MICHIANA AREA ELECTRICAL WORKERS'

HEALTH & WELFARE FUND SUMMARY PLAN DESCRIPTION

JANUARY 2019

MICHIANA AREA ELECTRICAL WORKERS' HEALTH & WELFARE FUND
Summary Plan Description

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INTRODUCTION

About Your Plan

In 1961 the Union and certain participating Employers signed a Health & Welfare Trust Fund Agreement which authorized the creation of a Plan for payment of health and welfare expenses of eligible participants and beneficiaries. Over the years the Plan has constantly been improved in an effort to provide the best benefits possible consistent with sound financial management of the Plan. This booklet contains both the current version of the Plan document and a Summary Plan Description (SPD, for short) explaining key features of the Plan.

The Health and Welfare Fund is maintained as a result of collective bargaining between your Employer and the Union.

Your Health & Welfare Fund receives its money from Employer contributions, on dates and in amounts called for by the labor contract negotiated with the Employer by your Union. **Money is not withheld from your paycheck in order to support the Fund.** The largest part of the contributions the Fund receives is returned directly to you and other participants in the form of benefits. Some of the contributions received are set aside for reserves. The Fund's reserves can be drawn on at times when the claims expenses exceed income.

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

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

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

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

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

The **Fund Consultant** assists the Trustees in determining the level of benefits which can be provided from Fund resources and advises the Trustees on other matters important to the Fund's operations.

The **Fund Auditor** examines the Fund's financial records each year and certifies them as to their accuracy, completeness and fairness as required by law and the standards governing independent accountants. In addition to the Fund Auditor's examination, the Trustees are required to submit annual financial statements and other reports to the

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

FREQUENTLY ASKED QUESTIONS

1. WHAT SHOULD I DO WITH THIS BOOKLET?

   This booklet is intended to provide you with a detailed summary of the Michiana Area Electrical Workers Health & Welfare Fund Plan and the Plan itself so that you will know your rights and benefits under the Plan. Please read it carefully and keep it handy for future reference.

2. WHAT IF I CAN'T FIND THE ANSWER IN THIS BOOKLET?

   While the answers to many frequently asked questions are in the booklet, you may sometimes have a question about something that the booklet does not seem to cover. The Administrative Manager will be happy to discuss any questions you may have concerning the Plan and how it applies to you.

3. DO THE EXAMPLES IN THE SPD APPLY TO MY BENEFITS?

   The SPD is a general explanation about how the Plan works. Some of the provisions of the Plan are explained by means of an example. These examples are included so that the provisions can be easily understood. They are not calculations of the benefits or rights of you or any other Participant. Your particular rights and benefits will be determined on the basis of your actual participation in the Plan.

YOUR RESPONSIBILITIES AS A PARTICIPANT

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

1. Take time to read this Summary Plan Description.
2. File an Employee Health Care (Enrollment) form
3. Notify the Fund Office promptly, in writing, if you have:
   a. a change of address; or
   b. a change in marital status; or
   c. a change in beneficiary; or
   d. a change in dependents.
   e. a change in your or you or your dependents health care coverage or insurance
4. Make self-payments on time and in the correct amount.

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

MEDICAL BENEFITS

Your hospitalization and medical coverage is provided by Anthem. Your prescription drug coverage is provided through Humana.

Contact numbers are as follows:

Anthem 800-810-BLUE (2583)
Claims Processing Office toll free at 1-855-337-9346.

Humana 877-823-2386

Michiana Area Electrical Workers' Health & Welfare Fund -877-244-9473

GENERAL DEFINITIONS

Active Participant – a participant who is working within the jurisdiction of the Fund for a Contributing Employer and having employer contributions remitted on his behalf.

Active Work – employment, occupation or other enterprise for pay or profit covered by a Collective Bargaining Agreement between the Union and an Employer.

Collective Bargaining Agreement - Any agreement between the Union and any Employer or association of Employers which provides for the making of Employer contributions to the Trust Fund including an Assent of Participation Agreement.

COBRA – Continuation of coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

Dependents/Eligible Dependents - Eligible Dependents are the following:

1. The legal spouse of an Eligible Employee or a Retired Employee if the spouse is not eligible for coverage under a health plan of the spouse's employer or qualifies for a waiver from coverage under the health plan of the spouse's employer;

2. Any unmarried natural child of the Eligible Employee if:

    a. the child is less than twenty-six (26) years old, excluding a person who would otherwise be entitled to benefits under this Plan as an Employee; or

    b. the child is over twenty-six (26) years of age and he/she is totally and permanently disabled because of a qualifying physical or mental handicap. To be considered a qualified physical handicap or mental retardation under this definition, it must:

        1) occur before the child reaches age nineteen (19); and

        2) be certified by a Physician; and

        3) render the child incapable of self-sustaining employment so as to make the child dependent upon the parents for financial support and maintenance.

        Initial proof of such disability and financial dependency must be furnished to the Trustees within sixty (60) days of the child's reaching twenty-six (26) years of age. Subsequent proofs may be required by the Trustees

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend dependent coverage up to age twenty-six (26). Dependents qualify whether they are

married or unmarried. If your dependent has another offer of employer-based coverage such as through his or her job) your dependent is still eligible to enroll under this Plan.

3. Your step child, foster child, a child under full legal guardianship, or a legally adopted child; including the legally required trial period prior to the approval of the adoption by a court.

   This means a child whom the Eligible Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by the Eligible Employee of a legal obligation for total or partial support of a child in anticipation of adoption of a child. Coverage of these pre-adoptive children is required by the Federal Omnibus Budget Reconciliation Act of 1993 and no pre-existing condition provisions are applied to this coverage. The child must be available for adoption and the legal process must have commenced.

4. In order to qualify under the definition of an Eligible Dependent the following conditions must be met:

   a. the child must be living with the Eligible Employee in regular parent-child relationship, except in the case of divorce; and

   b. the Employee contributes more than fifty percent (50%) toward the maintenance and support of the child; and

   c. legal documentation is presented, upon request, supporting the Dependent's status.

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

Dependent coverage terminates on the date:

1. The eligible child or surviving spouse marries; or

2. The qualifying disability ceases; or

3. The Dependent is employed on a full-time basis; or

4. The QMCSO terminates; or

5. The Employee's coverage is terminated.

Newborn coverage will begin on the date of birth for Sickness or Injury, including care or treatment of: (1) congenital defects; (2) birth abnormalities; (3) premature birth.

The term Eligible Dependent does not include any person who does not meet the above definition. It also does not mean anyone who lives outside the United States or Canada; or is in the armed forces of any country or has coverage under this Plan as a participant or as a dependent of another person. It also does not include a child fathered by a dependent child or born to a female other than the Eligible Employee or the Employee's legal spouse.

As required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of a Plan participant who is alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under this Plan with no-pre-existing conditions provisions applied.

If one spouse is covered under the Plan pursuant to the terms of a Collective Bargaining Agreement and one spouse is covered under the terms of a Participation Agreement:

1. Their children may be covered as Dependents of the husband or the wife, but not both; and

2. Neither may be covered as the Dependent of the other at the same time.

Eligibility Rules - The Eligibility Rules apply to Active Employees and their Dependents, Totally and Permanently Disabled Employees and their Dependents, and Self-Pay Employees and their Dependents and Retirees and their Dependents.

Eligible Employee - An Eligible Employee means any person who: (1) is working within the jurisdiction of and covered under the terms of the Collective Bargaining Agreement or Non-Bargaining Employee Participation Agreement entered into between the Union and the Employer, and (2) is eligible for benefits as set forth in the Michiana Area Electrical Workers' Health and Welfare Fund Eligibility Rules.

Eligible Person - An Eligible Person means an Eligible Employee, an Eligible Dependent, or a Retired Employee.

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

Employer - Employer or Contributing Employer means any association or individual employer which has a Collective Bargaining Agreement with the Union or other legally binding agreement and is thereby required to make contributions to this Fund on behalf of its Employees. Any employer not presently party to such a Collective Bargaining Agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement is also included in this definition.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Fund Office – The office of the Administrative Manager described in Section VII of this Summary Plan Description.

Health Insurance Portability and Accountability Act - The Federal Law, which limits the circumstances under which coverage may be excluded for medical conditions before you enroll and governs the use of Protected Health Information.

Participant – An Eligible Employee or Eligible Retiree.

Plan Administrator – The Board of Trustees.

Protected Health Information - Information maintained by a health care provider, health plan, employer, or health care clearinghouse which relates to past, present, or future physical or mental health or condition of an individual **that identifies the individual** or for which there is a reasonable basis to believe the information can be used to identify an individual.

Retired Employee or Retiree - Retired Employee or Retiree means an Employee who is at least fifty-five (55) years of age or older and has elected to cease active work and has notified the Fund, in writing, while still eligible for participation under all of the eligibility provisions of his or her intended retirement, and has been an Eligible Employee under this Plan for a minimum of thirty (36) continuous months immediately prior to retirement. The Plan year is May 1st through April 30th.

Reciprocity – The transfer of hours and contributions from one local union's jurisdiction to another. Reciprocity must be done through the Electronic Reciprocal Transfer System (ERTS).

Temporarily Disabled

Temporarily Disabled unless otherwise specifically defined, refers to disability resulting solely from a sickness or accidental bodily injury which prevents an Employee from engaging in any occupation or employment for compensation or profit or engaging in substantially all the normal activities of a person of like age and sex in good health on a temporary basis. Temporarily Disabled participants are expected to return to work.

Totally & Permanently Disabled

Totally and Permanently Disabled, unless otherwise specifically defined, refer to disability resulting solely from a sickness or accidental bodily injury which prevents an Employee from engaging in any occupation or employment for compensation or profit or engaging in substantially all the normal activities of a person of like age and sex in good health and the person is eligible for Social Security Disability Benefits. A copy of the Social Security Administration Notice of Award Letter is required for proof of total disability.

Totally Disabled and Total Disability - Totally Disabled and Total Disability, unless otherwise specifically defined, refer to disability resulting solely from a sickness or accidental

bodily injury which prevents an Employee from engaging in work as an electrician or in work in the Construction Trades.

Trust Agreement - Trust Agreement means the Agreement and Declaration of Trust establishing the Michiana Area Electrical Workers' Health and Welfare Fund as that instrument as may be amended from time to time.

Trust Fund - Trust Fund or Fund means the Michiana Area Electrical Workers' Health and Welfare Fund.

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

Union - Union means I.B.E.W. Local No. 153 and those other Unions, which have executed a collective bargaining agreement with an Employer who, in accordance with such agreement, participates in and contributes to the Michiana Area Electrical Workers Health and Welfare Fund.

SECTION I

ELIGIBILITY RULES

The Michiana Area Electrical Workers' Health and Welfare Fund provides benefits for you, your spouse and your Eligible Dependents.

This section describes eligibility for health care, prescription drug benefits, burial benefits and accidental death and dismemberment benefits.

INITIAL ELIGIBILITY

You and your Dependents, if any, shall become eligible for benefits on the first day of the second month following a full month of employment. A full employment month is defined as one hundred thirty (130) or more hours of work.

> **Example**: A full month of employment is attained during April. Your benefits will start June 1 through June 30.

Active Employees

Employers must pay contributions for health and welfare benefits based upon each hour you work.

The Fund uses an "hour bank" eligibility system for its Active Employees Program. Under this system, once you have met the Initial Eligibility Provisions, which are explained above, you can "bank" employer contributions which are in excess of those required for you to maintain eligibility each month. The Trustees reserve the right, in their sole discretion, to limit the number of hours or contributions which may be "banked". No Employee has any vested right to "banked hours". The current bank maximum is five hundred and twenty (520) hours.

Continuation of Eligibility

Once having become eligible, you will remain eligible if:

1. You continue to have at least one hundred thirty (130) hours of employer contributions made to the Fund on your behalf each month;

2. You have at least one hundred thirty (130) hours remaining in your hour bank which can be withdrawn to meet the eligibility requirement; or

3. You have less than one hundred thirty (130) hours remaining in your hour bank and you make a self-contribution at the then current contribution rate for each hour that the combination of working hours and hours in your hour bank is less than one hundred thirty (130) in accordance with the provisions governing self-contributions for Active Employees. For example, if you have only seventy (70) hours remaining in your hour bank and do not have any employer contributions remitted for the month in question, you would be billed for sixty (60) hours, which is the difference between one hundred thirty (130) hours and seventy (70) hours, and would need to make a self-contribution to continue your eligibility. Self-contributions are explained below.

4. If you become covered but subsequently fail to secure one hundred thirty (130) hours within a month, you may continue eligibility by self-contributions. Participants who do not have any employer contributions will be permitted to remit self-contribution payments at the rate of two hundred dollars ($200) per month for the first three (3) months. Participants will be permitted to **reset** to the lower contribution rate of two hundred dollars ($200) per month for three (3) months by returning to work for at least one hundred thirty (130) hours in one reporting month. The participant will then be eligible to remit the lower two hundred dollar ($200) self-contribution for a rolling twelve (12) month period. The self-payment rate for the next three (3) months will be based upon fifty percent (50%) of the actual cost of providing coverage and the self-payment rate for the next six (6) months will be based upon one hundred percent (100%) of the actual cost of providing coverage.

You may remit a maximum of eighteen (18) consecutive self-contributions if you are not doing Active Work.

Maximum Hour Bank

Currently you may not accumulate more contributions in your hour bank than the equivalent of the amount of contributions which would provide you with continued coverage for four (4) months. This may be subject to change from time to time in the sole discretion of the Trustees.

Self-Contributions

If you are an Active Employee and you lose your eligibility because the amount of employer contributions in your hour bank is insufficient, you may continue your eligibility by making a self-contribution in accordance with the following procedures. (You and your Dependents also

have the right to continue coverage under the COBRA Continuation Provisions, if the qualifications are met.)

When you are about to become ineligible, the Fund Office will attempt to notify you that a self-payment is required to continue your eligibility. This notice will state the amount of self-contribution required to continue your eligibility. The required self-contribution must then be post marked no later than the date indicated on the notice.

Acceptance of self-contributions from you is conditioned upon your becoming and/or remaining ineligible because of a lack of Active Work within the jurisdiction of the Fund or because you are currently doing Active Work for a contributing employer but for insufficient hours to remain eligible. Evidence that you are available for Active Work within the jurisdiction of the Fund is required. If you are *temporarily* disabled, you may also remit self-contributions to continue your coverage. Evidence of this *temporary* disability is required.

All self-contributions must be made by direct debit from your checking or savings account, check or money order made payable to "Michiana Area Electrical Workers' Health and Welfare Fund" and post marked within the prescribed time to the Fund Office, 6525 Centurion Drive, Lansing, MI 48917-9275.

Keeping Track of Bank Employer Contributions

A contribution advice notice is sent to you reflecting the contributions received and/or hours remaining in your hour bank for each month that (1) employer contributions are remitted in your behalf, (2) you remit a self-contribution and/or (3) contributions remain credited to your hour bank. YOU SHOULD CAREFULLY MONITOR YOUR CONTRIBUTION ADVICE NOTICE TO ASSURE THAT CONTRIBUTIONS FROM EMPLOYERS HAVE BEEN REMITTED IN YOUR BEHALF WHILE YOU ARE EMPLOYED, THAT SELF-CONTRIBUTIONS REMITTED WERE RECEIVED AND THAT THE HOURS IN EXCESS OF THOSE NEEDED FOR ELIGIBILITY PURPOSES HAVE BEEN CREDITED TO YOUR HOUR BANK. IF A DISCREPANCY IN EMPLOYER CONTRIBUTIONS IS NOTED, IT IS YOUR RESPONSIBILITY TO PROMPTLY NOTIFY THE UNION. IF A DISCREPANCY IS NOTED IN SELF-CONTRIBUTIONS OR HOUR BANK TOTAL, YOU SHOULD NOTIFY THE FUND OFFICE.

IT IS IMPORTANT that you keep the Fund Office informed of your current address. It is equally IMPORTANT that you make the required self-contribution when due even if you think you should be eligible by way of employer contributions. If the Fund later receives contributions, an appropriate refund of the self-contributions will be made by the Fund Office.

NON-BARGAINING UNIT PARTICIPANTS

Non-Bargaining Unit Participants are eligible for benefits provided they meet eligibility requirements. Such Participants include Local Union 153 business agents, Local Union 153 financial secretaries; other paid employees of Local Union 153; and supervisory and other

employees of Contributing Employers who have entered into participation agreements with the Trustees.

i. If you are such a Participant, you may continue eligibility for benefits provided your Employer has contributed to the Fund~~,~~ an amount equal to either one hundred thirty (130) hours or one hundred fifty (150) hours times the Health and Welfare Fund contribution rate as required in the current Collective Bargaining Agreement. This equals the Non Bargaining unit (NBU) cost of the program. The Board of Trustees has determined that if the Employer elects to remit one hundred fifty (150) hours per month, any hours in excess of those required for eligibility will be added to the NBU Participant's hour bank. However, if the Employer remits contributions for only one hundred thirty (130) hours per month, no hours will be added to the NBU Participant's hour bank

ii. If such contributions during any Eligibility Period do not equal the NBU Cost of the Program, you may continue eligibility by contributing directly to the Fund the difference between the amount of contributions made by Employer and the NBU actual cost of the program.

iii. If you are terminated and you have not received any credited contributions during any eligibility period, you may remit self-contributions. However, NBU Participants like you may make self- contributions only as long as they continue working for a Contributing Employer.

