* of obesity if the following criteria are met:

    - The patient has a Body Mass Index (BMI) of at least 40;
    - The obesity is 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 is performed in a Blue Cross PPO facility; and
- Before surgery is performed, the utilization review organization approves 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.

18. **Outpatient surgery** performed at an in-network (PPO) surgical center. You should pre-certify outpatient surgery with the review organization.

The Plan does not cover outpatient surgery performed at an out-of-network (non-PPO) surgical center, except when Medicare is primary and covers that facility.

19. **Physical therapy** performed by a licensed physical therapist (P.T.), physical therapy assistant (P.T.A.), and occupational therapy performed by a licensed occupational therapist (O.T.) or occupational therapy assistant (O.T.A.). Pre-certification for physical and/or occupational therapy is required after 12 combined visits (for all related medical conditions).

20. **Professional services** of a physician or surgeon.

    Professional services of an assistant surgeon are covered when required due to the complexity of the procedure.

    The Plan may also cover services and supplies of other licensed, qualified medical professionals who are performing the same types of clinical services that would be covered if rendered by a physician, provided those services are performed within the scope of the practitioner's license, certification and training. See page 77 for more information.

21. **Podiatry**.

22. **Pregnancy** expenses, including medically appropriate prenatal screening tests, and charges made by an attending physician during a birth or delivery of a newborn if the charge is required by the hospital.

    Prenatal genetic testing as follows, provided the tests are medically necessary and within the Level A recommendations established by the American College of Obstetrics and Gynecology (ACOG):

    a. First or second trimester screening tests for fetal aneuploidy disorders (e.g., Down Syndrome), or specific inherited disorders such as cystic fibrosis and sickle cell disease; and

    b. Follow-up diagnostic tests for the same conditions if an initial screening indicates a likelihood of a genetic defect.

    The Plan excludes screening and testing: a) of family members, b) by multiple methods for the same disorder(s), c) multigene panels for diseases such as cancer, d) tests to determine the child's gender or hereditary predispositions (predictive tests), and e) home testing kits. Pre-certification by the Plan's utilization review organization is recommended.

All prenatal genetic tests are NOT COVERED. You cannot assume that the tests will be covered just because the obstetrician recommends them.

23. **Prescription drugs,** medicines and supplies that are covered by the Plan but cannot be purchased through the Prescription Drug Program, such as drugs for obesity, infertility, and necessary supplies for diabetics or after any type of ostomy surgery (e.g. colostomy, ileostomy).

24. **Prosthetics** such as artificial limbs and artificial eyes, and conventional monofocal intraocular lenses following cataract surgery (but not multifocal lenses), including restoration or adjustment to prosthetic devices. You should pre-certify prosthetics with the utilization review organization.

25. **Radiation therapy and chemotherapy**.

26. **Residential treatment facility -** Treatment provided in a facility that meets the Plan's definition of a covered residential treatment facility and is located in the State of Illinois or in the state in which the patient is a resident or is a full-time college student. The Trustees will only grant an exception to these requirements if evidence is submitted that compliance with these requirements will present a hardship to the participant or patient. Note that not all facilities in Illinois will meet the Plan's qualifications – you should call the Fund Office before admission. The Plan will cover no more than 45 days for all related confinements. Confinements are considered "related" if they are for the same or related medical condition and are not separated by a twelve-month period during which the person received no treatment for that condition (other than maintenance medications).

    Residential treatment must be pre-certified by the review organization.

27. **Skilled nursing facility -** Treatment provided in a skilled nursing facility, up to a maximum of 45 days for all related confinements, provided that:

    a. The confinement begins within 14 days of a hospital confinement of at least three consecutive days;

    b. The confinement is due to the same or related causes as the hospital confinement;

    c. A hospital confinement would otherwise be needed;

    d. The confinement has been pre-certified by the review organization; and

    e. The facility must be in the State of Illinois or in the state in which the patient is a residence or is a full-time college student. The Trustees will grant exceptions only if evidence is submitted that compliance with this rule will present a hardship to the participant or patient. Note that not all facilities in Illinois will meet the Plan's qualifications – you should call the Fund Office before admission.

    The maximum room and board rate is limited to 50% of the semi-private room rate at the hospital at which the person had been a patient just prior to the skilled nursing facility confinement.

    Confinements are considered "related" if they are for the same or related medical condition and are not separated by a twelve-month period during which the person received no treatment for that condition (other than maintenance medications).

28. **Speech therapy** for correction of a congenital anatomic defect; or restoration or correction of normal speech that was lost as a result of a disease or injury.

In addition, the Plan will cover up to 40 speech therapy visits per calendar year for a child under age 12 for treatment of autism spectrum disorders, cerebral palsy or another congenital neurological or anatomical disorder, a hearing deficit caused by an illness, or dysphagia. Any visits in excess of 40 in a calendar year will not be covered.

To be covered, speech therapy must meet the following requirements:

a. It must require one-on-one sessions with a licensed speech-language pathologist;

b. It must be prescribed by a medical doctor (M.D. or D.O.); and

c. If the speech therapy is for a child, periodic progress reports must be submitted to show that the treatment:

- Continues to have measurable goals and objectives that require the skills of a trained speech-language therapist;
- Is not for drill and practice that can be performed at home; and
- Is not, other than incidentally, aimed at improving the child's school performance.

The Plan will NOT cover speech therapy for developmental and psychosocial delays, learning and educational problems, attention disorders, behavioral problems, verbal apraxia, or stuttering or stammering unless due to a specific disease or injury.

It is recommended that you pre-certify speech therapy services to ensure that they meet the Plan's medical necessity criteria.

29. **TMJ -** Services, supplies, or appliances to treat temporomandibular joint syndrome (TMJ).

30. **Transplants -** Organ and tissue transplants. Organ donor expenses will also be covered if the recipient is covered under the Plan, and the Plan will cover the tests and screenings for up to six potential donors per transplant procedure.

31. **Vasectomy -** Charges incurred for a voluntary vasectomy. (Female sterilization procedures are covered under the Preventive Benefit.)

32. **Urgent or immediate care** treatment at a licensed urgent care facility.

33. **Wig -** One wig for a chemotherapy patient, up to a maximum allowable amount of $500.

PREVENTIVE BENEFIT

The Plan covers a wide range of preventive services for eligible participants and their dependents. Those services are listed below.

- All covered preventive services provided by an in-network (PPO) provider will be paid at 100% with no deductible.
- Out-of-network services are subject to the deductible, out-of-network coinsurance, and allowable charge limitations.

- Most of the services in this list are determined by federal agencies. However, this Plan covers many preventive services in addition to the mandated coverages.
- All items listed are subject to change.

IMMUNIZATIONS
(Adults and Children)

Covered Immunization	Frequency
Diphtheria, tetanus and pertussis (DtaP)	As recommended by the Advisory Committee on Immunization Practices (ACIP) and that have been adopted by the Director of the Centers for Disease Control and Prevention, including: • Recommended Immunization Schedule for Persons Aged 0 Through 6 Years • Recommended Immunization Schedule for Persons Aged 7 Through 18 Years • Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind • Recommended Adult Immunization Schedule *Note: Immunizations for work or travel purposes are not covered.*
Hepatitis A (HepA)	
Hepatitis B (HepB)	
Human papillomavirus (HPV)	
Influenza (seasonal)	
Influenza type B (Hib)	
Measles, mumps & rubella (MMR)	
Meningococcal (MCV)	
Pneumococcal (PCV/PPSV)	
Polio (IPV)	
Rotavirus (RV)	
Varicella	
Zoster (shingles)	

ADULTS
(Age 19 and Older Unless Stated Otherwise)

Covered Service or Supply	Frequency
Abdominal aortic aneurysm ultrasound screening (men age 65-75 who smoke(d))	as determined by patient's physician
Alcohol misuse -brief behavior counseling	as determined by patient's physician
Blood pressure screening	one per calendar year
Cholesterol screening (men age 35+, or age 20+ if increased risk; women age 45+, or age 20+ if increased risk)	one per calendar year
Colorectal cancer screening (adults age 50-75), including colorectal exams, flexible sigmoidoscopies, barium enemas, and colonoscopies. Colonoscopy coverage includes medically indicated sedation/anesthesia, pathology and medically appropriate pre-screening specialist consultation.	within American Cancer Society age & frequency guidelines
Depression screening	as determined by patient's physician
Diabetes screening (adults with blood pressure greater than 135/80)	one per calendar year
Diet counseling (adults at increased risk for cardiovascular disease)	one per lifetime
Hepatitis B and Hepatitis C screening for persons at high risk	as determined by patient's physician
HIV screening	as determined by patient's physician
Lung cancer screening with low-dose CT for ages 55+ with history of smoking	one per calendar year
Obesity screening, and if patient is obese, up to 26 face-to-face counseling sessions with doctor (M.D./D.O.) or behavior therapist (Masters' or better) specializing in weight loss	on course of treatment per calendar year
Sexually transmitted infections counseling (adults at increased risk)	as determined by patient's physician
Skin cancer behavioral counseling (to age 24)	one per lifetime
Syphilis screening (persons at increased risk)	one per calendar year
Tobacco use intervention	two 90-day attempts per calendar year, consisting of four 10-minute counseling sessions

ADULTS
(Age 19 and Older Unless Stated Otherwise)

Additional Services Covered by the Fund	
Routine physical exam, including medically appropriate routine screening tests not already listed above (including male PSA test). Exam must be provided by medical doctor (M.D. or D.O.), physician's assistant (P.A.) or nurse practitioner (N.P.).	one per calendar year
Pharmacy Products	
Aspirin to prevent cardiovascular disease (men age 45-79; women age 55-79), when prescribed by physician	generic aspirin covered based on physician's recommendations
Bowel preps for a covered preventive colonoscopy	as prescribed - generics and OTCs only
Tobacco use interventions	all physician-prescribed medications (including OTCs) for two 90-day quit attempts per year
Vitamin D supplements for adults age 65 and older who are at increased risk of falling	as determined by patient's physician - generics only

FEMALES
(Childbearing Age or Older)

