

Electrical
Insurance
Trustees

**Health Care
Booklet
for Electrical
Construction
Workers**

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About This Booklet

This is a Summary Plan Description (SPD) that explains how you become eligible for coverage, how coverage can be lost and your *health care* benefits available as of January 1, 2002 to participants in the Electrical Insurance Trustees (EIT) Health & Welfare Plan for Construction Workers.

To understand the plan, you must read this whole booklet. This booklet also serves as the official plan document. If you need more information, you may examine copies of the collective bargaining agreement and other related documents at the Fund Office.

Benefits are contingent upon the financial adequacy of the plan to which employer contributions are made. The Trustees reserve the right to change, amend or end the plan at any time for any reason.

The Trustees want to ensure you that your personal information will be kept private. The information will only be disclosed to appropriate parties as required by the operation of the plan, such as to determine plan eligibility, benefit eligibility, process claims, set contribution rates or to occasionally monitor the performance of the claims administrators.

See the Glossary starting on page 63 for the definitions of various technical terms used throughout this booklet.

See the back of this booklet for New Address and Dependent Change forms.

Your Benefits At-A-Glance

What's Included

Your plan provides protection for you and your eligible family members against some of the financial impact of covered expenses for:

- Ⓢ medical,
- Ⓢ prescription drug,
- Ⓢ dental,
- Ⓢ orthodontic,
- Ⓢ vision, and
- Ⓢ hearing aids.

You share in the cost of your health care benefits through deductibles and copays for different services. Sharing the cost with you helps you stay involved in monitoring the value of the health care services you receive.

See page 66 for addresses and phone numbers of the claims administrators for the plan.

Benefit Summaries

Following are summaries of the health care benefits offered under the plan. To fully understand how the plan works, you need to read the more detailed information in each of the benefit sections.

Medical Benefits

You can visit any licensed physician or hospital you wish. In general, the plan pays a percentage of the charges for medically necessary covered services after you have met your deductible. When you use a PPO network hospital, you will receive the highest level of benefits available through your plan (see page 38 for information about PPO hospitals).

Medical Benefits		
Annual calendar year deductible	\$100 per person \$200 per family	
	Note: An additional \$200 penalty applies if the utilization review organization is not notified or does not certify hospital admissions and extensions. See page 38 for more information.	
Copays	PPO hospital: Plan pays 90% after deductible, you pay 10%	Non-PPO hospital: Plan pays 80% after deductible, you pay 20%
Annual calendar year out-of-pocket maximum	\$1,500 per family (including deductible but excluding mental health/substance abuse expenses)	
Lifetime maximum benefit	\$2 million per person; separate \$40,000 per person for substance abuse treatment	

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Medical Benefits	
Wellness benefits	<ul style="list-style-type: none"> • Plan pays 100% of physician fees for one annual physical per person, up to \$75 (charges in excess of \$75 will be applied to the calendar year deductible and paid at 80%) • Plan pays 90% for PPO hospital or 80% of reasonable and customary charges for non-PPO hospital for one annual coronary artery scan per person upon physician's referral (maximum benefit \$316) • Plan pays 100% for immunizations for children up to age 19 • No deductible applies
Physician office visits	<ul style="list-style-type: none"> • Plan pays 80% of reasonable and customary charges after deductible • You may use any licensed physician
Hospital services: inpatient, outpatient and diagnostic tests	<p style="text-align: center;">PPO hospital: Plan pays 90% after deductible</p> <p style="text-align: center;">Non-PPO hospital: Plan pays 80% of reasonable and customary charges after deductible</p> <p>Note: The utilization review organization must be notified of nonemergency hospital admissions at least three days before treatment or within 48 hours following an emergency admission or penalties may apply. See page 38 for more information.</p>
Mental health/ substance abuse benefits (not included in out-of-pocket maximum)	<ul style="list-style-type: none"> • Plan pays 100% after \$10 copay for in-network care • \$100 annual deductible per person if out-of-network services are used (separate from other calendar year medical deductible); then plan pays 80% of reasonable and customary charges • There is no referral requirement; members may access outpatient treatment directly • Treatment limited to 30 inpatient days and 30 outpatient visits per person per year unless additional days/visits are approved as medically necessary
Chiropractic and naprapathic services	<ul style="list-style-type: none"> • Plan pays 80% of reasonable and customary charges up to the first \$2,000 in covered expenses per person per calendar year • No deductible applies

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Medical Benefits	
Home health care and hospice services	<ul style="list-style-type: none"> • Plan pays 80% of reasonable and customary charges after deductible • A medical necessity review is required
Physical and occupational therapy	<ul style="list-style-type: none"> • Plan pays 80% of reasonable and customary charges up to the first \$2,000 in covered expenses per person per calendar year • A medical necessity review is required if covered expenses exceed \$2,000 per person per calendar year • No deductible applies
Speech therapy benefits	<ul style="list-style-type: none"> • Plan pays 80% of reasonable and customary charges up to the first \$2,000 in covered expenses per person per calendar year • A medical necessity review is required if covered expenses exceed \$2,000 per person per calendar year • No deductible applies
Other covered services: Ambulance services, durable medical equipment, prosthetic devices, casts and splints	Plan pays 80% of reasonable and customary charges after deductible

Prescription Drug Benefits

You can buy prescription drugs at a low cost through a participating pharmacy or through a convenient mail-order program. The medical deductible and copay provisions do not apply to the prescription drug benefits.

Prescription Drug Benefits	
Retail prescription drugs purchased through a network pharmacy (34-day supply)	<p>\$9 copay for generic drugs and drugs on the preferred list;</p> <p>\$18 copay for brand-name and non-preferred drugs</p>
Mail-order prescription drugs (90-day supply)	\$15 copay for all drugs (generic, preferred, non-preferred and brand-name)
Prescription drugs purchased at a nonparticipating pharmacy	No coverage

Dental and Orthodontic Benefits

You can choose to visit any licensed dentist when you need dental care. The plan pays a percentage of the charges for covered services, up to a maximum annual benefit. When your dependent needs orthodontic care, treatment must begin before age 16.

Dental Benefits	
Annual calendar year deductible	No deductible applies
Preventive care (two oral exams a year)	Plan pays 100%
Other care	Dental: Plan pays 80% of up to \$1,875 of expenses Orthodontic: Plan pays 80% of up to \$2,500 of expenses
Annual calendar year maximum benefit	\$1,500 per covered family member (excluding orthodontic)
Lifetime maximum benefit	Orthodontic: \$2,000 for each eligible covered dependent under the age of 19

Vision Benefits

You can choose to visit any licensed optician, optometrist or ophthalmologist when you need vision care. You will be reimbursed for part of the expense of eye exams, frames and lenses. The plan pays a percentage of the charges for covered services, up to a maximum annual benefit.

Vision Benefits	
Annual calendar year deductible	No deductible applies
Annual calendar year benefit maximum	\$500 per person
Exam	Plan pays 80% of up to \$625 of expenses
Lenses	Plan pays 80% for: Member: Two sets of framed lenses or two sets of contact lenses (or one of each) per year Covered dependent: One set of framed lenses or contact lenses (if required by prescription) per year
Frames	Plan pays 80% of \$125 (maximum benefit \$100)

Hearing Aid Benefits

The plan reimburses you for part of the expense of hearing exams and hearing aid instruments when you visit a legally qualified otologist or otolaryngologist. The plan pays a percentage of the charges for covered services, up to a maximum annual benefit.

Hearing Aid Benefits	
Annual calendar year deductible	No deductible applies
Annual calendar year benefit maximum	\$475 per person
Exam	Plan pays up to \$75; one visit per year per person
Instrument	Plan pays 80% of up to \$500 per year (maximum benefit \$400)

What Happens If...

e You Are a New Member

Health Care Benefits

(Medical, Prescription Drug, Dental, Orthodontic, Vision and Hearing Aid)

Member Eligibility

You are eligible for benefits beginning, retroactively, on the first day of the month after receipt of contributions from your employer for 600 hours of active work. You must have worked these hours within six consecutive months. Apprentice training school time may be calculated into your work history. When you receive your insurance acknowledgement, you will be requested to submit a copy of your birth certificate.

You cannot be covered as both a member and a dependent child under the plan.

Dependent Eligibility

Once you are eligible for benefits, you can also choose to cover your dependents. Eligible dependents include:

Eligible Dependents	What You Must Do to Add Dependents
Lawful spouse	Provide a copy of the marriage certificate. The certificate must have been processed by the state in which you were married. Also, provide a certified copy of the spouse's birth certificate, his or her Social Security number, and all insurance information to assist in the coordination of benefits.
Natural born unmarried children under the age of 19	Provide a certified copy of the birth certificate or paternity test. These documents must list the eligible member as one of the biological parents.
Unmarried stepchildren under the age of 19	Provide a certified copy of the child's birth certificate and a letter from you requesting coverage for the stepchild. You should include information on any other coverage the child has, including the policyholder name and Social Security number, policy name, policy number and mailing address. If there is no other coverage, indicate this in your letter.
Adopted children or children placed in your home for legal adoption under the age of 19	Provide a finalized copy of the adoption papers (in English) or an interim order through the courts.

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WHAT HAPPENS IF...

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Eligible Dependents	What You Must Do to Add Dependents
Unmarried children under the age of 23 if full-time students	To be eligible, the child must be a full-time student as determined by the educational institution, must rely on you or your spouse for more than 50% of his or her financial support, and normally reside in your home. Once your child reaches age 19 through age 22, you must provide verification of student status every term, semester, trimester, etc. of full-time enrollment. Verification includes a letter from the school's Registrar's office indicating full-time student status and dates of the term. Eligibility continues for 120 days after the last day of full-time attendance. Coverage stops on the dependent's 23rd birthday regardless of full-time student status.
Children ages 19 and older if physically or mentally disabled	To be eligible, the child must rely on you or your spouse for more than 50% of his or her financial support and normally reside in your home. The child is considered disabled if he or she is so severely impaired, physically or mentally, that he or she cannot perform in school or at work and he or she is not capable of self-support. The impairment must be considered permanent or expected to last at least 12 months. The determination must be based on medical evidence. The child is not considered disabled if disability is solely due to alcoholism or drug addiction. You have 31 days before your child turns age 19 (or age 23 if covered as a full-time student) to apply for continuation of dependent benefits. You may have to provide proof of disability and financial dependence on an ongoing basis.

If both you and your spouse are covered as members, you both may cover your eligible dependents under the plan. However, your and your dependents' coverage will be coordinated so the plan won't pay more than 100% of the covered expenses for services and supplies.

Welfare Benefits

(Disability, Death and AD&D)

Member Eligibility

You are eligible for benefits beginning, retroactively, on the first day of the month after receipt of contributions from your employer for 600 hours of active work. You must have worked these hours within six consecutive months. Apprentice training school time may be calculated into your work history. Dependents are not eligible for coverage under these benefits.

Naming a Beneficiary

Name your beneficiaries for any death or AD&D benefits by completing and returning the proper designation form. You are automatically the beneficiary of any disability benefits. Forms are available by contacting the Fund Office. You may change your beneficiary at any time by filing a new beneficiary designation form.

Pension Plan No. 2

Member Eligibility

You become a participant in Pension Plan No. 2 on the day your employer is obligated to make contributions for you under the plan. Participation automatically continues until you stop earning credited service because of a break in service. (See the Glossary for the definition of credited service.)

Pension Plan No. 5

Member Eligibility

You are automatically eligible to participate in Pension Plan No. 5 if your employer is required to make a contribution for you under the plan. You become a participant on the day your employer makes contributions on your behalf to the plan. Participation automatically continues until you receive the full value of your account.

Naming a Beneficiary

You should name a beneficiary for Pension Plan No. 5 benefits as soon as you become eligible to participate by completing the proper designation form. Your beneficiary will receive the remainder of your account if you die before you receive the full value of your account. Forms are available by contacting the Fund Office. You may change your beneficiary at any time by filing a new beneficiary designation form. However, if you are married for at least one year and you name a beneficiary other than your spouse, you must provide the written, notarized consent of your spouse with your beneficiary election.

Additional Security Benefit (ASB) and Supplemental Unemployment Benefit (SUB)

Member Eligibility

You are eligible for the ASB Plan if you are working as an “A” Construction Worker for a participating contractor. Your coverage begins on the first day your employer contributes to your ASB account.

If you are laid off, you will receive SUB Plan benefits if you have accumulated 1,040 hours within the most recent four contribution quarters before your layoff date. To keep your eligibility for benefits, contributions must be made on your behalf for at least 1,040 hours during the most recent four consecutive contribution quarters.

WHAT HAPPENS IF...

Naming a Beneficiary

You should name your beneficiary for ASB Plan benefits as soon as you become eligible to participate by completing the proper designation form. Forms are available by contacting the Fund Office. In the event of your death, your beneficiary will receive your account balance. If you do not have a beneficiary named, your account balance will be paid in the following order:

- ① your spouse,
- ② your children,
- ③ your parents, then
- ④ your estate.

① You Need Medical Care

PPO and Non-PPO Hospitals

You can visit any licensed physician you wish. In general, you pay the least for hospital services if you use one of the plan's PPO network hospitals. For hospital services, such as inpatient, outpatient and diagnostic tests, the amount you pay differs depending on if you visit a PPO network hospital or a non-PPO network hospital. If you visit a PPO hospital, the plan pays 90% of covered expenses after you pay the deductible, then you pay 10%. If you visit a non-PPO hospital, you pay 20% after the deductible. Your maximum out-of-pocket cost in any year is \$1,500.

See "Benefit Summaries," page 2 for quick summaries of your health benefits.

For a list of the plan's PPO network hospitals, log on to www.bcbsil.com or call the Fund Office.

Know Which Services Need Precertification

Before you receive medical care, make sure you're following the correct procedures so you will receive the highest level of benefits for those services.

Utilization Review Program

You, a family member or your physician must notify the utilization review organization at the number listed on page 66 three days before a scheduled procedure or within 48 hours following an emergency admission when you:

- ① are admitted to a hospital,
- ② need an extension to a hospital stay,
- ③ have outpatient therapies in excess of \$2,000 per person per year,
- ④ need durable medical equipment,
- ⑤ need home health care,
- ⑥ need hospice care, or
- ⑦ need skilled nursing facilities.

Failure to precertify may result in certain penalties and/or a reduction in benefits. See page 38 for more information about the utilization review program.

Information You Need

When you contact the utilization review organization, be prepared to provide the following information:

- name of the attending and/or admitting physician,
- name of the hospital/location where the admission has been scheduled,
- scheduled admission date, and
- preliminary diagnosis or reason for the admission.

Mental Health and Substance Abuse Care

For all in-network and out-of-network inpatient services, treatment must be precertified. Additional days or visits (above the 30-day or 30-visit limit) must be approved by the mental health and substance abuse claims administrator as medically necessary. See “Mental Health and Substance Abuse Benefits,” page 41 for specific coverage information for this type of care.

After Treatment

File a Claim if Necessary

After you’ve seen your provider, remember to file a claim if necessary. See “Filing Claims,” page 54.

You Need to File a Claim

Health Care Benefits

(Medical, Prescription Drug, Dental, Orthodontic, Vision and Hearing Aid)

Filing Network Health Care Claims

Generally, if you use a PPO network provider or a network pharmacy, your claim will be submitted directly to the appropriate claims administrator for you. You usually do not need to file a claim.