LOCAL UNION STAFF AND OFFICE STAFF OF THE SOUTH BEND & VICINITY JOINT APPRENTICESHIP AND TRAINING COMMITTEE

Health Care Contributions for these participants are based upon one hundred sixty (160) hours per month. However, the eligibility requirement is one hundred and thirty (130) hours per month.

APPRENTICES

Individuals that are considered new apprentices will receive contributions sufficient to provide for the Employee Assistance Program (EAP) and the Supplemental Benefit Account (SBA) benefits. Please refer to Section III for a detailed explanation of the benefits available.

GENERAL WORKER

Individuals that are considered General Workers do not qualify for the regular Schedule of Benefits. Contributions are remitted to the Fund to provide for Employee Assistance Program (EAP) services only, until such time as the General Worker has a total of two thousand (2,000) hours remitted to the Plan. Once two thousand (2,000) hours of contributions have been remitted on the General Worker's behalf, the hourly rate will increase and the contributions

remitted will then provide for benefits under the Fund's Supplemental Benefit Account (SBA). Please refer to Section III for a detailed explanation of the benefits available.

TEMPORARILY DISABLED PARTICIPANTS

If you are eligible and become Temporarily Disabled due to injury or illness, you may be eligible to receive disability credit which can maintain your eligibility for up to twelve (12) consecutive months.

Disability Hours Credit - Short Term Disability

To qualify for Disability Hours, you must be unable to perform covered employment and must:

1. Be eligible for payment of Weekly Accident and Sickness (Loss of Time) Benefits under the Plan, or

2. Submit evidence satisfactory to the Trustees that you are eligible for Weekly Worker's Compensation benefits as a result of a disability incurred within the jurisdiction of any Union participating in this Plan.

The first week of the disability will be covered for a disability caused by illness lasting 4 weeks or more.

Eligibility for Short Term Disability Benefits terminates when a Participant becomes a Retiree.

TOTALLY & PERMANENTLY DISABLED PARTICIPANTS

If you are eligible and become Totally Permanently Disabled due to injury or illness, you shall receive a credit for each month's cost of the program of $1/13^{th}$ while drawing weekly disability benefits. These credits will continue until you become eligible for Medicare or for twelve (12) months, whichever occurs first, as long as you submit a physician's certification of continuing total disability as requested.

PLAN 4 BENEFITS

The Michiana Area Electrical Workers Plan 4 is a separate trust fund whose purpose is to help participants in the Michiana Area Electrical Workers Health and Welfare Plan pay for their health care coverage after they retire. All Plan 4 benefits are paid directly to the Health and Welfare Plan.

Plan 4 benefits are paid in the form of an offset toward the cost of retiree health care coverage through the Michiana Area Electrical Workers Health and Welfare Plan. You must be eligible for

retiree health care coverage from the Health and Welfare Fund to receive benefits from Plan 4. Please refer to the Plan 4 Summary Plan Description for additional information.

RETIRED PARTICIPANTS

a. Retirement

A Retiree, as defined in this Plan, may, by paying the self-payment invoice, continue eligibility. (See the General Definitions for the definition of a Retiree.)

If you are not eligible for Medicare you will have the same benefits as the Active Participants. If you are eligible for Medicare, Medicare will be the primary carrier, however you will still be eligible for the same benefits as the Active Participants with the exception of Loss of Time/Disability Benefits. *Remember, once you are eligible for Medicare, you must obtain both Parts A and B of Medicare*.

You **are** required to enroll in both **parts A and B of Medicare** when you become eligible for Medicare. You should immediately forward a copy of your Medicare Card to the Fund Office. You **are not** required to enroll in the **Medicare Part D** Prescription Drug Program.

Because the current prescription drug benefit offered to you through the Michiana Area Electrical Workers' Health & Welfare Fund is as good as or better than that available under a Medicare prescription drug plan, the Trustees have decided to continue the current prescription drug coverage for Retirees. **It is therefore imperative that you do not enroll in the Medicare Part D Prescription Drug Program.**

b. Return to Active Work

If a Retiree wishes to return to Active Work and be classified as an Active Participant, he must notify the Fund in writing.

c. Termination of Coverage

Retiree Coverage is subject to termination by the Trustees at any time in their sole discretion.

SURVIVOR BENEFITS

In the event of your death while eligible, your Dependents covered under this Plan will receive Benefits without charge for three months following the month for which you were eligible. After these three months, the Dependent spouse may continue the Health coverage by requesting coverage and making the necessary payments to the Fund. The current self-payment rates are based upon the actual cost of providing coverage. For the first twenty-four (24) months the surviving spouse self-payment will be fifty-percent (50%) of the actual cost of coverage and

thereafter one hundred percent (100%) of the actual cost of coverage. This Survivor Benefit will terminate upon the earliest of:

(1) the death of the surviving Dependent;
(2) Remarriage of the Dependent spouse;
(3) elimination of this Benefit by the Trustees;
(4) termination of this Plan

SELF-PAYMENT RATES

The amount of the self-payment rate is determined by the Board of Trustees and may be adjusted periodically. You should contact the Fund Office for current rates.

INDUCTION INTO THE ARMED FORCES

If you are called to active duty in the Armed Forces of the United States, coverage may be provided by TRICARE for yourself and your Eligible Dependents. If the coverage does not meet the needs of your Dependents, or if you think that it would be too inconvenient for your Dependents to avail themselves of TRICARE coverage, you may elect to cover them under the Fund for up to eighteen (18) months under the COBRA self-payment provisions of the Fund. Please contact the Fund Office for an explanation of the options available to you.

TERMINATION OF COVERAGE

The Trustees have the right in their sole discretion to amend, suspend or terminate benefits in whole or in part at any time and for any or all classes of Participants. In addition, Coverage will automatically terminate on the earliest of:

1. the date this Plan terminates; or
2. the last day for which the cost of program has been paid; or
3. the date the Participant enters into full-time military, naval or air service; or
4. the date the Participant is no longer in an eligible class; or
5. the end of the last day of the month for which the Participant has become eligible, or
6. at any time the Participant ceases to qualify as a Participant as defined in the Trust Agreement.

Dependent Coverage will automatically terminate on the earliest of:

1. the last day for which the Dependent's cost of program has been paid: or
2. the date he or she is no longer a Dependent as defined in this Plan;
3. the date your Participant Coverage terminates, except as otherwise provided by COBRA.

No benefit payment shall be made for charges incurred after the date this Plan is terminated except as provided in any extended benefits provision of this Plan.

Eligibility for Employees In Covered
Employment Outside IBEW Local No.153 Jurisdiction

If you are an Eligible Employee and leave the jurisdiction of IBEW Local No.153 to work at the trade in covered employment under the jurisdiction of another IBEW Local Union, your eligibility in this Plan is governed by the requirements of this section of the Eligibility Rules.

Jurisdiction WITHOUT Reciprocity

If you leave the jurisdiction of IBEW Local No.153 to work in covered employment under the jurisdiction of an IBEW Local Union that does not have a Reciprocity Agreement with IBEW Local Union No.153, your eligibility (and that of any Eligible Dependents) terminates on the earlier of:

1. The first day of the month in which your accumulated work hours do not meet the requirements established by the Trustees, or

2. The date in which you become eligible for benefits under any other group health care plan.

Return to Jurisdiction (Reinstatement of Eligibility)

When you return to covered employment in the IBEW Local No.153 jurisdiction, your eligibility will be reinstated in this Plan on the date you first perform covered employment for an Employer required to contribute to this Fund, provided:

1. You return to covered employment in this jurisdiction within twelve (12) calendar months of your eligibility's termination; and

2. You have at least one hundred thirty (130) hours of Employer contributions made to the Fund on your behalf for work performed during the month immediately prior to the month in which you left this jurisdiction and termination occurred.

Eligibility reinstated under these provisions continues as described in Section I.

If you fail to meet these requirements or if you meet the requirements but return more than twelve (12) months after your eligibility terminates, then you must meet the requirements under "Initial Eligibility" in these Rules to reinstate eligibility.

Jurisdiction With Reciprocity

The Trustees of the Fund have entered into agreements with the Trustees of similar IBEW Welfare Funds operating in the jurisdiction of other IBEW Local Unions. Under these agreements (commonly called "Reciprocity Agreements"), contributions for hours worked at covered employment in the jurisdiction of another IBEW Local Union may be transferred to this Fund for use in continuing your eligibility.

The amounts to be transferred and the way those transfers are credited to your records are governed by the Reciprocity Agreements and by the administrative procedures adopted by the Trustees from time to time. Inquire about the availability of Reciprocity Agreement transfers at the Fund Office before you leave the IBEW Local No.153 jurisdiction to work in covered employment elsewhere.

General Provisions

Change of Eligibility Rules

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

A Note of Explanation

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

Remember: Changes in employment may affect Employer contributions paid on your behalf. For example, Employer contributions cease in the event you:

1. Change job classifications from covered to non-covered employment, even if that employment is with the same Employer; or

2. Change employment from a participating to a non-participating Employer.

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

Effective Dates Of Coverage

Employee

Your effective date of coverage as an Employee will normally be the date you satisfy the requirements of the Eligibility Rules.

Dependents

Your effective date of coverage, as a Dependent, will be the date the Employee, who sponsors you, becomes eligible or the date you satisfy the definition of Dependent, whichever is later. Your coverage is not delayed if you or the Employee who sponsors you is disabled on that date.

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

Termination Dates of Coverage

Employee

Your coverage as an Employee under all benefit provisions of the Plan terminates when the earliest of the following events occurs:

1. Failure to meet the requirements for continuing eligibility as shown in the Eligibility Rules, including a failure to make any self-payments or self-contribution in a timely manner; or

2. Termination of the coverage classification under which you were continuing your eligibility; or

3. Termination of the Plan itself.

Dependents

Your coverage as a Dependent under all benefit provisions of the Plan terminates when the earliest of the following events occurs:

1. Termination of eligibility for the Employee who sponsors you (for reasons other than the receipt of a Maximum Amount Payable); or

2. On the first of the month next following the date you fail to meet the definition of a Dependent; or

3. Failure to meet the requirements for continuing eligibility as shown in the Eligibility Rules, including failure to make any self-payments or self-contribution in a timely manner; or

4. Termination of the coverage classification under which you were continuing your eligibility; or

5. Termination of the Plan itself.

Health Insurance Portability and Accountability

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than twelve (12) months (18 months for late enrollees). The twelve (12) month (or eighteen [18] month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan or other source, a certificate of proof of coverage may help you obtain coverage without a pre-existing condition exclusion. You will be sent a certificate of prior health coverage automatically when you or your Dependents' coverage terminates.

If you have questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C., 20210.
You have a right to receive a certificate of prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new Plan Administrator to see if your new Plan excludes coverage for pre-existing conditions and if you need to provide a certificate or documentation of your previous coverage. To receive a certificate, please contact the Fund Office.

Family and Medical Leave

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

1. You are employed by an Employer with at least fifty (50) employees at your work site or with at least fifty (50) employees within a seventy-five (75) mile radius of your work site; and

2. You have been employed by the Employer at least twelve (12) months; and

3. You have worked at least one thousand, two hundred fifty (1,250) hours for the Employer during the twelve (12) months immediately before the requested leave.

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

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

Health Care Coverage Through COBRA

Introduction. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to participants and their dependents when they would otherwise lose group health coverage.

Nature of COBRA Continuation Coverage.

(1) COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A Participant, his Spouse, and dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

(2) A Participant will become a qualified beneficiary if coverage is lost under the Plan because either one of the following qualifying events happens:

(a) Hours of employment are reduced such that hours are insufficient to maintain eligibility, or

(b) Employment ends for any reason other than gross misconduct.

(3) The Spouse of a Participant will become a qualified beneficiary if coverage is lost under the Plan because any of the following qualifying events happens:

(a) Death of spouse;

(b) Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;

(c) Spouse's employment ends for any reason other than his or her gross misconduct;

(d) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(e) Divorce or legal separation from the participant.

(4) Dependent children become qualified beneficiaries if coverage is lost under the Plan because any of the following qualifying events happens:

(a) The parent-Participant dies;

(b) The parent-Participant's hours of employment are reduced such that hours in the hour bank are insufficient to maintain eligibility;

(c) The parent-Participant's employment ends for any reason other than his or her gross misconduct;

(d) The parent-Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);

(e) The parents become divorced or legally separated; or

(f) The child stops being eligible for coverage under the plan as a "Dependent child."

When COBRA Coverage Is Available. The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the Participant, the Employer must notify the Plan Administrator of this qualifying event within 30 days of the death. The Plan Administrator will monitor whether a qualifying event has occurred due to reduction in hours, termination of employment, or Medicare eligibility.

Participant/Spouse Obligation to Give Notice to Plan of Certain Qualifying Events. In the event of divorce, legal separation, or a Dependent child loses eligibility for coverage as a Dependent child (for example, exceeds age limitations), or if after COBRA coverage is elected a

qualified beneficiary becomes covered under another group health plan, the Participant and his Spouse both have an obligation to notify the Plan Administrator of such event within 60 after this qualifying event occurs. This notice must include: the name of the Participant, the social security number of the Participant, the name of the qualified beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the qualifying event (for example, the date of a divorce), and the date on which the qualifying event occurred. If timely notice is not provided, the right to COBRA coverage is forfeited.

Further, failure to timely notify the Plan of a divorce, legal separation, or a child losing eligibility gives the Plan the right to hold the Participant and his Spouse separately and fully liable for any benefits paid by the Plan which would not have been paid had the Plan received timely notification of such event. At its sole election, the Plan may suspend the payment of future benefits until such amount has been recovered.

How COBRA Coverage Is Provided.

- Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Participants may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.
- The COBRA notice will contain information regarding the premium that must be paid for COBRA coverage, which is 102% of the cost to the Plan for such coverage. If the period of COBRA coverage is extended due to disability, discussed below, the premium is 150% of the cost to the Plan.
- Coverage under the Plan will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium. See below regarding the election period for COBRA coverage.

Duration of COBRA Coverage.

COBRA continuation coverage is a temporary continuation of coverage, as follows:

(1) When the qualifying event is the death of the Participant, the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce,

legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

(2) When the qualifying event is the end of employment or reduction of the Participant's hours of employment, and the Participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Participant lasts until 36 months after the date of Medicare entitlement.

- For example, if a Participant becomes entitled to Medicare eight months before the date on which his eligibility terminates, COBRA continuation coverage for his Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

(3) In all other events, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

(4) Disability Extension

- If the qualified beneficiary or anyone in his family covered under the Plan is determined by the Social Security Administration to be disabled and notifies the Plan Administrator in a timely fashion, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.
- The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.
- The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

(5) Second Qualifying Event Extension

- If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered Spouse and Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the participant or former Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if such event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.
- The Plan Administrator must be notified of this second qualifying event within 60 days of such event.

(6) **Notwithstanding the foregoing, months on self-payment will count towards allowable months of COBRA coverage.**

The Election Period for COBRA Continuation. Qualified beneficiaries have 60 days after receipt of the Election Notice, which will be sent to each qualified beneficiaries last known address, to elect COBRA continuation coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

Premium Payment for COBRA Coverage. Following an election, a qualified beneficiary has 45 days to pay the initial COBRA premium. If this is not timely paid, coverage will not be reinstated and the qualified beneficiary will not be given a second chance to reinstate coverage.

- Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. If payments are not made within this period, coverage will terminate and the qualified beneficiary will not be given an opportunity to reinstate coverage.
- If, for whatever reason, the Plan pays medical benefits for a month in which the premium was not timely paid, the qualified beneficiary will be required to reimburse the Plan for such benefits.
- The premium equals the cost to the Plan of providing coverage plus a 2% administration fee. In the event of extended coverage as a result of a disability for

the 19th – 29th months of coverage, the Plan will charge 150% of the cost of providing coverage.

Scope of Coverage. COBRA coverage only pertains to health benefits available under the Plan. Coverage for such benefits under COBRA is the same as those the qualified beneficiary had the day before coverage initially terminated. Coverage may change while on COBRA coverage due to Plan amendments that affect all Participants in the Plan. A qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated Active Employees.

Enrollment of Dependents During Period of COBRA Coverage and Coverage Options. A child born to, adopted by, or placed for adoption with a Participant during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the Participant has elected continuation coverage for himself. If a Participant desires to add such a child to COBRA coverage, he must notify the Plan Office within 30 days of the adoption, placement for adoption, or birth. During the COBRA coverage period, a Participant may add an Eligible Dependent who initially declined COBRA coverage because of alternative coverage and later lost such coverage due to certain qualifying reasons. If a Participant desires to add such a child to COBRA coverage, he must notify the Plan Office within 30 days of the loss of coverage.

Qualified Medical Child Support Orders. If a Child is enrolled in the Plan pursuant to a qualified medical child support order while the Participant was an Active Employee under the Plan, he is entitled to the same rights under COBRA as any dependent Child.

Termination of COBRA Coverage. COBRA continuation coverage terminates on the earliest of the following: the last day of the maximum coverage period, the first day timely payment (including payment for the full amount due) is not made, the date upon which the Plan terminates, the date after election of COBRA that a qualified beneficiary becomes covered under any other group health plan, or the date after election if a qualified beneficiary becomes entitled to Medicare benefits and such entitlement would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred.