Covered Service or Supply	**Frequency**
BRCA testing and counseling (women with a family history of BRCA 1 or BRCA 2 risk factors)	once per lifetime
Breast cancer screening (women age 40+)	one per calendar year
Breastfeeding support, supplies (including rental of standard (non-hospital grade) breast pump), and counseling.	as needed, including up to 6 visits with a lactation specialist. Breast pump rental limited to R&C for purchase price.
Cervical cancer screening	one per calendar year
Chlamydial infection screening (women age 24 or younger or at increased risk)	one per calendar year
Contraception (non-oral)—FDA-approved contraceptive methods for women (IUDs, Depo Provera, etc.) that require a prescription, *excluding* birth control pills, which are covered as described below, but including surgical sterilization. Also applies if purchased at a pharmacy.	as prescribed
Contraceptive counseling	one office visit per calendar year
Domestic and interpersonal violence screening	one per calendar year
Gonorrhea screening (women at increased risk)	one per calendar year
HPV DNA testing	every three years starting at age 30
Mammograms (women age 40+)	one per calendar year
Osteoporosis screening (women age 60; age 55 if increased risk of osteoporotic fractures)	as determined by patient's physician
Preconception and prenatal care. *"Prenatal care" means routine doctor visits, and does not include delivery, tests, ultrasounds or care for high risk pregnancies.*	as prescribed
Prenatal screening for anemia, bacteriuria, gestational diabetes, Hepatitis B, HIV and other infections, Rh incompatibility and syphilis	one each per pregnancy
Well-woman preventive care visit to obtain the recommended preventive services that are age and developmentally appropriate,	one per calendar year
Pharmacy Products	
Aspirin for pregnant women at high risk for preeclampsia	as prescribed - generics only
Breast cancer chemoprevention drugs (women age 35 and over at high risk)	as prescribed - generics only
Folic acid supplements (women capable of pregnancy)	0.4 to 0.8 mg (400 - 800 µg) per day - generics only

FEMALES
(Childbearing Age or Older)

Oral contraception—FDA-approved oral medications (birth control pills)—as prescribed.	as prescribed. Generics and brands without generic equivalents = 100% retail and mail. All others = regular co-pays apply

CHILDREN
(Through 18 Years Unless Stated Otherwise)

Covered Service or Supply	Frequency
Alcohol/drug assessment	as recommended by the American Academy of Pediatrics and Bright Futures
Anticipatory guidance	
Autism screening	
Behavioral assessment	
Cervical dysplasia screening	
Developmental screening	
Dyslipidemia screening	
Health history	
Hemoglobin screening	
Lead screening	
Measurements, including height, weight, BMI, blood pressure, etc.	
Metabolic screening	
Oral health risk assessment	
Physician examination	
Sensory (vision and hearing) screening	
STI/HIV screening	
Tuberculin testing	
Depression screening (children age 12 and older)	as determined by patient's physician
Fluoride varnish to primary teeth for children under age 5	one per lifetime
Hepatitis B screening (adolescents at high risk)	one per lifetime
HIV screening (children age 11 and older)	as determined by patient's physician
Newborn screenings for hemoglobinopathies, hearing loss, hypothyroidism, phenylketonuria (PKU), and heritable disorders (as recommended by the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children that went into effect May 21, 2010)	one each per lifetime
Obesity screening and counseling (children age 6+)	as determined by patient's physician
Sexually transmitted disease screening and counseling (adolescents)	as determined by patient's physician
Skin cancer behavioral counseling (age 10+)	one per lifetime
Tobacco use education and brief counseling to prevent initiation of tobacco use in school-aged children and adolescents	one per lifetime
Visual acuity screening (children <5 years)	one per calendar year
Additional Services Covered by the Fund	
Well-baby and well-child exams, check-ups, tests, school and sports physicals. Exams must be provided by medical doctor (M.D. or D.O.), physician's assistant (P.A.) or nurse practitioner (N.P.).	within frequency guidelines established by the American Academy of Pediatrics, or as required by the child's school
Pharmacy Products	
Iron supplements (children age 6-12 months at increased risk for anemia)	as prescribed by patient's physician
Oral fluoride (children 6 months+ if water source deficient in fluoride)	as prescribed through age 5
Prophylactic medication for gonorrhea (newborns)	once per lifetime

PRESCRIPTION DRUG PROGRAM

Prescription drug benefits for Medicare-eligible retirees and dependents of retirees are NOT provided through the program described below. Instead, benefits are provided through a separate Plan-sponsored Medicare Part D plan. Information about the Part D plan will be provided to persons covered by that program. (A brief summary is provided on page 55.)

The Plan's Prescription Drug Program is administered by Sav-Rx, a pharmacy benefit manager, in accordance with a contract with the Trustees. Your co-pay amounts are listed in the Schedule of Benefits applicable to your benefit plan.

YOUR CO-PAYS

Your co-pay amounts or percentages are shown in the Schedule of Benefits for your benefit class. Co-pays vary depending on your benefit plan, whether the drug is a generic, preferred brand or non-preferred brand. Co-pay amounts also vary according to where you purchase the drugs, and the quantity purchased.

- **30-Day Retail Card Program -** Your prescription retail card enables you to purchase covered prescription drugs at any participating pharmacy. The 30-day retail card program is for short-term or acute prescription drugs, such as antibiotics or pain relievers. All the large retail pharmacy chains, and most independent pharmacies participate in the Sav-Rx network.
- **Mail-Order Program -** The mail-order program is for long-term or maintenance prescription drugs, the prescription medications you take on an on-going basis for chronic conditions such as high blood pressure, heart disease, diabetes, arthritis, etc. For each prescription refill, you can order the amount prescribed by your physician up to a 90-day supply.

  When your physician prescribes a long-term or maintenance medication, you must use a retail pharmacy for the first two short-term fills (each fill can be for up to a 30-day supply) of that medication. *You must use the mail-order or 90-day retail option for the fourth and all subsequent fills.*

- **90-Day Retail Program -** You also have the option of obtaining your long-term or maintenance (90-day) prescriptions from any Walgreen pharmacy under the 90-day retail program. Your co-pays will be higher than the mail-order co-pays because the cost of drugs purchased at the retail level is higher than the cost of the mail-order pharmacy.

Out-of-Pocket Limit for Drug Co-Pays

For all benefit plans other than Plans 11 and 11-C, the out-of-pocket limits under the Major Medical Benefit and the Prescription Drug Program are integrated. This means that your prescription drug co-pay amounts apply to the in-network out-of-pocket limit under the medical plan. If your out-of-pocket limit is met during a calendar year, your prescription drug co-pays will be $0 for the remainder of that year. Similarly, if your family's in-network out-of-pocket limit is met, your eligible family members will have no prescription drug co-pays for the remainder of that calendar year. The out-of-network out-of-pocket limit will apply if you incur a covered prescription drug expense at out-of-network pharmacy

Plans 11 and 11-C have a separate out-of-pocket limit for prescription drugs. The amount of the individual and family out-of-pocket limits for prescription drugs are shown on the applicable Schedule of Benefits.

Drugs that are excluded from coverage, including the difference in cost between the brand and the generic drug when the mandatory-generic rule applies, do not apply to out-of-pocket limits.

When There Is Other Prescription Drug Coverage

Most pharmacies are automatically able to coordinate coverage between two prescription drug plans. If not, you should use your primary plan's drug program. If this Plan is the secondary plan, co-pays from the primary plan can be submitted to the Fund Office for consideration under the coordination of benefits provisions.

If You Do Not Use a Participating Pharmacy

If you or your dependents elect not to use the Prescription Drug Program, you may submit a claim for a covered prescription drug to Sav-Rx, the Plan's pharmacy benefit manager, who will re-price the prescription based on their negotiated rate, and reimburse you for a portion of the cost. Contact the Fund Office for more information.

CLINICAL MANAGEMENT PROGRAMS

Mandatory Generic Substitution

If a covered person declines an available federally-rated generic substitute, the individual will be responsible for the difference in cost between the brand and the generic drug in addition to the brand-name co-pay. The additional payment amount will not apply to the person's individual or family out-of-pocket limit.

The difference in cost between the brand and the generic will be waived if the prescription benefit manager determines the use of the brand to be medically necessary based on the receipt of a letter of medical necessity from the prescribing physician.

Mandatory Mail-Order for Long-Term Medications

When your physician prescribes a long-term or maintenance medication, you must use a retail pharmacy for the first two short-term fills (each fill can be for up to a 30-day supply) of that medication. You must use the mail-order or 90-day retail option for the fourth and all subsequent fills.

Specialty Drugs

Specialty drugs require pre-certification by Sav-Rx. In addition, each fill is limited to a 30-day supply, and in most cases must be purchased through Sav-Rx's dedicated specialty pharmacy. The types of medications considered to be "specialty drugs" for this purpose are determined by Sav-Rx and are subject to change.

Prior Authorizations

Certain drugs that are not classified as specialty drugs may also require review and prior authorization by Sav-Rx to determine if the drugs are medically necessary and are being prescribed and used in accordance with accepted medical practice as well as federal guidelines. Medications in this category include, but are not limited to, oral and topical pain medications, topical dermatologics, central nervous system stimulates, and androgens.

Non-Sedating Antihistamines (NSAHs)

Your over-the-counter (OTC) non-sedating antihistamines (NSAHs), such as Claritin, Allegra and Zyrtec, are covered under the Plan's prescription drug program for the generic co-pay if you have a doctor's prescription.

Prescription NSAHs will not be covered without prior authorization by the Sav-Rx clinical team. In order to obtain a prior authorization, the prescribing physician must certify that the patient has previously tried OTCs but did not achieve the desired therapeutic benefit.

Step Therapy for Proton Pump Inhibitors (PPIs)

A step therapy program applies to proton pump inhibitors (PPIs), the class of drugs used to reduce gastric acid. This program requires patients who are being treated on a long-term basis with PPIs to try less costly, over-the-counter (OTC) and generic PPIs first. OTCs will be covered for the generic co-pay if there is a written doctor's prescription.

COVERED DRUGS

This program covers drugs and medicines that require a physician's written prescription to be dispensed by a licensed pharmacist. The Plan also covers insulin and diabetic supplies, and certain prescription and over-the-counter-products covered under the Preventive Benefit. (See the list of covered preventive services and supplies that starts on page 47.)

PRESCRIPTION DRUG PROGRAM EXCLUSIONS AND LIMITATIONS

The following are not covered under the Prescription Drug Program, regardless of whether you or your dependent has a physician's prescription:

1. Over-the-counter (non-prescription drugs), except for non-sedating antihistamines (NSAHs) and proton pump inhibitors (PPIs) with a written doctor's prescription.
2. Experimental, investigative or inappropriate drugs.
3. Drugs to treat infertility or obesity. (These drugs are covered under the Major Medical Benefit – not under the Prescription Drug Program – and are subject to the limits listed in your Schedule of Benefits. You must file a claim with the Fund Office to receive these benefits.)
4. Drugs for treatment of sexual dysfunction except for prescription erectile dysfunction drugs for 12 months after a nerve-sparing radical prostatectomy. In addition, until June 30, 2017, there is a trial program permitting coverage for on-demand erectile dysfunction drugs if erectile dysfunction is the result of a medical condition, such as diabetes or hypertension and prior authorization is obtained from Sav-Rx. Coverage is for up to four doses per month with a patient co-pay of 70%. The program may be extended by the Trustees if it is deemed desirable. In addition, daily dose prescription erectile dysfunction drugs, such as Cialis®, prescribed for benign prostatic hyperplasia (BPH), are covered subject to ordinary co-pays if prior authorization is received from Sav-Rx. There is no current expiration for the prescriptions described in the previous sentence.
5. Drugs for growth disorders (except when pre-authorized by the utilization review organization for treatment of an illness).

6. Drugs filled at Wal-Mart and Sam's Club pharmacies.
7. Drug supplies to replace lost or stolen medications, or refills earlier than allowed.
8. Any drug for the treatment of any condition, sickness, or injury that is excluded under the Plan, as specified on pages 64-67.