Filing Out-of-Network Health Care and Dental Claims

If you do need to submit a claim, call the claims administrator's number listed in the "Claims Administrators" section on page 66 for a Request for Benefit Payment form. You'll need to specify the type of claim form you need — general medical, general dental, orthodontic, vision or hearing.

Complete the necessary form in full, attach a statement from your physician or dentist and include bills or receipts for all covered expenses. Mail the claim form and required documentation to the appropriate claims administrator designated on the claim form.

See "Claims Procedures," page 54 for more information on this process.

Coordination of Benefits

When you or your eligible family members are covered by more than one health care plan, benefits may be payable under both plans. When this happens, the benefit payments are coordinated so that your total benefits from both plans do not exceed 100% of the allowed expenses.

See "Coordination of Benefits (COB)," page 56 for the coordination rules that apply to this plan.

Note: Prescription drug benefits under this plan are not coordinated with any other coverage. You or your dependents must receive prescription drug benefits through the primary plan to have them covered.

Welfare Benefits

(Disability, Death and AD&D)

Disability Claims

Notify the Electrical Insurance Trustees of your disability as soon as possible. The Fund Office will send a claim form for you, your employer and your physician to complete and return.

Retroactive payments will not be made for any period of disability that began more than one year before the Fund Office receives the completed claim form.

Death Claims

Your beneficiary should notify the Fund Office of your death and obtain a claim form. The claim form must be completed and filed with the Fund Office within one year of the date of your death. Your beneficiary will need to provide the Fund Office with any information the Trustees require. This may include a certified copy of the death certificate.

AD&D Claims

You or your beneficiary must contact the Fund Office to obtain a claim form if you are dismembered due to an accidental injury or you die while covered under this plan. The claim form must be completed and returned within 90 days of the date of the accident or death. You or your beneficiary also may be asked to supply other information as requested.

See “You Become Disabled,” page 25 for more information.

Additional Security Benefit (ASB) and Supplemental Unemployment Benefit (SUB)

ASB and SUB Claims

Follow the steps below to file a claim:

- 1.** If you are a Journeyman, register in person at the Local Union 134 Referral Hall and be available for work. If you are an apprentice, report to the Training Center.
- 2.** You must file an application for benefits and present a severance notice indicating the layoff is because of “lack of work” or “reduction in workforce.” Your application must be filed within seven calendar days of your layoff. Applications are available from the Local Union 134 Referral Hall and the Fund Office. Applications for apprentices are available from the Training Center. Apprentices may not withdraw unemployment funds from their ASB accounts.
- 3.** Apply to the appropriate state agency for state unemployment compensation. Then provide a copy of your state unemployment stub to the Fund Office within 14 calendar days of the pay date on the check. *Benefits will not be paid on check stubs received after the 14-day deadline.*
- 4.** If you are employed during the four consecutive weeks after applying for benefits, you must requalify for ASB and SUB Plan benefits, file a new application and meet all eligibility requirements. You must notify the Fund Office when you accept employment in Local Union 134 or any other jurisdiction.

WHAT HAPPENS IF...

You or Your Dependents Have Other Health Care Coverage

Coverage Under Another EIT Plan

If you are eligible for health care coverage as a member under another EIT plan, and become covered by that plan, your benefits under this plan will stop while you are covered by the other plan. You cannot receive benefits as a member under two different EIT plans at the same time. You also cannot receive benefits as a member and a dependent child under two EIT plans.

You can, however, be covered as a dependent spouse under one EIT plan and a member under another EIT plan. In this case, coordination of benefits will apply.

Coordination of Benefits

When you or your eligible family members are covered by more than one health care plan, benefits may be payable under both plans. When this happens, the benefit payments are coordinated so that your total benefits from both plans do not exceed 100% of the necessary, reasonable and customary costs of the services provided.

See “Coordination of Benefits (COB),” page 56 for the coordination rules that apply to this plan.

Note: Prescription drug benefits under this plan are not coordinated with any other coverage. You or your dependents must receive prescription drug benefits through the primary plan to have them covered.

Coverage Under Another Company’s Plan

Coordination of Benefits

When you or your eligible family members are covered by more than one health care plan, benefits may be payable under both plans. When this happens, the benefit payments are coordinated so that your total benefits from both plans do not exceed 100% of the necessary, reasonable and customary costs of the services provided.

See “Coordination of Benefits (COB),” page 56 for the coordination rules that apply to this plan.

Note: Prescription drug benefits under this plan are not coordinated with any other coverage. You or your dependents must receive prescription drug benefits through the primary plan to have them covered.

You Change Your Marital Status

Health Care Benefits

(Medical, Prescription Drug, Dental, Orthodontic, Vision and Hearing Aid)

Marriage

In the case of a marriage, you may want to add dependents to your coverage, such as your new spouse and any stepchildren. If your spouse is already covered as a member under this plan, he or she can be covered as a dependent, too. Contact the Fund Office to make benefit changes and provide the following information as applicable:

Eligible Dependents	What You Must Do to Add Dependents
Lawful spouse	Provide a copy of the marriage certificate. The certificate must have been processed by the state in which you were married. Also, provide a copy of the spouse's birth certificate, his or her Social Security number, and all insurance information to assist in the coordination of benefits.
Unmarried stepchildren under the age of 19	Provide a certified copy of the child's birth certificate and a letter from you requesting coverage for the stepchild. You should include information on any other coverage the child has, including the policyholder name and Social Security number, policy name, policy number and mailing address. If there is no other coverage, indicate this in your letter.
Unmarried children under the age of 23 if full-time students	To be eligible, the child must be a full-time student as determined by the educational institution, must rely on you or your spouse for more than 50% of his or her financial support, and normally reside in your home. Once your child reaches age 19 through age 22, you must provide verification of student status every term, semester, trimester, etc. of full-time enrollment. Verification includes a letter from the school's Registrar's office indicating full-time student status and dates of the term. Eligibility continues for 120 days after the last day of full-time attendance. Coverage stops on the dependent's 23rd birthday regardless of full-time student status.
Children ages 19 and older if physically or mentally disabled	To be eligible, the child must rely on you or your spouse for more than 50% of his or her financial support and normally reside in your home. The child is considered disabled if he or she is so severely impaired, physically or mentally, that he or she cannot perform in school or at work and he or she is not capable of self-support. The impairment must be considered permanent or expected to last at least 12 months. The determination must be based on medical evidence. The child is not considered disabled if disability is solely due to alcoholism or drug addiction. You have 31 days before your child turns age 19 (or age 23 if covered as a full-time student) to apply for continuation of dependent benefits. You may have to provide proof of disability and financial dependence on an ongoing basis.

WHAT HAPPENS IF...

If both you and your spouse are covered as members, you both may cover your eligible dependents under the plan. However, your and your dependents' coverage will be coordinated so the plan won't pay more than 100% of the covered expenses for services and supplies.

Divorce or Legal Separation

If you get divorced or legally separated, contact the Fund Office to make benefit changes. Your ex-spouse's and any stepchildren's health care coverage will end at the time of your divorce or legal separation. Upon termination of coverage, your ex-spouse and stepchildren will be notified of COBRA rights.

A Qualified Medical Child Support Order (QMCSO) may be required to document your responsibility for medical coverage of your dependents. If a court order says you are responsible for medical coverage, be sure to notify the Fund Office.

If you do not notify the Fund Office of your divorce or legal separation and the plan pays benefits for an ineligible dependent (e.g., an ex-spouse or stepchild) you may be required to reimburse the plan for any such benefits paid. See "Refund for Overpayment of Benefits," page 57.

Welfare Benefits

(Disability, Death and AD&D)

You may wish to contact the Fund Office to update your beneficiary designation for your benefit coverage. Your beneficiary election applies to both the basic death and the accidental death benefit. You may change your beneficiary at any time by filing a new beneficiary designation form.

Pension Plan No. 2

Your new spouse may be entitled to a benefit under this plan when you die. Contact the Fund Office to add your spouse to their benefit records.

Pension Plan No. 5

If you already have a beneficiary form on file and then you get married, your current beneficiary form is valid to the date you have been married for one year. On the date you have been married for one year, you must complete a new beneficiary form (including your spouse's consent). Contact the Fund Office for a form.

Additional Security Benefit (ASB)

You may want to update your beneficiary designation for your ASB account. Contact the Fund Office for a new beneficiary designation form.

You Become a Parent

Notify Your Employer

You should notify your employer and the Fund Office as soon as you learn that you will become a parent. Family leave benefits may be available during and after a pregnancy or adoption. If you do not provide notice, your coverage would end when a shortage of hours occurs.

Health Care Benefits

(Medical, Prescription Drug, Dental, Orthodontic, Vision and Hearing Aid)

Contact the Fund Office to add your new dependent for coverage. You will need to provide the following information as applicable:

Eligible Dependents	What You Must Do to Add Dependents
Natural born unmarried children under the age of 19	Provide a certified copy of the birth certificate or paternity test. These documents must list the eligible member as one of the biological parents.
Adopted children or children placed in your home for legal adoption under the age of 19	Provide a finalized copy of the adoption papers (in English) or an interim order through the courts.

If both you and your spouse are covered as members, you both may cover your eligible dependents under the plan. However, your dependents' coverage will be coordinated so the plan won't pay more than 100% of the covered expenses for services and supplies.

Welfare Benefits

(Disability, Death and AD&D)

You may wish to contact the Fund Office to update your beneficiary designation for your benefit coverage. Your beneficiary election applies to both the basic death and the accidental death benefit. You may change your beneficiary at any time by filing a new beneficiary designation form.

Additional Security Benefit (ASB)

You may want to update your beneficiary designation for your ASB account. Contact the Fund Office for a new beneficiary designation form.

WHAT HAPPENS IF...

Ⓢ Your Dependent Loses Eligibility for Health Care Coverage

If Your Dependent is Going to Lose Eligibility

You should contact the Fund Office to notify them that your dependent is going to lose eligibility due to:

- Ⓢ dependent child reaching age 19 (or age 23 if he or she is a full-time student living with you and financially dependent on you),
- Ⓢ dependent child's loss of student status after reaching age 19,
- Ⓢ dependent child's marriage, or
- Ⓢ your divorce or legal separation.

You can also obtain information from the Fund Office on COBRA continuation of coverage procedures and costs.

If You Divorce or Legally Separate

Ex-spouses and stepchildren who are no longer eligible for coverage because of divorce or legal separation may be able to continue coverage through COBRA for up to 36 months from the date on which coverage ends.

Notify the Fund Office of the family status change. Once coverage is terminated, your ex-spouse and stepchildren will receive COBRA information, including COBRA procedures, necessary forms and costs.

If you do not notify the Fund Office of your divorce or legal separation and the plan pays benefits for an ineligible dependent (e.g., an ex-spouse or stepchild) you may be required to reimburse the plan for any such benefits paid. See "Refund for Overpayment of Benefits," page 57.

e You Work in Another Jurisdiction

Have Your Contributions Transferred

If you work partly in another jurisdiction and wish to continue health care benefit coverage and/or welfare benefit coverage under this plan, you must have your employer's (outside the jurisdiction) contributions transferred to this plan.

To do this, you must sign a reciprocity authorization in the jurisdiction where the work is to be performed. You should sign the agreement *before* you begin the work, as only your time completed on or after the date it is signed is transferred. Please note, it may take longer for your time from these outside jurisdictions to be received and calculated than from Local 134 contractors.

If You Do Not Arrange for Contributions to be Transferred

If you do not arrange to have your employer's contributions transferred to this plan, your membership in this plan will end when you fail to work:

- e** 300 contributed hours in the latest coverage quarter, and
- e** 1,200 contributed hours in the previous four consecutive calendar quarters.

e You Are Laid Off

Health Care Benefits

(Medical, Prescription Drug, Dental, Orthodontic, Vision and Hearing Aid)

Your health care coverage may continue if you are registered through the Referral Hall and available for work. You can make self-pay contributions for up to three consecutive quarters. You will be notified if you are eligible for self-pay. See "Self-Pay Contributions," page 32 for more information.

You may then apply for COBRA continuation of coverage (see page 35).

Welfare Benefits

(Disability, Death and AD&D)

You may continue your disability/death/AD&D coverage if you are registered through the Referral Hall and available for work. You can make self-pay contributions for up to three consecutive quarters. You will be notified if you are eligible for self-pay. See "Self-Pay Contributions," page 32 for more information.

Coverage under the EIT Plan will end when you stop making self-pay contributions. However, you may then apply for life insurance conversion.

WHAT HAPPENS IF...

Pension Plan No. 2

Active participation continues until you stop earning credited service because of a break in service. If you are laid off because of a reduction in workforce, you may have an “excused absence,” provided you return to covered employment within 31 days after the layoff ends. Excused absences are combined with your hours of covered employment to determine whether a break in service has occurred.

Pension Plan No. 5

Contributions stop during the period of layoff. However, you continue as a participant until you receive the full value of your account.

Additional Security Benefit (ASB) and Supplemental Unemployment Benefit (SUB)

The ASB Plan benefit works together with the SUB Plan benefit to provide you with extra income during a layoff, if you are eligible.

ASB Plan benefits are payable for the first 13 weeks, provided there is enough money in your account. ASB payments will stop when the earliest of the following occurs:

- ① you return to work,
- ② you have no money left in your ASB account,
- ③ you receive 13 weeks of payments, or
- ④ you are not registered at the Referral Hall, you are not available for work for any reason or you did not follow Daybook procedures. (Contact the Referral Hall for information on Daybook procedures.)

The SUB Plan benefit will begin the 14th week of your layoff and continue for up to 39 weeks, if you are eligible. SUB payments will stop if you are not registered at the Referral Hall, you are not available for work for any reason or you did not follow Daybook procedures.

To receive ASB or SUB Plan benefits, you must follow these steps:



- 1.** If you are a Journeyman, register in person at the Local Union 134 Referral Hall and be available for work. If you are an apprentice, report to the Training Center.
- 2.** You must file an application for benefits and present a severance notice indicating the layoff is because of “lack of work” or “reduction in workforce.” Your application must be filed within seven calendar days of your layoff. Applications are available from the Local Union 134 Referral Hall and the Fund Office. Applications for apprentices are available from the Training Center. Apprentices may not withdraw unemployment benefits from their ASB account.
- 3.** Apply to the appropriate state agency for state unemployment compensation. Then provide a copy of your state unemployment stub to the Fund Office within 14 calendar days of the pay date on the check. *Benefits will not be paid on check stubs received after the 14-day deadline.*
- 4.** If you are employed during the four consecutive weeks after applying for benefits, you must requalify for ASB and SUB Plan benefits, file a new application and meet all eligibility requirements. You must notify the Fund Office when you accept employment in Local Union 134 or any other jurisdiction.

You Retire

Health Care Benefits

(Medical, Prescription Drug, Dental, Orthodontic, Vision and Hearing Aid)

Your and your eligible dependents' health care benefits may be continued after you retire. You (and your eligible dependents) are eligible for retiree medical benefits if you are receiving a benefit from and have 10 years of eligibility service under Pension Plan No. 2, *and* you:

-  have been covered as an active member under this plan throughout the two years before your retirement, or
-  have at least 30 years of credited service under Pension Plan No. 2.

Unless you retire on a disability pension, you are not eligible for retiree health care benefits until you reach age 62. If you remain in active employment when you reach age 65, generally you will be eligible for the same benefits as you were before age 65.