In the case of a qualified beneficiary entitled to a disability extension, COBRA continuation coverage terminates on the later of: (a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination from Social Security that the qualified beneficiary is no longer

disabled, whichever is earlier; or (b) the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Omnibus Budget Reconciliation Act of 1993 requires that group health plans recognize and comply with "Qualified Medical Child Support Orders." This document sets forth the Fund's procedure for processing medical child support orders that are claimed to be Qualified Medical Child Support Orders.

Receipt of Order

The Fund Office shall promptly notify the Participant and each alternate recipient (i.e., a person to receive benefits according to the Order) of the Order's receipt and the Fund's procedures for determining whether a medical child support order is a Qualified Medical Child Support Order. The Fund Office shall forward a copy of the Order to Fund Counsel.

Determination of Qualification

Within a reasonable period after receipt of such Order, the Plan Administrator, with the assistance of the Fund Counsel, shall determine whether such order is a qualified medical child support order and notify the Participant and each alternate recipient of such determination.

The procedures to determine whether medical child support orders are qualified medical child support orders shall follow the criteria established by Section 609 of ERISA, and any applicable regulation and administration actions by agencies charged to enforce Section 609. Those criteria include:

1. Inclusion of the order in a judgment order or decree made pursuant to state domestic relations law or made pursuant to state domestic relations law or made pursuant to a law relating to medical child support described in 42 U.S.C. § 1396g issued by a court of competent jurisdiction or administrative process that has the force or effect of law in the state issuing the order.

2. Creation, assignment or recognition of the right of an alternate recipient to receive Fund benefits to which a Participant or a beneficiary is entitled.

3. Whether the alternate recipient is a child of the Participant or a child adopted by or placed for adoption with a Participant.

4. Inclusion of the name and last known mailing address of the affected Participant and the name and last known mailing address of the alternate recipient.

5. Inclusion of a description of the type of coverage to be provided by the Fund or the manner in which such coverage is to be determined.

6. Identification of the period for which the order applies.

7. Identification of the Fund as the plan to which the order supplies.

8. Verification that the order does not require the Fund to provide benefits or a form of benefits other than one provided by the Fund, provided that the Fund shall satisfy requirements of applicable laws relating to medical child support described in 42 U.S.C. §1908.

Effect of National Medical Support Notices

The Fund shall recognize as Qualified Medical Child Support Orders "National Medical Support Notices" that comply with the provisions of applicable final regulations under ERISA Section 609.

Status of Alternate Recipients

Alternate recipients shall be deemed Fund Participants for purposes of applicable reporting and disclosure requirements and shall be treated as Fund beneficiaries for all other purposes.

Direct Payments

Payments for benefits or claims for reimbursements made by alternate recipients under Qualified Domestic Child Support Orders shall be made to the alternate recipients or their legal guardians as applicable.

Notification Issues

The Fund Office shall notify an alternate recipient or the alternate recipient's legal guardian of its determination concerning a medical child support order which is claimed to be a Qualified Medical Child Support Order within a reasonable time after receipt. Alternate recipients shall be entitled to designate a representative for the receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order. The custodial parents or guardians of minor alternate recipients shall be considered their designated representatives absent an express written request of other representatives.

SECTION II

Customer Service Information

If you need to call or write about a claim or your coverage, it's important to give the Claims Processing Office the contract number that's printed on your ID card. **You'll receive the quickest service possible if you contact the Claims Processing Office.**

Use the phone number that's printed on the back of your ID card, or refer to the number below. Customer service hours are Monday through Friday from 7:30 a.m. to 4:30 p.m. Eastern Standard Time.

To Call	To Write
1-855-337-9346	Michiana Area Electrical Workers' Claims Processing Office P.O. Box 4963 Troy, MI 48099-4963

Anthem (participating providers)..... 1-800-810-BLUE (2583)
Provider Eligibility Benefits..... 1-800-676-2583
Claims Processing Office..... 1-855-337-9346
Member Eligibility/Michiana Fund Office 1-877-244-9473
Hines & Associates.....1-888-236-2652

Web site Addresses
Anthem Blue Cross Blue Shield Home Page ..... www.anthem.com

General Information

Your Identification Card

Your ID card is your key to receiving quality health care benefits.

Your ID Card includes:

Enrollee Name is same as the Participant. All communications are addressed to this name.

Group Number tells us you are an Anthem member.

Your ID card is issued once you enroll and are eligible for coverage. It lets you obtain services covered under your health care plan. Only the Participant's name appears on the ID card. However, the ID card can be used by all Eligible Dependents under your Plan.

Here are some tips about your ID card:

Sign the signature strip immediately to help prevent fraudulent use.

Carry your card with you at all times to help avoid delays when you need medical attention.

If you or any Eligible Dependent in your family needs a card, please call the Fund Office.

Only you and your Eligible Dependents may use the cards issued for your Plan. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.

Call your Fund Office if your card is lost or stolen. You can still receive services by giving the provider your contract number to verify your coverage.

Customer Service

As a Participant you are very important to the Fund. You should call the Claims Processing Office number anytime you have a question about your health care Plan.

To help us serve you better, here are some important tips to remember:

Have your ID card ready

If you are questioning a service contact the Claims Processing Office and please provide:

- Patient and provider's name
- Date the patient was treated
- Type of service, such as an office visit
- Charge for each service

- When corresponding with us, please make sure your ID card number is on each page and you should keep a copy for your records.

When visiting our Claims Processing Office, please bring a copy of any bills, forms or other materials related to your inquiry.

Preventing Fraud

The Claims Processing Office tries to prevent fraudulent use of your ID card. Only you and the Eligible Dependents listed on your enrollment form are covered for services.

Providers may ask for identification other than the ID card. Checking the identification of the cardholder is one way of preventing unauthorized use of your card.

If you suspect health care fraud, let us know by notifying us in either of the following ways:

- Write the Claims Processing Office at the following address:

  Michiana Area Electrical Workers'
  Claims Processing Office
  P.O. Box 4963
  Troy, MI 48099-4963

- Contact Anthem online on **www.anthem**

Choosing a Network Provider
What You Need to Know

This section provides information to help you understand and use your Anthem coverage. You will find information about:

- Network providers
- Non-network providers
- Anthem/BlueCard PPO program
- Care out of the country

Anthem PPO is designed to provide you with the highest level of benefits and the lowest out-of-pocket costs when you choose PPO providers. You also have the freedom to receive care from a non-network provider, but with higher out-of-pocket costs.

Network Providers

Anthem PPO uses a network of physicians, hospitals, and other health care specialists who have signed agreements with Anthem/Blue Cross Blue Shield to accept the approved amount as payment in full for covered services. When you use PPO network providers, your out-of-pocket costs for covered services are limited to the **deductible and copayments** listed in this section.

Here is what you need to do when you need medical care:

Choose a PPO provider by logging onto the Web site

Make your appointment directly with that provider

> **Note:** When scheduling your appointment, it's a good idea to confirm that the provider is still in the PPO network.

With Anthem PPO, you do not have to choose just one provider for your care and you do not have to notify Anthem if you decide to change physicians. Just remember to select PPO network providers and you will stay in-network.

To receive benefits at the in-network level, your care must be received from a PPO provider. You do not need to use a PPO provider for the following services. However, you must follow any coverage requirements outlined in this SPD booklet:

Services for which a PPO network has not yet been established

Services covered under a separate prescription drug, dental, vision, or hearing plan

> **Special Note for Parents of Students:** If you have Dependents attending school and living away from home, you should help them choose a PPO physician near their school. Remember to access the Web site for PPO providers.

Change in Network Status

Your physician is your partner in managing your health care. However, physicians retire, move, or otherwise cease to be affiliated with the Anthem PPO network. Should this happen, your physician should notify you that he or she is no longer in the PPO network. You should try to find another PPO physician. If you wish to continue care with your current physician, a customer service representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

Non-Network Providers

When you receive care from a provider who is not part of the PPO network, without a referral form from a PPO network provider, your care is considered out-of-network. Before choosing a non-network provider, you should verify if the service would be covered. **Some services such as preventive care services are not covered out-of-network.**

You are responsible for your out-of-network deductible and copayments.

Coverage at nonparticipating hospitals may be limited.

Be sure to find out your provider's participation status before you receive services.

> **Note: The Plan does not cover services at nonparticipating outpatient physical therapy facilities, mental health or substance abuse treatment facilities, freestanding ambulatory surgery facilities, home health care agencies, hospice programs or skilled nursing facilities.**

If you use a provider who **does not participate** with Anthem, you may be responsible for any difference between the provider's charge and the Anthem approved amount and may need to file your own claims. When you use nonparticipating providers, the Claim Office will send you the Anthem approved amount, less applicable out-of-network deductible and copayments. You are responsible for paying the provider.

Anthem/BlueCard PPO Program

With the Anthem/BlueCard Program, you can locate doctors and hospitals quickly and easily. When you need medical care **outside the state in which you live,** you can receive in-network benefits by using the Anthem/BlueCard PPO Program.
To take advantage, just follow these steps:

Call 1-800-810-BLUE (2583) for the names and addresses of doctors and hospitals in the area where you need care.

> **Note:** If you need emergency medical care, please seek care immediately from the nearest hospital or physician.

When you arrive at the doctor's office or hospital, show your Anthem ID card. Remind the provider that you are covered under the Anthem/BlueCard Program.

Pay applicable deductibles and copayments required by your Plan.

Anthem PPO providers will bill their local Anthem/Blue Card Plan for covered services you receive. The local Anthem/Blue Card Plan will not reduce its payments to BlueCard PPO providers by the out-of-network deductible and/or copayments. You are responsible only for the in-network deductible and copayments (*if applicable*) and for services not covered by your Plan.

You will not be expected to pay out-of-network deductibles or copayments if:

You are referred to a non-network provider by an Anthem/BlueCard participating PPO provider, or

You receive treatment for an accidental injury or a medical emergency.

> **Note:** If you are referred to a nonparticipating provider and you are charged out-of-network deductibles and/or copayments, please call the Claims Processing Office at: 1-855-337-9346.

> **Important:** You may need to submit itemized receipts directly to the Claims Processing Office if you receive services from a non-network provider. Also **Anthem/BlueCard does not include prescription drugs, dental, vision and hearing services.**

Care Out of the Country

Your coverage applies no matter where you are only if:

- The hospital and physician are accredited
- The physician is licensed

Most hospital and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. When you submit your claim, tell the Claims Processing Office if the charges are in U.S. or foreign currency. Be sure to indicate whether payment should go to you or the provider. The Claims Processing Office will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, minus any deductibles or copayments that may apply.

How Your Anthem PPO Plan Works

Anthem PPO gives you the choice of receiving care from a PPO network physician or outside the network from any physician. The choice is always yours.

When a PPO physician provides or refers your hospital and medical services, it is called "*In-Network*."

When a PPO physician does **not** provide or refer your services, it is called "*Out-of-Network*."

Each person enrolled in an Anthem PPO plan is entitled to an unlimited lifetime benefit.

Here's a diagram that shows how Anthem PPO works. Please note that some services in your Plan may not require in-network deductibles or copayments.

When you use any PPO **physician**	When you choose a **physician** who is	
	A Anthem participating physician	A nonparticipating physician
Your plan may require: An in-network deductible (if any) An in-network percent copayment for most covered services A fixed dollar copayment for selected office services and hospital emergency room services A percent copayment for mental health care, substance abuse treatment and private duty nursing You have: No balance billings* No claim forms to file* **You're in-network**	You pay: An in-network deductible An out-of-network percent copayment for most covered services A fixed dollar copayment for hospital emergency room services A percent copayment for mental health care, substance abuse treatment and private duty nursing You have: No balance billings* No claim forms to file* **You're out-of-network**	You pay: An out-of-network deductible An out-of-network percent copayment for most covered services A fixed dollar copayment for hospital emergency room services A percent copayment for mental health care, substance abuse treatment and private duty nursing You have: Balance billings Claim forms to complete **You're out-of-network**

*If you receive care from a nonparticipating physician, even when referred by an Anthem PPO network or Blue participating physician, you may be billed for the difference between the

physician's charge and the Anthem approved amount, and you may have to file your own claims.

In-Network Guidelines

To receive benefits at the in-network level, a PPO provider must provide or refer your hospital or medical care. The following lists those exceptions where the Claims Processing Office will pay services at the in-network level if they are received from a non-network provider.

Referrals

Referral care services are services received from a provider not part of the PPO network, **but coordinated by your PPO network physician.**

> **Important:** A referral from your PPO provider does not guarantee payment. To be covered, the service must be a covered benefit and you must have **a written referral** from your PPO physician. You may be required to pay amounts above the Anthem approved amount if the provider you are referred to does not participate with the Anthem PPO network.

Emergency Care

When you think emergency care is needed, go to the nearest medical facility. The initial exam to treat a life-threatening medical emergency or accidental injury is covered at the in-network level when the diagnosis meets medical emergency guidelines.

> **Note:** Follow-up care is not considered emergency care.

PPO Network Exceptions

The following are examples of types of services covered at the in-network level of benefits when performed by an Anthem participating provider:

- Home health care through an approved agency
- Freestanding substance abuse treatment programs
- Hospice programs
- Ambulance providers
- Durable medical equipment suppliers
- Prosthetic and orthotic suppliers
- Freestanding physical therapy facilities

- Ambulatory surgery facilities
- Skilled nursing facilities

Your In-Network Deductible

When you receive services in-network you must pay an in-network deductible of **four hundred dollars ($400)** per individual or **one thousand, two hundred dollars ($1,200)** per family before payment will be made for benefits. This deductible is required each calendar year.

Note: A family is defined as **four** or more members.

When one individual has met the in-network deductible, benefits are payable for that individual. In-network services for the remaining family members will be paid when the full family (four [4] or more members) deductible has been met.

Note: In-network deductible amounts also apply toward the out-of-network deductible.

The in-network deductible **does <u>not</u>** apply to:

- Preventive care services
- Covered services received in a PPO network physician's office
- Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office.
- Services subject to a fixed dollar copayment
- Chiropractic spinal manipulation
- Pre-natal and post-natal care visits
- Prescription Drugs
- Allergy testing and therapy
- Injections
- Hospice care benefits

Your In-Network Copayments

You are responsible for the following **fixed dollar** copayments, which do not apply toward your deductible or copayment maximum:

Thirty dollars ($30) for office visits, which includes urgent care visits and office consultations

One hundred fifty dollars ($150) per visit for all hospital emergency room treatment whether received in-network or out-of-network.

> **Reminder:** The one hundred fifty dollars ($150) copayment will be waived if you are admitted into the hospital or if your care was required for treatment of an accidental injury.

Once you have met your in-network deductible, you will be responsible for a **ten percent (10%)** in-network co-insurance for most covered services. The in-network percent co-insurance does **not** apply to:

Preventive care services

Covered services received in a PPO network physician's office

Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office

Services subject to a fixed dollar copayment

Chiropractic spinal manipulation

Pre-natal and post-natal care visits

Allergy testing and therapy

Injections

Hospice care benefits

Out-of-Network Guidelines

When you receive services from providers who are not in the PPO network (out-of-network), you will be responsible for paying out-of-network deductibles and copayments. **Preventive care services are not covered out-of-network.**

When you receive services at non-participating outpatient physical therapy facilities, free standing ambulatory surgery facilities, home health care agencies, hospice programs or skilled nursing facilities, no benefits are payable from the Plan.

Your Out-of-Network Deductible

Your coverage requires you to pay a **four hundred dollars ($400)** per individual or **one thousand, two hundred dollars ($1,200)** per family deductible before payment will be made for out-of-network benefits. This deductible is required each calendar year.

> **Note:** A family is defined as **four** or more members.

When one individual has met the out-of-network deductible, benefits are payable for that individual. Out-of-network services for the remaining family members will be paid when the full family (four or more members) deductible has been met.

Note: Out-of-network deductible amounts also apply toward the in-network deductible.

The out-of-network deductible **does <u>not</u>** apply to participating providers for the following:

- The initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Referrals to a non-network provider by a PPO network provider
- Home health care agencies
- Freestanding substance abuse treatment programs
- Ambulance providers
- Durable medical equipment providers
- Prosthetic and orthotic suppliers
- Freestanding physical therapy facilities
- Ambulatory surgery facilities
- Skilled nursing facilities
- Private duty nursing
- Hospice care
- Prescription Drugs

Your Out-of-Network Percent Copayments

After you have met your out-of-network deductible, you are responsible for thirty per cent (30%) of the approved amount for most covered services.

Out-of-Network Copayment Maximum

After you have paid **one thousand, five hundred dollars ($1,500)** per individual or **four thousand dollars ($4,000)** per family in out-of-network copayments, you do not need to pay any further **out-of-network copayments** for the rest of that year. However, you are still required to pay fixed dollar copayments.

Note: Out-of-network copayments also apply toward the in-network copayment maximum.

The following **cannot** be used to meet your out-of-network copayment maximum:

- Deductibles, in-network or out-of-network
- Fixed dollar copayments
- Charges for non-covered services
- Charges in excess of the Anthem approved amount
- Prescription Drugs

Out of Pocket Limits

The out-of-pocket payments you make for most covered medical expenses, including deductibles and copayments, will count toward meeting any individual or family out-of-pocket limit. Further, out-of-pocket payments for office visits and prescription drug costs will be aggregated for purposes of the out-of-pocket limits.