The exclusions above are not directly applicable to the Medicare Part D Plan (PDP). The PDP plan has its own set of exclusions and limitations.

MEDICARE PART D PRESCRIPTION DRUG PLAN (PDP) FOR RETIREES

The prescription drug benefits for participants with primary coverage through Medicare – this applies to all retirees and their dependents – are provided through the Plan-sponsored UnitedHealthCare Medicare prescription drug plan (PDP), an insured group Part D plan, with a supplemental plan provided through Sav-Rx. Because of the supplemental benefit (called a "wraparound" benefit), participant co-pays can be kept low, with no donut hole or additional deductible.

How it Works

The two plans work together behind the scenes to coordinate benefits with no additional enrollment requirements or claim filing on the participant's part. All PDP plan participants have to do is use two prescription ID cards instead of one.

UnitedHealthCare and Sav-Rx will provide you with information concerning your co-pays, covered and non-covered drugs, and instructions for using the mail-order and specialty pharmacies. (Although the PDP program has been developed to mirror the Plan's active prescription drug program, it is governed by federal rules, so certain differences are unavoidable.)

UnitedHealthCare and Sav-Rx will handle customer service, prior authorizations and appeals.

UnitedHealthCare will be your primary prescription drug plan, and Sav-Rx will provide supplemental coverage.

When a retiree or a dependent of retiree becomes eligible for Medicare, they MUST start using the Part D (EGWP) plan. Call the Fund Office immediately if you need the applicable I.D. cards, and be sure to give your two new cards to your pharmacist.

Enrollment Is Automatic

You will automatically be enrolled in the new program when Medicare becomes your primary plan. Except for using your two new I.D. cards, you do not need to take action in order to continue accessing your prescription drug benefits.

You have the option to NOT participate in the PDP. However, if you decline to participate, you will not have any prescription coverage through the IBEW Local 701 Fund. In that case, your self-payment for this Fund's retiree coverage will NOT be reduced, and you will need to obtain creditable drug coverage elsewhere. If you do not enroll in creditable coverage without a gap in coverage, you may be subject to a late enrollment penalty. To disenroll, call the Fund Office at 1-630-393-1701, prompt #3.

MEMBERS ASSISTANCE PROGRAM (MAP)

The Member's Assistance Program (MAP) is part of your health and welfare benefit. Members and their eligible dependents have access to professional counselors. The MAP can help you with:

Depression
Stress
Anxiety
Financial issues
Smoking cessation
Many other person problems

Early intervention in the treatment or psychological and substance abuse programs has been shown to improve the overall quality of people's lives.

If you think you need help in any of these areas, call the MAP first. MAP personnel can help you directly, and, if needed, help you find additional supportive resources and services.

Note that if you are referred for other services by MAP, Med-Care Management must pre-certify all inpatient treatment, including treatment at residential treatment facilities, and all partial inpatient and intensive outpatient treatment after 12 days/visits.

The sooner you call, the sooner the MAP can help!!! The Members Assistance Program office is located in the IBEW Local 701 union building, in Suite 1120. Their direct phone number is 1-630-791-2673.

All MAP services are strictly confidential.

DENTAL BENEFIT

Dental Network of America (DNoA)

The Fund has an agreement with Dental Network of America (DNoA), who is a dental preferred provider (PPO) network administrator, an affiliate of Blue Cross Blue Shield of Illinois. DNoA offers the DNoA Preferred Network, which is a large network of participating dentists who have agreed to charge negotiated fees that are lower than what these dentists normally charge.

You will save money on your family's dental bills when you use DNoA dentists.

This is a voluntary program—you are not required to use a DNoA dentist, and your benefits won't be reduced if you use a non-participating dentist.

How Dental Benefits Are Determined

When you or any of your dependents have expenses for covered dental charges, the Plan will pay a specific percentage of such covered charges up to the calendar year maximum shown in your Schedule of Benefits. The annual maximum does not apply to preventive and routine services (those paid at 100%) for children under age 19.

Preventive and Routine (100%)

1. Prophylaxis, or cleaning, which may be done by a dental hygienist, twice per calendar year.
2. Oral examination and diagnosis which may be done twice per calendar year.
3. X-rays, if necessary (full mouth x-rays once every three calendar years).
4. Topical fluoride applications for dependent children under age 19 once per calendar year.
5. Sealants for dependent children under age 19.
6. Periodontal prophylaxis, up to four per calendar year. (Periodontal cleanings will count toward the two regular cleanings that are allowed per year.)

Minor Restorative (80%)

1. Emergency treatment for relief of pain.
2. Restorative services, including amalgam, synthetic, porcelain and plastic fillings.
3. Endodontics, including pulpal therapy and root canal filling.
4. Oral surgery, including extractions. Note: Covered charges for surgical removal of partially or completely bony impacted teeth are covered under the Major Medical Benefit. Tissue-only impactions are covered under the Dental Benefit.
5. Periodontics, including treatment for disease of gums.

Major Restorative (50%)

1. Gold restorations when the teeth cannot be restored with another filling material.
2. Crowns, inlays, onlays and jackets when the teeth cannot be restored with a filling material.
3. Prosthetics such as bridges, partial dentures and complete dentures.
4. Implants.
5. Replacement prosthetics, such as crowns, bridges, dentures and implants, are covered if dentally necessary, provided the original prosthetic is at least five years (60 months) old.

Orthodontia

If your Schedule of Benefits includes orthodontia coverage, the Plan will pay 50% of the necessary treatment up to the maximum benefit on your schedule. Orthodontia benefits are only payable for dependent children, and only if the treatment begins while the child is under the age of 19.

Date of Incurral

For payment purposes, treatment is considered to have been incurred on the date the service is rendered. However, for the following services that require more than one visit, the incurral date is considered to be: 1) for full or partial dentures, when the impression is taken for the appliances; 2) for root canal therapy, when the tooth is opened; and 3) for fixed bridgework, crowns and other gold restorations, when the tooth is first prepared.

Dental Benefit Exclusions

Covered dental charges do not include charges for:

1. Any treatment or service not prescribed by a dentist or oral surgeon.
2. Services and supplies that are cosmetic in nature, including charges for bleaching or whitening of teeth, or personalization or characterization of dentures.
3. Services, supplies or appliances provided in connection with the jaw, any jaw implant or the joint of the jaw (the temporo-mandibular joint).
4. Periodontal splinting.
5. Replacement of a removable prosthetic due to loss or damage.
6. Adjunctive tests for oral cancer screening (for example, Vizilite).
7. Any treatment or service excluded under the provisions of “General Plan Exclusions and Limitations,” beginning on page 64.

VISION BENEFIT

Vision Benefits are not provided under Plan B, the low-option self-pay plan.

The Plan offers two options for receiving your vision benefits – a preferred provider program through National Vision Administrators (NVA), and an "indemnity" (scheduled out-of-network) program. Because of the discounts available through NVA, you will usually get a better value by using an NVA provider. The benefits provided under both programs are shown in your Schedule of Benefits.

Covered Vision Charges

Covered vision charges include the following:

1. Complete examinations by a licensed optometrist or ophthalmologist once per calendar year.
2. Frames – one pair every two calendar years.
3. Lenses – one pair of eyeglass lenses per calendar year, or one or more sets of contact lenses in lieu of eyeglass lenses. Benefits for contact lenses are limited to the annual allowance shown on your Schedule of Benefits. Lenses must be prescribed by a licensed optometrist or ophthalmologist.
4. Safety glasses for active participants – one pair each calendar year.

Vision Benefit Exclusions

No payments will be made for:

1. Sunglasses (unless prescribed to be worn substantially at all times).
2. Routine yearly examinations required for employment.
3. Special procedures (such as vision training) or special supplies.
4. Anti-reflective coatings.
5. Medical or surgical treatment of the eye.
6. Two pairs of glasses instead of bifocals.
7. Any treatment or service excluded under the provisions of "General Plan Exclusions and Limitations," beginning on page 64.

Extension of Vision Benefits

Vision Benefits will be continued under the Plan if you have ordered glasses, frames or lenses, and coverage subsequently ends, as long as these glasses, frames or lenses are picked up within 30 days after coverage ends.

HEARING BENEFIT

Covered Expenses and Benefits

When you or any of your dependents have charges for a hearing examination recommended by a physician and performed by an audiologist or certified hearing specialist, the Plan will pay up to the amount shown in your Schedule of Benefits. Hearing exams are covered once every two calendar years.

When you or any of your dependents have charges for a hearing aid instrument as a result of the related examination provided by an audiologist or by someone who is certified to dispense hearing aids, the Plan will also pay up to the amount shown in your Schedule of Benefits. One hearing aid per ear is covered every three calendar years.

For the purpose of this benefit, a "hearing aid" is a wearable instrument designed for the ear for the purpose of compensating for impaired hearing. It excludes other assisted listening devices such as amplifiers and FM systems.

Hearing Benefit Exclusions

No payment will be made for:

1. More than one examination in a two-consecutive-year period.
2. Hearing aids not prescribed by a physician and provided by an audiologist or one certified to dispense hearing aids.
3. Hearing examinations or hearing aids required by an employer in connection with the person's occupation.
4. Charges made by a speech pathologist or any charges for speech therapy, speech readings or lessons in lip reading.
5. Charges for rental or purchase of amplifiers.
6. Replacement of a hearing aid due to theft, loss or any other reason within three consecutive years of purchasing and receiving the hearing aid.
7. Any treatment or service excluded under the provisions of "General Plan Exclusions and Limitations," beginning on page 64.

SPECIAL FUND PROGRAM

The Special Fund program is a health reimbursement account (HRA). It covers a wide range of healthcare expenses not payable by the regular health care Plan. Special Fund accounts can also be used to make active and retiree self-payments when you lose eligibility or retire.

The Special Fund program is administered by a third party HRA program administrator in accordance with the terms of a contract with the Fund. The HRA administrator will provide eligible participants with additional information about how to use the program, and a debit card that can be used to cover your co-pays at medical facilities, offices and drug stores.

Your Special Fund Account

When you work for an employer that participates in the Special Fund program, a separate contribution will be made on your behalf and credited to your individual Special Fund account.

You determine how and when to use your account. You can choose to use it to pay for qualified expenses or other services not covered by the regular Plan, or to make self-payments to continue coverage.

The amount in your Special Fund account rolls over from year to year and will remain available to you until you need it, subject to the forfeiture rule described below.

Qualified Expenses

Qualified expenses are costs incurred for medical care as defined under Section 213(d) of the Internal Revenue Code. Qualified expenses include, but are not limited to:

- Medical expenses, including deductibles and coinsurance
- Prescription drug co-pays
- Dental services, including deductibles, coinsurance, and non-covered services
- Home modifications and equipment to accommodate a disabled person
- Infertility treatment
- Vision expenses
- Hearing care expenses
- Active and retiree self-payments to this Plan
- Premiums for other healthcare plans
- Medicare Part B premiums
- Medigap policies
- Electronic body scans
- OTC drugs (doctor's prescription required)
- Weight loss programs
- Residential homes for care of an intellectually or developmentally disabled dependent
- Certain transportation expenses to receive specialized treatment

For a complete list of qualified Special Fund expenses, refer to IRS Publication 502 for the tax year in question.