Note: If you retire at age 60 and meet the qualifications above, you are eligible for COBRA coverage for 18 months. You can then request interim coverage, which extends your coverage for up to six months (you pay the full cost of the coverage). This interim coverage will take you to age 62, at which time you would be eligible for retiree coverage (see page 53). You must contact the Fund Office to request interim coverage.

Welfare Benefits

(Disability, Death and AD&D)

You may have the right to convert your death benefit to an individual life insurance policy when you retire. Contact the Fund Office for more information.

Your disability and AD&D benefits will end upon your retirement.

Pension Plan No. 2

You may receive your pension benefits under Pension Plan No. 2 as early as age 55 with at least 10 years of eligibility service. Your pension is paid to you as long as you live. After your death, your eligible spouse or children may continue to receive a portion of your pension.

Applying for Pension Plan No. 2 Benefits

To apply for your Pension Plan No. 2 benefits, you or your beneficiary should contact the Board of Trustees of Electrical Contractors Association and Local Union 134, I.B.E.W. Joint Pension Trust of Chicago for benefit forms. You or your beneficiary must file an application with the Fund Office, who will then file your application with the Trustees. You or your beneficiary may be asked to supply evidence of age and any other additional information that is necessary.

The application should be received by the Fund Office at least 90 days before you expect the first payment.



WHAT HAPPENS IF...

Pension Plan No. 5

You may receive your pension benefits under Pension Plan No. 5 as early as age 55 with at least 10 years of eligibility service. Depending on your election, your benefit will be paid as a cash lump sum (that is, your full account balance) or in the form of an annuity.

Applying for Pension Plan No. 5 Benefits

To apply for your Pension Plan No. 5 benefits, you or your beneficiary should contact the Fund Office for benefit forms. You or your beneficiary must file an application with the Fund Office, who will then file your application with the Trustees. You or your beneficiary may be asked to supply evidence of age and any other additional information that is necessary.

The application should be received by the Fund Office at least 90 days before you expect the first payment.

Additional Security Benefit (ASB)

If you have retiree coverage under the health plan, you may be reimbursed from your ASB account for deductibles, copayments or Medicare Part B premiums you pay. Contact the Fund Office for an application for reimbursement.

Other Things to Consider

Contact the Social Security Administration at (800) 772-1213 *at least* three months before you plan to retire to apply for Social Security and Medicare Benefits.

Ⓢ You Fail to Meet the Contributed Hours Requirements

Health Care Benefits

(Medical, Prescription Drug, Dental, Orthodontic, Vision and Hearing Aid)

Self-Pay Contributions

If you fail to meet any contributed hours requirements, your health care benefit coverage will end. However, your health care coverage may continue if you are registered through the Referral Hall and available for work. You can make self-contributions for up to three consecutive quarters. You pay the difference between the hours paid for by your employer(s) and the hours required for continued coverage at the employer's current rate of contribution per hour. You may apply for COBRA continuation of coverage in the fourth consecutive quarter (see page 35).

You will be notified by the Fund Office if you are eligible to continue coverage through self-pay.

Note: If you are on an approved family medical leave or military leave of absence, your coverage may also continue. Contact the Fund Office for more information.

Welfare Benefits

(Disability, Death and AD&D)

Self-Pay Contributions

If you fail to meet any contributed hours requirements, your welfare benefit coverage will end. However, you may continue your disability/death/AD&D coverage by making self-pay contributions for up to three consecutive quarters. You pay the difference between the hours paid for by your employer(s) and the hours required for continued coverage at the employer's current rate of contribution per hour.

You will be notified by the Fund Office if you are eligible to continue coverage through self-pay.

Pension Plan No. 2

Active participation ends if your employer no longer makes required contributions or you stop earning credited service because of a break in service. Contact the Fund Office for more information.

Pension Plan No. 5

Active participation ends if your employer no longer makes required contributions. You continue as a participant until you receive the full value of your account. Contact the Fund Office for more information.

Supplemental Unemployment Benefit (SUB)

SUB Plan benefits will be cancelled if you do not work the required number of hours.

e You Terminate Employment

Health Care Benefits

(Medical, Prescription Drug, Dental, Orthodontic, Vision and Hearing Aid)

Continuing Benefits

If you terminate your employment with a contributing employer, your benefit coverage will end. However, you may be able to continue your health care benefit coverage — medical, prescription drug, dental, orthodontic, vision and hearing aid — for yourself and your eligible dependents for a limited period of time under COBRA. See page 35.

When your or your covered dependent's health care coverage under the plan ends, you will receive a certificate of prior health coverage. Show this to your new employer to avoid a loss of coverage and/or pre-existing conditions limitations.

Welfare Benefits

(Disability, Death and AD&D)

Converting Your Death Benefit

You may have the option to convert your death benefit to an individual life insurance policy if you terminate your employment. Contact the Fund Office for more information.

Disability and AD&D coverage will end if you terminate employment.

Pension Plan No. 2

Receiving Your Pension

You may be entitled to receive your pension benefit when you terminate employment if you are at least age 55 with 10 or more years of eligibility service. Contact the Fund Office for more information.

Pension Plan No. 5

Receiving Your Pension

You may be entitled to receive your entire account balance when you terminate employment if you are at least age 55 with 10 or more years of eligibility service. Contact the Fund Office for more information.

Additional Security Benefit (ASB)

Requesting Payment

You can request payment from your ASB account nine months after your industry employment ends. Industry employment is employment within the trade and geographic jurisdiction of Local Union 134. Contact the Fund Office for a claim form.



You Become Disabled

Health Care Benefits

(Medical, Prescription Drug, Dental, Orthodontic, Vision and Hearing Aid)

If you become disabled as a result of an accident or injury while an active member, you may be entitled to receive a benefit from the plan. You or your beneficiary must notify the Fund Office of your disability.

In the following cases, your health care coverage will be continued:

-  If you become disabled, your health care coverage will continue for up to 13 weeks, provided you are receiving weekly accident and sickness benefits or Workers' Compensation.
-  After the 13-week period ends, you may continue to be eligible for an additional 104 weeks of coverage if you have been a participant for at least one year before your disability began and provide proof of continued disability to the Trustees.

You may also be eligible for COBRA continuation coverage when your health care coverage would otherwise end. In the event of a disability, COBRA coverage may be continued for up to a total of 29 months. See page 36 for more information.

Welfare Benefits

(Disability, Death and AD&D)

Filing a Claim

To file a claim for disability benefits, contact the Fund Office for a claim form.

Converting Your Death Benefit

If you become totally and permanently disabled while an active member under age 70, you may convert your basic death benefit to a series of 114 monthly payments.

You must provide proof of disability (including your Social Security award) within one year after it begins. The Trustees may require proof of continuance of disability at any time during the first two years, and once a year thereafter. Installments will stop if you fail to furnish satisfactory proof of your disability.

Pension Plan No. 2

Receiving Your Pension

You may be eligible for a disability pension if your employment ends because of a disability that begins after you have at least 10 years of eligibility service. You get your full monthly pension amount, without reduction, even if you retire before your normal retirement date. However, if you start receiving disability pension benefits, disability benefit payments under the plan will stop.

Contact the Fund Office to apply for disability benefits and to see if you qualify for a disability pension. The Trustees may require up to two medical exams during any calendar year.

WHAT HAPPENS IF...

Pension Plan No. 5

Receiving Your Pension

You can receive your entire account balance by filing a completed application form if you leave employment within the trade or jurisdiction of I.B.E.W. Local 134 and you are receiving a Social Security disability benefit. You must file an application form with the Trustees. Forms are available by contacting the Fund Office.

Additional Security Benefit (ASB)

Requesting Payment

If you are disabled, you can withdraw the balance of your ASB account as long as you are not receiving a disability benefit from an Electrical Insurance Trustees disability plan. You must have filed an application for Social Security disability benefits to be eligible for this withdrawal. Contact the Fund Office for more information.

Other Information

Be sure to apply for Social Security benefits by contacting the Social Security Administration at (800) 772-1213.

Ⓢ You Have a Workers' Compensation Claim

Contact the Fund Office

If you become disabled because of an occupational injury or illness, your benefits will continue during your disability for up to 13 weeks. To continue coverage you must have filed a claim with your employer and Workers' Compensation.

If you are still disabled after 13 weeks, you may be eligible for an additional 104 weeks of coverage if:

- Ⓢ you have been a participant in the plan for at least one year before your disability began, and
- Ⓢ you provide the Trustees with proof of continued disability.

Contact the Fund Office for the necessary application form.

☺ You or Your Dependent Dies

If You Die

Health Care Benefits

If you die, your surviving spouse will remain eligible for coverage for 360 days, whether or not he or she is entitled to Medicare. Your eligible dependent children will also remain eligible for coverage for 360 days. If your child stops attending school during this time, he or she is eligible for 120 days of coverage from the last day of full-time attendance (not to exceed a total of 360 days). Your spouse and eligible dependent children may then apply for and continue coverage under COBRA for up to 36 months by paying the applicable premium. See page 35 for more information about COBRA.

Welfare Benefits

Your beneficiary must notify the Fund Office of your death and obtain a claim form. The claim form must be completed and filed with the Fund Office within one year of the date of your death. The Trustees may require your beneficiary to submit necessary information to the Fund Office.

You or your beneficiary must contact the Fund Office to obtain a claim form in the event you need to file an accidental death or dismemberment claim. The claim form must be completed and returned within 90 days of the date of the accident or death. You or your beneficiary also may be asked to supply other information as requested.

Pension Plan No. 2

If you die while actively employed, your spouse may be eligible for a monthly benefit from Pension Plan No. 2. To apply for pension benefits, your spouse may contact the Fund Office for benefit forms. He or she may be asked to supply evidence of age and any other additional information, such as a death certificate.

If a Dependent Dies

Things to Consider

- ☺ Cancel dependent health care coverage, if appropriate.
- ☺ Update your beneficiary designations for welfare coverage, Pension Plan No. 5 and the Additional Security Benefit Plan.
- ☺ Adjust W-2 withholding rate.

WHAT HAPPENS IF...

Pension Plan No. 5

Your beneficiary will receive the remainder of your account balance if you die before receiving the full value of your Pension Plan No. 5 account. If you had not designated a beneficiary or your beneficiary does not survive you, your account will be paid in the following order:

- ① your spouse,
- ② your children,
- ③ your parents, then
- ④ your estate.

To apply for pension benefits, your beneficiary may contact the Fund Office for benefit forms. He or she may be asked to supply evidence of age and other additional information, such as a death certificate.

Additional Security Benefit (ASB)

If you have money in your ASB account when you die, your beneficiary will receive your account balance. If you had not designated a beneficiary or your beneficiary does not survive you, your account will be paid in the following order:

- ① your spouse,
- ② your children,
- ③ your parents, then
- ④ your estate.

Your beneficiary should contact the Fund Office for more information.

Benefit Eligibility

Members

You are eligible for the plan beginning, retroactively, on the first day of the month after receipt of contributions for 600 hours

of active work. You must have worked these hours within six consecutive months. Apprentice training school time may be calculated into your work history.

Dependents

You can also choose to cover your dependents under the plan. Eligible dependents include:

Eligible Dependents	Requirements
Lawful spouse	Provide a copy of your marriage certificate. The certificate must have been processed by the state in which you were married.
Natural born unmarried children under the age of 19	Provide a certified copy of the birth certificate or paternity test. These documents must list the eligible member as one of the biological parents.
Unmarried stepchildren under the age of 19	Provide a copy of the child's birth certificate and a letter with information on any other coverage the child has, including the policyholder name and Social Security number, policy name, policy number and mailing address. If there is no other coverage, indicate this in your letter.
Adopted children or children placed in your home for legal adoption under the age of 19	Provide a finalized copy of the adoption papers (in English) or an interim order through the courts.
Unmarried children under the age of 23 if full-time students	To be eligible, the child must be a full-time student as determined by the educational institution, must rely on you or your spouse for more than 50% of his or her financial support, and normally reside in your home. Once your child reaches age 19 through age 22, you must provide verification of student status every term, semester, trimester, etc. Verification includes a letter from the school's Registrar's office indicating full-time student status and dates of the term. Eligibility continues for 120 days after the last day of full-time attendance. Coverage stops on the dependent's 23rd birthday regardless of full-time student status.
Children ages 19 and older if physically or mentally disabled	To be eligible, the child must rely on you or your spouse for more than 50% of his or her financial support and normally reside in your home. The child is considered disabled if he or she is so severely impaired, physically or mentally, that he or she cannot perform in school or at work and he or she is not capable of self-support. The impairment must be considered permanent or expected to last at least 12 months. The determination must be based on medical evidence. The child is not considered disabled if disability is solely due to alcoholism or drug addiction. You have 31 days before your child turns age 19 (or age 23 if covered as a full-time student) to apply for continuation of dependent benefits. You may have to provide proof of disability and financial dependence on an ongoing basis.

If Both You and Your Spouse Are Covered Members

If both you and your spouse are covered as members, you both may cover your eligible dependents under the plan. However, your and your dependents' coverage will be coordinated so the plan won't pay more than 100% of the covered expenses for services and supplies.

Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a legal judgment, decree or order issued under a state domestic relations law by a court or an administrator. A QMCSO creates or recognizes the rights of a child to coverage for health care benefits.

Under a child support order, a court can require you to provide coverage to a child under this plan.

The Fund Office will notify you if any of your children are affected by a QMCSO. You may contact the Fund Office to request a free copy of the procedures the plan uses to determine whether a medical child support order is qualified.

When Coverage Begins

Benefit coverage begins on the first day of the month after you complete the eligibility requirements (see "Benefit Eligibility," page 29). Your dependents are eligible to join the plan on the same day you are eligible for coverage.

If you marry, your new spouse and your spouse's dependent children are eligible for coverage on your marriage date. For new-born eligible dependents, coverage begins on date of birth. For adopted children, coverage begins as directed in the final adoption papers. For children placed in your home, coverage begins on the date verified in the interim order.

Maintaining Your Coverage

Once you become eligible, you and your dependents will continue health care coverage depending on the contributions received from your employer. You need contributions received for at least:

- Ⓜ 300 hours in the most recent contribution quarter, or
- Ⓜ 1,200 hours in the most recent four contribution quarters.

The Fund Office reviews your contributed hours four times a year to determine your eligibility for benefits. Here's how it works:

- Ⓜ About halfway through each quarter, your contributed hours in the previous quarter are calculated.
- Ⓜ If you worked sufficient hours for the quarter of review or the previous 12 consecutive months, your benefits continue until the next review.
- Ⓜ If you fail both hours requirements, your coverage ends.
- Ⓜ Benefits continue for the current quarter, while the calculations of the prior quarter are being reviewed. Current hours are not a factor in your termination of benefits.

This table summarizes the eligibility rules:

As of the end of this quarter:	If you meet one of the contributed hours requirements, coverage continues through:	If you fail to meet either contributed hours requirement, coverage ends on this date (unless you make self-pay contributions):
January 1 – March 31	Quarter 3, ending September 30	June 30
April 1 – June 30	Quarter 4, ending December 31	September 30
July 1 – September 30	Quarter 1, ending March 31	December 31
October 1 – December 31	Quarter 2, ending June 30	March 31

If you are unable to work because of a sickness or injury, you may be credited with 25 hours for each week of proven disability during any one period of continuous disability. You must be:

- Ⓜ eligible for accident and sickness or long-term disability benefits from the Welfare Fund, and
- Ⓜ receiving disability benefits from Workers' Compensation.