Currently, expenses you pay for covered medical expenses subject to a copayment percentage count toward your individual or family out-of-pocket limit once you have satisfied the deductible amount (four hundred dollars [$400]/person or one thousand, two hundred [$1,200]/family). Once you have paid one thousand, five hundred ($1,500)/individual or four thousand dollars ($4,000)/family out-of-pocket for covered medical expenses with a copayment percentage, the Plan will pay one hundred percent (100%) of these covered medical expenses you incur during the rest of the year. Expenses you pay for covered medical expenses subject to a flat dollar copayment (such as for office visits or prescription drugs) do not count toward your individual or family out-of-pocket limit.

Expenses you pay for covered medical expenses subject to a flat dollar copayment will count toward the out-of-pocket limit for covered medical expenses with a flat dollar copayment. Once you have paid six thousand, three hundred fifty dollars ($6,350)/person or twelve thousand, seven hundred dollars ($12,700)/family for covered medical expenses with a flat dollar copayment, the Plan will pay one hundred percent (100%) of these covered medical expenses you incur during the rest of the year. The flat dollar copayment out-of-pocket limit will be increased annually by the premium adjustment percentage specified by the Department of Health and Human Services for the calendar year.

The flat dollar copayment limit will be applied in addition to the current deductible and copayment percentage limits. Additionally, both PPO and non-PPO expenses will continue to apply to the out-of-pocket limits.

However, any out-of-pocket payments you make for the following do not count toward meeting either the copayment percentage or flat dollar copayment out-of-pocket limits:

- Charges by out-of-network providers that are in excess of the Anthem approved amounts.
- Expenses not considered covered medical expenses.
- Expenses incurred after any applicable maximum benefit or other limitation has been reached for a particular type of treatment.
- Expenses for the difference in cost between the generic drug cost and the brand name drug cost when a generic equivalent is available.

Anthem PPO Hospital Coverage

This section explains your Anthem PPO **hospital** benefits. Please check each section of this SPD booklet carefully for a complete explanation of your benefits.

> **Important:** Unless otherwise indicated, all services described in this section are subject to both in-network and out-of-network deductibles and copayments, as *applicable*.

Medical Necessity

A service must be medically necessary to be payable by your health care coverage. Medical necessity for the payment of **hospital services** requires that **all** of the following conditions be met:

The covered service is for the treatment, diagnosis, or symptoms of an injury, condition or disease.

The service, treatment or supply is **appropriate** for the symptoms and is consistent with the diagnosis.

Appropriate means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The services are not mainly for the convenience of the member or health care provider.

The treatment is not generally regarded as experimental or investigative by Anthem.

The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment Programs.

> **Important:** In some cases, you may be required to pay for services even when they are medically necessary. These limited situations are:
>
> When you don't inform the hospital that you are an Anthem member either at the time of admission or within 30 days after you have been discharged.

When you fail to provide the hospital with information that identifies your coverage.

Service Before Coverage Begins or After Coverage Ends

Unless otherwise stated in this SPD booklet, Anthem will not pay for any services, treatment, care or supplies provided before your coverage under this Plan becomes effective or after your coverage ends.

If your coverage begins or ends while you are an inpatient at a facility, the Plan payment will be based on the facility's contract with Anthem. The Anthem payment may cover:

The services, treatment, care or supplies you receive during the entire admission, **or**

The services, treatment, care or supplies you receive while your coverage is in effect.

In addition, if you have other health insurance coverage when you are admitted to or discharged from a facility, your other health insurance carrier may be responsible for paying for the care you receive before the effective date of your Plan coverage or after it ends.

Pain Management

The Plan considers pain management an integral part of a complete disease treatment plan. The Plan covers the comprehensive evaluation and treatment of disease, including the management of symptoms such as pain that may be associated with these diseases. Your health care benefits provide for such coverage and are subject to plan limitations.

Payment of Benefits

Under your health plan, covered services and supplies are called **"benefits."** The payment allowed for benefits is called the **"approved amount."** Anthem determines the approved amount and it is the lesser of the billed charge or maximum payment amount allowed for covered services. Applicable deductibles and copayments are deducted from the Anthem approved amount.

Hospital Benefits Inpatient

Room and Board

Your benefits include the cost of a semi-private room; use of specialty care units such as intensive, burn, or cardiac care; meals and special diets; and general nursing care. However, the cost of a private room is not covered. If you request a private room, your coverage will pay the cost of a semi-private room. You will be required to pay the difference.

General Medical Care Days

You have an **unlimited number of inpatient days** for the diagnosis and treatment of general medical conditions. The following types of admissions are also considered general medical care:
Medical and nursery care – includes delivery room costs and routine nursery care for a newborn during an eligible mother's hospital stay. After the hospital stay, the newborn is covered as a dependent child. **You must notify the Fund Office to add the child to your coverage within thirty (30) days of birth.**

> **Important:** Maternity benefits are payable only for the Participant or the Participant's spouse. Other Eligible Dependents covered by your Plan are excluded.
>
> **Note:** Under the federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. However, the attending physician may, after consulting with the mother, discharge the mother or the newborn earlier. The Plan also may not require a provider to obtain authorization for prescribing a length of stay not in excess of the forty-eight (48)/ninety-six (96) hour minimum.

Cosmetic surgery – includes correction of birth defects, conditions resulting from accidental injuries or traumatic scars, and the correction of deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.

Dental surgery – includes removal of impacted teeth or multiple extractions **only** when concurrent hazardous medical condition, such as a heart condition exists. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.

The Fund does not cover regular dental benefits.

Inpatient Mental Health Care and Substance Abuse Treatment Days

Your coverage provides benefits for inpatient mental health and inpatient substance abuse services. A mental health or substance abuse treatment admission can include individual and group therapy sessions and family counseling when provided through an approved facility.

A fully licensed psychologist with hospital privileges can be directly reimbursed for the following inpatient services:

Individual psychotherapeutic treatments.

Family counseling for members of a patient's family.

Group psychotherapeutic treatment.

Inpatient consultations when your physician requires assistance of a consulting psychologist in diagnosing or treating your mental health condition.

> **Important:** Inpatient mental health care and substance abuse treatment admissions are covered only if they meet Severity of Illness and Intensity of Service criteria. Your physician **must** call Hines & Associates Office at **1-888-236-2652** for guidance.
>
> **Mental Health and Substance abuse benefits are covered at in-**network facilities and must be pre-certified by Hines.

Hospital Services and Supplies

The following services and supplies are covered when they are needed during a hospital admission:

Anesthesia – includes administration, cost of equipment, supplies, and the services of a hospital anesthesiologist when billed as a hospital service.

Blood services – includes blood derivatives (but not whole blood), blood plasma, and supplies used for administering the services.

Laboratory and pathology tests – includes laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service.

Drugs – includes medicines prescribed and given during a hospital admission.

Durable medical equipment – includes items such as oxygen tents, wheelchairs, and other hospital equipment used during the hospital stay.

Medical and surgical supplies – includes gauze, cotton and solutions used during the hospital admission.

Prosthetic and orthotic appliances – includes items that are surgically implanted in the body, such as heart valves.

Special treatment rooms – includes operating, delivery, and recovery rooms.

CAT and MRI scans – covers scans of the head and body when required for eligible diagnoses and when performed in a facility approved by the Plan.

Diagnostic tests – includes EKGs, EMGs, EEGs, thyroid function tests, and nerve conduction studies required in the diagnosis of an illness or injury.

Therapeutic radiology – includes radiological treatment by X-ray, isotopes, or cobalt for a malignancy.

Diagnostic radiology – includes ultrasound and X-rays required for the diagnosis of an illness or injury.

Hospital Benefits Outpatient

The following services are covered when performed in the **outpatient** department of a hospital or, where noted, in a freestanding facility approved by the Plan.

Emergency Medical Care in the Emergency Room

Your benefits include the initial exam and treatment of accidental injuries or conditions determined by the Plan to be medical emergencies. The following are not considered emergency care:

Routine care for minor medical problems such as headaches, colds, slight fever and back pain
Follow-up care

> **Note:** The exam, diagnosis, and treatment of illness or injury by a physician is payable when you are seen in the physician's office or in a **non-hospital** urgent care center.

Pre-Admission Testing

Testing **must** be performed in the outpatient department of a hospital within seven days before a scheduled hospital admission or surgery. These tests must be valid at the time of admission and must not be duplicated during the hospital stay.

Outpatient Physical, Occupational and Speech Therapy (in network only)

Benefits are payable when provided in:

The outpatient department of PPO network and participating hospitals

Participating outpatient physical therapy facilities

In addition, physical therapy services are payable when provided in the physician's office or the office of an independent licensed physical therapist.

Physical, occupational, and speech therapy services provided for rehabilitation are payable up to a combined maximum of sixty (60) visits per calendar year. The sixty (60) visit maximum renews each calendar year for all hospital-based, freestanding facility or physician's office.

> **Important:** Payment for therapy is based on the diagnosis and the location. Ask your physician or therapist to call the Claims Processing Office at 1-855-337-9346 to verify if the prescribed therapy will be rendered in a payable location before receiving physical therapy treatment.

Your therapy must:

Be prescribed by the patient's attending physician

Require the assistance and supervision of the appropriate licensed therapist

Be designed to improve or restore the patient's functioning level after a loss in musculoskeletal functioning due to an illness or injury

Be given for a condition that is capable of significant improvement in a reasonable and generally predictable period of time.

Examples of covered therapy are:

Physical therapy prescribed to restore the musculoskeletal functioning of legs

Physical therapy used in conjunction with a treatment program to accelerate the healing of an acute injury or illness involving the muscles or joints

Your coverage **does <u>not</u>** pay for:

Long-standing, chronic conditions such as arthritis

Health club membership or spa membership

Developmental conditions or learning disabilities

Congenital or inherited speech abnormalities

Inpatient hospital admissions principally for speech or language therapy

Outpatient Substance Abuse Treatment

Treatment is covered when provided in approved in-network outpatient substance treatment facilities. The following criteria for the program must be met:

You must have Plan benefits available when you enter the program

Your physician must assign a diagnosis of substance abuse and must certify whether the treatment required is residential or outpatient. All substance abuse admissions must be pre-certified by Hines & Associates.

Your physician must:

Provide an initial physical examination

Provide and supervise your care during detoxification, and

Provide follow-up care during rehabilitation.

The services must be medically necessary for treatment of your condition.
The services must be approved by the Claim Office and provided by a participating substance abuse treatment program. Lab work in connection with substance abuse is subject to Plan co-payments and deductible.

> **Reminder:** These services are subject to a percent coinsurance as well as an annual/lifetime dollar maximum.

Outpatient Mental Health Care

Services are payable in **participating** outpatient mental health care facilities.

Benefits include:

Counseling services provided by a physician, a fully licensed psychologist, or by the facility's staff

Family counseling for members of the patient's family

Ancillary services for patients who are admitted and discharged on the same day of treatment

Prescribed drugs given by the facility in connection with treatment

Psychological testing by a physician, fully licensed psychologist, or a limited licensed psychologist when prescribed and billed by a physician or fully licensed psychologist

Chemotherapy

Treatment is payable in a hospital, in the outpatient department of a hospital, or in a physician's office. Your benefits include the administration and cost of drugs (except those taken orally) when ordered by a physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration (FDA) for use in chemotherapy, and provided as part of a chemotherapy program.

Hemodialysis

Hemodialysis services are covered to treat acute kidney failure and end stage renal disease (ESRD). You can receive treatment in the outpatient department of a hospital or in a licensed facility. You can also receive dialysis services in the home if the owner of the patient's home gives the hospital prior written permission to install the equipment.

Your physician must arrange for home hemodialysis and all services must be billed by a participating hospital that has an approved hemodialysis program. Benefits include cost of the equipment, installation, training, and necessary hemodialysis supplies.

Important: Dialysis services for the treatment of ESRD are coordinated with Medicare. It is important that individuals with ESRD apply for Medicare coverage regardless of age. The Plan is the primary payer for up to 33 months, which includes the three-month waiting period, if the member is under 65 and is eligible for Medicare solely because of ESRD.

Alternatives to Hospital Care

As an alternative to hospital care, your coverage provides the following benefits:

Home Hemophilia Program

Your benefits include all medications and medical supplies needed for in-home treatment for hemophilia, including syringes, needles and the antihemophilic factor. Your physician must prescribe all services and all services and supplies must be billed by a participating hospital. Your benefits also include training the patient or a family member on how to inject the antihemophilic factor, when the training is provided through an approved facility.

Home Health Care (In – Network only)

To receive benefits under the Home Health Care program, a physician who certifies that the patient is confined to the home due to illness, must prescribe and submit a detailed treatment plan to the home health care agency.

Once the agency accepts the patient into its program, the following services are covered when billed by the agency:

Part-time health aide services if the patient is receiving skilled nursing care or physical or speech therapy and the health care agency has identified a need for the patient to have these services

Social services and nutritional guidance when requested by the patient's physician

Physical, speech, and occupational

Nursing care when supervised by a registered nurse employed by the home health care agency

Your coverage **does <u>not</u>** pay for:

- General housekeeping services
- Transportation to or from a hospital or other facility
- Elastic stockings, sheepskin or comfort items such as lotion, mouthwash, body powder, etc.
- Physician services

- Custodial or nonskilled care

Skilled Nursing Care (In – Network only)

Care in a skilled nursing facility is covered when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve. In addition, the Plan requires written confirmation of the need for skilled care from the patient's physician. Once prescribed, your coverage will provide benefits for the period necessary for the care and treatment of the patient, up to a maximum of **one hundred twenty (120) days** per calendar year. All services must be provided at a participating skilled nursing facility. Services must also be pre-authorized and ordered by a physician.

Your Skilled Nursing Care coverage **does <u>not</u>** pay for:

Custodial care

Care for senility or mental retardation

Care for residential substance abuse.

Care for long-term mental illness.

Individual Case Management Program (ICMP)

A case management nurse evaluates patients for ICMP who have been referred by a hospital, physician, or a family member. When the patient is accepted as a candidate for ICMP, a nurse works with the patient's family and physician to develop a personal treatment plan, called the Alternative Benefit Plan. The plan can include services not normally included in your coverage. The analyst also identifies all payable services and payment arrangements related to the plan.

Whenever possible, the nurse will identify more than one provider for services recommended in the plan. The patient and family then have the option to select the provider.

After reviewing the Plan documents, the patient and family can decide whether or not to accept the plan. Participation is entirely voluntary.

If you have questions about Individual Case Management, you may call a Hines case management representative at 1- 888-236-2652

Hospice Care

A hospice is an agency that is primarily involved in providing care to terminally ill individuals and can be used as an alternative to hospitalization. A patient is considered terminally ill when the attending physician has certified in writing that life expectancy is six months or less.

The patient or his/her representative may apply for hospice care benefits with a referral by the patient's attending physician. Your request must be in writing to the hospice agency **and all hospice services must be arranged through a participating hospice provider.**

Electing Hospice Benefits

Hospice benefits are divided into three (3) election periods: two (2) ninety (90) day periods and one (1) thirty (30) day period. A patient must exhaust the two (2) ninety (90) day periods before electing the thirty (30) day period. Election periods continue until the patient exhausts all three (3) periods or cancels his or her hospice benefits.

When the patient elects to enter into the program, the hospice benefits will replace the patient's benefits for conditions related to the terminal illness. The hospice benefits will be more specific to the patient's needs and may include alternative services that provide more appropriate care. However, medical services **unrelated** to the terminal illness are covered according to your coverage. The patient may cancel, in writing, all hospice benefits at any time. When services are canceled, the patient's regular coverage resumes.

Levels of Care

The hospice program provides four levels of care:

Routine home care that consists of services provided to patients who are living at home and are not receiving continuous home care (see next item). Benefits include counseling, home health care, and physical therapy. Such care must not exceed eight hours per day.

Continuous home care that consists of nursing care services provided to patients during crisis periods to enable them to stay at home. Such care is covered up to twenty-four (24) hours per day during periods of crisis.

Inpatient respite care that consists of short-term inpatient services to allow the home care provider short periods of relief. Such care must be provided in an participating facility on a non-routine or occasional basis and in increments of five (5) days or less in any thirty (30) day period.

General inpatient care that consists of services for pain control and acute and/or chronic symptom management that cannot be provided in other less intensive settings.

Hospice Services

The following benefits are payable under the hospice program up to the maximum day limit amount that is reviewed and adjusted annually. Please call the Claims Processing Office at 1-855-337-9346 for the current maximum amount.

Nursing care when provided by or under the supervision of a registered nurse

Medical social services by a qualified social worker, provided under the supervision of a physician

Counseling services for the patient and caregivers, when care is provided in the home and for family bereavement after the patient's death

Medical appliances and supplies to provide comfort to the patient and when approved by the Plan

Durable medical equipment when furnished by the hospice program for the patient's home

Physical, speech and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional skills

> **Important:** Hospice benefits are covered at one hundred percent (100%) of the approved amount. There is a separate dollar maximum for services provided by a physician who is not part of the hospice team. Please call the Claims Processing Office at 1-855-337-9346 for information about the current dollar maximum. You are not required to meet deductibles or make copayments.

Human Organ Transplants

The following types of human organ transplants are covered when received at a participating hospital or, where noted, in an approved transplant facility, and designated transplant facility.

Organ and Tissue Transplants

Benefits are payable for services performed to obtain, test, store and transplant the following examples of human tissues and organs:

Cornea
Kidney
Skin
Bone Marrow (described below)

The Plan will pay covered services for donors if the donor does not have transplant benefits under any health care plan.