In addition, medical expenses are only covered under this program if the expenses are:

1. Incurred on or after January 1, 2017;
2. Not reimbursable by this Plan, another health plan, or any other party;
3. Incurred for you or a dependent while the person is covered under the Plan, and in the case of a dependent, incurred while you can claim the person as a dependent under federal income tax rules; and
4. Not claimed as deductions on your or a dependent's federal income tax return.

Every time you are reimbursed from your Special Fund for a qualified expense, the amount of the reimbursement will be deducted from your account balance.

Examples of Excluded Expenses

Your Special Fund account can NOT be used for any charges that are incurred either prior to January 1, 2017, by a person who is not eligible for regular Plan benefits, or that are not considered by the IRS to be deductible medical expenses. Items which the IRS does not consider deductible medical expenses include but are not limited to the following:

- Air purifiers or humidifiers
- Burial expenses
- Child or elder care
- Clothing
- Cosmetic surgery
- Electrolysis
- Food/dietary supplements
- Hair transplants
- Health club memberships
- Household help
- Infant formula
- Personal trainers
- Premiums for life insurance or loss of income insurance
- Swimming, horseback, dancing lessons, etc.
- Vitamins, minerals
- Weight loss machines

In addition, please note that because of federal rules, you cannot use your account for expenses incurred when you (or the dependent) are/were not covered under the regular medical plan.

How to Use Your Special Fund

Paperless Options - The HRA administrator offers several paperless claim-submission options. You can use your debit card or upload claims through their website. Information about these options will be sent to participants who are eligible for this program.

If you receive a balance due statement from a doctor or hospital and want to use your Special Fund account to pay for it, you can write your debit card account number on the statement just like you would if you were paying with a credit or debit card. Note that you must wait until this Plan has processed the claim before you can pay the unpaid balance from your Special Fund account.

Some purchases will require documentation to substantiate that the expense is covered under this program. The HRA administrator will contact participants through the online participant portal if additional documentation is required.

Paper Claims - You can also submit paper claims to the HRA administrator. Claim forms are available on their website.

Call the third party HRA administrator at 1-877-282-8665 if you have any questions about how to use your debit card, your account balance, eligible expenses, or how to file claims.

Self-Payments to this Fund - You can also use your Special Fund account to make self-payments for active or retiree coverage, or to pay COBRA premiums to this Fund. Contact the Fund Office for information on how to authorize these types of payment(s) from your account.

Reimbursements - Unless you use your debit card to pay a provider directly, reimbursement checks will be issued by the HRA administrator and made payable to you, the participant. Benefits cannot be assigned to a provider.

Claim Filing Time Limit - Special Fund reimbursement requests can be submitted to the HRA administrator at any time; however, such requests must be received no later than the end of the calendar year following the calendar year in which the expense was incurred.

More Information About the Special Fund Program

Tracking Your Account Balance - You can track your account activity online securely through the HRA administrator's website: www.tasconline.com.

Additional Cards - Additional cards for your other family members are free. Call the HRA administrator or go to their website if you need another debit card.

When You Retire - Your Special Fund account balance is not forfeited when you retire, provided you remain eligible for benefits under this Plan as a retiree.

In the Event of Your Death or Disability - Death or disability benefits cannot be paid from your Special Fund. However, in the event of your death, the balance in your account can be used by your surviving spouse or eligible dependents to make self-payments to continue their coverage, and for their qualified expenses as long as they remain covered under the Plan.

Forfeiture for Inactivity - Your Special Fund account can only be forfeited due to inactivity. An account will be considered inactive if it has a balance of less than $100 and no account activity for the prior two years (24 months). An account with a balance of $100 or more will be forfeited after four years (48 months) with no activity. "No account activity" means no employer contributions into the account and no withdrawals out of the account for qualified expenses.

Special Fund Accounts Are Not Vested - The Special Fund program is not a pension plan or bank account. You are not vested in the balance. Because this is a health and welfare benefit, all amounts in individual accounts remain general assets of the IBEW Local 701 Welfare Fund. The Trustees reserve the right to eliminate or modify this program at any time and in their sole discretion.

Opt-Out Option - Federal law requires that participants have the option to opt out of this program. If you want to opt out and forfeit your account balance, you can do so at any time. Opting out is permanent, and any future employer contributions made on your behalf will revert to general Fund assets. Contact the Fund Office if you need more information about opting out.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

No benefits are provided for any of the following:

1. Any charges for an **abortion**, except when the life of the mother would be endangered if the fetus were carried to term or when medical circumstances warrant an abortion.
2. **Adoption** expenses.
3. Any charge or portion of a charge that is determined to be in excess of the amount considered to be the **allowable charge** (as defined on page 74).
4. **Alternative, complementary or non-standard treatments**, such as acupressure, aversion therapy, hair analysis, herbal treatments, hippotherapy, holistic treatments, homeopathy, hypnosis, meditation, mind-body stress management, naprapathy, naturopathy, relaxation therapy, soft-tissue manipulative therapy or yoga.
5. Any treatment or service resulting from service in the **armed forces**, unless the person is legally required to pay such charge.
6. **Claims filed later** than the time frame allowed. For medical, dental and Special Fund claims, this means the calendar year following the year in which the claim was incurred.
7. **Cosmetic** surgery and treatment, except for:
    a. *Treatment of injuries* sustained in an accident, provided the treatment is received within five years or the accident (unless a delay is medically necessary); and
    b. *Breast reconstruction* following a mastectomy, including surgery and reconstruction of the non-affected breast in order to produce a symmetrical appearance, prosthesis and treatment of any physical complications of all stages of the mastectomy, including lymphedema.
8. **Court-ordered** treatment unless the treatment is medically necessary.
9. Treatment of injuries sustained while committing (or in the act of committing) a **crime punishable as a Class X, 1 or 2 felony**.
10. **Custodial care**, which shall include services and supplies, including room and board and other institutional services that are provided to a person, whether disabled or not, primarily to assist him/her in activities of daily living, except as specifically provided as hospice or home health care under the Major Medical Benefit.
11. The cost to repair or replace **damaged, lost, missing or stolen** equipment, prosthetics or medications.
12. **Dental services** and supplies rendered for treatment of the teeth, the gums (other than for tumors, or cysts that are not the result of infections to the teeth or gums) or other associated structures primarily in connection with the treatment or replacement of teeth, including treatment rendered in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, unless the charges are for services rendered for the repair of accidental injury to sound natural teeth within twelve months of the accident, or are specified as payable under the Dental Benefit.
13. **Drug testing** for employment purposes or when court-ordered.

14. Unless specifically stated as covered, services or supplies provided for the purpose of **education or training**, regardless of the type or purpose of the education, the recommendation of the attending doctor or the qualifications of the individual providing the education.

15. Any treatment or service due to an illness that is covered by a Workers' Compensation Act or other similar legislation, or due to any injury arising out of or in the course of **employment** for profit, except for treatment or services for asbestosis.

16. **Environmental control devices** such as air conditioners, humidifiers, dehumidifiers, or purifiers, even if recommended by a physician.

17. Any expenses for services or treatments that are **experimental, investigative or inappropriate** (as defined on page 75) based on medical circumstances and/or the advanced stage of a covered person's illness or the likelihood that the service or treatment will measurably improve the covered person's illness or medical condition.

18. **Eyeglasses or eye examinations** for the correction of vision or fitting of glasses, except as specifically provided under the Vision Benefit, or with respect to refractive surgery, when covered under the Major Medical Benefit.

19. **Food, nutritional supplements or vitamins**. Exceptions:

    a. The Plan will cover physician-prescribed enteral or parenteral nutrition administered in accordance with a treatment plan that has been approved and is being managed by the utilization 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.

    b. In certain cases, and when pre-approved by the utilization 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 an inborn error of metabolism. If the Plan's criteria are met, coverage will be provided for up to 12 months at the out-of-network payment percentage.

20. **Genetic testing**, unless such testing is performed in connection with an actual treatment plan for a diagnosed illness, for certain prenatal testing as specified under the Major Medical Benefit, or unless covered under the Plan's Preventive Benefit. Note that not all prenatal genetic testing is covered – see page 45 for more information. Carrier testing, pre-implantation testing of embryos, hereditary predisposition testing, prenatal tests to determine gender, and home testing kits are not covered.

21. **Hearing aids** or the fitting thereof, except as specifically provided under the Hearing Benefit.

22. **Marijuana**, whether or not prescribed by a doctor.

23. **Marriage counseling**, or family counseling that is not for direct treatment of an illness.

24. Any charge for services, treatments or supplies after the maximum benefit has been paid or **maximum limitation** has been reached for that type of treatment or service on behalf of that individual.

25. Any treatment, service or supply furnished by a person residing within the individual's home, or who is a **member of the individual's immediate family** (a spouse, child, stepchild, brother, stepbrother, sister, stepsister, parent, or stepparent of the individual or spouse).

26. An **MRI in lieu of a mammogram** because the patient has had cosmetic breast surgery.
27. Services provided by a **non-covered provider** based on the Plan's definitions and coverage provisions. For example, the Plan does not cover skilled nursing facilities or residential treatment facilities that do not meet the Plan's definitions of these facilities. In addition, the Plan does not cover the services or alternative medicine providers such as massage therapists, herbalists or naturopaths.
28. Expenses for services for which you would **not be legally required to pay** in the absence of coverage under this Plan or another insurance plan.
29. Any service, treatment or supply rendered when the individual was **not eligible for benefits**, including charges incurred before the individual's effective date or after the individual's coverage has terminated.
30. Treatment or services that are **not medically necessary**.
31. Any treatment, service or supply **not prescribed by a physician** for the treatment and diagnosis of an illness or injury, unless the service is specifically stated as covered.
32. Any treatment or service for **organ transplants**, except as specified under the Major Medical Benefit (page 47).
33. **Physical or occupational therapy** or other therapeutic services that are provided on a group (not one-on-one) basis.
34. **Residential treatment facility** confinements in excess of 45 days for all related confinements.
35. Any **routine or preventive** charges incurred in the absence of a diagnosis, except as specifically provided under the Preventive Benefit or the Major Medical Benefit.
36. Any treatment or service to treat a **self-inflicted injury or illness** or any injury or illness resulting from a suicide or an attempted suicide, unless the injury or illness resulted from a medical condition (including both physical and mental health conditions).
37. **Sex/gender change** or reassignment surgical procedures and/or complications arising from such procedures, regardless of the reason the services are performed.
38. Any treatment for **sexual dysfunction**, including impotence or sex transferal, except for erectile dysfunction drugs as specified on page 53.
39. **Shoes** including orthopedic and corrective shoes, arch supports or shoe inserts.
40. **Skilled nursing facility** confinements in excess of 45 days for all related confinements.
41. **Special home construction or modification** to accommodate a disabled person or to facilitate the use of equipment, including but not limited to wheelchair ramps and stair lifts.
42. **Speech therapy** for developmental and psychosocial delays, learning and educational problems, attention disorders, behavioral problems, verbal apraxia, or stuttering or stammering unless due to a specific disease or injury.
43. Any treatment provided at a **surgical center that is not in the Plan's PPO network**. (This does not apply when Medicare is primary and covers the facility.)
44. **Surrogacy** or surrogacy fees, or charges for donor or storage services.