It is your responsibility to know when your coverage will end due to insufficient contributed hours. Notice of loss of coverage from the Fund Office is not an obligation of the Welfare Fund, its Trustees or the Fund Office.

Self-Pay Contributions

You have the opportunity to make self-pay contributions to maintain your and your dependents' coverage under the plan. You pay, at the current contractor rate, for the hours required to continue coverage. Your shortfall is calculated using both contributed hours requirements: 300 contributed hours per quarter and 1,200 contributed hours in the last 12 consecutive months. You pay the lesser amount.

You can maintain coverage by self-pay contributions for up to three consecutive quarters if you are registered at the Referral Hall or apprentice school and available for work.

Here's an example of how self-pay contributions are calculated. Let's assume you had 250 contributed hours in the last quarter ending March 31 and 1,000 contributed hours during the 12 consecutive months ending March 31. Your shortfall is calculated as follows:

	Hours Per Quarter	Hours Per 12 Months
Required contributed hours	300	1,200
Actual contributed hours	250	1,000
Shortfall	50	200

In this example, the lesser amount of shortfall is 50 contributed hours. You could maintain your coverage for the next quarter by self-paying based on 50 contributed hours. Keep in mind, your self-pay contributions will vary each quarter depending on the amount of shortfall hours.

If You Work in Another Jurisdiction

If you work partly in another jurisdiction under a reciprocity agreement and you wish to maintain participation in this plan, your employer's contributions must be transferred to this plan. To initiate the transfer, you must sign a reciprocity authorization in the jurisdiction where the work is to be performed. You should sign the agreement *before* you begin the work as only your time completed on or after the date signed is transferred. Please note, it may take longer for your time from these outside jurisdictions to be received and calculated than from Local 134 contractors.

If you do not arrange to have your employer's contributions transferred to this plan, your membership in this plan will end when you fail to work:

- Ⓢ 300 contributed hours in the latest coverage quarter, or
- Ⓢ 1,200 contributed hours in the previous four consecutive calendar quarters.

You Are Eligible for Another EIT Plan

If you are eligible for health care coverage as a member under another EIT plan and become covered by that plan, your benefits under this plan will stop while you are covered by the other plan. You cannot receive benefits as a member under two different EIT plans at the same time. You also cannot receive benefits as a member and a dependent child under two EIT plans.

You can, however, be covered as a dependent spouse under one EIT plan and a member under another EIT plan. In this case, coordination of benefits will apply. See page 56 for more information on coordination of benefits.

Continuing Coverage When Disabled

If you become disabled and are unable to work, your coverage will continue during your disability for 13 weeks. To continue coverage, you must receive weekly accident and sickness benefits or Workers' Compensation.

If you are still disabled after 13 weeks, you may be eligible for an additional 104 weeks of coverage if:

- Ⓢ you have been a participant in the plan for at least one year, and
- Ⓢ you provide the Trustees with proof of continued disability.

Reinstatement of Coverage

If you lose coverage due to the contributed hours requirements, you can reinstate your coverage. Reinstatement begins, retroactively, on the first day of the month after receipt of contributions for 300 hours of active work. You must have worked these hours during any three consecutive months.

If you do not qualify for reinstatement within 52 weeks, you can become eligible for coverage like a new member. This means you need to complete 600 contributed hours of active work within six consecutive months.

Suspension of Benefits

If your participating employer has not submitted contributions for the hours you worked, coverage for you and your covered dependents will be suspended if you continue working for that employer while they are delinquent. Your coverage will be retroactively reinstated once your employer pays all amounts due the Fund Office or if you stop working for that employer. You must stop work for that employer and sign the out-of-work list at the Referral Hall within seven days after being notified of your suspension of benefits.

Suspension of benefits is not a COBRA qualifying event. You and your eligible dependents are not entitled to COBRA solely because benefit coverage is suspended. See page 35 for information about events that do qualify you and your dependents for COBRA.

When Coverage Ends

Your coverage under the plan ends when the first of the following occurs:

- ⓪ you fail to meet either contributed hours requirement,
- ⓪ your employer fails to make the required contributions to the plan on your behalf,
- ⓪ you retire,
- ⓪ you die,
- ⓪ you become eligible under another plan administered by EIT, or

- ⓪ the plan ends, for any reason.

Your dependent coverage ends:

- ⓪ when your coverage ends (please note, your dependents' coverage will continue for up to 360 days following your death),
- ⓪ for your spouse and any stepchildren, at the time of your legal divorce or legal separation,
- ⓪ on your dependent's death,
- ⓪ when your dependent child reaches the age limit, or
- ⓪ you become eligible under another plan administered by EIT.

Coverage ends...	However, coverage may continue if...
If you fail to meet the hours requirement	You are registered through the Referral Hall and available for work. You will be offered the self-pay contributions option. This option can be offered for three consecutive quarters. If payment is received by the requested date, benefits will continue. You may apply for COBRA continuation of coverage in the fourth consecutive quarter (see page 35).
If you work outside the jurisdiction of Local Union 134	You work for a participating employer outside Local Union 134 jurisdiction and you sign a reciprocal agreement to have your employer's contributions transferred to this plan.
If you die	You are survived by a spouse and/or other eligible dependents. Coverage continues for 360 days and then ends unless they apply for and pay COBRA continuation of coverage (see page 35).
If you retire	You are receiving a benefit from and have 10 years of eligibility service under Pension Plan No. 2 <i>and</i> you have either been a member in this plan for two consecutive years immediately before your retirement or you have 30 years of credited service under Pension Plan No. 2. You must also be at least age 62. If you meet these requirements, you are eligible for the retiree medical benefits described on page 53. Note: If you retire at age 60 and meet the qualifications above, you are eligible for COBRA coverage for 18 months. You can then request interim coverage, which extends your coverage for up to six months (you pay the full cost of the coverage). This interim coverage will take you to age 62, at which time you would be eligible for retiree coverage (see page 53). You must contact the Fund Office to request interim coverage.
If the plan is discontinued	No further coverage.

The Trustees will make every effort to notify you by mail if you lose coverage for any reason. The notice will be sent to the address on file at the Fund Office. Be sure to notify

the Fund Office in writing if you or any covered dependent has a change of address. You can use the New Address form at the back of the booklet to notify the Fund Office.

Coverage Under Special Circumstances

Military Leave of Absence

If you are on a military leave of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA), your and your dependents' coverage will continue under the plan.

You must provide the Fund Office with a copy of your orders that gives both a report date and a discharge date. You will receive five hours of credit for each day you are on a military leave. For additional information about a military leave of absence, contact the Fund Office.

Family Medical Leave Act (FMLA)

You are entitled to request up to a 12-week FMLA leave in any 12-month period for the following reasons:

- Ⓢ birth and care of a newborn child;
- Ⓢ placement of a child with you for adoption or foster care;
- Ⓢ care of your spouse, child or parent with a serious health condition; or
- Ⓢ a serious health condition that prevents you from performing your job.

If your request is granted, your health care coverage under the plan continues during your approved leave.

To be eligible for FMLA, you must:

- Ⓢ have worked at least 12 months for a participating employer, and
- Ⓢ have at least 1,250 hours of contributions within the last 12 months from the leave starting date.

If you would like to take an FMLA leave of absence, you must notify your employer and the Fund Office. For more information about FMLA or if you have any questions, please contact the Fund Office.

COBRA Coverage

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, requires that members and their covered dependents be able to continue certain health care coverage when they would otherwise lose coverage. Coverage continues at your own expense.

Under COBRA, you and your covered dependents (or former dependents) have the right to continue medical, prescription drug, dental, orthodontic, vision and hearing aid coverage. Or you may elect to continue medical and prescription drug coverage only. You receive the same benefits as active members for the option you choose. COBRA *does not extend* to other benefits under this plan, such as accident and sickness, long-term disability, dismemberment or death.

COBRA coverage for you and your covered dependents continues for up to 18 months if you become eligible for COBRA because your hours are reduced below the number required for coverage.

COBRA coverage is also available to your covered dependents for up to 36 months if their coverage ends because:

- Ⓢ you die,
- Ⓢ a covered child becomes ineligible due to age,
- Ⓢ you get a divorce or legal separation, or
- Ⓢ you become entitled to Medicare.

You or a family member is responsible for notifying the Trustees of any event that makes continuation of coverage applicable. Such events include divorce, death, or becoming Medicare entitled because of disability or a dependent becoming ineligible because of age.

COBRA and Disability

You may elect to continue COBRA for you and your covered dependents for a total of 29 months (11 additional months), if you:

- Ⓢ elected COBRA coverage based on a reduction of hours, and
- Ⓢ become disabled (as determined by the Social Security Administration) anytime within the first 60 days of COBRA.

To elect the 11-month extension, notify the Fund Office within 60 days of Social Security's determination of disability and within the first 18 months of COBRA coverage.

Newborn and Adopted Children

Newborns and children adopted by you while you are covered under COBRA are eligible to elect COBRA coverage immediately. Your new child is a "qualified beneficiary" with independent election and second qualifying event rights.

Cost of COBRA Coverage

You pay 102% of the regular contribution rate or the cost of coverage for members and dependents (100% of the premium plus a 2% administration fee).

Applying for COBRA Coverage

You will receive an election form from the Fund Office and more information about COBRA coverage if you become eligible for it. In the case of a divorce or ineligibility of a dependent child, the qualified beneficiary must notify the Fund Office to receive an election form.

To continue coverage, you or your affected dependent must elect COBRA coverage within 60 days after an event qualifies you for COBRA or after the Fund Office mails your election form, whichever is later. Your spouse and dependent children have separate election rights. You have an additional 45 days from the date you return your election form to pay the premiums necessary to avoid any gap in coverage. Any claims you file are not paid until the plan receives your contribution.

When COBRA Coverage Ends

COBRA coverage ends on the earliest of the following dates:

- Ⓢ You or your dependent becomes eligible for another group health plan, unless that plan contains a pre-existing condition limit (but only with respect to the individual who has the pre-existing condition). If a pre-existing condition is excluded by the other group plan, coverage will continue under this plan until the condition is covered by the other plan.
- Ⓢ You or your dependent becomes entitled to Medicare.
- Ⓢ The plan ends.
- Ⓢ The COBRA continuation period — 18, 29 or 36 months — ends.

COBRA Administrator

If you have any questions about your eligibility for COBRA, or you do not receive coverage information within 14 days of notification of a qualifying event, contact the Fund Office.

Coverage Summary At-A-Glance

The following table summarizes when coverage begins, continues, ends and resumes.

Coverage Begins	Coverage Continues	Coverage Ends	Coverage Resumes
Retroactively on the first day of the month after receipt of contributions for 600 hours of active work. You must have worked these hours within six consecutive months. (Electrical apprentice training school hours may count as hours of work.)	If you have 300 contributed hours in the most recent contribution quarter or 1,200 contributed hours in the previous four contribution quarters.	When contributed hours are less than 300 hours in the latest contribution quarter and 1,200 hours in the previous four contribution quarters (see “When Coverage Ends,” page 34).	If, within 52 weeks of leaving plan coverage, you have 300 contributed hours during three consecutive months; otherwise see “Coverage Begins” in this table.

Medical Benefits

How the Medical Benefit Works

When you need medical care, you can choose to visit any licensed physician or hospital you wish. In general, the plan pays a percentage of the charges for covered services after you have met your deductible.

Eligible expenses for treatment of an illness or injury must be medically necessary. (See the Glossary for the definition.)

Annual Deductible

For most services, you must satisfy a deductible before the plan begins to pay benefits. The calendar year deductible is \$100 per person, up to a maximum of \$200 per family. A separate \$100 calendar year deductible applies to out-of-network mental health and substance abuse treatments (see page 41).

Copays

For most services, once you satisfy the deductible the plan pays 80% of covered reasonable and customary medical expenses. You pay 20%. However, if you are hospitalized and use one of the plan’s PPO hospitals, the plan pays 90% of covered expenses. You pay 10% (see “Participating Provider Option (PPO),” page 38 for an explanation of PPO hospitals).

Annual Out-of-Pocket Maximum

The plan limits the amount you have to pay for covered medical expenses in any calendar year. Your annual maximum out-of-pocket expense is \$1,500 per family. After you reach the out-of-pocket maximum, the plan pays 100% of the remaining covered expenses for the rest of the year.

The out-of-pocket maximum does *not* include:

- ⓔ amounts in excess of reasonable and customary charges (see the Glossary for the definition),
- ⓔ mental health and substance abuse treatment expenses,
- ⓔ prescription drug expenses, and
- ⓔ claims paid by third parties.

New deductible and copay requirements apply each January 1 for the remainder of the calendar year.

Lifetime Maximum

The plan's lifetime maximum benefit is \$2 million per person. Substance abuse treatment has a separate \$40,000 lifetime maximum.

Participating Provider Option (PPO)

A PPO hospital is a member of a network of hospitals that has agreed to provide services at lower costs to network participants. By using one of the plan's PPO network hospitals you receive a higher level of coverage with a lower out-of-pocket cost than if you use a non-PPO hospital. When you use a PPO hospital, the plan pays 90% of covered hospital expenses and you pay 10%. If you live within 10 miles of a network hospital but you visit a non-PPO hospital, you pay 20%. If you live more than 10 miles away from all PPO network hospitals, out-of-area benefits are available. Coverage is generally the same as if you visit a non-PPO hospital. For a list of the plan's PPO network hospitals, log onto www.bcbsil.com or call the Fund Office.

Utilization Review Program

The utilization review process helps you receive the appropriate levels of care in the proper setting and for an appropriate length of time. The plan's utilization review organization must certify in advance any:

- ⓔ hospital stays,
- ⓔ certain services which follow, or
- ⓔ alternative courses of inpatient treatment from what was initially approved.

This helps ensure that your treatment is medically necessary. It also helps to keep your health care costs under control.

You, a family member or your physician is responsible for notifying the utilization review organization at the number listed on page 66 when you:

- ⓔ are admitted to a hospital,
- ⓔ need an extension to a hospital stay,
- ⓔ have outpatient therapies in excess of \$2,000 per person per year,
- ⓔ need durable medical equipment,
- ⓔ need home health care,
- ⓔ need hospice care, or
- ⓔ need skilled nursing facilities.

When you contact the utilization review organization, be prepared to provide the following information:

- ⓔ name of the attending and/or admitting physician,
- ⓔ name of the hospital/location where the admission has been scheduled,
- ⓔ scheduled admission date, and
- ⓔ preliminary diagnosis or reason for the admission.

The review organization will review the medical information provided and may follow up with the physician. Keep in mind, the utilization review organization may determine that the services to be provided are not medically necessary.

Precertifying a Hospital Admission

When you or a family member are hospitalized, you must notify the utilization review organization for your treatment to be reviewed. Notice must be received:

- Ⓢ at least three days before treatment for non-emergency hospital admissions, or
- Ⓢ within 48 hours following an emergency admission.

Note: By law, benefits for any hospital stay in connection with childbirth for the mother or the newborn cannot be restricted to less than:

- Ⓢ 48 hours following a normal vaginal delivery, or
- Ⓢ 96 hours following a cesarean section.