Bone Marrow Transplants

Benefits for **allogeneic** bone marrow transplants are payable only when the bone marrow of another person is transplanted into the patient to treat the following conditions and is not considered experimental or investigational.

Acute lymphocytic leukemia

Acute non-lymphocytic leukemia

Aplastic anemia

Beta Thalassemia, major

Chronic myeloid leukemia
Hodgkin's disease (relapsed and stages III or IV)

Hurler's syndrome

Myelodysplastic syndromes

Myelofibrosis

Neuroblastoma (stage III or IV)

Non-Hodgkin's lymphoma (intermediate or high grade)

Osteopetrosis

Severe combined immune deficiency disease (SCID)

Sickle cell disease (when complicated by stroke)

Wiskott-Aldrich syndrome

Allogeneic bone marrow transplants are payable when the donor is an immediate relative (mother, father, sister or brother) and has four (4) of the six (6) important HLA genetic markers as the patient. **Donors outside of the immediate family must have five (5) of the six (6) important HLA genetic markers as the patient.**

Reminder: HLA (human leukocyte antigens) generic markers are specific chemical groupings of many body cells, including white blood cells used to detect the constitutional similarity of one person to another.

Your coverage also includes transplants of the patient's own bone marrow (**autologous**) and/or transplanting the patient's own peripheral blood stem cells when used to rescue a patient after receiving high doses of chemotherapy. The transplant cannot be considered experimental or investigational.

Only the following conditions are covered:

Acute lymphocytic leukemia

Acute non-lymphocytic leukemia

Ewing's sarcoma

Germ cell tumors of ovary, testes, mediastinum and retroperitoneum

Hodgkin's disease (stage III or IV)

Medulloblastoma

Metastatic breast cancer (stage IV)

Multiple myeloma

Neuroblastoma (stage III or IV)

Non-Hodgkin's lymphoma (intermediate or high grade)

Primitive neuroectodermal tumors

Wilms' Tumor

Payable benefits for bone marrow transplants include:

High-dose chemotherapy and/or total body radiation

Blood tests on immediate relatives for evaluation as donors (if tests are not covered by the potential donor's health plan)

Harvesting the marrow and/or peripheral blood stem cells if the donor meets specific genetic marker requirements for **allogeneic** bone marrow transplants; harvesting and storing the marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year for **autologous** bone marrow transplants

Search of the National Bone Marrow Donor Program Registry for a donor (a search will begin only when the need for a donor is established)
Infusion of colony stimulating growth factors

Hospitalization in an intensive care unit, special care unit, or private room

Services you receive as a donor of bone marrow and/or peripheral blood stem cells (e.g., infusion of growth stimulating factors, hospitalization, blood tests and harvesting as indicated above)

> *Reminder:* The Plan also will pay for similar services related to or for high-dose chemotherapy, total body radiation, allogeneic or autologous bone marrow and/or peripheral blood stem cell transplants to treat conditions other than those listed above if the services are not otherwise **excluded from coverage as experimental or investigational.** This benefit does not limit or preclude coverage as antineoplastic drugs when the law requires that these drugs, and the reasonable cost of their administration, be covered.

Your coverage **does <u>not</u>** pay for:

Any services related to or for allogeneic bone marrow transplants and/or peripheral blood stem cell transplants when the donor does not meet the HLA genetic marker matching requirements.

Purging of and/or positive stem cell selection of bone marrow stem cells, or peripheral blood stem cells.

Harvesting and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplant within one year.

Health care services provided by persons who are not legally qualified or licensed to provide such services.

Services that are not medically necessary.

Any facility, physician or associated services related to any of the above exclusions.

Specified Oncology Clinical Trials

Covers antineoplastic drugs to treat stages II and III breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial. This benefit does not limit or preclude coverage of antineoplastic drugs when the law requires that these drugs, and the reasonable cost of their administration, be covered.

In order for services to be payable as eligible benefits:

The inpatient admission and length of stay **must** be medically necessary and preapproved (NO retroactive approvals will be granted);

The services **must** be performed at a National Cancer Institute (NCI)-designated cancer center or an affiliate of an NCI-designated center;

The treatment plan, also called protocol, **must** meet the guidelines of the February 19, 1993, American Society of Clinical Oncology (ASCO) statement for clinical trials; and

The patient must be an eligible member with hospital/medical/surgical coverage.

> **Note:** If the above requirements are not met, you will be responsible for **all** charges. Human Organ Transplants are also covered when received at a designated cancer center.

Covered Services

- Covered services are payable when directly related to a bone marrow transplant, peripheral blood stem cell transplant, high-dose chemotherapy or total body radiation.

- When pre-certified by the Plan, the following services are covered:

- Allogeneic transplants (including syngeneic transplants when the donor is the identical twin of the patient)

- Blood tests to evaluate donors (if not covered by the potential donor's health plan).

- Search of the National Bone Marrow Donor Program Registry for a donor (a search will begin only when the need for a donor is established). The registry's bill must be submitted to us by the designated cancer center.

- Infusion of colony stimulating growth factors.

- Harvesting (including peripheral blood stem cell phereses) and storage of the donor's bone marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year (if not covered by the donor's health plan).

- Purging of, or positive stem cell selection of, bone marrow or peripheral blood stem cells.

- High-dose chemotherapy and/or total body radiation.

- Infusion of bone marrow and/or peripheral blood stem cells

- Autologous transplants

- Infusion of colony stimulating growth factors.

- Harvesting (including peripheral blood stem cell phereses) and storage of the donor's bone marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year (if not covered by the donor's health plan).

- Purging of, or positive stem cell selection of, bone marrow or peripheral blood stem cells.

- High-dose chemotherapy and/or total body radiation.

- Infusion of bone marrow and/or peripheral blood stem cells.

- Preapproved hospitalization in an intensive care unit, special care unit, or private room.

- Up to a total of five thousand dollars ($5,000) for travel, meals, and lodging expenses directly related to preapproved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins on the date of approval and ends one hundred eighty (180) days after the transplant. The Plan will pay the expenses of an adult patient and one companion (or two companions if the patient is

under age eighteen [18]). Within the five thousand dollars ($5,000), the following amounts apply to the **combined** expenses of the patient and eligible companion(s):

- Up to sixty dollars ($60) per day for travel
- Up to fifty dollars ($50) per day for lodging
- Up to forty dollars ($40) per day for meals.

Your coverage **does <u>not</u>** pay for:

- Services performed at a center that is not a National Cancer Center (NCI)-designated center or an affiliate of a NCI-designated center.
- A hospital admission, a length of stay at a hospital, **or any service that has not been preapproved.**
- Harvesting (including phereses) and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplantation within one year.
- Any other services related to any of the above exclusions.
- Items or services, such as investigational drugs, non-health care services and/or research management (such as administrative costs) that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company).
- Items that are not considered directly related to travel, meals, and lodging expenses. They include, **but are not limited to,** dry cleaning/clothing/laundry services, kennel fees, entertainment (cable, movie rentals, televisions, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers/cards/stationery/stamps, household products, household utilities, including cell phone charges, maid, baby-sitter/ day care services.

Specified Human Organ Transplants

Hospital care for specified human organ transplants performed during the transplant benefit period is covered at one hundred percent (100%) of the approved amount only when the transplant is received at an Anthem **designated transplant facility**. The transplant network utilized by the Plan is Blue Distinction, a nationwide of centers of excellence network through Anthem. Services at a non-approved facility are not payable.

Benefits apply only to transplants of the:

- Liver
- Partial liver (a portion of the liver taken from a cadaver or living donor)
- Heart

- Lung(s)
- Lobar lung (transplantation of a portion of a lung from a cadaver or living donor)
- Heart-lungs
- Pancreas
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Combined small intestine-liver

- All payable human organ transplant services, except anti-rejection drugs, must be provided during the **benefit period** that begins five (5) days before the transplant surgery and ends one (1) year after the surgery.

- The transplant facility or your physician **must** request authorization from the Plan before surgery. Authorization for the transplant surgery will be sent to you and the transplant facility or your physician (whoever requests the preauthorization).

  Note: Call the Hines & Associates at **1-888-236-2652** to confirm a facility's participation status.

When **preapproved** and directly related to the transplant, the Plan will pay for the following services. Benefits are limited to a one million dollars ($1,000,000) maximum for each type of human organ transplant.

- Facility and professional services.
- Anti-rejection drugs and other transplant-related prescription drugs, as needed. Payment will be based on the amount Anthem determines to be reasonable and necessary. The Plan payment for the drugs is limited only by the one million dollars ($1,000,000) maximum.
- Medically necessary services needed to treat a condition rising out of the organ transplant surgery if the condition occurs during the benefit period, and is a direct result of the organ transplant surgery. The Plan will pay for any medically necessary service needed to treat a condition as a result of the organ transplant surgery, if it is a benefit under the Plan.
- Up to ten thousand dollars ($10,000) for travel, meals and lodging directly related to preapproved services. The Plan will pay the cost of transportation to and from the designated transplant facility for an adult patient and one companion eligible to accompany the patient (or two [2] companions if the patient is under age eighteen [18] or if the transplant involves a living related donor). Within the ten thousand dollars ($10,000), the Plan will pay the reasonable and necessary costs of meals for the patient and eligible companion(s), up to a combined maximum of forty dollars ($40) per day, and the costs of lodging for the eligible companion(s).
- Reasonable and necessary cost of acquiring the organ, which includes surgery to obtain the organ, storage of the organ and transportation of the organ. The total payment for all

services combined for each transplant will not be more than the one million dollars ($1,000,000) maximum.

Your specified transplant coverage does not cover:

- Non-covered services.
- Living donor transplants other than liver and lobar lung transplants.
- Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin).
- Anti-rejection drugs that do not have Food and Drug Administration marketing approval.
- Transplant procedures and related services that are not preapproved.
- Transplant surgery that is not performed in a designated facility.
- Transportation, meals and lodging costs under circumstances other than those related to the initial **preapproved** transplant surgery.
- Any expenses incurred for transportation, meals and lodging after the initial transplant surgery and hospitalization.
- Items not considered directly related to travel, meals, and lodging expenses. They include, **but are not limited to**, dry cleaning/clothing/laundry services, kennel fees, entertainment (cable, movie rentals, television, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers/cards/stationery/ stamps, household products, household utilities including cell phone charges, maid, baby sitter/day care services.
- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, if not covered by your hospital/medical/surgical coverage.
- Experimental transplant procedures.

Anthem PPO Physician Benefits

This section explains your Anthem PPO **physician** benefits. Please check each section of this SPD booklet carefully for a complete explanation of your benefits.

> **Important:** Unless otherwise indicated, all services described in this section are subject to both in-network and out-of-network deductibles and copayments, *as applicable*, listed in this section. Remember, some services listed in this section are not covered out-of-network.

Medical Necessity

Medical necessity for **physician services** is determined by physicians acting for their respective provider types and/or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that:

- The covered service is generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- The covered service is essential or relevant to the evaluation or treatment of the disease, injury, condition, or illness. It is not mainly for the convenience of the members or physicians.

- The covered service is reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.
- In the absence of established criteria, medical necessity will be determined by physician or professional review according to generally accepted standards and practices.
- The Plan determination of medical necessity for **payment** purposes is based on standards of practice established by physicians.

Preventative Care Services

The following preventive services are covered when they are received in-network. Preventive benefits are payable at one hundred percent (100%) of the approved amount. **These services are not covered out-of-network, with or without a referral.**

Health maintenance exams – covers one (1) per member per calendar year which includes a comprehensive history and physical examination, and the following laboratory and radiology procedures:

- Chemical profile
- Complete blood
- Urinalysis
- EKG
- Thyroid Testing
- Colonoscopy
- Chest X-ray

- **Gynecological exams** – covers one (1) per member per calendar year.

- **Pap Smear Screening (laboratory services only)** – covers one (1) per member per calendar year when prescribed and performed by a PPO physician. More frequent pap smears are covered because of the suspected or actual presence of a disease or when required as a post-operative procedure.

- **Well-baby and child care visits** – covers routine visits to a physician to monitor the development and well being of children. These visits are covered through age fifteen (15) as follows:

  - Six (6) visits per year through twelve (12) months
  - Six (6) visits per year, thirteen (13) months through twenty-three (23) months
  - Six (6) visits per year, twenty-four (24) months through thirty-five (35) months
  - Two (2) visits per year, thirty-six (36) months through forty-seven (47) months

- Visits beyond forty-seven (47) months are limited to one (1) per member per calendar year under the health maintenance exam benefit

Immunizations – The Plan will pay for childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics.

Note: The Plan periodically updates the list of eligible immunizations. Please call the customer service number in this section to inquire about immunizations.

- **Fecal occult blood screening** – covers one (1) per member per calendar year.
- **Flexible sigmoidoscopy exams** – covers one (1) per member per calendar year.
- **Prostate specific antigen (PSA) screening** – covers one (1) per member per calendar year.

Prescribed Contraceptive Devices

Your benefits include coverage for physician-prescribed contraceptive devices such as diaphragms, intrauterine devices or contraceptive implants designed to prevent pregnancy. This benefit is part of your medical-surgical coverage. Contraceptive devices are subject to the same deductible you pay for in-network medical-surgical services.

Office Visits

The exam, diagnosis and treatment of illness or injury by a physician is payable when you are seen in the physician's office, outpatient clinic, or outpatient department of a hospital. Injections are covered with an eligible diagnosis.

Allergy Services

Your coverage plan covers allergy testing, survey testing and therapeutic injections when performed by or under the supervision of a physician. Benefits are not payable for fungal or bacteria skin tests, such as those given for tuberculosis or diphtheria, self-administered or over-the-counter medications, psychological testing, evaluation or therapy for allergies, environmental studies, evaluation, or control.

Autism Benefits

The Fund will provide the following benefits for Autism Spectrum Disorders (ASD)

- Applied behavior analysis, a specialized treatment for autism
- Physical therapy, speech therapy and occupational therapy provided as part of the treat for ASD
- Nutritional counseling provided as part of the treatment of ASD
- Other mental health benefits to diagnose and treat autism
- Other medical services used to diagnose and treat autism

Chiropractic Services

Your benefits include the following chiropractic services:

- **New patient office visits** – covers one (1) every thirty-six (36) months. A new patient is one who has not been seen by the same provider in thirty-six (36) months.
- **Office visits** – covers one (1) per member every calendar year for established patients.
- **Chiropractic traction** – number of payable visits is determined by your physical therapy benefit.
- **Chiropractic manipulation** – limited to one (1) per day, up to a maximum of twenty-four (24) medically necessary visits each calendar year.

Maternity Care

Your benefits include delivery and pre-and-post-natal services for the Participant or the Participant's spouse. Other Eligible Dependents covered by the Plan are excluded.

The initial inpatient examination of the newborn is a benefit when performed by a physician other than the anesthesiologist or the delivering physician.

> **Note:** Maternity care benefits also are payable when provided by a certified nurse midwife. Delivery must be in a hospital or an approved birthing center.

Surgical Services

Surgical benefits include the surgical fee and pre- and post-operative medical care given by the surgeon. Surgery is covered inpatient and outpatient, in the physician's office, and in participating ambulatory surgical facilities.

Multiple surgeries (two [2] or more surgical procedures performed by the same physician during one [1] operative session) are subject to the following payment limitations:

- When surgeries are through **different** incisions, the Plan will pay the approved amount for the most costly procedure and one half (1/2) of the approved amount for the less costly procedure.
- When the surgeries are through the **same** incision they are considered related and the Plan will pay the approved amount for the more difficult procedure.

> **Reminder:** Anthem PPO network and Blue Card participating providers accept the approved amount as payment in full. However, nonparticipating providers may bill you for the difference.

- **Cosmetic or reconstructive surgery** is covered only for the correction of birth defects, for conditions resulting from accidental injuries or traumatic scars, and for correction of deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.

- **Breast reconstruction surgery** is covered for:

  - Reconstruction of the breast on which the mastectomy was performed.
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  - Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

- **Dental surgery** is covered only for the removal of impacted teeth or multiple extractions. The patient must be hospitalized for the surgery because a concurrent medical condition exists, such as a heart condition.

- **Voluntary sterilization** for both male and female patients is covered regardless of medical necessity.

Your surgical services also include:

Technical surgical assistance (TSA) – TSA is a covered benefit for certain major surgeries that require surgical assistance by another physician. TSA is covered inpatient and outpatient, and in an approved ambulatory surgery facility.

Anesthesia – Services for giving anesthesia are payable to a physician other than the operating or assisting physician, and to certified registered nurse anesthetists. The Plan does not pay for local anesthesia.

Temporomandibular Joint Syndrome (TMJ) or Jaw-Joint Disorder

Benefits for TMJ or jaw-joint disorder are limited to surgery directly to the jaw joint, X-rays (including MRIs), and arthrocentesis (injection procedures). Other than the exceptions noted, benefits are ***not*** payable for reversible or irreversible medical or dental treatment of the mouth, teeth, jaw, jaw joint, skull and the muscles/nerves/tissue related to the jaw joint. These exclusions include (but are not limited to): appliances, crowns, inlays caps restorations, grindings, orthodontics, dentures, partial dentures or bridges.

If you are not sure that your prescribed treatment will be covered, ask your provider to contact the Claims Processing Office for approval **before** treatment begins.