45. **Telemedicine** charges except for one-on-one real-time consultations with covered providers for services that the Plan would have covered if the same services had been provided during a face-to-face consultation.

46. **Transportation** except as specifically provided under the Major Medical Benefit.

47. Any treatment or service that is compensated for or furnished by the **United States government** or any agency thereof, unless the person is legally required to pay such charge.

48. **Vision therapy** or orthoptics.

49. Any treatment or service resulting from war or any act of **war, declared or undeclared**.

50. Treatment for **weight control or smoking cessation**, except as specifically provided under the Preventive Benefit or the Major Medical Benefit.

OTHER LIMITATIONS ON YOUR BENEFITS

COORDINATION OF BENEFITS (C.O.B.)

Benefits are coordinated when both you and your spouse and/or your dependent children are covered by this Plan as well as by another group health plan. Coordination allows benefits to be paid by two or more plans, up to but not to exceed 100% of the allowable expenses on the claim.

General C.O.B. Information

1. Benefits are coordinated on all employee, retiree and dependent claims. C.O.B. applies to medical, prescription drug, vision, dental/orthodontia and hearing benefits.

2. Benefits are coordinated with other group plans and Medicare. If you are covered under a personal individual plan for which you pay the full premiums, this Plan will not coordinate with that plan but will pay its normal benefits. Benefits are also not coordinated with Medicaid, or, in most cases, TriCare (the health care program provided by the U.S. armed service). Benefits are not coordinated with private insurance plans, or with plans that do not coordinate benefits.

3. You must file a claim for any benefits to which you are entitled from any other source. Whether or not you file a claim with these other sources, your Plan payments will be calculated as though you have received any benefits to which you are entitled.

4. Benefits are coordinated based on "allowable expenses," which are expenses that are eligible to be considered for reimbursement.

5. If a person is covered by two or more plans that provide benefits on the basis of negotiated fees, any amount in excess of the highest of the primary plan's negotiated fees is not an allowable expense. If both plans contract with the same provider, and if the provider's contract has no provision to the contrary, the lower of the two negotiated fees will be the allowable expense.

6. A plan that pays "primary" benefits is the plan that is required to pay its benefits first. The plan that pays "secondary" benefits is the plan that pays its benefits after the other plan has paid its benefits. The plan that is primary will pay benefits as if it were the only existing coverage without regard to the other plans.

When This Plan is Secondary

When this Plan is secondary, the Plan benefits normally payable will be reduced to the extent that the total amount of benefits paid by all plans will not exceed 100% of the allowable amount. The allowable amount is the in-network negotiated fee, or, for out-of-network charges, the reasonable and customary charge, for medical care or treatment that is covered at least in part by either plan.

This Plan will not pay benefits for expenses which would have been covered by another plan but which are either not paid or are subject to a reduction in benefits because the person failed to take the action required under the other plan's rules. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment, or any other required notification or procedure of the

other plan, including failing to file a claim on time, or failure to provide missing information requested by the other plan.

When this Plan pays reduced benefits due to these rules, only the reduced amount will be charged against any applicable payment limits of the Plan.

If the other plan pays benefits that should have been reduced because of coordination of benefits, the amount by which the benefits should have been reduced may be paid to the other plan. Amounts so paid will be considered benefits under this Plan.

IMPORTANT This Plan has a Working Spouse Rule under which benefits are reduced if your spouse declines to enroll in the coverage offered by your spouse's employer. For more information see page 24.

Order of Payment

If all plans have a C.O.B. provision, benefits are determined based on the first of the following rules that applies:

1. **Non-dependent or dependent -** The plan that covers the person other than as a dependent, for example as an employee or retiree, is primary, and the plan that covers the person as a dependent is secondary. (See "If There Is a Third Plan" on page 71 if the claimant is also covered by Medicare.)

2. **On claims for children -** If a child is covered under two or more plans, the following provisions determine which plan pays first:

   a. When the natural parents are married (and not separated or divorced), or when they are not married but living together, the plan covering the parent whose birthday comes first in the year will pay first and the plan covering the parent whose birthday comes later in the year will pay second (this is known as the "birthday rule").

   b. When the natural parents are separated or divorced, or are not married and not living together, benefits are payable according to any existing court decree. If there is no court decree stating who is responsible for a child's health care, the plan covering the parent with custody (if not remarried) pays first and the plan covering the parent without custody pays second. If the parent with custody has remarried, that parent's plan pays first, the stepparent's plan pays second and the plan covering the parent without custody pays third.

      The birthday rule will apply if a court decree awards joint custody without specifying that one party has the responsibility to provide health coverage, or in any other situation not addressed in the above rules.

   c. *Married and/or employed child.* If no court order applies and the child is employed and/or married, the Plan covering the child as an employee will pay first, the Plan covering the child as a spouse will pay second, and the Plan covering the child as a dependent child will pay third. This rule will not apply if the other plan uses the longer/shorter rule below.

3. **Active or inactive employee -** The plan that covers a person as an active employee is prime over a plan that covers the person as a laid-off or retired employee. The same order applies to the person's dependents.

4. **Continuation (COBRA) coverage -** If a person whose coverage is provided under a right of continuation provided by federal or state law ("COBRA") also is covered under another plan, the plan covering the person

as an employee or retiree (or as that person's dependent) is primary, and the COBRA coverage is secondary. However, this rule will not apply if the person is covered as a dependent under one plan and as a non-dependent under the other plan. In that case, the plan covering him as a non-dependent is primary, even if the non-dependent coverage is COBRA coverage.

5. **Longer or shorter length of coverage -** The plan that covered the person as an employee or retiree longer is primary.

6. **Two Plan employees -** If you and your spouse are both covered as employees under this Plan and one of you has a claim, the Plan will pay primary benefits on the claim as the claim of an employee and then pay secondary benefits on the claim as the claim of a dependent. Claims for the dependent children of two Plan employees will be coordinated, subject to rules in No. 2 above.

7. **Other situations -** If the preceding rules do not determine the primary plan, this plan will follow the guidelines established by the National Association of Insurance Commissioners (NAIC) to determine the order of payment. If the NAIC guidelines do not apply to a particular situation, the allowable expenses will be shared equally between the plans, but in no case will this plan will pay more than it would have paid had it been primary.

Right of Repayment

If a payment of any amount has been made that is in excess of that permitted by coordination of benefits, this Plan has the right to recover such amount from any party that has received such payment.

Right to Receive and Release Necessary Information

The Fund may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Fund deems to be necessary for such purposes of implementing these coordination of benefit rules. Any person claiming benefits under this Plan shall furnish to the Fund Office such information as may be necessary to implement these rules.

Coordination of Benefits with Medicare

Important Information About Medicare

This Plan will pay secondary to Medicare whenever it is allowed to do so by law. The rules governing when the Plan can pay secondary are determined by the Centers for Medicare and Medicaid (CMS), a federal agency. This section summarizes those rules.

If you are retired, Medicare will be primary and this Plan will be secondary. Medicare will also be primary for your spouse if she is also entitled to Medicare.

When this Plan is secondary to Medicare, it will pay its benefits as though you are enrolled in Parts A and B, whether or not you are actually enrolled. The same rule applies to claims incurred by your spouse. When Medicare will be the primary plan (for example, when you retire), you and your spouse are each responsible for enrolling in Medicare Part A and Part B when you are first eligible to do so. If you want information about Medicare enrollment, contact your local Social Security office (at least 30 days before your 65th birthday, if possible).

IMPORTANT
You MUST enroll in Medicare Parts A and B when Medicare is your primary plan!

For Persons With COBRA and Medicare

Under the COBRA coverage rules, your COBRA will terminate when you become eligible for Medicare. However, if you already have Medicare on your COBRA election date, you are allowed to elect COBRA and keep both coverages. If you do have dual coverage (Medicare and COBRA), the rules governing which plan pays first are as follows:

- Medicare will be primary if your Medicare entitlement is due to age or disability. This means you must be enrolled in Part B because the Plan will pay claims as if you have Part B. Medicare will also be primary for your spouse if she has Medicare.
- If you have Medicare due to end stage renal disease (ESRD), your COBRA coverage will be primary for the first 30 months of ESRD Medicare entitlement. Medicare becomes primary after that. The same rule applies to a spouse with ESRD Medicare.

If There Is a Third Plan

If a person who is eligible for Medicare due to age is also covered under a plan as a retired worker and under a third plan as a dependent of an actively working spouse, the plan covering the person as a dependent will pay first, Medicare will pay second, and the plan covering the person as a retired worker will pay last. Similarly, if a person who is eligible for Medicare due to age is covered as a retired worker under one plan and as an active worker under another plan, the plan covering the person as an active worker will pay first, Medicare will pay second, and the plan covering the person as a retired worker will pay last.

SUBROGATION

In the event the Fund pays or is obligated to pay benefits on behalf of a participant or his/her dependents for illness or injury to the participant or dependents and the participant or dependents have the right to recover the amounts of such benefits from any other person, corporation, insurance carrier or governmental agency, including uninsured or underinsured insurance coverage, or any other first-party contract or claim, the Trustees of the Fund and the Fund shall be subrogated to all of the participant's or dependents' right of recovery against such person, corporation, insurance, carrier, governmental agency or uninsured or underinsured insurance coverage or any other first-party or third- party contract or claim and shall have a right of reimbursement from the participant or dependent to the full extent of payments made by the Fund and for the cost of collection of these amounts, including attorney's fees. The full amount of benefits paid shall include any Preferred Provider Organization charge or other payment to a medical discount provider paid with respect to the involved benefits which shall be considered part of the amount of benefits paid. The Trustees and the Fund shall have an equitable lien by agreement in the amount set forth in this paragraph and this equitable lien by agreement shall be enforceable as part of an action to enforce plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed. The Trustees' and the Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the participant or dependents, as opposed to the general assets of the participant or dependents, and enforcement of the equitable lien by agreement does not require that any of these particular assets received be "traced" to a specific account or other destination after they are received by the participant or dependents. The Trustees' and the Fund's equitable lien by agreement is from the first dollar received and its enforcement does not require that the participant or dependents be

"made whole" or that the entire debt be paid to the participant or dependents prior to the lien's payment. The Trustees' and the Fund's equitable lien by agreement is also not reduced by the legal fees incurred by the participant or dependents in recovering the amounts or by any state law doctrine, such as the "common fund" doctrine, which would purport to impose such a reduction.