Neither you nor your physician need to precertify any length of stay less than these periods. However, the physician, after consulting with the mother, may discharge the mother or newborn before the 48 or 96 hours.

If you do not precertify when required, the following apply:

- Ⓢ You pay a **\$200** penalty for failure to precertify a hospital admission.
- Ⓢ Your room and board expenses may be covered at **50% of the reasonable and customary charges** for any admission reviewed but not approved and for not precertifying the admission.

The penalty and additional covered expenses apply toward your out-of-pocket maximum.

Certifying Additional Days

If your physician feels it's necessary for you to be confined longer than already certified, you, your physician or the hospital may request an extension. Call the utilization review organization no later than the last day that has already been certified. If an extension is not certified, a continued hospital stay may not be considered medically necessary.

Case Management

After the utilization review organization evaluates your case, you may be assigned a case manager. If you or a covered dependent has a serious or prolonged illness, the case manager may discuss available treatment alternatives with you and your physician. The case manager will continue to monitor your case for the duration of your condition.

Centers of Excellence

The plan includes coverage for medically necessary, qualified transplant procedures through the Centers of Excellence Program — a national transplant network. The Centers of Excellence Program is a voluntary program that coordinates care for those needing bone marrow transplants or solid organ transplants or other specialized care for a life-threatening and complex illness. The program is based on the idea that the more experience a facility has with treating a complex medical condition, the better it becomes at providing the treatment. You and your covered dependents receive care at medical facilities that have been identified as excelling in the type of treatment required.

Transplant procedures must be pre-authorized by the plan's utilization review organization and take place at one of the plan's national transplant network hospitals.

Qualified procedures include:

- ⓔ heart,
- ⓔ liver,
- ⓔ single or bilateral lung,
- ⓔ combination heart/bilateral lung,
- ⓔ pancreas, and
- ⓔ bone marrow.

Medical and surgical benefits provided through the network include coverage of inpatient professional services and related institutional services and organ procurement services for pre-authorized transplants.

Covered Medical Expenses

Generally, the plan pays 80% of reasonable and customary charges after the deductible for covered medically necessary services. However, if you use a PPO network hospital, the plan pays 90% after the deductible for medically necessary services. Covered services include:

- ⓔ Semiprivate hospital room and board, routine nursing services and ancillary charges.
- ⓔ Intensive or cardiac care services.
- ⓔ Cardiac rehabilitation, including phase 1 and phase 2 services started within six months of release from an inpatient confinement. Excluded are programs primarily for exercise such as phase 3 services.
- ⓔ Medical services and supplies, including anesthesia and its administration.
- ⓔ X-rays, laboratory tests and other diagnostic services.
- ⓔ Physicians' charges for medical care and treatment, including surgery.
- ⓔ Transportation charges from the place where a disability began to a hospital equipped to furnish special treatment. Transportation includes professional ambulance service, railroad, regularly scheduled airline or air ambulance.
- ⓔ Charges for treatment by a licensed physical or occupational therapist.
- ⓔ Charges for treatment of morbid obesity (see Glossary for definition).
- ⓔ Artificial limbs or eyes.
- ⓔ Orthotic devices including casts, splints, trusses, crutches and braces. Excludes dental braces and over-the-counter orthotics.
- ⓔ Oxygen and rental of equipment to administer it.
- ⓔ Rental, or purchase at the option of the plan, of durable medical equipment. Includes glucose and apnea monitoring devices, transneuromuscular stimulators, wheelchairs, manually operated hospital beds and oxygen machines. Excludes sports equipment, convenience items like wheelchair lifts, extended warranties, repairs and consumable items (e.g., air cleaners, air purifiers, vacuum systems and filters).
- ⓔ Dental care, artificial tooth implants and x-rays needed because of an accidental injury to sound and healthy natural teeth. Restorative dental care needed due to chemical, x-ray or surgical treatment of mouth cancer.
- ⓔ Syringes for anything other than diabetes, which are covered under prescription drug benefits.
- ⓔ Tuberculosis vaccines.
- ⓔ Mastectomy procedures including:
 - reconstruction of the breast on which the mastectomy has been performed,
 - surgery and reconstruction of the other breast to produce a symmetrical appearance, and
 - prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Additional Medical Benefits

Wellness Benefits

Wellness benefits are designed to encourage preventive treatment and routine exams that can detect problems early. Wellness benefits are not subject to the annual deductible.

Routine physical exam: You and your covered dependents may receive a routine physical exam once per year. The plan pays 100% of the first \$75 of the physicians' fees per covered person, per year (any charge in excess of \$75 will be applied to the calendar year deductible and paid at 80%). Please note, services must be billed as a physical exam to be covered as a wellness benefit.

Coronary artery scan: You or your covered dependents may obtain a coronary artery scan to detect calcification once a year upon a physician's referral. The plan will pay 90% if you use a PPO hospital or 80% of reasonable and customary charges if you use a non-PPO hospital (maximum benefit \$316).

Immunizations: Immunizations for children up to age 19 are covered at 100% by the plan. The plan also covers flu shots for members and covered dependents at 100%.

Members Assistance Program (MAP)

The MAP provides counseling and education for covered members and dependents for up to three sessions per problem area at no charge.

For general information about the services provided, call the MAP at the number listed on page 66.

Mental Health and Substance Abuse Benefits

All in-network and out-of-network inpatient services for mental health/substance abuse treatment must be precertified by calling the mental health and substance abuse claims administrator at the number listed on page 66. Outpatient care does not require precertification. However, additional days or visits (above the 30-day or 30-visit limit) will be covered only if the mental health and substance abuse claims administrator approves the treatment based on medical necessity.

There is an annual \$100 deductible per person for out-of-network services, *in addition to* the \$100 calendar year deductible that applies to other medical benefits under this plan. The deductible for mental health and substance abuse does not count toward your medical plan annual out-of-pocket maximum.

If you or your covered dependent is in treatment for mental health conditions or substance abuse when plan coverage ends, benefits will continue until the lesser of:

- Ⓢ the balance of the treatment period,
- Ⓢ 60 days, or
- Ⓢ benefits are exhausted.

Mental Health Treatment

A licensed psychiatrist, psychologist, licensed clinical professional counselor, licensed professional counselor or clinical social worker must perform the treatment. Psychological evaluations are not covered if they relate to:

- Ⓢ fitness to act as a custodial parent,
- Ⓢ diagnosis of a learning disability, or
- Ⓢ diagnosis of Attention-Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADHD) (unless preauthorized).

Mental Health and Substance Abuse Benefits			
	In-Network	Out-of-Network	Limits
Deductible	No deductible	\$100 annual deductible per person	Separate from medical deductible; applies for inpatient and outpatient out-of-network services
Members Assistance Program (MAP)	1-3 sessions at no cost to members	No coverage	
Inpatient care: hospital expenses include room and board, drug, x-ray, detoxification and lab and physician charges	Inpatient care covered at 100%	Inpatient care covered at 80% of reasonable and customary charges	Treatment limited to 30 inpatient days per person per year ^{1,2} , combined for both in- and out-of-network services
Outpatient care	Outpatient care covered at 100% after \$10 copay per visit	Outpatient care covered at 80% of reasonable and customary charges	Treatment limited to 30 outpatient visits per person per year ² , combined for both in- and out-of-network services
Structured intensive outpatient substance abuse program³	Care covered at 100% after \$10 copay per visit \$150 maximum out-of-pocket per program	Care covered at 80% of reasonable and customary charges	No limit, other than \$150 out-of-pocket maximum for in-network services per program
Lifetime limit (combined for all in- and out-of-network benefits)	Mental Health — Included in \$2 million medical benefit lifetime limit Substance Abuse — \$40,000 per person		
Precertification and review	Precertification is required for all inpatient services. Precertification is not required for outpatient services except for visits in excess of 30	Precertification is required for all inpatient services. Precertification is not required for outpatient services except for visits in excess of 30 Failure to call within 24 hours of an admission will result in a reduction of coverage. Benefits will be payable at 50% of the out-of-network benefit levels	All coverage is subject to medical necessity Emergency: For emergency admission, notification must be received within 48 hours to be covered at the in-network level

¹ Two partial hospitalizations or two residential treatments are considered one inpatient day.

² Days or sessions above the 30-visit limit will be reviewed and authorized based on medical necessity.

³ A program which provides two or more hours of care, two or more days per week. The program offers individual/group therapy, as well as family education.

Substance Abuse Treatment

The maximum lifetime benefit for treatment of substance abuse is \$40,000. (This is separate from the \$2 million lifetime maximum medical benefit limit.) Any prior benefits you received from all EIT plans for these services will be included in the maximum lifetime benefit for substance abuse.

Treatment must be performed at a licensed or certified facility for alcohol and/or drug treatment. Expenses for enrolling in court-ordered safety counseling courses are not covered.

Attention-Deficit Disorder (ADD)/Attention-Deficit Hyperactivity Disorder (ADHD) Benefits

The plan covers the initial assessment process, treatment and maintenance medication for Attention-Deficit Disorder (ADD) and Attention-Deficit Hyperactivity Disorder (ADHD). You must follow the mental health and substance abuse precertification requirements for any inpatient treatment and for approval of days/visits in excess of 30 for medical necessity.

Chiropractic Benefits

The plan covers treatment performed by a licensed chiropractor or naprapath for you or your covered dependents. *Chiropractic care* means adjustments, manipulation or other treatment (including naprapathy) to detect and correct imbalance or dislocation of the bone structure in the human body. *Naprapathic care* is a form of chiropractic care but follows a more holistic approach and does not use drugs in treatment.

The plan pays 80% of up to \$2,000 (combined limit for chiropractic and naprapathic care) of reasonable and customary charges per person per calendar year. No deductible applies.

Home Health Care Benefits

The plan covers part-time or intermittent basis home nursing care of a homebound member or covered dependent if:

- ⓔ care is provided by a licensed home health care organization,
- ⓔ continued hospitalization of the member or covered dependent would otherwise be required, and
- ⓔ care is reviewed and certified in advance as medically necessary by the utilization review organization.

Covered services include professional services of appropriately licensed and certified individuals in skilled nursing and home health aide care, as well as other care approved by the plan.

The following home health care benefits are *not* covered:

- ⓔ Expenses for custodial or homemaker services, food and housing.
- ⓔ Supportive items such as air conditioners, hand rails, ramps, telephones and similar items.
- ⓔ Benefits that are the subject of other plan provisions, such as prescription drugs, durable medical equipment, ambulance service or diagnostic services.
- ⓔ Items excluded from coverage by any other plan provision.

Hospice Care Benefits

The plan covers services provided for a terminally ill member or covered dependent if:

- ⓔ care is provided by a hospice care organization, hospital or skilled nursing/inpatient rehabilitation facility;
- ⓔ the attending physician statement indicates the life expectancy of the individual to be six months or less; and

- Ⓢ care is reviewed and certified in advance as medically necessary by the utilization review organization.

Covered services include professional services of appropriately licensed and certified individuals in skilled nursing and home health aide care, as well as other care approved by the plan.

The following hospice care benefits are *not* covered:

- Ⓢ Expenses for custodial or homemaker services, food and housing.
- Ⓢ Supportive items such as air conditioners, hand rails, ramps, telephones and similar items.
- Ⓢ Benefits that are the subject of other plan provisions, such as prescription drugs, durable medical equipment, ambulance service or diagnostic services.
- Ⓢ Items excluded from coverage by any other plan provision.
- Ⓢ Charges for pastoral, financial, legal, bereavement or other counseling.
- Ⓢ Charges associated with funeral arrangements.

Physical and Occupational Therapy Benefits

Physical and occupational therapy benefits cover expenses for restoring physical capabilities lost due to an accident or illness.

Physical therapy is covered by the plan if:

- Ⓢ treatment is ordered by a physician;
- Ⓢ treatment is performed by a licensed physical therapist using physical means, hydrotherapy or bio-mechanical and neurophysiological principles; and
- Ⓢ services are expected to allow the member or covered dependent to regain physical capabilities lost due to an accident or illness.

Occupational therapy is covered by the plan if:

- Ⓢ treatment is ordered by a physician,
- Ⓢ treatment is performed by a licensed occupational therapist using constructive means designed and adapted to restore physical capabilities lost due to an accident or illness, and
- Ⓢ services are expected to allow the member or covered dependent to perform tasks required by his particular occupation or the ordinary tasks of daily living.

The plan pays 80% of up to \$2,000 each of reasonable and customary charges per person per calendar year for the treatment. No deductible applies. If more than \$2,000 in covered expenses is requested for physical or occupational therapy, a medical necessity review will be required. Coverage will be discontinued if significant progress is not made within a reasonable and predictable period of time, or if progress stops or becomes minimal.

Speech Therapy Benefits

Speech therapy benefits cover expenses for restoring a speech function. Speech therapy is covered by the plan if:

- Ⓢ therapy is ordered by a physician;
- Ⓢ therapy is performed by a licensed speech therapist; and
- Ⓢ services are expected to restore a speech function lost due to disease, injury or surgery.

The plan pays 80% of up to \$2,000 of reasonable and customary charges per person per calendar year for the treatment. No deductible applies. If more than \$2,000 in covered expenses is requested, a medical necessity review will be required. Coverage will be discontinued if significant progress is not made within a reasonable and predictable period of time, or if progress stops or becomes minimal.

Medical Expenses Not Covered

Following is a list of expenses *not* covered by the plan:

- ⓔ Deductibles and amounts in excess of reasonable and customary charges.
- ⓔ Copays and the annual out-of-pocket maximum.
- ⓔ Expenses over the lifetime maximum benefit of \$2 million per person.
- ⓔ Expenses over the substance abuse lifetime maximum benefit of \$40,000 per person.
- ⓔ Expenses for services that, in the judgment of the claims administrator, are not medically necessary.
- ⓔ Expenses incurred after coverage has ended.
- ⓔ Expenses to treat a member's illness or injury arising from any electrical work and any other paid work. Expenses for a dependent paid or payable under any Workers' Compensation law (whether performed for pay or not) and any other paid work.
- ⓔ Medical expenses incurred while you or a dependent is not under the care of a licensed physician, surgeon or licensed midwife.
- ⓔ Charges for outpatient therapy or counseling unless provided directly and personally by a psychiatrist, licensed psychologist, licensed clinical social worker or substance abuse counselor authorized by the appropriate mental health and substance abuse review organization.
- ⓔ Maternity expenses for anyone not a member or lawful wife of a member. Maternity expenses for dependent children will *not* be covered.
- ⓔ Charges for marriage counseling.
- ⓔ Premarital exams.
- ⓔ Dental services covered under a separate plan of dental benefits (see "Covered Dental Expenses," page 48).
- ⓔ Cosmetic, plastic or reconstructive surgery unless needed to:
 - correct the effects of an injury if the surgery is performed in the year of the injury or the next year,
 - improve a congenital deformity, or
 - improve a deformity resulting from disease or medically necessary surgery.

For some conditions photographs may be required for appraisal of medical necessity.

- ⓔ Eye exams to prescribe or fit glasses. Visual therapy is covered under a separate plan of vision benefits (see "Vision Benefits," page 50).
- ⓔ Treatment for infertility, including related prescribed drugs.
- ⓔ Charges for an experimental or investigational procedure or drug.
- ⓔ Confinement in other than an accredited hospital with 24-hour nursing care, and organized facilities for diagnosis and major surgery.
- ⓔ Treatment in a hospital operated by the federal government or a federal agency for a disability connected to military service.
- ⓔ Illness or injury resulting from any act of war or international armed conflict, participating in a riot or the commission of a criminal act.
- ⓔ Treatment for which there would be no charge if these benefits were not available.
- ⓔ Services provided by a relative or a person who ordinarily resides with you.