Note:

- **Irreversible** treatment of the mouth, teeth, or jaw is intended to bring about permanent change to a person's bite or position of the jaws. It includes but is not limited to dentures, bridges, crowns, caps, inlays, **restorations, grinding and orthodontics.**

  Reversible treatment of the mouth and jaw is **not** intended to result in permanent alteration of the bite or position of the jaws; it is directed at managing the patient's symptoms.

Inpatient Medical Care

Medical supervision by a physician is payable while you are in the hospital or in a skilled nursing care. Inpatient medical care in a skilled nursing facility is limited to two visits per week.

Inpatient and Outpatient Consultations

Medical consultations are payable when your physician requires assistance in diagnosing or treating a condition or because special skill or knowledge of the consulting physician is required.

Diagnostic and Radiation Services

Physician services are payable to diagnose disease, illness, pregnancy or injury through:

Diagnostic radiology – includes X-rays, ultrasound, radioactive isotopes, and Magnetic Resonance Imaging (MRI) and CAT scans of the head and body when performed for an eligible diagnosis.

Laboratory and pathology tests.

Diagnostics test – includes EKGs, EMGs, EEGs, thyroid function tests, nerve conduction and pulmonary function studies.

Radiation therapy – includes radiological treatment by X-ray, isotopes, or cobalt for a malignancy.

Mammography screening – includes one (1) screening per member per calendar year, regardless of age. More frequent mammograms are covered if prescribed by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedures.

Routine mammograms, when performed by a PPO network provider will be payable at one hundred percent (100%) of the approved amount. When performed by a non-network provider, mammograms are not covered.

Other Covered Services

Your coverage includes the following services:

Durable Medical Equipment (DME)

Benefits include rental or purchase (whichever is less expensive) and repair of durable medical equipment when prescribed by a physician. The prescription must include a description of the equipment and a diagnosis. For rental equipment, a new prescription must be written when the current prescription expires.

Your coverage **does <u>not</u>** pay for:

- Exercise and hygienic equipment
- Comfort and convenience items
- Self-help devices, such as elevators
- Deluxe equipment, such as motorized wheelchairs unless medically necessary and required so the patient can operate the equipment themselves
- Experimental or investigational equipment.

Medical Supplies

Your benefits include coverage for medical supplies and dressings for use in the home when prescribed by a physician for the treatment of a specific medical condition.

Prosthetic and Orthotic Appliances

Prosthetic and orthotic appliances are payable when they are prescribed by a physician and supplied by a licensed orthotist or prosthetist. Benefits cover temporary appliances, delivery, service and fitting charges. Adjustment or replacement of eligible appliances is payable only when required because of wear, growth or change in the patient's condition.

Benefits are also payable for orthotic inserts (custom) and orthopedic shoes. Benefits are limited to one pair per individual per calendar year for each inserts or shoes.

A device that replaces a limb or part of a limb must be furnished by a provider who is fully accredited by the American Board of Certification in Orthotics and Prosthetics, Inc. (ABC). Members may call the Claims Processing Office listed on the first page of this Section II for information about a provider's status.

> **Important:** Benefits are not payable for non-rigid devices and supplies such as elastic stockings, garter belts, arch supports, corsets, hearing aids and hair prosthesis such as wigs or hair implants.

Private Duty Nursing

Nursing services are covered in your home when medically necessary and required on a twenty-four (24) hour basis. Services must be prescribed by a physician and provided by a registered or licensed practical nurse that is not related to or living with the patient. The attending physician must complete a Certification Statement each month the patient is required to have private duty nursing care.

Professional Ambulance Services

Ambulance services are covered to transport a patient up to one hundred (100) miles unless the destination is the nearest medical facility capable of treating the patient's condition. The services must be medically necessary, prescribed by a physician (when used for transferring a patient), and provided in a vehicle qualified as an ambulance and part of a licensed ambulance

operation. Air ambulance is also covered when no other means of transport is available or the patient's condition requires air transport rather than ground ambulance. For air ambulance, the provider must be licensed as an air ambulance service and is not a commercial air carrier.

Your coverage **does <u>not</u>** pay for:

- Transportation for the convenience of the patient or the patient's family, or for the preference of the physician.
- Ambulance services provided by a fire department, rescue squad, or other carrier whose fee is a voluntary donation.

What's Not Covered

Your Anthem PPO coverage **does <u>not</u>** cover:

- Pre-marital or pre-employment examinations.
- Care and services available at no cost to you in a veterans, marine, or other federal hospital or any hospital maintained by any state or governmental agency.
- Medically necessary services received in an inpatient basis that can be provided safely in an outpatient or office setting.
- Custodial care, rest therapy, and care in nursing or rest home facilities.
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists.
- Treatment of temporomandibular joint syndrome (TMJ) and related jaw-joint problems by any method other than direct surgery on the jaw joint, arthrocentesis (injections) or X-rays.
- Eye examinations and eyeglasses or other corrective vision appliances.
- Medical services or supplies provided or furnished while coverage is not in effect (that is **before** the effective date of coverage or **after** the coverage termination date).
- Health care services provided by persons who are not legally qualified or licensed to provide such services.
- Routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions.
- Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication), or basal metabolism tests.
- Items for the personal comfort or convenience of the patient.
- Psychiatric services after determination that the patient's condition will not respond to treatment.
- Psychological tests for vocational guidance or counseling.
- Services and supplies that are not medically necessary according to accepted standards of medical practice.
- Services provided through a medical clinic, or similar facility provided or maintained by an employer.
- Treatment of occupational injury or disease that the employer is obligated to furnish or otherwise fund.

- Care and services received under another certificate offered by Anthem or another Anthem/Blue Cross Blue Shield plan.
- Care and services payable by government-sponsored health care programs, such as Medicare, for which the member is eligible and in which the member should be enrolled as primary.
- Cosmetic surgery and related services solely for improving appearances, except as specified in this booklet.
- Treatment of a condition caused by military action or war, declared or undeclared.
- Services, care, devices or supplies considered experimental or investigational.

    - Services for which a charge is not customarily made; services for which the patient is not obligated to pay or services without cost.

    - Examination, preparation, fitting, or procurement of hearing aids.

    - Tests other than those identified in the benefit section that are not required in, and related to the diagnosis of an illness or injury.

    - Dialysis services after thirty-three (33) months of ESRD treatment.

    - Services that are not included in your plan coverage documents.

    - Transportation and travel except as specified in this SPD booklet.

    - Services covered under any other Anthem plan or under any other health care benefits plan.

    - Screening services, unless otherwise stated, excluding mammograms.

    - Deductibles or copayments paid by the member under any other plan.

    - Physical therapy services performed by a chiropractor.

    - Services, care, supplies, or devices not prescribed by a physician.

    - Services provided during non-emergency medical transport.

    - Voluntary abortions.

General Limitations

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

1. Declared or undeclared war, or any act thereof, or military or naval services of any country;

2. Mental counseling, physical therapy, supplies or prosthesis for sexual dysfunction or inadequacies;

3. Growth hormones;

4. Programs or prescription medications for the purposes of smoking cessation;

5. Expenses incurred for the purpose of reversing tubal ligations, vasectomies or other sterilization procedures;

6. Education, special education, job training or work hardening whether or not given in a facility that also provides medical or psychiatric treatment beyond the first medically necessary visit. Special education or like services, regardless of: the type of education, the purpose of the education, their recommendation of the attending physician or the qualification of the individual rendering the educational services;

7. Rest cures or custodial care;

8. Services, treatment or care rendered by a member of the Eligible Person's family;

9. Treatment or services for or in connection with financial counseling;

10. Treatment or services for primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetics therapy, vision perception training, or carbon dioxide therapy;

11. Dietary or nutritional counseling, books, pamphlets or classes;

12. Artificial insemination, invitro fertilization, or embryo transfer process.

13. Services, treatment or supplies received from a dental or medical department maintained by a mutual benefit association of this or another employee benefit plan or labor union;

14. Services, treatment or supplies, which are payable or furnished under any policy of insurance or other medical benefit plan or service plan for which the Trustees shall, directly or indirectly, have paid for all or a portion of the cost;

15. Services related to obesity, diet or weight control, including but not limited to: exercise programs, surgery, special diet or diet supplements, pre-natal vitamins, amphetamines, or any form of diet medication whether or not recommended or supervised by a physician, including dietary or nutritional counseling, books, pamphlets or classes;

16. Implantation within the human body of artificial mechanical devices designed to replace human organs other than pacemakers or similar such devices which merely assist rather than replace the function of the organ;

17. Ambulance service or transportation (such as by ambulance, air ambulance, railroad or bus) in excess of one hundred (100) miles unless judged by the Trustees as essential for treatment of a life-threatening illness or injury;

18. Special home construction to accommodate a disabled person;

19. Speech therapy, other than charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) while eligible in the Plan and as a result of a disease or accidental injury. Speech therapy to improve speech in the absence of disease or accidental injury (such as for a learning disability or speech delay) is considered special education and is not covered;

20. Supplies or equipment for personal hygiene, comfort or convenience;

21. Charges incurred for any abortion procedure performed on a Dependent child except where the pregnancy is the result of rape as evidenced by a police report.

22. Gender re-assignment and changes associated with gender-reassignment

23. Genetic testing and/or DNA testing

Prescription Drug Coverage

When medication is a necessary part of your total health care program, your health plan includes Humana Rx coverage for the following prescription drug services.

What's Covered

You have coverage for:

Federal legend and state-controlled drugs

Compound medications containing at least one federal legend drug ingredient

Injectable insulin

Disposable needles and syringes dispensed with insulin or chemotherapeutic drugs

Contraceptive medications prescribed by a physician

Covered drugs may be dispensed in quantities of up to a thirty (30) day supply or for maintenance medications, ninety (90) days.

Generic Equivalent Drugs

Pharmacists will **dispense the generic equivalent when appropriate.** Generic equivalent drugs can be produced by more than one manufacturer and distributed under more than one name. The Food and Drug Administration requires that these generic drugs meet the same standards for active ingredients as brand name drugs. Your pharmacist has a complete list of generic equivalent drugs included in your coverage.

Your pharmacist will dispense your prescription with a brand name drug under the following conditions:
If your doctor prescribes a brand name medication to be "dispensed as written" when a generic alternative is available. The doctor must write "Dispense as Written" or "DAW" on the prescription.

If **you** (not your doctor) **request the brand name drug**, you must pay the difference between the Humana approved amount for the brand name drug and the maximum allowable cost for the generic equivalent, in addition to your copayment.

Co-Branded Drugs

Co-branded drugs are chemically equivalent drugs sold under different brand names. They are designated "preferred" and "nonpreferred." When dispensing brand name drugs that are co-branded, your pharmacist must fill your prescription with the brand name drug identified as "preferred" by Humana.

When your prescription is filled with a co-branded drug, Humana will pay the approved amount for the preferred co-branded drug less your copayment. If your prescription is filled with a nonpreferred, co-branded drug, you must pay the full cost of the drug unless the prescribing physician requests and obtains authorization for the nonpreferred drug from the Humana Pharmacy Services Department.

Your Copayment

Your copayment depends on whether the drug involved is a Tier 1, 2, or 3 drug as indicated in the following table:

DESCRIPTION	IN-NETWORK	OUT-OF-NETWORK
Generic drugs (Tier 1)	$5 copay/prescription (1-30 days) $10 copay (31-90 days) (retail & mail order)	$5 copay/prescription (1-30 days) $10 copay (31-90 days) (retail & mail order)
Preferred brand drugs (Tier 2)	$30 copay/prescription (1-30 days) $60 copay (31-90 days) (retail & mail order)	$30 copay/prescription (1-30 days) $60 copay (31-90 days) (retail & mail order)
Non-preferred brand drugs (Tier 3)	$50 copay/prescription (1-30 days) $100 copay (31-90 days) (retail & mail order)	$50 copay/prescription (1-30 days) $100 copay (31-90 days) (retail & mail order

Note: If the approved amount of the drug is less than your minimum copayment, then you will pay the approved amount for the covered drug.

Choosing Your Pharmacy

You must have your prescriptions filled at a network pharmacy. Remember that when your prescriptions are filled through a non-network pharmacy, you will pay the associated costs.

Network Pharmacy

With Humana, a *network* pharmacy is a pharmacy that is part of the Humana **Rx** network. Network pharmacies will file claims for you and they receive payment directly from Humana.

Important: Pharmacies may need to verify your eligibility by contacting the Fund Office.

Humana Customer Service – 800-731-6501 or 574-232-2131

Mail-Order (Home Delivery) Prescription Drugs

Your mail-order prescription drug program is available for long-term and ongoing prescription drug needs. If you are taking medication on a regular basis, ordering your prescriptions through the mail-order program is convenient. In addition to mailing your prescriptions to the mail-order pharmacy, your physician can phone in/fax your prescription orders. Refills on your mail-order prescriptions can be ordered by mail, telephone, or the Internet.

When prescribed by your physician, you can order up to a ninety (90) day supply (three months) of medication by mail from Humana and pay the applicable copayment (refer to "Your Copayment") for each prescription or refill.

Ordering from Humana Mail Order requires no claim forms. Your medication is delivered to your home, postage-paid, within ten (10) to fourteen (14) business days from the date you mailed your order.

Note: Benefits are not payable for drugs obtained from nonparticipating/non-network mail-order providers, including Internet providers.

If you have questions, you can call Humana at **1-800-731-6501.** You can also visit their Web site at **www.humana.com** to order refills, check on the status of your mail-order prescriptions, or request mail-order envelopes.

What's Not Covered

Your Prescription Drug coverage **does <u>not</u>** cover:

Drugs that cost less than your minimum copayment

Administration of covered drugs or any covered drug entirely consumed at the time and place of the prescription

Refills not authorized by a physician

Any medication that does not require a prescription, except insulin

Therapeutic devices or appliances, even if prescribed by a physician (e.g., support garments regardless of their intended use)

The charge for any prescription refill in excess of the number specified by the prescriber

Refills dispensed after one year from the date of the original order

More than a thirty-four (34) day supply of a covered drug, except for specified maintenance drugs that are covered for one hundred (100) unit doses or two hundred (200) unit doses (retail pharmacy)

Prescription drugs that are used primarily for improving appearance rather than for treating a disease

Diagnostic agents

Any vaccine given solely to resist infectious diseases

Any drug Humana determines to be experimental or investigational

Drugs or services payable by government-sponsored health care programs, such as Medicare, for which you are eligible

Drugs or services obtained before the effective date of coverage or after the coverage termination date

More than twelve (12) doses of an impotence drug such as Viagra in a thirty-four (34) day period

Non-preferred co-branded drugs, unless they are preauthorized

Any drug or device prescribed for "indications" (uses) other than those specifically approved by the Federal Food and Drug Administration

Drugs that are not labeled either, "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only," except for state-controlled drugs.

Medicare Coverage for Eligible Members

Medicare Coverage

Medicare is a federal health care program designed to provide health care benefits to persons who are sixty-five (65) or older, to persons who have End Stage Renal Disease (ESRD) and to certain disabled persons. The Social Security Administration is the sole authority for determining your Medicare eligibility. If you are enrolled in this coverage, you are called a "beneficiary."

You become eligible for Medicare when you are sixty-five (65) (or earlier if you are disabled or have ESRD). If you are eligible by reason of age, you may enroll at any time during a seven (7) month period. This period begins three (3) months before the month in which you reach sixty-five (65), and includes the actual month of your birthday and the three (3) months following your birthday month. During this period, you must apply for Medicare through your local Social Security Administration office.

Medicare coverage has two (2) parts: hospital insurance (Part A) and medical insurance (Part B). Hospital insurance helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. Medical insurance helps pay for physician's services and other medical services and items.

The hospital insurance portion is provided at no cost to you. However, you must pay monthly for the medical insurance portion. This premium is adjusted annually. You will be notified of the change before each new year.

Medicare eligible participants are enrolled into the Humana Medicare Advantage plan. This plan covers both medical and prescription drugs. Humana processes all claims.

Employed Persons Aged 65 or Older

When you reach sixty-five (65) and become eligible for Medicare, but are still eligible through a Fund of twenty (20) or more persons, you have two options for health care coverage. You may:

Continue your regular current coverage as your primary health care plan, **or** Select Medicare as your primary health care plan.

The following explains these options:

Option 1

You may continue your regular current coverage as your primary health care plan. This is automatic unless you indicate in writing that you do not want to continue this coverage.

> **Important: If you continue to be covered through your Fund for your primary health care benefits, you should still apply for Medicare benefits, especially Part A.**

Part A of Medicare, the hospital insurance, is offered at no cost to you. It may provide **additional** benefits to your group coverage.

Part B of Medicare, the medical insurance, is available for a monthly premium. However, you can delay enrollment in Part B without penalty.

If you delay enrolling for Medicare Part B coverage when you reach sixty-five (65), you may enroll during the special enrollment period that begins on the first day of the first month in which you are no longer covered by your group plan and ends two (2) months later.

Option 2

You may select Medicare as your primary health care plan. However, if you select this option, federal regulations prohibit your Fund from providing you with Supplemental coverage. You must file a written notice with your Fund Office and with Medicare if you choose this option.

Reminder: If you have a spouse who is sixty-five (65) or older and is covered under your health plan, your Fund must provide the same coverage you select for your spouse until you retire or leave employment.