The participant or his or her dependents or the participant acting on behalf of a minor dependent shall execute and deliver such documents and papers, including but not limited to an assignment of the claim against the other party or parties, assignment to the minor child or any parental claim to recover medical expenses of the minor child, and/or a Subrogation or Reimbursement Agreement to the Fund, as the Trustees may require. The participant or dependents shall do whatever else is necessary to secure the rights of the Trustees and the Fund including allowing the intervention by the Trustees or the Fund or the joinder of the Trustees or the Fund in any claim or action against the responsible party or parties or any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim.

If the participant or dependents do not attempt a recovery of the benefits paid by the Fund or for which the Fund may be obligated, the Trustees or the Fund shall, if in the Fund's best interest and at the Trustees' sole discretion, be entitled to institute legal action or claim against the responsible party or parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all benefit amounts paid to the participant or dependents or paid on their behalf, together with the costs of collection, including attorney's fees.

In the event of any recovery by judgment or settlement against the responsible party or parties or by payment by an uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, payment of the lien from the proceeds of the recovery shall take place in the following fashion. Initially, the reasonable costs of collection of the equitable lien by agreement, including the Fund's attorney's fees, shall be distributed to the Fund. Next, the amount of benefits paid from the Fund to and on behalf of the participant or dependents, to the full extent of benefits paid or due as a result of the occurrence causing the injury or illness, shall be distributed to the Fund. The remainder or balance of any recovery shall then be paid to the participant or dependents and their attorneys if applicable.

In the event of any failure or refusal by the participant or dependents to execute any document requested by the Trustees or the Fund or to take other action requested by the Trustees or the Fund to protect the interests of the Trustees or the Fund, the Trustees may withhold payment of benefits from the Fund or deduct the amount of any payments from amounts otherwise payable form the Fund for future claims of the participants or dependents. After making claim for benefits from the Fund, the participant or dependents shall take no action which might or could prejudice the rights of the Trustees or the Fund.

In the event the participant or dependents recover any amount by settlement or judgment from or against another party or by payment from any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim the Fund will request repayment of the amount of its equitable lien for the full amount of benefits paid by the Fund. If the participant and/or dependents refuses or fails to repay such amount, then in that event, the Fund shall be entitled to recover such amounts from participant and/or dependents by instituting legal action against the participant and/or dependents and/or by deducing such amounts as may be due on future claims submitted by the participant and dependents. Once a settlement or judgment is reached on the claim additional bills cannot be submitted with respect to the same injury.

The participant or dependents shall be required to pay their own legal fees and costs and to hire only attorneys who agree to waive the common fund doctrine and to remit the gross rather than the net proceeds from litigation.

The Trustees shall pay no legal costs or fees from the Fund without receiving a recovery and then only, in their sole discretion, within the terms of this provision. In the event that an attorney is hired by or on behalf of the participant or his/her dependents and the Fund is given notice and an opportunity to pursue its own subrogation recovery, the Fund shall not be required to hire such attorney. If the attorney representing the eligible individual nevertheless wishes to proceed, and creates a common fund from which the Trustees can recover pursuant to their equitable lien by agreement for subrogation and reimbursement, the Trustees, on behalf of the Fund, may agree to pay up to 10% of its recovery to include the attorney's legal fees. This 10% shall also include any prorated portion of the cost of recovery. If the attorney agrees to proceed, he will be considered to have waived the common fund doctrine.

These provisions shall apply to any case in which the Fund or Trustees have not been repaid the full amount of benefits made for and on behalf of a participant or beneficiary, together with cost of collection, as of the date of this provision, and any subrogation and reimbursement claim or lien presented by the Fund or Trustees, where the Fund or Trustees have not been repaid the full amount of benefits made for and on behalf of a participant or beneficiary, together with cost of collection, as of the date of these provisions, shall be construed to involve an equitable lien by agreement under these provisions.

(If you want more information about Subrogation, contact the Fund Office.)

Note About Asbestosis Treatment - If you seek services and/or treatment for asbestosis, the Plan will cover your care as if it were not the result of a job-related exposure except that the Fund will be subrogated to any judgment settlement or payment based on a Workers' Compensation claim or suit.

DEFINITIONS

Allowable Charge

The maximum covered charge for a service rendered or supply furnished by a health care provider that will be considered for payment.

1. For in-network facilities and professional providers, the allowable charge is the contracted fee.
2. For out-of-network facility charges, the allowable charge is the reasonable and customary amount, as defined on page 77. For out-of-network professional fees, the allowable charge is 120% of Medicare's allowable charge.
3. If this Plan is secondary to Medicare, the allowable charge means only that amount which is an allowable charge under Medicare's benefit rules.

Contributing Employer

An employer who, according to the terms of a collective bargaining agreement or participation agreement, agrees to contribute to the IBEW Local 701 Welfare Fund on an employee's behalf.

Cosmetic

A treatment or procedure for the primary purpose of changing the person's appearance. The fact that the patient may suffer psychological or behavioral consequences absent the treatment or procedure does not make it non-cosmetic or covered by the Plan.

Custodial Care

Care designed mainly to help a person with daily living activities. It is not care primarily intended to help a person recover from an injury or illness.

Dependent

The following categories of individuals:

1. Your spouse;
2. Your natural or adopted children who are less than 26 years of age;
3. Your unmarried stepchildren who are less than 26 years of age, and
4. Your unmarried child older than age 26 who is deemed totally and permanently disabled by a federal or state authority due to a disability that began prior to age 26. For purposes of this paragraph, "permanently disabled" means that the child is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of twelve (12) months or more. The Plan may require you to furnish proof of the child's continued disability from time to time, but not more often than once in a 12-month period. Coverage will terminate if the Plan determines, based upon medical evidence, that the child is no longer disabled or if the child does not undergo an examination or furnish proof required by the Plan.

"Children" means children who are naturally born to you, or are legally adopted by you ("legally adopted" means from the time the child is placed in your home for purposes of adoption). "Children" also include other children for whom you have legal guardianship, or children listed as alternate recipients in Qualified Medical Child Support Orders (QMCSOs). The Trustees, in consultation with the Fund legal counsel, have adopted procedures for determining whether a particular court order qualifies as a QMCSO. If you would like a copy of the Plan's QMCSO procedures, please call or write the Fund Office. If you are a responsible party in a court action involving a child, you should request a copy of the Plan's procedures BEFORE the final order is entered.

"Stepchildren" are children who were born to your current legal spouse or who were legally adopted by your spouse before your marriage.

Dependent coverage terminates at the end of the month during which the person no longer meets the definition of a dependent.

Durable Medical Equipment

Equipment that meets all the following criteria: 1) It is related to the patient's physical disorder; 2) It is appropriate for in-home use; 3) It can stand repeated use; 4) It is manufactured solely to serve a medical purpose; 5) It is not merely for comfort or convenience; and 6) It is normally not useful to a person not ill or injured.

Eligible Dependent

A dependent who is eligible to receive benefits under this Plan in accordance with the dependent eligibility rules beginning on page 23 (actives) and page 32 (retirees).

Eligible Participant

An actively employed individual who is eligible to receive participant benefits under this Plan in accordance with the eligibility rules beginning on page 16.

Eligible Retiree

An individual who is eligible to receive post-retirement benefits from this Welfare Fund in accordance with the eligibility rules beginning on page 30.

Emergency

An "emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part.

Experimental, Investigative or Inappropriate

A service or treatment on which the consensus of expert medical opinion, based on reliable evidence (i.e., published reports and/or articles) indicates that further trials or studies are needed to determine the safety, efficiency and outcomes compared to standard treatment.

Experimental, investigative or inappropriate also means services or treatments that are:

- Not yet recognized as having proven beneficial outcomes;

- Primarily confined to a research setting;
- Not appropriate based on medical circumstances and/or given the advanced stage of the individual's illness or the likelihood that the service or treatment will measurably improve the individual's illness or medical condition; or
- Not calculated to yield a favorable result.

Fund

The Electrical Workers' General Welfare Fund, usually referred to as the IBEW Local 701 Welfare Fund.

Home Health Agency

A public or private agency that specializes in giving nursing or therapeutic services in the home; is licensed as a home health agency; and operates within the scope of its license.

Hospice

An agency, or a facility or part of one that provides inpatient, outpatient or home care for terminally ill persons who have been diagnosed by a physician as having a life expectancy of six months or less; is licensed as a hospice or hospice agency and operating within the scope of such license; meets the minimum standards for certification under the Medicare program; has full-time supervision by at least one physician; and provides 24-hour nursing service by registered nurses.

Hospital

A licensed institution that is in the Plan's PPO network or accredited by an accrediting agency approved by the Centers for Medicare and Medicare (CMS) that provides inpatient and/or outpatient medical care and treatment for sick and injured persons. Services provided by a hospital must also include all of the following:

1. Facilities for diagnosis of injury and illness on its premises;
2. care of patients who are convalescing from injury or illness.

An institution that is used primarily as a rest home, nursing home, convalescent home, or a place for the aged shall be excluded from this definition of hospital.

Medically Necessary

A service, supply or treatment that:

1. Is essential for the diagnosis or treatment of the injury or illness for which it is prescribed or performed;
2. Is within the medical standard of care (it meets generally accepted standards of medical practice);
3. Is ordered by a physician; and
4. Is not experimental, investigative or inappropriate.

The fact that a physician may prescribe, order, recommend or approve a service or supply does not, by itself, make it medically necessary or make the expense a covered charge.

Mental or Nervous Disorder; Mental/Nervous Disorder

Illnesses in which psychological, intellectual, emotional, or behavioral disturbances are the dominating feature as manifested in maladaptive behavior or impaired functioning, whether caused by genetic, physical, chemical, biological, environmental, psychological, social, or cultural factors, meeting the criteria further described in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, but excluding V codes, and developmental and learning disorders.

Participant

A person who is covered by a collective bargaining agreement, or performs work that is covered under a collective bargaining agreement, between the Union and a contributing employer, or any individual on whose behalf an employer is obligated to make contributions to the Fund, including non-bargained persons employed by the Union or the Fund. A person who met this definition and then retired and qualified for post-retirement Plan coverage is also a "participant."

Physician

A legally qualified doctor or surgeon who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).

Additional Covered Providers - Although not included in the definition of "physician," benefits are payable for services provided by the following types of licensed providers when the services are within the Plan's normal covered expense provisions and are rendered within the scope of each such individual's license and specialty: a chiropractor (DC), a dentist (D.D.S. or D.M.D.), a podiatrist (D.P.M.), an optometrist (O.D.), a physical therapist (P.T.), a physical therapy assistant (P.T.A.) working under the supervision of a P.T., an occupational therapist (O.T.), an occupational therapy assistant (O.T.A) working under the supervision of an O.T., a speech therapist (S.T.), a nurse (L.P.N., R.N.), a nurse practitioner (N.P.) if payment would have been made under this Plan to a doctor for the same services, a physician assistant (P.A.) working under the direct supervision of a physician, and a licensed nutritionist. The Plan also covers a certified surgical assistant (C.S.A.) or nurse anesthetist (C.R.N.A.) if payment would have been made under this Plan to a doctor for the same services. With respect to covered mental/nervous or substance abuse treatment, the following will also be considered covered practitioners: clinical psychologist (Ph.D. or Psy.D.), licensed Masters-level clinical social worker or therapist (such as L.SW., L.C.S.W, M.S.W., L.P.C. or L.C.P.C.).