- ⓔ Services provided without charge or paid through any other plan.
- ⓔ Expenses that are reimbursable by Medicare.
- ⓔ Treatment of any intentionally self-inflicted injury (except in cases of mental illness).
- ⓔ Broken appointments.
- ⓔ Prescribed drugs and medicine dispensed by a physician or licensed pharmacist and covered under a separate plan of prescription drug benefits (see “Prescription Drug Benefits,” this page).
- ⓔ Any court ordered services or testing.
- ⓔ Nursing home or assisted living facilities and services.
- ⓔ Over-the-counter drugs or baby formulas.
- ⓔ Massage therapists.
- ⓔ Dietitian used for weight loss (except in cases of morbid obesity) and *all* weight loss programs.
- ⓔ Personal convenience items.
- ⓔ Nutritional supplements.
- ⓔ Claims filed more than one year after the date the expense was incurred.

Prescription Drug Benefits

The plan contracts with a network of pharmacies to fill prescriptions for you and your covered dependents. Before filling a prescription, ask the pharmacy if it is a member of the plan’s network. Prescriptions purchased at a nonparticipating pharmacy are not covered under this plan.

You must present your prescription drug identification card to receive benefits for drugs bought at a pharmacy. For your covered dependents’ prescriptions, you will also need to provide a date of birth.

The prescription drug benefit is separate from your medical benefit. So, prescription drug copays do not apply to the medical plan deductible and out-of-pocket maximum. Nor do the medical benefit deductible and copay provisions apply to the prescription drug benefit.

When you purchase up to a 34-day supply of prescribed drugs and medications, the plan pays 100% after you pay a:

- ⓔ \$9 copay for generic drugs and drugs on the preferred drug list, or
- ⓔ \$18 copay for brand-name and non-preferred drugs.

If you do not present your prescription drug identification card, you will be reimbursed for a drug, provided you:

- ⓔ pay the full price of the prescription at the time of purchase,
- ⓔ have your pharmacist fill out a claim form, and
- ⓔ submit the claim form to the prescription drug claims administrator for reimbursement.

However, your reimbursement may be less than if you had presented your card at the time of service. You will pay the copay *and amounts above the network pharmacy's discount* to the pharmacy.

Mail-Order Prescriptions

If you take prescribed drugs on a long-term or continuing basis, you can buy them by mail. You pay a \$15 per prescription copay for a 90-day supply. For further information, order forms and preaddressed envelopes, contact the plan's prescription drug mail service provider at the number listed on page 66.

Covered Prescription Drug Expenses

Covered drugs include:

- ⓔ Prescribed drugs that are lawfully obtainable only from a licensed dispenser of drugs under the written order of a physician or dentist licensed to prescribe.
- ⓔ Injectable insulin.
- ⓔ Prescribed syringes and hypodermic needles in quantities compatible with the number of doses of insulin prescribed. Please note, you must fill the insulin order first for the syringes to be covered by the plan.

Call the prescription drug claims administrator at the number listed on page 66 to determine whether or not a new drug is covered.

Prescription Drug Expenses Not Covered

The following are *not* covered under the plan:

- ⓔ Contraceptive devices, regardless of the purpose for which they are prescribed. (Oral contraceptives are covered, but skin implant contraceptives such as Norplant are not.)

- ⓔ Fertility drugs.
- ⓔ Drugs or medications lawfully obtainable without a prescription, except insulin.
- ⓔ Therapeutic devices and appliances, support garments or other nonmedical items, regardless of their intended use.
- ⓔ Drugs labeled "caution — limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual.
- ⓔ Charges for the administration of prescription drugs or injectable insulin.
- ⓔ Drugs taken by or administered to an individual in whole or in part while an inpatient in a hospital or other health care facility for dispensing pharmaceuticals.
- ⓔ A quantity in excess of the number specified by the prescriber or a 34-day supply (90-day for mail-order).
- ⓔ Any refill dispensed more than one year after the date of the prescription.
- ⓔ Prescription drugs that may be properly received without charge under local, state or federal programs, including Workers' Compensation.
- ⓔ Renova (Tretinoin).
- ⓔ Lifestyle drugs such as drugs treating weight loss (except in the case of morbid obesity) and hair loss. Drugs prescribed for erectile dysfunction (ED) in excess of six doses per month.
- ⓔ Prescriptions purchased at a nonparticipating pharmacy.
- ⓔ Expenses for drugs obtained through another medical or prescription drug plan (no coordination of benefits).
- ⓔ Claims filed more than one year after the date the expense was incurred.

Dental Benefits

Your dental benefits provide regular, preventive care that helps keep your and your covered dependents' teeth and gums healthy.

How the Dental Benefit Works

Dental benefits provide comprehensive coverage for preventive and other types of dental services, including orthodontia. (Orthodontic benefits are described on page 49.) When you need dental care, you must visit a licensed dentist. The plan pays a percentage of the charges for covered services, up to a maximum annual benefit. You pay no deductible for dental benefits.

Benefit Amount

Preventive care: Preventive care is covered at 100%. Preventive services include two oral exams a year, including teeth cleaning, fluoride applications (up to 19 years of age) and dental x-rays (two bitewings per year and one full mouth x-ray every 36 months).

Other care: The plan pays 80% of other covered dental expenses.

Annual maximum: The maximum amount the plan will pay *each calendar year* is \$1,500 per person. When you or your covered dependents reach this limit, you are responsible for the full cost of any additional services received.

Covered Dental Expenses

Your dental benefits provide coverage of reasonable and customary charges for the following types of services:

- ⓔ Two oral exams, including teeth cleaning and scaling, every calendar year.
- ⓔ Fluoride applications up to age 19.

- ⓔ Dental x-rays (bitewings limited to two per year; full mouth limited to once every 36 months).
- ⓔ Extractions and oral surgery.
- ⓔ Fillings and inlays.
- ⓔ Crowns and initial installation of fixed bridgework.
- ⓔ Artificial tooth implants.
- ⓔ Treatment of diseases of the gums and tissue of the mouth.
- ⓔ Initial installation of removable partial or full dentures.
- ⓔ The addition of teeth to an existing removable partial or full denture or fixed bridgework, or its total replacement, if made necessary by drifting of anchor teeth.
- ⓔ Repair or recementing of crowns, inlays, bridgework or dentures.
- ⓔ Treatment for tooth damage that results from the grinding or biting of teeth (occlusal services).

Dental Expenses Not Covered

Dental benefits do *not* cover:

- ⓔ Expenses to treat a member's illness or injury arising from any electrical work or any other paid work. Expenses for a dependent paid or payable under any Workers' Compensation law (whether performed for pay or not) or any other paid work.
- ⓔ Treatment by someone other than a licensed dentist or physician. The plan will cover teeth cleaning by a licensed dental hygienist who is supervised by a dentist.
- ⓔ Any work performed directly by a lab and billed to you without a prescription from a dentist, such as manufacture or repair of dentures, liners and other devices and appliances. Services and supplies of any kind furnished directly by a lab.

- ⓔ Replacement of a lost or stolen prosthetic device.
- ⓔ Services and supplies that are solely for cosmetic reasons, such as bonding or whitening.
- ⓔ General anesthesia for dental procedures (Please note, local anesthesia is a covered dental expense).
- ⓔ Services that are not medically necessary.
- ⓔ Treatment in a hospital operated by the federal government or a federal agency for a disability connected to military service.
- ⓔ Illness or injury resulting from any act of war or international armed conflict, participation in a riot or the commission of a criminal act.
- ⓔ Treatment for which there would be no charge if these benefits were not available.
- ⓔ Services provided by a relative or a person who ordinarily resides with you.
- ⓔ Services provided or paid through any other plan.
- ⓔ Treatment of any intentionally self-inflicted injury (except in cases of mental illness).
- ⓔ Broken appointments.
- ⓔ Claims filed more than one year after the date the expense was incurred.

Orthodontic Benefits

Orthodontic benefits cover *your eligible dependents* for services that help properly align teeth and correct malocclusion.

How the Orthodontic Benefit Works

When your covered dependent needs orthodontic care, he or she must visit a licensed orthodontist or dentist. The plan pays a percentage of the charges for covered services, up to a maximum annual benefit. You pay no deductible.

Orthodontic treatment must begin before age 16 and may continue beyond age 19 (when the dependent would otherwise lose eligibility), provided your covered dependent remains:

- ⓔ a full-time student,
- ⓔ unmarried,
- ⓔ financially dependent on you, and
- ⓔ a resident in your household.

Benefit Amount

The plan pays 80% of the first \$2,500 of expenses for each covered dependent under age 19. That's a lifetime maximum orthodontia benefit of \$2,000 per covered dependent.

Cost

Generally, an orthodontist establishes the total cost of his or her services, supplies and appliances before treatment starts. This is paid by an initial down payment with regular monthly payments thereafter. You are responsible for the initial down payment. You will be reimbursed for the down payment (but not more than 16% of the entire treatment — 80% of 20%), and the plan will make regular monthly payments of the benefit for the remaining costs. The plan's

payments for orthodontic services will end when you meet the lifetime maximum benefit or coverage under the plan ends.

To receive your monthly reimbursements, you must:

- ⓔ continue to qualify as a plan member, and
- ⓔ submit paid receipts from your orthodontist for your monthly payment.

You cannot receive your total reimbursements in less than 24 months unless your dentist certifies that the orthodontic correction is completed.

Orthodontic Expenses Not Covered

Orthodontic benefits do *not* cover:

- ⓔ Expenses for the member.
- ⓔ Expenses for a dependent paid or payable under any Workers' Compensation law (whether performed for pay or not) or any other paid work.
- ⓔ Treatment by anyone who is not a licensed orthodontist or dentist.
- ⓔ Replacement of lost or stolen retainers.
- ⓔ Services or supplies furnished on or after the date your dependent turns age 16, unless those procedures began before age 16.
- ⓔ Services and supplies that are solely for cosmetic reasons.
- ⓔ Treatment for which there would be no charge if these benefits were not available.
- ⓔ Services provided by a relative or a person who ordinarily resides with you.
- ⓔ Services provided without charge or paid through any other plan.
- ⓔ Broken appointments.
- ⓔ Claims filed more than one year after the date the expense was incurred.

Vision Benefits

The plan covers expenses for medically necessary eye care.

How the Vision Benefit Works

You must visit a licensed optician, optometrist or ophthalmologist. You will be reimbursed for part of the expense of eye exams, frames and lenses (receipts must accompany claim forms). The plan pays a percentage of the charges for covered services, up to a maximum annual benefit. You pay no deductible.

Benefit Amount

For each member and covered dependent, the plan pays 80% of the first \$625 of reasonable and customary covered expenses each year. That's a maximum annual benefit of \$500 per covered person.

Covered Vision Expenses

The plan pays benefits for the following medically necessary expenses in a calendar year:

- ⓔ Complete vision analysis, including eye exam, refraction, visual therapy and case history.
- ⓔ Two sets of framed lenses or two sets of contact lenses (or one set of each) for a member if required by a prescription. One set of framed lenses or contact lenses for a dependent if required by a prescription. The cost of frames is covered at 80% of the first \$125. That's a maximum benefit of \$100.
- ⓔ One set of unframed lenses to replace damaged lenses.

- ⓔ Telescopic lenses or other vision aids and the professional services needed to fit, administer or prepare them for use if conventional lenses cannot improve sight to 20/70 in the better eye.
- ⓔ Chromex lenses for the color-blind and the professional services needed for their prescription.

Vision Expenses Not Covered

The plan does *not* cover:

- ⓔ Expenses to treat a member's illness or injury arising from any electrical work or any other paid work. Expenses for a dependent paid or payable under any Workers' Compensation law (whether performed for pay or not) or any other paid work.
- ⓔ Replacement of lost or stolen glasses, or broken frames.
- ⓔ Services in connection with vision therapy, orthoptics, vision training, aniseikonia, or medical or surgical treatment of the eye unless performed by a licensed medical physician or licensed therapist.
- ⓔ Any surgical treatment in place of corrective lenses such as LASIK, photorefractive keratectomy (PKR) or radial keratotomy (RK).
- ⓔ Treatment in a hospital operated by the federal government or a federal agency for a disability connected with military service.
- ⓔ Charges for services or supplies covered in whole or in part under any other portion of this benefit plan.
- ⓔ Illness or injury resulting from any act of war or international armed conflict, participation in a riot or the commission of a criminal act.
- ⓔ Treatment for which there would be no charge if these benefits were not available.
- ⓔ Services provided by a relative or a person who ordinarily resides with you.
- ⓔ Services or supplies provided without charge or paid through any other plan.
- ⓔ Expenses that are reimbursable by Medicare.
- ⓔ Treatment of any intentionally self-inflicted injury (except in cases of mental illness).
- ⓔ Broken appointments.
- ⓔ Claims filed more than one year after the date the expense was incurred.

Hearing Aid Benefits

The plan covers medically necessary hearing aid-related expenses.

How the Hearing Aid Benefit Works

You must visit a legally qualified otologist or otolaryngologist when you need hearing aid care. You will be reimbursed for part of the expense of hearing exams and hearing aid instruments (receipts must accompany claim forms). For hearing aid instruments, the prescription must include the name, model number, battery power and frequency response. The plan pays a percentage of the charges for covered services, up to a maximum annual benefit. You pay no deductible.

Benefit Amount

The plan pays:

- ⓔ up to \$75 for a hearing exam, and
- ⓔ 80% of the first \$500 of reasonable and customary charges for a hearing aid instrument each year. That's a maximum annual benefit of \$400 per covered person.

Covered Hearing Aid Expenses

The plan pays benefits for the following expenses in a calendar year:

- ⓔ Charges for a hearing exam performed by a legally qualified otologist or otolaryngologist, up to \$75.
- ⓔ Charges for a hearing aid instrument prescribed by a legally qualified otologist or otolaryngologist up to the maximum benefit amount.

Hearing Aid Expenses Not Covered

The plan does *not* cover:

- ⓔ Charges for services or supplies that are covered in whole or in part under any other portion of this plan or any other plan.
- ⓔ Exams not performed and hearing aid instruments not prescribed by a legally qualified otologist or otolaryngologist.
- ⓔ Replacement of lost or stolen hearing aid instruments.
- ⓔ Batteries or repair of hearing aid instruments.
- ⓔ Expenses to treat a member's illness or injury arising from any electrical work or any other paid work. Expenses for a dependent paid or payable under any Workers' Compensation law (whether performed for pay or not) or any other paid work.
- ⓔ Illness or injury resulting from any act of war or international armed conflict, participation in a riot or the commission of a criminal act.
- ⓔ Treatment for which there would be no charge if these benefits were not available.
- ⓔ Services provided by a relative or a person who ordinarily resides with you.
- ⓔ Expenses that are reimbursable by Medicare.
- ⓔ Treatment of any intentionally self-inflicted injury (except in cases of mental illness).
- ⓔ Broken appointments.
- ⓔ Claims filed more than one year after the date the expense was incurred.