Medicare Supplemental Coverage

If you have Supplemental coverage, it works with your Medicare coverage to extend your health care benefits. **You will not be eligible for Medicare supplemental benefits if you do not enroll in both Part A and Part B of Medicare.**

What's Covered

You have coverage for the following:

Part A Benefits

Inpatient hospitalization – covers your Medicare Part A deductible and coinsurance required from the sixty-first (61st) day through the ninetieth (90th) day of a hospital admission. It also extends the number of your inpatient days to three hundred sixty-five (365).

Lifetime reserve days – covers the daily coinsurance required by Medicare.

Skilled nursing care – covers the daily coinsurance required by Medicare for days twenty-one (21) through one hundred (100).

Part B Benefits

Physician care – covers the yearly deductible required by Medicare and twenty percent (20%) of Medicare's reasonable charge.

Outpatient psychiatric care – covers the special fifty percent (50%) coinsurance required by Medicare in addition to the twenty percent (20%) coinsurance for physician care

Humana Prescription Drug Benefits

Humana is the Pharmacy Benefit Manager. You can contact Humana at 800-731-6501

How the prescription structure works

Covered prescription drugs are assigned to one (1) of four (4) different tiers with corresponding cost share amounts. The tiers are described in the chart below.

The cost share for each prescription is based on the current assigned tier of the drug.

	Network pharmacies A 30-day supply (A 90-day supply At two times your 30-day cost*)	**Mail-order benefit** A 90-day supply at only Two times your 30-day cost*
Tier 1 – Generic or Preferred Generic	$5.00 copay	$10.00 co-pay
Tier 2 – Preferred Brand	$30.00 copay	$60.00
Tier 3 – Non-Preferred Brand	$50.00 copay	$100.00
Tier 4 – Specialty Tier	$50.00* copay	N/A*
*Specialty drugs are not available in a 90-day supply. Regardless of tier placement, Specialty drugs are limited to a 30-day supply. **Shingles Vaccination covered at 100%		

Mail-order benefit

For your convenience, you may receive a coverage for a maximum ninety (90) day supply per prescription or refill through the mail (maximum thirty [30] ay supply for Specialty drugs). The same requirements apply when purchasing medications through a participating mail-order pharmacy as apply when purchasing in person at a pharmacy. Members can visit the Humana Website or call Humana at the number on your ID card for more information, including mail-order forms.

What's Not Covered

Your Medicare Supplemental coverage **does <u>not</u>** cover:

Custodial nursing care (such as help with walking, getting in and out of bed, eating, dressing, bathing, and taking medications) at home or in a nursing home

Intermediate nursing care in a nursing home

Private duty nursing or skilled nursing care not approved by Medicare

Charges that are more than Medicare's allowed amount

Injury or sickness covered by Workers Compensation

Admissions or care provided by a government-owned or -operated hospital unless payment is required by law

Admissions that begin before the effective date of coverage

Admissions that begin after the coverage termination date

Medical care, services or supplies provided or furnished while coverage is not in effect (that is, before the effective date of coverage or after the coverage termination date)

Drugs other than prescription drugs furnished during your stay in a hospital or skilled nursing facility

Dental care, dentures, routine physicals and immunizations, cosmetic surgery, routine foot care, and examinations for eyeglasses or hearing aids

Please refer to the Humana Medicare Summary of Benefits for additional Benefit information.

To File a Claim

When you use your benefits, a claim must be filed before payment can be made. Anthem PPO network and Blue participating providers should automatically file all claims for you. All you need to do is show your ID card. However, nonparticipating providers may or may not file a claim for you.

To file your own claim, follow these steps:

Ask your provider for an itemized statement with the following information:

- Patient's name
- Participant's name and Plan number (from your ID card)
- Provider's name, address, phone number, and federal tax ID number
- Date and description of services
- Diagnosis (nature of illness or injury)
- Admission and discharge dates for hospitalization

Important: If you receive medical services out of the country, try to get all receipts itemized in English. Cash register receipts, canceled checks, or money order stubs may accompany your itemized statement, but may not substitute for an itemized statement.

Make a copy of all items for your files and send the original to the Claims Processing Office at the address listed in this section. **It is important that you file claims promptly because most services have a two-year filing limitation.**

Important: You will receive payment directly from the Claims Processing Office. The check will be in the Participant's name, not the patient's name.

The example below shows the information the Humana Claim Office requires in order to review your claim:

1. NAME AND ADDRESS OF PROVIDER*
2. FULL NAME OF PATIENT
3. DATE OF SERVICE
4. CHARGE
5. DIAGNOSIS AND TYPE OF SERVICE

PHYSICIAN RECEIPT

(1) George S. Smith, M.D.
100 Market Street
Hometown, State

(2) For professional services to:
John Doe

(3) DATE OF SERVICE	(4) CHARGE	(5) DIAGNOSIS/SERVICE
5-31-90	$25.00	Anemia/Office visit
6-11-90	$15.00	Sprained Ankle/ X-Ray, Ankle
5-22-90	$ 8.00	Anemia/Complete Blood Count
6-5-90	$15.00	Sprained Ankle/ X-Ray, Ankle
6-3-90	$ 8.00	Anemia/Complete Blood Count

**Include tax identification number for out-of-state physician.*

If the patient does **not** have Medicare coverage, send all of the claim information to:

Humana
XXX
XXXX
XXXX

Explanation of Benefit Payments (EOBP)

After the Claims Processing Office processes claims for services you receive, they will send you an Explanation of Benefit Payments (EOBP). **The EOBP is not a bill.** It is a statement that helps you understand how your benefits were paid. At the top of the EOBP you'll find customer service numbers and an address to use for inquiries. Briefly the EOBP tells you:

The family members who received services.

The date services were provided ("claims processed from….to….").

"Summary of Balances" includes the provider(s) of the services, detail about charges and payments, including the amount saved by using network providers.

"Summary of Deductibles and Copayments" provides your deductible and copayment requirements as well as deductibles and copayments paid to date.

"Helpful Information" includes messages and reminders.

"Detail on Services" summarizes the payment and shows your balance.

If you see an error, contact your provider first. If your provider cannot correct the error, call the customer service number on your EOBP.

If you think your provider is intentionally billing the Plan for services you did not receive, or that someone is using your card illegally, please contact the Claims Processing Office.

Write the Claims Processing Office at the following address:

Michiana Area Electrical Workers' Health and Welfare Fund
Claims Processing Office
P.O. Box 4963
Troy, MI 48099-4963

Coordination of Benefits (COB)

Coordination of Benefits (COB) is how health care carriers coordinate benefits when you are covered by more than one group health care plan. Under COB, carriers work together to make sure you receive the maximum benefits available under your health care plans. Your health care plan requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans.

COB ensures that the level of payment, when added to the benefits payable under another group plan, will cover up to one hundred percent (100%) of the eligible expenses as determined between the carriers. In other words, COB can reduce or eliminate out-of-pocket expenses for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for care.

How COB Works

If you are covered by more than one group plan, COB guidelines (explained below) determine which carrier pays for covered services first.

Your primary plan is the carrier that is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.

Your secondary plan is the carrier that is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by the carriers.

The Working Spouse Rule requires that working spouses of participants enroll in their employers' health plans. Spouses that do not enroll in their employers' health plans will have **no coverage** through the Fund unless they qualify for the HARDSHIP EXEMPTION as explained below.

You must provide information regarding your marital status and your spouse's employment status (if you are married) on an annual basis.

THE BASIC "WORKING SPOUSE RULE"

If your spouse works and is eligible for coverage through his or her employer (a plan in which the employer contributes some or all of the premiums), then his or her plan is primary and the Fund will be secondary for all your spouse's medical claims. The Fund will not pay any of your spouse's health care expenses if **your spouse does not elect his or her employer's coverage**.

HARDSHIP EXEMPTION – the Working Spouse Rule will not apply if your spouse:

1. **Has gross annual wages of less than twenty thousand dollars ($20,000), or**

2. **Has gross annual wages greater than or equal to twenty thousand dollars ($20,000) but less than thirty thousand dollars ($30,000) and must pay more than one hundred fifty dollars ($150) per month toward the cost of the least expensive health plan offered by his or her employer.**

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

Dual Coverage Saves you Money – When your spouse is covered by his or her employer's plan and this Plan at the same time, the two plans together will usually pay one hundred percent (100%) of his or her covered claims under the coordination of benefits rules. If your spouse requires a hospitalization or surgery, you will generally come out ahead financially from the dual coverage, even after your spouse's premiums are taken into account.

Additional provisions and exceptions to the Working Spouse Rule:

1. The Working Spouse Rule only applies to your spouse's claims, not to claims incurred by your other Eligible Dependents.

2. It applies to Retirees as well as Active Participants, but only if the Retiree's spouse is still actively employed.

3. It does not apply to COBRA coverage, meaning that if your spouse terminates employment and declines COBRA, this Plan will pay its normal benefits.

4. The Working Spouse Rule only applies to medical and drug expenses.

5. The Rule applies without regard to whether or not your spouse's employer requires its employees to pay for part of the premium, whether or not the employer offers an incentive to induce employees not to enroll, and whether or not the employer offers a single-only coverage option. It also applies if the employer only offers medical coverage as an option under a cafeteria plan.

6. No reductions will apply to a particular claim if you can demonstrate that your spouse's claim would have been denied under the employer's plan (for example, if the claim was for a pre-existing condition incurred during the pre-existing waiting period).

7. The provision will also be waived if the only health plan offered by your spouse's employer is an HMO plan, and your residence is more than twenty-five (25) miles outside the HMO service area.

8. If your spouse is covered under his or her employer's plan, then your spouse must receive his or her medical care in accordance with that plan's rules. This Fund will not cover the amount of the other plan's noncompliance penalties, or any charges incurred because of failure to follow the other plan's rules, including failure to use HMO providers or follow the HMO's referral procedures. (This is not a new rule, and it also applies to claims for your Eligible Dependents when your spouse's plan is primary).

9. You are required to provide accurate and timely information to the Fund about your spouse's employment status and benefit entitlement, and the Fund Office may require verification of this information from your spouse's employer.

Guidelines to Determine Primary and Secondary Plans

Contract Holder Versus Dependent Coverage

The plan that covers the patient as the employee (subscriber or contract holder) is primary and pays before a plan that covers the patient as a dependent.

Contract Holder (Multiple Contracts)

If you are covered under more than one health care plan, your primary plan is the one on which you are an active member (such as an employee), and your secondary plan is the one of which you are an inactive member (such as a retiree). If you are active under both plans, the plan that has been in effect the longest will be your primary plan.

Dependents (The "Birthday Rule")

If a child is an Eligible Dependent covered under both the mother's and father's plans, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.

Children of Divorced or Separated Parents

For children of divorced or separated spouses who are Eligible Dependents, benefits are determined in the following order **unless a court order places financial responsibility on one parent**:

Plan of the custodial parent.

Plan of the custodial parent's new spouse (if remarried).

Plan of non-custodial parent.

Plan of non-custodial parent's new spouse.

If the primary plan cannot be determined by using the guidelines above, then the "birthday rule" will be used to determine primary liability.

Filing COB Claims

Remember to ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier's payment statement to the secondary carrier. When you submit claims to the Claims Processing Office for reimbursement of the balance, please follow these steps:

Obtain an Explanation of Benefits (EOB) or payment statement from the primary carrier.

Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.

If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.

Make sure the provider's name and complete address are on your receipts. Please be sure to include the provider's tax ID number.

Send these items to:

Michiana Area Electrical Workers' Health and Welfare Fund
Claims Processing Office
P.O. Box 4963
Troy, MI 48099-4963

Please make copies of all forms and receipts for your own files, because the Claims Processing Office cannot return the originals to you.

Updating COB Information – Your Responsibility

It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, notify the Fund Office immediately. The Plan may periodically ask you to update your COB information. Please help the Plan to serve you better by responding to requests for COB information quickly.

Subrogation and Reimbursement

Were you or your Dependent injured in an accident for which someone else is liable? If so, that person or that person's insurance company may be responsible for paying your or your Dependent's related medical and accident and sickness expenses and these expenses would not be covered under the Plan. However, waiting for a third party to pay for these injuries may be difficult; recovery from a third party may take a long time (you may have to go to court) and your creditors may not wait patiently. Because of this, as a service to you, the Fund will advance you or your Dependent benefit payments related to such an accident based on the Fund's rights of reimbursement and subrogation. You must reimburse the Fund if you obtain any recovery from any person or entity.

You, your Dependent, or both are required to notify the Fund Office within ten (10) days of any accident or Injury for which someone else may be liable. Further, the Fund Office must be notified within ten (10) days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgment or payment relating to the accident in any lawsuit initiated to protect the Fund's claims.

If you and your Dependent receive any benefit payments from the Fund for an Injury or Sickness and you or your dependent recover *any* amount from *any* third party or parties in connection with such Injury or Sickness, you or your Dependent must reimburse the Fund from that recovery the total amount of all benefit payments the Fund made or will make on your or your Dependent's behalf in connection with such Injury or Sickness.

In addition, if you or your Dependent receive any benefit payments from the Fund for any injury or sickness, the Fund is subrogated to all rights of recovery available to you or your Dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such Injury or Sickness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such Injury or Sickness in your or your dependent's name and also has a right to intervene in any such action brought by you or your dependent, including any action against an insurance carrier under any uninsured or under-insured motor vehicle policy.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the

Injury or Sickness, and regardless of whether you or your dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's rights of reimbursement and subrogation provide the Fund with a first priority lien on the proceeds of any recovery in connection with the injury or sickness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your or your Dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable. Neither the "common fund" doctrine nor the "make-whole" doctrine apply to the Fund's right of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the *full* amount of *all* related benefits payments; this amount is not offset by legal costs, attorney fees or other expenses incurred by you or your Dependent in obtaining recovery. **The Fund shall automatically have a first priority lien on any amount received by you, your dependent or a representative of you or your Dependent (including an attorney) that is due to the Fund under this Section. Any such amount shall be deemed to be held in trust by you, your Dependent, and each attorney representing you or your Dependent for the benefit of the Fund until paid to the Fund. While held in trust such amount shall not be commingled with any other property or distributed without the prior written consent of the Fund Office.**

Consistent with the Fund's rights set forth in this Section, if you or your Dependent submit claims to or receive any benefit payments from the Fund for an injury or sickness that may give rise to any claim against any third party, you, your Dependent, or both will be required to execute a Subrogation, Assignment of Rights, and Reimbursement Agreement ("Subrogation Agreement") affirming the Fund's rights of reimbursement and subrogation related to such benefit payments and claims. This Agreement must also be executed by each attorney representing you or your Dependent.

Because benefit payments are not payable unless you sign a Subrogation Agreement, *no claims of you or your Dependent will be considered filed and will not be paid until the fully signed Agreement is received by the Fund.* This means that, if you file a claim and your Subrogation Agreement is not received promptly, the claim will be untimely and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, the Plan excludes coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recoverable by, or on behalf of, you or your Dependent in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payments you, your Dependent, or your attorney may receive as a result of the accident or injury, no matter how these amounts are characterized or who pays these amounts, as provided in this Section.

Under this provision, you, your Dependent, and your representatives are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of you or your Dependent's receipt of any recovery. You or your Dependent also must not do anything to impair or prejudice the Fund's rights. For example, if you or your Dependent choose not to pursue a claim against a third party, you or

your Dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office immediately. Where you or your Eligible Dependent choose not to pursue a claim against a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your Dependent (and your attorney if you or your Dependent have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the claim.

You or your Dependent must also notify the Fund before accepting any payment prior to the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your Dependent waive any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your Dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against your future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation Agreement and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

This reimbursement and subrogation program is a service to you and your Dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays for any injuries.

No-Fault Auto Insurance and Your Coverage

If you or an Eligible Dependent are involved in a motor vehicle accident, payment for medical services will be coordinated between the Fund and your auto insurance carrier as follows:

Whether your auto coverage is coordinated or uncoordinated, your auto insurance carrier is primary. The Fund will be secondary to your auto insurance even if you live in a no-fault state. It is important that you discuss this with your auto insurance company.

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SECTION III

SUPPLEMENTAL BENEFIT ACCOUNT

The Supplemental Benefit Account (SBA) provides for coverage of deductibles, co-payments and other benefits under the plan (please refer to the "Covered Benefits" in this section for a detailed listing of the covered benefits).

Funding

For every hour worked, employer contributions are made to your Supplemental Benefit Account (SBA).

These are not vested benefits; the Trustees have the legal right to use any or all of your SBA balance for any Plan purposes or obligations.

Participation

Contributions are required from the Employers for Active Participants working within the jurisdiction of and covered under the terms of the Collective Bargaining Agreement as well as Non-Bargaining Unit (NBU) participants employed by Local Union 153 or the Joint Apprenticeship and Training Fund.

Eligibility

You must be eligible based upon the Plan's regular **Active** Participant eligibility provisions or the Plan's self-payment provisions on the date services for Covered Benefits are rendered.

Each month, the SBA balance will be listed on your monthly contribution advice notice.

You may continue to utilize the SBA provided you are eligible by way of employer contributions, the hour bank, or Retiree self-payments. However, as explained below, you can lose your SBA

Reimbursable Benefits

Eligible expenses include reimbursement of self-payments and those defined by the Internal Revenue Service (IRS) which are listed under Covered Benefits in this section.

Reimbursement

You must submit an itemized bill for dental and vision services. For all other services you must submit the appropriate payment voucher to the Fund Office.