Plan

The health care benefit plan provided by the Electrical Workers General Welfare Plan Fund. The Plan is usually referred to as the IBEW Local 701 Welfare Plan.

Reasonable and Customary Charges

The amount charged for medical services or supplies made by a majority of medical service providers in the community. In determining the reasonable and customary charge, the Plan uses standard tables commercially available for such purpose, and it is the current practice of the Fund to allow up to the 90th percentile reported in these tables.

Note that maximum amount allowable by the plan for out-of-network professional medical fees is 120% of Medicare's allowable amount for the same service in the same location. This amount is not intended to represent a "reasonable and customary" fee.

Residential Treatment Facility

A state-licensed facility other than a hospital providing non-acute inpatient treatment of substance abuse or mental/nervous disorders is considered a skilled nursing facility if it satisfies the requirements for a "skilled nursing facility" below.

Skilled Nursing Facility

A licensed institution, other than a hospital, which:

1. Provides inpatient medical care and treatment to convalescing patients;
2. Provides full-time supervision by at least one physician or registered nurse;
3. Provides 24-hour nursing service by licensed professional nurses; and
4. Is in the Plan's medical PPO network or accredited as an inpatient facility by a CMS-approved accreditation agency. ("CMS" is the Centers for Medicare and Medicaid, a federal agency.)

Substance Abuse

Alcoholism, alcohol abuse, drug addiction, drug abuse, or any other type of addiction to, abuse of, or dependency on any type of drug, narcotic, or chemical, except nicotine.

Surgical Center

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 legally constituted and licensed institution that is established, equipped and operated primarily for the purpose of performing surgical procedures. The Plan does not cover services by out-of-network surgical centers except when Medicare is primary and covers that facility.

Trustees

The Trustees of the Electrical Workers General Welfare Fund.

Union

The International Brotherhood of Electrical Workers, Local No. 701 and any other Unions which may become parties to the established Agreements and Declarations of Trust.

CLAIM AND APPEAL PROCEDURES

CLAIM FILING PROCEDURES

In order for the Plan to pay benefits, a claim must be filed with the Fund Office or the claims office designated for receiving claims in accordance with the procedures described below. A claim can be filed by the provider, you, your eligible dependent or by someone authorized to act on behalf of you or your eligible dependent.

1. A claim is considered to have been filed on the date it is received at the correct office, even if the claim is incomplete. Claims are received during regular business hours, Monday through Friday.
2. A "claim" is a request for Plan benefits, normally because the claimant has incurred a healthcare expense. A request for confirmation of Plan coverage is not a claim if you have not yet incurred the expense unless the Plan conditions payment on the receipt of prior approval. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy.
3. Most claims must be filed before the end of the calendar year following the year in which the claim was incurred. Life and AD&D insurance claims must be filed within 90 days of the loss.
4. You may designate another person as your authorized representative for purposes of filing a claim. Except in the case of an urgent care claim, such designations must be in writing.
   - Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you.
   - A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as your authorized representative. You have no right to assign any interest in your benefits or any right to recover benefits to any person, including a provider, and a provider is not a beneficiary under the Plan. All claims, internal or external appeals and judicial appeals must be brought in the name of the participant or beneficiary who incurred the claim.

WHERE TO SEND CLAIMS

Claims Offices

Type of Expense	Where to Send Claims
Medical (Hospital and Physician) Claims Most providers will automatically file their claims for you. If you use an out-of-network provider who will not submit claims to Blue Cross, send a paper claim on a standard claim form to the Fund Office.	Your local Blue Cross Blue Shield plan
When this Plan is the Secondary Payer to Another Plan Submit a copy of the other plan's explanation of benefits the Fund Office.	IBEW Local 701 Welfare Fund 28600 Bella Vista Parkway Suite 1110 Warrenville, IL 60555
Prescription Drug Claims In most cases you will not need to file prescription drug claims, but if you have a special situation, send your claim to Sav-Rx.	Sav-Rx OON Claims 224 North Park Avenue Fremont, NE 68025 Group / Plan No. IBEW701

Claims Offices

Dental Claims Dentists can use standard dental claim forms.	IBEW Local 701 Welfare Fund 28600 Bella Vista Parkway Suite 1110 Warrenville, IL 60555
Out-of-Network Vision Claims Submit itemized bills with a completed NVA claim form. Claim forms are available from NVA or the Fund Office website.	National Vision Administrators P.O. Box 2187 Clifton, NJ 07015 Plan No. is 10900001
Special Fund (HRA) Claims Submit itemized bills, explanations of benefits from all other plans (including this one), and a TASC claim form available from www.tasconline.com or the Fund Office.	TASC P.O. Box 7511 Madison, WI 53707
Hearing Claims **Loss of Time (Disability) Benefits** **Life and AD&D Insurance Claims**	IBEW Local 701 Welfare Fund 28600 Bella Vista Parkway Suite 1110 Warrenville, IL 60555

CLAIM PROCESSING TIME PERIODS

The amount of time the applicable Plan can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

1. A claim is "post-service" if you have already received the treatment or supply for which payment is now being requested. Most claims are post-service claims.
2. A "disability claim" is a claim for Weekly Loss of Time Benefits.
3. A "pre-service claim" is a request for pre-authorization of a type of treatment or supply that requires approval in advance of obtaining the care.
4. An "urgent care claim" is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, health, or ability to regain maximum function, or that could subject you to severe pain that cannot be adequately managed without the proposed treatment.
5. A "concurrent care claim" is also a type of pre-service claim. A claim is a concurrent care claim if a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved.

If all the information needed to process your claim is provided to the claims office, your claim will be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are as follows:

- Post-service claims – 30 days.
- Disability claims – 45 days.
- Pre-service claims – 15 days.

6. Urgent care claims – 72 hours.Full-time supervision by at least one physician;

7. 24-hour nursing service by registered nurses;

8. Surgery or formal arrangements for available surgical facilities; and

- Therapeutic
- Concurrent care claims – 24 hours if the concurrent care is urgent and if the request for the extension if made within 24 hours prior to the end of the already authorized treatment. If the concurrent care is not urgent, then the pre-service time limits apply.

When Additional Information Is Needed (Claimant Extension)

If additional information is needed from you, your doctor or the provider, the necessary information or material will be requested in writing. If the request goes to your provider, you will receive a copy of the request. The request for additional information will be sent within the normal time limits shown above, except that the additional information needed to decide an urgent care claim will be requested within 24 hours.

It is your responsibility to see that the missing information is provided to the claims office. The normal processing period will be extended by the time it takes you to provide the information, and the time period will start to run once the claims office has received a response to its request. If you do not provide the missing information within 45 days (48 hours for an urgent care claim), the claims office will make a decision on your claim without it, and your claim could be denied as a result.

Plan Extension

The time periods above may be extended if the claims office determines that an extension is necessary due to matters beyond its control (but not including situations where it needs to request additional information from you or the provider). You will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

- Post-service claims – 15 days.
- Disability claims – 30 days (a second 30-day extension may be needed in special circumstances).
- Pre-service claims – 15 days.

Claim Denials

If all or a part of your claim is denied after the claims office has received all other necessary information from you, you will be sent a written notice giving you the reasons for the denial. The notice will include reference to the Plan provisions on which the denial was based and an explanation of the claim appeal procedure. If applicable, it will give a description of any additional material or information necessary for you to perfect the claim, and the reason such information is necessary. The notice will provide a description of the appeal procedures and the applicable time limits for following the procedures. It will also include a statement concerning your right to bring a civil action under section 502(a) of ERISA. In cases where the Plan relied upon an internal rule, guideline, protocol or similar criterion to make its decision, the notice will state that the specific internal rule, guideline, protocol or criterion will be provided to you free of charge upon request. If the decision was based on medical necessity or if the treatment was deemed experimental, the notification will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. For urgent claims, a description of the Plan's expedited review process will be provided.

CLAIM APPEAL PROCEDURE

Internal Appeals

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 applicable claims 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 claims 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, IBEW Local 701 Welfare Fund, Fund Office, 28600 Bella Vista Parkway, Suite 1110, Warrenville, IL 60555.

3. For all pre-service claims, the Review Committee will be the Plan's utilization review organization (Med-Care Management, Inc.). You may orally request a review of a denied urgent care claim by calling Med-Care at 1-800-367-1934, 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.

4. The Review Committee will not include the person, or a subordinate of the person, who made the original claim denial.

5. If you wish, another person may represent you in connection with an appeal. If another person claims to be representing you in your appeal, the Review Committee has the right to require that you give the Plan a signed statement, advising the Review Committee that you have authorized that person to act on your behalf regarding your appeal. Any representation by another person will be at your own expense. You (and your authorized representative, if any) may request to appear in person before the Review Committee. If the Trustees grant your request, you and your representative's appearance must be at your own expense.

6. You or your authorized representative may review pertinent documents and may submit comments and relevant information in writing.

   - Upon written request, the claims office will provide reasonable access to, and copies of, all documents, records or other information relevant to your claim.
   - If the claims office obtained an opinion from a medical or vocational expert in connection with your claim, the claims office will, on written request, provide you with the name of that expert.
   - The claims office will not charge you for copies of documents you request in connection with an appeal.

7. In deciding your appeal, the Review Committee will consider all comments and documents that you submit, regardless of whether that information was available at the time of the original claim denial. The review will not defer to the initial denial, and will take into account all comments, documents, records and other information submitted by you, without regard to whether such information was previously submitted or relied upon in the initial determination.

8. 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. If a

medical professional was consulted in connection with the original claim denial, the Review Committee will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.

Notification Following Internal Appeal

- If your appeal is for an urgent care claim, you will be notified of the decision about your appeal as soon as possible, taking into account the circumstances, but not later than 72 hours after receipt of your request for review. In the case of non-urgent pre-service claims, you will be notified no later than 30 days after receipt of your request for review.
- A review and determination for disability and post-service claims will be made no later than the date of the meeting of the Trustees that immediately follows the Plan's receipt of a request for review. The Review Committee meets on a monthly basis. However, if the request is filed within 30 days preceding the date of such meeting, a determination may be made by no later than the date of the second meeting.
- If special circumstances (such as the need to hold a hearing) require a further extension of time, a determination will be made not later than the third meeting of the Trustees. Before the start of the extension, you will be notified in writing of the extension, and that notice will include a description of the special circumstances and the date as of which the determination will be made.
- You will be informed of the Trustees' decision, normally within five calendar days of the review. The decision will be in writing unless the appeal was for an urgent care claim and you are advised by telephone or fax. When you receive the written decision, it will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to you claim, and a statement of your right to bring an action under section 502(a) of ERISA. If applicable, you will also be informed of your right to receive free of charge upon request the specific internal rule, guideline, protocol or similar criterion relied on to make the decision. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request.