Benefits for Retired Members

You may be eligible for retiree health care benefits under this plan. As with active members, benefits are contingent upon the continuation of the plan by the Trustees and on the financial adequacy of the plan. The Trustees reserve the right to change, amend or end this coverage at any time for any reason. Examples of changes that may occur as retiree health care costs continue to rise include but are not limited to special retiree deductibles or copays, or caps on prescription drug expenses.

Who Is Eligible

You (and your eligible dependents) are eligible for retiree benefits if you are receiving a benefit from and have 10 years of eligibility service under Pension Plan No. 2, and you:

- ⊕ have been covered as an active member under this plan throughout the two years before your retirement, or
- ⊕ have at least 30 years of credited service under Pension Plan No. 2.

Benefit Amount

The lifetime maximum benefit per person is \$2 million. This includes benefits paid before retirement.

If You Are Not Medicare Eligible

You are not eligible for benefits until you reach age 62, unless you retired on a disability pension. When you reach age 62 (or if you retired on a disability pension), you will receive the same benefits as an active member until you reach age 65 or become entitled to Medicare.

If You Are or Become Medicare Eligible

You are eligible for the same benefits as active members, but Medicare is the primary plan. That is, Medicare will pay benefit costs before the plan pays. Expenses not reimbursable by Medicare may be covered by this plan.

The plan assumes you are covered for Part B of Medicare. If you don't enroll for Medicare Part B coverage, you must pay the amount Medicare would otherwise have paid (e.g., 80% of Medicare eligible expenses). The plan does not cover the cost of Medicare premiums.

If You Die

If you die, your surviving spouse will remain eligible for coverage for 360 days, whether or not he or she is eligible for Medicare. Your spouse may then continue coverage under COBRA for up to 36 months by paying the applicable premium (see "COBRA Coverage," page 35). Your eligible dependent children will also remain eligible for coverage for 360 days. If your child stops attending school during this time, he or she is eligible for 120 days of coverage from the last day of full-time attendance (not to exceed a total of 360 days).

Claims Procedures

Filing Claims

Generally, your provider will submit a claim directly to the claims administrator. However, if you need to submit the claim, call the appropriate claims administrator's number listed on page 66 for a Request for Benefit Payment form. Specify the type needed — general medical, general dental, orthodontic, vision or hearing. For medical claims, you can complete the form and attach the bills that explain your treatment. For dental claims, you and your dentist each complete part of the form. To speed the reimbursement process, you'll want to give the form to your provider as soon as possible.

When you submit your Request for Benefit Payment form, it should be completed fully, following the instructions printed on the form. Failure to do so may delay payment or result in denial of benefits. Attach a statement from your physician or dentist together with bills or receipts for all covered expenses, including those that count toward the deductible. Receipts for vision, prescription drug and hearing aid services also must be attached to requests for payment. To make sure you receive all the benefits you are entitled to, you should keep copies of bills or receipts for supplies, as well as those for hospitalization and treatment. If all charges are not detailed on the request form, attach an itemized statement.

For treatment at a hospital, present your medical benefits identification card. If your provider is in the PPO network, you usually won't have to submit a claim — the PPO provider will do it for you. *Be sure to contact the utilization review organization at least three days before a nonemergency hospital admission or within 48 hours after an emergency admission (see page 38 for more information about the utilization review program).*

If a person entitled to benefits is unable to complete a Request for Benefit Payment form, the Trustees may pay benefits to the spouse or a blood relative, or to any person whom the Trustees determine is rightfully entitled to the payment.

After completing all necessary forms, mail your claim to the appropriate claims administrator. Once your claim has been documented, the administrator who handles your claim must initially process it according to the type of claim you file.

Effective July 1, 2002, the law will require that the following time frames apply to claims processing. If you file:

- Ⓢ **An urgent care claim** (involving threats to the patient's life or health): The claim must be decided as soon as possible considering the medical emergency, but no later than 72 hours after it is received (up to 48-hour extension).
- Ⓢ **A non-urgent pre-service claim** (for services requiring notification of the utilization review organization, e.g., hospitalization): The claim must be decided within 15 days after it is received (up to 15-day extension).
- Ⓢ **A non-urgent post-service claim** (after you have received services): The claim must be decided within 30 days after it is received (up to 15-day extension).
- Ⓢ **A concurrent care claim** (decision to reduce or terminate previously-approved benefits while you are under care): The claim must be decided sufficiently in advance to give you an opportunity to appeal and obtain a decision before the benefit is reduced or terminated.
- Ⓢ **Any other claim under the plan:** The claim must be decided within 90 days after it is received (up to 90-day extension).

In some cases more time may be needed to process your claim. If this happens, you'll be notified that an additional processing period is required. The circumstances requiring the

extension, any information needed to make a claim acceptable and the date by which the plan expects to make a decision (indicated as extensions above), will be included in the notification. For urgent care claims, you must send in any additional or missing information in a reasonable amount of time (that is, within 48 hours). For non-urgent care claims, you'll be given up to 45 days to provide any missing information. If your claim involves medical judgment, the plan must consult with a health care professional. You or your beneficiary may always examine materials related to a claim, such as the plan's official documents.

Please note that claims must be filed within one year of the date they are incurred or reimbursement will be denied.

Appealing Denied Claims Before July 1, 2002

If you question a benefit determination for claims filed prior to July 1, 2002, you may ask in writing for clarification. The Fund Office will investigate the matter. If the written reply is not satisfactory and you wish a review by the Trustees, submit a second written request to the Fund Office within six months after the date of reply. The Fund Office will forward it for final decision by the Trustees. The decision on your request will be made within 60 days after its receipt or within 120 days if notice is sent to you that the Trustees require further information. If for any reason the Trustees do not act upon your request within the time set forth above, the request shall be deemed denied.

Appealing Denied Claims on or After July 1, 2002

If your claim is denied, in whole or in part, you may appeal the denial. You will receive a written notice explaining why and on which specific plan provisions the claim has been denied. The notice also will explain how to file an appeal. You must file an appeal by writing to the Trustees within 180 days after

a denial of a health care claim or within 60 days after a denial of all other claims. You or your beneficiary may choose to name a representative to handle your appeal.

Appeals are decided by the Trustees who did not conduct the initial review of your claim. Decisions on appeals will be made according to the type of claim you file.

If your appeal is:

- Ⓢ **An urgent care claim:** The appeal must be decided as soon as possible, but no later than 72 hours after it is received (no extensions).
- Ⓢ **A non-urgent pre-service claim:** The appeal must be decided within 30 days after it is received, or 15 days for each appeal, if two mandatory appeals are allowed (no extensions).
- Ⓢ **A non-urgent post-service claim:** The appeal must be decided within 60 days after it is received, or 30 days for each appeal, if two mandatory appeals are allowed (no extensions).
- Ⓢ **Any other claim under the plan:** The claim must be decided within 60 days after it is received (up to 60-day extension).

Note: An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service or post-service claim, depending on the facts.

The Trustees' decision on an appeal is final. If either you or your beneficiary still believes a claim for benefits has been improperly denied, you or your beneficiary may contact the plan administrator.

Besides having the right to appeal, you or your authorized representative can examine any documents, records and other information relevant to your denied claim. You can also submit, in writing, reasons why you think the claim should not be denied. If your claim for benefits is denied, you can file suit in a state or federal court.

General Plan Provisions

Coordination of Benefits (COB)

When you and any covered dependent have other health care coverage, benefits from this plan will be coordinated with the other coverage. Your total benefits will not be more than 100% of the necessary, reasonable and customary costs of the services provided. Benefits payable from other plans are considered, even if:

- ⓐ you do not request payment of them, or
- ⓑ the other plan refuses to pay due to a failure to follow plan rules. For example, if your dependents have primary coverage under a health maintenance organization (HMO), your dependent must access care through the HMO and follow all procedures of the HMO.

The plan will pay benefits as discussed in each benefit section. In any case, where more than one plan may provide benefits, applications for benefit payments should be made to all plans concerned. Keep in mind, however, that prescription drug benefits under this plan are not coordinated with any other coverage. You or your dependents must receive prescription drug benefits through the primary plan to have them covered.

Using COB provisions, one group plan has “primary” responsibility and pays first. The other group plan has “secondary” responsibility and considers any additional benefits not covered by the primary carrier. Generally, this is how COB works:

1. The amount payable by a plan covering a person as a member will be determined first. Then, the benefits of a different plan covering the same person as a dependent are determined.

2. If a child is covered by more than one plan, or under this plan by both parents:
 - Primary coverage for a dependent child will be the plan of the person (member or spouse) whose birth date (month and day) occurs first in the calendar year.
 - If the father and mother have the same birthday, the plan that has covered the child the longest will be primary.
 - If the other plan coordinates benefits based on the sex of the parents, the child’s primary plan will be the male parent’s primary plan.
 - Primary coverage for a dependent child whose parents are separated or divorced will be determined in the following order:
 - The plan of the parent with legal custody of the child; or
 - If a court decree establishes financial responsibility for a child’s health care expenses, the primary plan is the plan of the parent with that responsibility.
3. When none of these situations applies, the medical plan that has covered a person the longest will pay first.

Claims Administrators’ Rights

The plan has the right to receive and release necessary information to determine whether coordination of benefits or any similar provisions apply to a claim. If the plan makes larger payments than are necessary under the COB provision, the appropriate claims administrator has the right to recover those excess payments. Recovery may be made from any insurance company, any organization and/or any persons to or for whom those payments were made. In the case of underpayment, the plan may reimburse another plan directly instead of paying the person requesting benefit payment.

Integrating Benefits with Medicare

While you are actively employed, regardless of your age, the plan is primary to Medicare for you and your covered dependents. Benefits under the plan are determined before Medicare's benefits. Medical coverage for retired members who are age 65 or older is provided by Medicare.

Medicare Coverage for Disabled Individuals

If you or your covered dependents are totally disabled for at least 24 months and do not have current employment status, Medicare will provide primary medical coverage. Once you or your dependent is declared disabled by Social Security, the disabled individual should apply for coverage under Medicare Parts A and B.

Medicare Coverage for Individuals with End-Stage Renal Disease

In all situations involving end-stage renal disease (ESRD), regardless of age or Medicare status, the plan is the primary payor of medical expenses for the first 30 months of entitlement to Medicare because of ESRD. After the first 30 months of ESRD entitlement, Medicare is the primary payor, and the plan is the secondary payor.

Refund for Overpayment of Benefits

The plan has a right to a refund from you or your dependent, if either of the following apply.

- ② You or your covered dependent recovers money for expenses incurred due to an illness or injury for which a benefit has been paid under this plan. The amount to be refunded will be the lesser of the full amount that you or your covered dependent recovers or the amount of benefits paid by the plan.

- ② The plan pays benefits for an ineligible individual you had listed as a covered dependent. The amount to be refunded is the amount of benefits paid by the plan.

Right of Subrogation and Refund

If you or your dependent incurs medical or dental charges due to injuries caused by a third party, you may have a claim against the third party, or an insurer, for payment of those medical or dental charges. By accepting benefits for those charges under this plan, you automatically assign the plan any rights you or your dependent may have to recover payments from the third party or insurer.

This subrogation right allows the plan to pursue any claim you or your dependent has against any third party or insurer, whether or not you or your dependent chooses to pursue that claim. The plan may make a claim directly against the third party or against the insurer. If you or your dependent file a claim, the plan has a right to any amount recovered by you or your dependent, whether or not it is designated as payment for medical or dental expenses. This remains in effect until the plan is paid in full.

When you accept benefits under this plan, you acknowledge the plan's right to subrogation and reimbursement. The plan's rights to subrogation and reimbursement give the plan priority over *any* funds paid by a third party to you or your dependent relative to the injury or sickness. This includes priority over any claim for non-medical or dental charges, attorneys' fees or other costs and expenses. The plan's rights are limited to the extent to which it has made or will make payments for medical or dental charges, as well as any costs and fees incurred as a result of enforcing its rights under the plan.

When a right of recovery exists, *no* benefits will be paid unless and until you return a signed agreement to the Fund Office stating that you will do whatever is necessary to secure the plan's right of subrogation. In addition, you must not do anything to hinder the plan's right to subrogate.

If the entire amount paid by the plan is not refunded out of the amount you receive from the third party or insurer, the Trustees reserve the right to deduct the missing amount from your future claims or from your dependents' future claims.

Assigning Benefits

Generally, benefits from the plan belong to you. You may not sell, assign, transfer or garnish these benefits.

Evidence of Medical Coverage

According to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, if you lose coverage under this plan, you are entitled to a certificate that shows evidence of your prior medical coverage.

The claims administrator promptly provides this certificate if:

- ⓔ you or your covered dependents lose coverage under the plan,
- ⓔ you or your dependents lose coverage under COBRA, or
- ⓔ whenever you submit a written request within 24 months after either of the above events.

The certificate identifies:

- ⓔ who was covered under the plan,
- ⓔ the period of coverage, and
- ⓔ any waiting periods.

This certificate is used to determine pre-existing condition exclusion periods in the future because, according to HIPAA, your period of coverage under this plan will offset the exclusion period of a new medical plan.

If you leave this plan and enroll in coverage under another medical plan, check with your new plan's administrator to find out whether:

- ⓔ the plan has a pre-existing condition exclusion, and
- ⓔ you need to provide a certificate or other documentation of your medical coverage through this plan.

Plan Administration

This section contains important administrative information about the benefits provided to you by the Electrical Insurance Trustees. The information in this section applies to all of your benefits and includes details about your rights as provided under ERISA — the Employee Retirement Income Security Act of 1974.

Although ERISA does not require an employer to provide benefits, it does set standards on how a plan is run. It also requires that you be kept fully informed of your rights and benefits — the details of which are included in this booklet.

Your plan is sponsored and administered by a joint labor-management Board of Trustees. The fund administrator assists the Board of Trustees in the administration of the Welfare Fund. The fund administrator and other personnel of the administration office are employees of the Fund Office.

Plan Information

Plan Name

The official name of the plan is the Electrical Insurance Trustees Health & Welfare Plan for Construction Workers. This summary describes the health care benefits (medical, prescription drug, dental, orthodontic, vision and hearing) provided by the plan. A separate Summary Plan Description describes the welfare benefits (sickness, disability, life, and accidental death and dismemberment insurance) provided under the plan.

Plan Administrator and Sponsor

The plan administrator controls and manages the operation and administration of the plan. The administrator and sponsor of the plan is:

Electrical Insurance Trustees
221 North LaSalle Street, Suite 200
Chicago, IL 60601-1273
(312) 782-5442

Employer Identification Number

The employer identification number is 36-1033970.

Plan Number

The plan number is 501.

Agent for Legal Process

The agent for service of legal process concerning the plan is:

Sean P. Madix
Fund Administrator
221 North LaSalle Street, Suite 200
Chicago, Illinois 60601-1273

Service may also be made on the Board of Trustees or an individual Trustee at the addresses listed under "Trustees."

Trustees

The plan Trustees who authorize the plan benefits have authority to:

- ⓔ resolve questions concerning the plan,
- ⓔ make rules to implement the plan,
- ⓔ construe the plan terms, and
- ⓔ determine when plan benefits will be paid.