External Appeals

If you appeal to the Review Committee but the process still results in a denial of your claim, you may, in certain cases, request an additional review by an independent review organization (IRO). An independent external review is available for claims denied based on clinical or scientific judgments, such as decisions based on medical necessity. It does not apply to claim denials related to a person's eligibility for coverage. You must apply for the external review within four months after the date of receipt of the written appeal decision you received from the Fund. To request an external review, call or write the Fund Office. Fund Office staff will provide you with the information you need to file your formal request for an external review and provide you with the information you need to complete the process. The appellant must pay a $25 administrative fee for each external review, which will be refunded if the appeal is granted.

You may apply for an expedited external review if the claim involves a medical condition for which the regular timeframe for completion of an appeal would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination (denial) concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Your Right to a Timely Decision

If the Plan fails to make timely decisions or otherwise fail to comply with the applicable federal regulations, you may go to court to enforce your rights. A claimant may not file suit against the Plan until the claimant has exhausted all of the procedures described in these procedures. The time limit for filing suit is one year from the date a decision was required to be provided under these Claim and Appeal Procedures.

Claim and Appeal Procedures for Life/AD&D Claims

Life/AD&D insurance claims should be filed with the Fund Office who will forward them to Union Labor Life Insurance Company, the insurer of these benefits. Since the Fund is the holder of the insurance contract, notices from Union Labor Life may be issued to the Fund instead of you.

Union Labor Life will normally issue an approval or denial of a life/AD&D claim within 90 days of the date it receives the claim. An extension of 90 days will be allowed if special circumstances are involved. The Fund Office will notify you in writing of any extension the insurer requires to review your claim, and the notice will state the special circumstances involved and the date by which it expects to reach a decision.

If Union Labor Life denies your claim, the Fund Office will issue you a notice written in an understandable manner explaining the reasons for the denial. The notice will also include an explanation of the claim appeal procedures.

Review of claim denials and final decisions on appeal are Union Labor Life's responsibility.

GENERAL PLAN PROVISIONS

PRIVACY OF AN INDIVIDUAL'S HEALTH INFORMATION

The IBEW Local 701 Welfare Fund will use and disclose protected health information (individually identifiable health information, regardless of the form in which it is kept) only to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information. The Fund will not disclose protected health information to the Plan Sponsor, the Board of Trustees of the IBEW Local 701 Welfare Fund, or permit a health insurance issuer or HMO to disclose protected health information, unless this disclosure complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information. The Fund further complies with HIPAA by providing to individuals covered by the Plan, in accordance with HIPAA and its Regulations, a Notice of Privacy Practices detailing the Fund's practices regarding protected health information.

PAYMENT OF BENEFITS

Medical benefits provided by this Plan for PPO services are always paid directly to the provider. Benefits for non-PPO services will also be paid directly to the provider unless you can provide proof that you already paid the bill.

NVA, the Plan's vision network and claims administrator, pays in-network providers directly. Out-of-network claims will be paid to you.

In-network dental claim payments will be made to the dentist. Out-of-network dental claims will be paid to you unless benefits have been assigned to the provider.

Weekly Loss of Time Benefits will be paid to you every two weeks during any period for which benefits are payable. Any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of due proof.

Life Insurance benefits will be paid to your designated beneficiary. If your designated beneficiary does not survive you, death benefits will be paid to the person(s) specified in your life insurance policies or to your estate.

You may not assign your benefit claim to a third party for payment or collection.

TRUSTEE INTERPRETATION AND AUTHORITY; DECISIONS REGARDING BENEFITS

The Trustees or persons acting for them, such as a claims appeal committee, have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Decisions of the Trustees (or, where appropriate, decisions of those acting for the Trustees) 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 or

those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.

All benefits under the Plan are subject to the Trustees' authority to change them. The Trustees have the authority to increase, decrease, change, amend, or terminate benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine to be in the best interests of the Plan participants and beneficiaries.

Benefits under this Plan will be paid only when the Board of Trustees or persons delegated by them decide, in their sole discretion, that the participant or beneficiary is entitled to benefits.

The Plan is maintained for the exclusive benefit of the Plan's participants and their dependents. All rights and benefits granted to a participant under the Plan are legally enforceable.

The right to change or eliminate any and all aspects of benefits provided for retirees is a right specifically reserved to the Trustees, since retiree coverage is not an "accrued" or "vested" benefit. The Trustees have the authority to amend or terminate such benefits and to increase self-payments for the coverage at any time. Any such change shall be effective even though a Participant has already become an eligible retiree.

PLAN DISCONTINUATION OR TERMINATION

This Plan of Benefits may be discontinued or terminated under certain circumstances, for example if future collective bargaining agreements and participation agreements don't require employer contributions to the Fund. In such event, benefits for covered charges incurred before the termination date will be paid on behalf of eligible family members as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the funds available in the trust fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

LENGTH OF MATERNITY CONFINEMENTS

A federal law requires that a person who is eligible for maternity benefits and her newborn infant are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarian section. Further, a Plan cannot require the provider (hospital or physician) to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. (The attending provider may, however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Caesarian section.)

The Plan will provide benefits for the covered charges incurred by an individual eligible for maternity benefits during the prescribed time periods (48 hours or 96 hours), subject to all applicable Plan eligibility and benefit payment provisions and limitations as set forth in this Summary Plan Description booklet.

YOUR RIGHTS UNDER ERISA

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the Plan or insurance policies. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant.

As a participant in the IBEW Local 701 Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Fund Office may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries misuse the Plan's money, or if you believe you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. If you have any questions about your Plan, you should contact the Fund Office.

Assistance With Your Questions

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also find answers to your questions and list of EBSA field offices at the website of the EBSA at www.dol.gov/ebsa.

How to Read or Get Plan Material

You can read the material listed in the previous section by making an appointment at the Fund Office during normal business hours. This same information can be made available for your examination at certain locations other than Fund Office. The Fund Office will inform you of these locations and tell you how to make an appointment to examine this material at these locations. Also, copies of the material will be mailed to you if you send a written request to the Fund Office. There may be a small charge for copying some of the material. Before requesting material, call the Fund Office to find out the cost. If a charge is made, your check must be attached to your written request for the material.

NONDISCRIMINATION STATEMENT

The IBEW Local 701 General Welfare Fund (the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The Plan provides language assistant services to persons whose primary language is not English, and free aids and services where necessary to people with disabilities to communicate effectively with us. If you need these services, contact the Fund Office.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Fund Office by mail, telephone or in person at the IBEW Local 701 Welfare Fund, 28600 Bella Vista Parkway, Suite 1110, Warrenville, IL 60555, telephone 1-630-393-1701, #3. If you need help filing a grievance, Fund Office personnel are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

* * *

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-630-393-1701 #3.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-630-393-1701 #3.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-630-393-1701 #3

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-630-393-1701 #3 (번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-630-393-1701 #3.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-630-393-1701 #3 (رقم هاتف الصم والبكم: 1-630-393-1701 #3).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-630-393-1701 #3.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-630-393-1701 #3.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-630-393-1701 #3.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-630-393-1701 #3.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-630-393-1701 #3.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-630-393-1701 #3 (पर कॉल करें।

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-630-393-1701 #3.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-630-393-1701 #3.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-630-393-1701 #3.

INFORMATION ABOUT THE PLAN

Name of Plan

The Electrical Workers General Welfare Fund, usually referred to as the IBEW Local 701 Welfare Fund.

Plan Sponsorship and Administration

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the employers and the Union which have entered into collective bargaining agreements which relate to this Plan. If you wish to contact the Board of Trustees, you may do so by calling or writing the Fund Office.

The Trustees are assisted in the day-to-day administration of the Plan by a salaried Fund Administrator. The Trustees are also assisted by Fund Legal Counsel, a Fund Consultant and a Fund Auditor who have contracts to provide the professional services the Fund.

Source of Financing/Plan Participation

All contributions to the Plan are made by employers in accordance with their collective bargaining agreements or participation agreements with the International Brotherhood of Electrical Workers, Local No. 701. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of participants working under the collective bargaining agreements. Employees are entitled to participate in this Plan if they work under one of the collective bargaining agreements or participation agreements and if their employers make the required contributions to the Fund on their behalf. Administrative employees of IBEW Local 701 and its affiliates, including this Fund, are also entitled to participate in the Plan. The Fund also receives self-payments from employees, retirees and dependents for the purpose of continuing coverage under the Plan. The Fund may also receive rebates from its pharmacy benefits manager.

Type of Plan/Accumulation of Assets/Payment of Benefits

Benefits are provided from the Fund's assets which are accumulated under the provisions of the collective bargaining agreement and the Trust Agreement and held in a trust fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Fund's assets and reserves are invested appropriately. The Fund's custodial bank is BMO Harris.

The Fund provides medical, prescription drug, surgical, hospital, disability, dental/orthodontia, vision and hearing benefits on a self-insured basis. When benefits are self-insured, the benefits are paid directly from the Fund to the claimant or beneficiary. The self-insured benefits payable by the Fund are limited to the Fund assets available for such purposes. Although, as described earlier in this Summary Plan Description, Blue Cross reprices PPO claims involving medical, surgical and hospital benefits, and National Vision Administrators processes claims involving vision benefits, the services of these companies are in the nature of claim processing and/or limited to the amount the Fund must pay providers, and all benefits paid remain self-insured.

This Plan is not an insurance policy and no benefits other than the Life and Accidental Death and Dismemberment (AD&D) Insurance benefits, and the Medicare Part D plan for retirees are provided through insurance companies. The Fund provides Life and AD&D Insurance through the Union Labor Life Insurance Company,

1625 Eye St. N.W., Washington, D.C., 20006, telephone 1-202-682-0900. The Fund's Medicare Part D plan is insured through the UnitedHealthCare Insurance Company, 185 Asylum St., Hartford, CT 06103, telephone 1-860-702-5000.

Agent for Service of Legal Process

The Fund Counsel to the Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon Fund Counsel at the address shown on page 92.

Plan Year

The records of the Plan are kept separately for each plan year. The plan year begins June 1 and ends on May 31.

Identification Numbers

The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 36-2951116.

BOARD OF TRUSTEES

Union Trustees

Frank Furco, III
I.B.E.W. Local 701
28600 Bella Vista Parkway
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Gibson Electric & Technology Solutions
3100 Woodcreek Drive
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Fund Administrator

Terry J. Musto
IBEW Local 701 Welfare Fund
28600 Bella Vista Parkway
Suite 1110
Warrenville, IL 60555
1-630-393-1701

Fund Legal Counsel

Arnold & Kadjan
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Suite 1650
Chicago, IL 60601

Fund Consultant

Foster & Foster, Inc.
One Oakbrook Terrace
Suite 720
Oakbrook Terrace, IL 60181

Fund Auditor

Calibre CPA Group
566 W. Lake Street
Chicago, IL 60661