As of January 1, 2002, the Trustees are as follows:

Employer Trustees

William T. Divane, Jr.
Divane Bros. Electric Company
2424 North 25th Avenue
Franklin Park, Illinois 60131-3323
(847) 455-7143

I. Steven Diamond
Malko Electric Company
6200 Lincoln Avenue
Morton Grove, Illinois 60053-2851
(847) 967-9500

Thomas C. Halperin
Commercial Light Co.
245 Fencl Lane
Hillside, Illinois 60162-2001
(708) 449-6900

Kenneth Bauwens
Jamerson & Bauwens Electrical Contractors, Inc.
3055 MacArthur Blvd
Northbrook, Illinois 60002
(847) 291-2000

Michael R. Walsdorf
Advent Systems, Inc.
435 West Fullerton Avenue
Elmhurst, Illinois 60126-1404
(630) 279-7171

Union Trustees

Michael Fitzgerald

Michael J. Caddigan

Samuel Evans

Daniel Meyer

Richard Sipple

600 West Washington Boulevard
Chicago, Illinois 60661-2490
(312) 454-1340

Future of the Plan

Although the Electrical Insurance Trustees intend to continue the plan indefinitely, the Trustees reserve the right to amend or end the plan at any time for any reason. Changes may be made retroactively, if necessary, to qualify or maintain the benefits under the Internal Revenue Code or the Employee Retirement Income Security Act of 1974 (ERISA). If the plan is amended or ends, you may not receive benefits as described in this booklet. However, you may be entitled to receive different benefits, or benefits under different conditions.

Discretion of Trustees and Fund Administrator

The Trustees and the fund administrator have full discretion in determining any and all questions related to the plan, the fund or the operation of the plan. This discretion also applies to:

- Ⓔ any claim for benefits,
- Ⓔ the construction of the language or meaning of the rules and regulations adopted by the Trustees,
- Ⓔ this Summary Plan Description, and
- Ⓔ any writing concerned with or provided in connection with the operation of the plan.

The good faith decision of the Trustees or the fund administrator is binding upon anyone dealing with the plan or claiming any benefit under the plan.

Plan Funding

Coverage for you and your dependents under the plan is paid for by contributions from the participating employers. The amount of the contribution is established by the collective bargaining agreement. Assets are held in trust by the Trustees and disbursed by them. Investments are made by Great Lakes Advisors; Goldman, Sachs, Inc.; Northern Trust Global Investments; and Invesco.

Plan Year

The plan year begins on July 1 and ends on the following June 30.

For More Information

All questions and requests for information should be sent to the Trustees at the following address:

**Attention: Fund Administrator
221 North LaSalle Street, Suite 200
Chicago, Illinois 60601-1273**

You may also call (312) 782-5442 for more information.

Your Rights Under ERISA

As a participant in the Electrical Insurance Trustees Health & Welfare Plan for Construction Workers, 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 the following rights:

Ⓢ Receive Information about Your Plan and Benefits

- You may examine, free of charge, all documents governing the plan including insurance contracts, collective bargaining agreements and the latest annual report (Form 5500 Series). These documents are available at the plan administrator's office and at other specified locations. The annual report also is filed with the U.S. Department of Labor and is available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
- You may obtain copies of all documents governing the operation of the plan, including updated Summary Plan Descriptions by writing to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- You may also receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Ⓢ Continue Group Health Plan Coverage

- You may continue health care coverage for yourself, your spouse or your 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 and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

- If you have creditable coverage from another plan, you will receive a certificate of coverage that helps to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your new group health plan. You will be provided a certificate of creditable coverage, free of charge, from the Electrical Insurance Trustees Health & Welfare Plan for Construction Workers or your health insurance insurer when:
 - you lose coverage under the plan,
 - you become entitled to elect COBRA continuation coverage, or
 - your COBRA continuation coverage ends.

You may also request a certificate of coverage before your coverage ends, or for up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after you enroll in your new coverage.

Ⓢ Prudent Actions by Plan Fiduciaries

- In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for operating the plan. These people are called "fiduciaries" of the plan. They have a duty to act prudently and in the interest of you and other plan participants and beneficiaries.

- No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you are otherwise entitled or from exercising your rights under ERISA.

Ⓢ Enforcement of Your Rights

- If your claim for a benefit is denied, in whole or in part, the plan administrator must give you a written explanation of the reason for the denial, and you can obtain copies of documents relating to the decision, without charge. You also have the right to have the plan administrator review and reconsider your claim, all within certain defined time schedules.
- Under ERISA, there are steps you can take to ensure the above rights. For instance, if you request materials from the plan administrator 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 plan administrator.
- If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. You may also file suit in a federal court if you disagree with a decision, or the lack of a decision, concerning the qualified status of a medical child support order. If plan fiduciaries misuse the plan's money or if 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 (for example, if the court finds your claim is frivolous), it may order you to pay these costs and fees.

Ⓢ Assistance with Your Questions

- If you have any questions about this plan, you should contact the plan administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or contact the:

Division of Technical
Assistance and Inquiries
Pension and Welfare
Benefits Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

- You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Glossary

The definitions included in this glossary will help you understand your plan benefits.

Chiropractic and Naprapathic

Care — Skeletal adjustments, manipulation or other treatment (including naprapathy) in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Treatment is performed to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Copay — The percentage of covered charges that you and the plan share for the cost of your health care, up to any plan maximums. For example, you pay 20% copay, the plan pays 80%.

A copay is also a fee charged by the plan for certain health care services or care. For example, copays are charged when you have prescriptions filled or you receive emergency services. This fee is usually a flat amount.

Cosmetic Surgery — Plastic or reconstructive surgery or other services and supplies which improve, alter or enhance appearance, whether or not performed or used for emotional or psychological reasons.

Credited Service — Credited service is used to determine the amount of your pension benefit under Pension Plan No. 2. It also may be used to determine eligibility for health care coverage after you retire. Generally, you receive one full year of credited service for each calendar year in which you have 1,600 hours of covered employment. Before 1976, you received one-fourth of a year of credited service for each 400 hours you worked during each year — up to the maximum full year of credited service. After 1975, you receive one full year of credited service for each year in which you work 1,600 hours. For each year in which you have at least 400, but fewer than 1,600

hours, you receive credited service in proportion to your number of hours — up to the maximum full year of credited service. Refer to the Electrical Contractors' Association (ECA) and Local 134 International Brotherhood of Electrical Workers (I.B.E.W.) Joint Pension Trust Pension Plan No. 2 for more information on credited service.

Deductible — The amount you pay for covered services each year before the plan begins to pay benefits.

Durable Medical Equipment

(DME) — Medical equipment that can withstand repeated use without significant deterioration. DME is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of an illness or injury. DME is covered when it is designed and medically necessary to assist an injury or illness of the covered person and is appropriate for use in the home.

Eligibility Service — Eligibility service is used to determine when you qualify for a pension under Pension Plan No. 2. It also may be used to determine eligibility for health care coverage after you retire. You receive one year of eligibility service for each calendar year in which you have at least 400 hours of covered employment. Generally, covered employment includes any period of work for which your employer is obligated to make contributions to the plan. You also receive one year of eligibility service for each calendar year in which you have at least 1,000 hours of non-covered employment with a participating employer. The 1,000-hour period must immediately precede or follow covered employment with the same employer. Refer to the ECA and Local 134 I.B.E.W. Joint Pension Trust Pension Plan No. 2 for more information on eligibility service.

Home Health Care (HHC) —

Physician-ordered services for part-time or intermittent home nursing care by a licensed HHC organization when continued hospitalization would otherwise have been required if home care was not provided.

Hospice Care — Services provided for a terminally ill person. To be considered “terminally ill,” the covered individual must provide a statement from the attending physician indicating the life expectancy to be six months or less. Hospice care programs provide either home care or inpatient care through an affiliated hospital or nursing facility.

In-Network (PPO Hospital) — A health care service or supply furnished by a PPO network hospital. In general, in-network services are covered at a higher benefit level than out-of-network services.

Investigational/Experimental —

Procedures, drugs, devices, services and/or supplies which are:

- Ⓢ provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness; and/or
- Ⓢ are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the community at the time they are rendered to a covered person; and
- Ⓢ specifically with respect to drugs, combination of drugs and/or devices, are not finally approved by the Federal Drug Administration at the time used or administered to the covered person.

Lifetime Maximum — The total amount of benefits you can receive under the plan in a lifetime.

Medically Necessary (Medical Necessity) — Health care services and supplies that are:

- Ⓢ determined by the claims administrator to be medically appropriate;
- Ⓢ necessary to meet the basic health needs of the patient;
- Ⓢ rendered in the most cost-efficient manner and setting appropriate for the delivery of the service or supply;
- Ⓢ consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations, or governmental agencies that are accepted by the claims administrator;
- Ⓢ consistent with the diagnosis of the condition;
- Ⓢ required for reasons other than the convenience of the patient or physician; and
- Ⓢ demonstrated through prevailing peer-reviewed medical literature to be either:
 - safe and effective for treating or diagnosing the sickness or condition for which their use is proposed, or
 - safe with promising efficacy for treating a life-threatening sickness or condition in a clinically controlled research setting using a specific research protocol that meets standards equal to those defined by the National Institutes of Health.

Morbid Obesity — A condition that exists when weight is at least twice the ideal weight for frame, age, height and sex, according to the Federal Guidelines on Obesity.

Occupational Therapy — Physician-ordered treatment by a licensed occupational therapist. The physically disabled person is treated by means of constructive activities designed and adapted to promote the functional restoration of the person's abilities lost or impaired by disease or accidental injury to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

Out-of-Area — A medical care service or supply that is provided outside the PPO network area (if you live more than 10 miles away from all in-network hospitals).

Out-of-Network (Non-PPO Hospital) — A medical care service or supply furnished by a hospital that does not participate in the PPO network. In general, out-of-network services are covered at a lower benefit level than services from a PPO network hospital.

Orthotic Devices — Appliances such as braces and splints which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or sickness.

Out-of-Pocket Maximum — The most that you will pay toward your covered health care expenses in a calendar year. This protects you from severe financial loss in the event of a serious illness or injury.

Participating Provider Option (PPO) — A medical organization that allows you to choose from a list of participating hospitals. The hospitals agree to provide appropriate medical care for negotiated rates to plan participants. You pay less for services when you use participating PPO hospitals because their charges are based on the negotiated rates.

Physical Therapy — Physician-ordered treatment by a licensed physical therapist using physical means, hydrotherapy or bio-mechanical and neurophysiological principals.

Plan Administrator — The plan administrator controls and manages the operation and administration of the benefits and programs of a plan. The Trustees serve as the plan administrator for the Electrical Insurance Trustees Health & Welfare Plan for Construction Workers.

Preventive Care — Health care services intended to prevent or provide early diagnosis of illness or injury, such as routine physical exams, gynecological exams, well-child care and immunizations.

Reasonable and Customary (R&C) Charges — The charges considered appropriate in your geographic area for medically necessary services, treatments, supplies or drugs. You pay any charges over the reasonable and customary amount.

Referral Hall — The Referral Hall refers to the Union office where members must register as being available for work.

Skilled Nursing Facility (SNF) — A licensed facility that provides 24-hour professional nursing services on an inpatient basis to persons convalescing from injury or sickness. SNFs maintain a complete medical record on each service recipient and are supervised on a full-time basis by a physician.

Speech Therapy — Speech therapy as directed by a physician and performed by a licensed speech therapist. Treatment is covered by the plan if the services are expected to restore a speech function lost due to disease, injury or surgery.

Utilization Review Organization (URO) — The organization responsible for precertifying or authorizing medical services received from a hospital or other inpatient facility. (See page 66.)

Welfare Fund — Refers to the assets held in trust for the Electrical Insurance Trustees Health & Welfare Plan for Construction Workers.

Claims Administrators

For...	Contact...	At...
<p>Medical, Vision & Hearing Aid Medical benefit PPO network provider information, vision and hearing aid information, forms and claim information</p>	Blue Cross and Blue Shield of Illinois (BCBSI)	1-800-862-3386 www.bcbsil.com
<p>The Medical Services Advisory (MSA) Program — the plan's utilization review organization</p>	Blue Cross and Blue Shield of Illinois (BCBSI)	1-800-635-1928* www.bcbsil.com
<p>Mental Health and Substance Abuse Information on mental health and substance abuse benefits</p>	CIGNA Behavioral Health	1-888-218-7210 www.cignabehaviorial.com
<p>The Members Assistance Program (MAP) counseling and education information</p>	MAP (CIGNA Behavioral Health)	1-888-218-7210
<p>Prescription Drug Information, order forms and preaddressed envelopes for mail service</p>	AdvancePCS	1-800-966-5772 during business hours www.pcshs.com
<p>Dental and Orthodontic Dental and orthodontic benefit information, forms and claim information</p>	Blue Cross and Blue Shield of Illinois (BCBSI)	1-800-367-6401 www.bcbsil.com

* Monday through Friday, 7:00 a.m. through 7:00 p.m. Central Standard Time. Weekend and after-hours emergency calls are answered by an answering service.

Medical, Vision and Hearing Aid Claims

Generally no claim forms are required when you use a Blue Cross and Blue Shield participating provider. In most cases, participating providers agree to submit your claims for you. If the provider does not submit the claim, you may submit your claims directly to Blue Cross and Blue Shield at the following address:

Blue Cross and Blue Shield of Illinois (BCBSI)
 P.O. Box 1364
 Chicago, IL 60690

Prescription Drug Claims

Retail Purchases: If you do not have your prescription drug card, you must pay for the prescription when purchased and have the pharmacist fill out an AdvancePCS claim form. You must then submit your claim to:

AdvancePCS, Inc.
 P.O. Box 52116
 Phoenix, AZ 85072

Dental and Orthodontic Claims

All claims should be submitted to:

Blue Cross and Blue Shield of Illinois (BCBSI)
 PreDent Plan for Dental Care
 P.O. Box 2935
 Chicago, IL 60690

Mental Health and Substance Abuse Claims

All claims should be submitted to:

CIGNA Behavioral Health
 P.O. Box 46270
 Eden Prairie, MN 55344-6270

Note: If you do not file a claim within one year of the date you incur an expense, reimbursement will be denied.

New Address Form

If you move, please complete this form:

Name: _____

Social Security Number: _____ - _____ - _____

New Address: _____

Old Address: _____

Employer: _____

Signature: _____

Date: _____

Send completed form to the Fund Office at:

Electrical Insurance Trustees
221 North LaSalle Street, Suite 200
Chicago, Illinois 60601-1273



Dependent Change Form

Name: _____

Social Security Number: _____ - _____ - _____

Address: _____

Employer: _____

Complete this section to add dependents; attach a copy of the marriage or birth certificate, or court order for adoption.

Name of Spouse: _____

Social Security Number: _____ - _____ - _____

Date of Birth: ____ / ____ / _____ Date Married: ____ / ____ / _____

Name(s) of Child(ren): Social Security Number: Date of Birth: Date Adopted:

Complete this section if your spouse and/or child(ren) are no longer dependents. In case of divorce, attach a copy of the divorce decree.

Name of Spouse: _____

Social Security Number: _____ - _____ - _____

Date No Longer a Dependent: ____ / ____ / _____

Name(s) of Child(ren): Social Security Number: Date No Longer a Dependent:

Signature: _____ Date: ____ / ____ / _____

Send completed form to the Fund Office at:

**Electrical Insurance Trustees
221 North LaSalle Street, Suite 200
Chicago, Illinois 60601-1273**