Claims will be reimbursed on a monthly basis. However, you can submit claims as frequently as you want. The Fund Office will hold the claims until the next reimbursement period.

Accruing Account Balances

Your SBA balance will continue to grow each year if you do not use it. However, if no contributions have been made to your SBA for more than twenty-four (24) months, your SBA will be closed and the balance will used by the Fund to pay for administrative expenses.

Non Covered expenses

- Expenses incurred prior to January 1, 2005
- Expenses for which you are eligible to receive reimbursement from another source
- Occupational Injuries
- Non-eligible expenses

For a more complete listing of expenses not covered, please refer to the section entitled "Examples of Non-Eligible Health Care Expenses".

Work in an area outside of the jurisdiction of the Fund

If you are working in the jurisdiction of another IBEW Local, contributions must be remitted to the Fund at the current contribution rate plus the SBA contribution.

If Employees from areas outside the jurisdiction of the Union work in the jurisdiction of the Union, contributions will be transferred to their Home Health and Welfare funds based upon the lesser of the contribution rates specified in the applicable collective bargaining agreements.

Covered Benefits

The following list identifies some of the common medical, dental and health related expenses that the **Internal Revenue Service** considers to be deductible expenses.
(*Reimbursement for Co-Payments)

Abortion, Legal *	Guide dog and its upkeep
Acupuncture	Hair transplant or wigs (medically necessary)
Alcoholism and drug addition treatments*	Health spa in home (to extent value of home not increased). Whirlpool baths (medically necessary)
Ambulance*	Hearing aids and batteries
Artificial limbs and teeth*	Hospital services-including meals and lodging, clinic costs
Birth control pills*	HMO Health Maintenance Organization) co-pays
Braces	Insulin*
Braille books and magazines (to the extent prices exceed prices for regular books and magazines)	Iron Lung
Car (Special medical equipment within)	Laboratory & x-ray fees*
Contact lenses including saline solution and enzyme cleaner	Lead-based paint removal to prevent lead poiso

Crutches or Wheelchairs*	Legal fees to allow treatment for mental illness
Dental Treatment	Lip-reading lessons
Diathermy	Lodging for medical care
Electrolysis or hair removal (medically necessary)	Medical information plan (amount paid to plan t keeps your medical information)
	Mentally retarded, special home
Eye Examination	Nurses' expenses and board
	Nursing care*
Eyeglasses	Skilled Nursing home (if for medical reasons)*
False Teeth	Operations and related treatments*
Fees for health club (medically necessary)	Orthopedic shoes
Fees to doctors, hospitals, etc. for: Anesthesiologist* Chiropractor* Christian Science practitioners Clinic charges* Dentist Dermatologist, General Practitioner* Gynecologist* Internist* Midwife* Neurologist* Obstetrician* Ophthalmologist / Optometrist Osteopath, licensed* Physical Therapist* Podiatrist* Practical Nurse* Psychiatrist* Psychoanalyst (medical care only)* Psychologist (medical care only)* Sex therapist (medical care only)* Surgeon*	Over-the-counter drugs- see specific list attache
	Oxygen equipment*
	Prescribed drugs and medicine (including vitami that require a prescription)*
	Radial Keratotomy*
	Rental of medical equipment*
	Sanitarium
	Smoking cessation programs
	Special schooling for physically or mentally hand family member
	Sterilization*
	Telephone & television equipment which display Audio part of TV programs (for the deaf)
	Therapy (for medical treatment)*
	Transplants*
	Travel costs to obtain medical care & prescriptic
	Weight Loss programs

Examples of Non-Eligible Health Care Expenses

Any illegal treatment	Diaper service
Cosmetic services and procedures (unless necessary to Restore normal functioning)	Health and beauty aids
Food for weight loss programs	Karate or Kick boxing classes
Medications specifically used for cosmetic purposes	Over-the-counter drugs (including health & beauty aids, vitamins, and nutritional supplements) for general well being.
Cost of remedial reading classes for non-disabled child	Teeth Whitening
Dancing or ballet, even when recommended by doctor	Funeral Expenses
Hospital benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self-employment tax	Nursing Care for a healthy baby
Travel your doctor told you to take for a rest or change	Individual Health Care Premiums paid

SECTION IV

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) provides short term counseling benefits for the Participant and immediate family members. Participants and Dependents can contact the EAP for marital counseling, alcohol or drug problems, depression etc.

New Avenues EAP provides short term counseling benefits for the Participant and immediate family members. Participants and Dependents can contact New Avenues EAP for marital counseling, alcohol or drug problems, depression etc.

New Avenues can be contacted toll free at 1-800-731-6501. You can also obtain information about New Avenues at www.NEWAVENUESOnline.com. Your counseling session will be completely confidential and the information discussed during the session will not be shared with anyone.

Funding

Employer Contributions to the EAP for you and other Eligible Employees are made as required by the Collective Bargaining Agreement.

Eligibility

You must be eligible based upon the Plan's **Active** Participant eligibility provisions on the date services for Covered Benefits are rendered.

Covered Benefits

You are eligible for a counseling session each year at no cost because this is an Employer funded program. The costs of further counseling sessions will either be your responsibility or billed directly to the Health and Welfare Fund if you are eligible and the services are covered under the Plan.

Counseling sessions may include but are not limited to:

- Alcohol or Substance Abuse
- Stress, Anxiety & Depression
- Anger Management
- Parenting concerns
- Psychological / emotional problems
- Grief or Trauma Issues

For additional information regarding the EAP and how to contact the EAP, please contact the Fund Office.

SECTION V

WEEKLY ACCIDENT AND SICKNESS BENEFITS (LOSS OF TIME)

If you become Totally Disabled from non-occupational accidental bodily injury or sickness, the Plan will pay the Weekly Benefit shown in the schedule of Benefits. Benefits begin with the date of disability specified in the schedule of Benefits and continue while you remain Totally Disabled, up to the benefit maximum during one period of disability shown in the Schedule of Benefits below.

Active Employees Only

Application for Loss of Time Benefits

For the Fund to consider Loss of Time, you must submit a fully completed claim form.

1. Both you and the physician must complete the form.

2. If possible, have your present Employer complete his portion of the claim form. If you were laid-off at the time of disability, indicate this on your claim form.

3. The Fund must receive a "Return to Work Notice" completed by your physician.

Period of Disability

All disability absences will be considered as having occurred during a single period of disability unless evidence acceptable to the Trustees is furnished that:

1. The cause of the latest disability absence cannot be connected with the causes of any prior disability absences, and the latest disability absence occurs after return to Active Work for at least one day; or

2. The causes of the latest disability absence can be connected with the causes of a prior disability, but the two were separated by a return to Active Work for at least two weeks.

Limitations

No benefits are payable under this benefit provision for any period or day of disability for which you are not under the regular care and attendance of a physician. A **Chiropractor** is not considered a physician for the purposes of disability benefits.

No benefits are payable under this benefit provision for any period on or after the date you become a Retiree, even if you would normally be considered eligible based on Employer contributions for hours worked before retirement.

The benefits provided under this provision are not assignable.

Weekly Accident and Sickness Benefits are also subject to all General Plan Exclusions and Limitations

Benefits paid under this Section are not eligible for and do not contribute to the Co-payment limits under Section II.

Schedule of Benefits for
Weekly Loss of Time Benefits (Employee Only)

Non Occupational Benefits

- Payment begins – for Accident or Hospital Confinement -----1st day
- Payment begins – for Sickness----------8th day
  If the illness last four (4) or more weeks, payment begins with day one (1)
- Weekly Benefit----------$400.00
- Maximum Benefit----------26 weeks

  Participants may be eligible to receive an additional 26 weeks of eligibility credit provided they are still disabled beyond the 26 weeks. Please contact the Fund Office for further information.

This benefit is only payable until you retire or begin receiving a monthly benefit from the Michiana Area Electrical Workers Pension Fund or Social Security.

SECTION VI

DEATH AND DISMEMBERMENT BENEFITS

Death Benefits – Active and Retired Employees Only

If you die from any cause, a death benefit is payable in the amount of $7,500.00 and is processed by the Fund Office. The Fund Office must be provided with acceptable proof of death on forms provided by the Trustees.

Beneficiary Designation

You must file a written designation of Beneficiary with the Fund Office on a properly completed form. If you have not made an irrevocable designation of Beneficiary, you may name a new Beneficiary without your prior Beneficiary's consent by filing a new form with the Fund Office. The change of Beneficiary will be effective retroactively to the date you sign the form, whether or not you are living when the Fund Office receives it. The Plan is not responsible for any payments made before the change of Beneficiary form is received. If you do not designate a Beneficiary or if your Beneficiary does not outlive you, the death benefit will be paid to the living in the following order:

1. Spouse;
2. Children, including legally adopted children;
3. Parents;
4. Brothers and sisters; or
5. Personal Representative, Executor or Administrator of your estate.

If two (2) or more persons are entitled to the death benefit, they will share equally. If you have designated your spouse as beneficiary, this designation shall be void upon the dissolution of your marriage to such spouse.

Notice of Claim

Written notice of your death must be given to the Fund Office within twelve (12) months of the date of death. If written notice is not given within such twelve (12) month period, the Plan will not be liable for any benefits otherwise payable under this Section due to your death.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Employees Only

If you lose a limb or an eye or if you die from a bodily injury, the Plan will pay benefits up to the Principal Sum in the Schedule of Benefits provided:

1. The injury was caused solely by an accident occurring while covered; and

2. The loss is directly related to the accident and is independent of all other causes; and

3. The loss occurs within one hundred and eighty (180) days after the accident.

The amount of Benefit payable is based on the following:

Life	$7,500
Both hands	Full Life Benefit
Both feet	Full Life Benefit
Both eyes	Full Life Benefit
One hand and one foot	Full Life Benefit
One hand and one eye	Full Life Benefit
One foot and one eye	Full Life Benefit
One hand	One Half Life Benefit
One foot	One Half Life Benefit
One eye	One Half Life Benefit

The payments will be made directly to you if living, otherwise to your Beneficiary.

"Loss" with reference to hand or foot means complete severance through or above the wrist or ankle joint and with reference to eye means the irrecoverable loss of the entire sight in such eye.

Limitations

Benefits ***are not*** payable for loss resulting from or caused directly or indirectly, wholly or partly, by:

1. Bodily disease or mental infirmity or hernia;

2. Ptomaine or bacterial infections, except infections caused by pyogenic organisms, which shall occur with or a cut or wound or disease of any kind;

3. Self-destruction or injury and/or attempted self-destruction or injury while sane or insane;

4. Committing an assault or a felony; and

5. War, act of war, riot or duty in the armed forces while such country is engaged in an act of war.

SECTION VII

General Plan Exclusions and Limitations

The following exclusions and general limitations apply to all benefits provided by the Michiana Area Electrical Workers' Health & Welfare Fund unless specifically waived by a particular benefit section.

Routine Care and Elective Procedures

Benefits under this Plan are for the treatment of sickness or accidental bodily injury when rendered by hospitals and physicians. Routine care, cosmetic surgery, diet medication or supplements, which are not medically necessary to correct a condition which threatens the health of an Eligible Person are not eligible for benefits from this Plan. The Trustees reserve the right to have an Eligible Person examined by a physician of their own choice and at their own expense to make their determination regarding any benefit payable or eligibility rule of this Plan.

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

Medical Necessity

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

Work Related Injuries and Illnesses

Payment will not be made by the Plan for expenses incurred because of disease, defect or accidental injury which occurs during, or arises out of, any occupation for wage or profit. If the Eligible Person's claim under Workers' Compensation or any Occupational Disease Law is rejected, the illness or injury will not be considered work-related and payment will be made.

1. A claim under Workers' Compensation will be considered to have been rejected under the following circumstances:

a. when, after a hearing by the Indiana Workers' Compensation Board (or a corresponding agency in another state), there has been a final administrative determination denying the claim and no lawsuit seeking court review of the decision has been filed; or

b. when a decision has been rendered by the Indiana Workers' Compensation Board (or corresponding agency in another state), a party has sought court review of the decision and a final court determination has been made rejecting the claim.

Treatment Sponsored by Governmental Units

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

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

2. For treatment by a physician employed by the Federal Government or other governmental unit; or

3. For services or supplies furnished by or at the request or direction of the Federal Government, any of its agencies, or other government unit unless the Eligible Person is legally required to pay.

This exclusion will not prevent coordination of benefits with a plan specifically established by a governmental unit for its own civilian employees and their dependents.

Treatment Without Charge

Payment will not be made for confinement in any hospital or treatment by a physician when the hospital or physician makes no charge which the Eligible Person is legally required to pay or there would have been no charge but for the benefits available under this Plan.

Illegal Occupation or Commission of Felony

The Trustees will not be liable for loss to which a contributing cause was the commission of or attempt to commit a felony by the person whose injury or sickness is the basis of claim, or to which a contributing cause was such person's being engaged in an illegal occupation. This exclusion will not apply to an illness and/or injury sustained due to a medical condition (physical or mental) or domestic violence.

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

Experimental Treatment or Procedures

Benefits under this Plan are for the treatment of accidental bodily injury or sickness by generally recognized medicines, surgery and other techniques or devices. Medicines, treatment techniques and devices which are not generally recognized by professional peer groups (such as the American Medical Association) or by regulatory governmental authorities (such as the Food and Drug Administration) will be considered experimental and will not be considered eligible expenses under this Plan. For the purposes of this provision, recognized treatment or medicines used in a non-routine manner (frequency or dosage) will be considered experimental.

Liability for Accidental Injuries

Benefits under this Plan are considered secondary and excess coverage, including but not limited to other coverage through, any automobile insurance or common carrier's liability (such as bus or commercial airline). No payment shall be made until proof is submitted to and judged acceptable by the Trustees that a proper claim has been made for other coverage. Normal Plan benefits shall be paid if other coverage has been denied or shall be coordinated with other coverage payments, if any.

Physical or Dental Examination and Autopsy

The Trustees at their own expense have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim when and as often as they may reasonably require during pendency of claim under the Plan, and to make an autopsy in case of death, where it is not forbidden by law.

Free Choice of Physician

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

Workers' Compensation Not Affected

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

Circumstances That May Result in Loss Of Eligibility Of Benefits

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

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

REMEMBER: You must work the required number of hours or make timely self-payments in order to maintain your eligibility.

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

General Limitations

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

1. Declared or undeclared war, or any act thereof, or military or naval services of any country;

2. Services, treatment or supplies received from a dental or medical department maintained by a mutual benefit association of this or another employee benefit plan or labor union;

3. Services, treatment or supplies, payable or furnished under any policy of insurance or other medical benefit plan or service plan for which the Trustees shall, directly or indirectly, have paid for all or a portion of the cost;

4. Services or treatment rendered or supplies furnished primarily for cosmetic purposes;

5. Expenses incurred for services performed or supplies furnished by other than a legally qualified physician;

6. Services, treatment or supplies rendered or furnished:

    a. Before the individual concerned became an Eligible Person; or

    b. Without the recommendation and approval of a legally qualified physician;

7. Services related to obesity, diet or weight control, including but not limited to: exercise programs, surgery, special diet or diet supplements, pre-natal vitamins, smoking cessation, amphetamines, or any form of diet medication whether or not recommended or supervised by a physician, including dietary or nutritional counseling, books, pamphlets or classes;

8. Mental counseling, physical therapy, supplies or prosthesis for sexual dysfunction or inadequacies (including VIAGRA);

9. Implantation within the human body of artificial mechanical devices designed to replace human organs other than pacemakers or similar such devices which merely assist rather than replace the function of the organ;

10. Ambulance service or transportation (such as by ambulance, air ambulance, railroad or bus) unless judged by the Trustees as essential for treatment of a life-threatening illness or injury in excess of one hundred (100) miles;

11. Expenses incurred for services performed and supplies furnished by other than a physician;

12. Growth hormones;

13. Programs or prescription medications for the purposes of smoking cessation;

14. Expenses incurred for the purpose of reversing tubal ligations, vasectomies or other sterilization procedures;

15. Special home construction to accommodate a disabled person;

16. Education, special education, job training or work hardening whether or not given in a facility that also provides medical or psychiatric treatment beyond the first medically necessary visit. Special education or like services, regardless of: the type of education, the purpose of the education, their recommendation of the attending physician or the qualification of the individual rendering the educational services;

17. Rest cures or custodial care;

18. Speech therapy, other than charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) while eligible in the Plan and as the result of a disease or accidental injury. Speech therapy to improve speech in the absence of disease or accidental injury (such as for a learning disability or speech delay) is considered special education and is not covered;

19. Supplies or equipment for personal hygiene, comfort or convenience;

20. Services, treatment or care rendered by a member of the Eligible Person's family;

21. Treatment or services for or in connection with financial counseling;

22. Treatment or services for primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, or carbon dioxide therapy;

23. Cosmetic or reconstructive surgery which:

a. is not necessary for the prompt repair of accidental bodily injury, sickness or disease which occurs while the patient is not eligible; and

b. is not performed within two (2) years from the date of a covered loss.

24. Dietary or nutritional counseling, books, pamphlets or classes;

25. Charges incurred for any abortion procedure performed on a Dependent child except where the pregnancy is the result of rape as evidenced by a police report;

26. Charges incurred for travel, whether or not recommended by a physician;

27. Artificial insemination, invitro fertilization, or embryo transfer process;

28. Life style drugs;

29. Acupuncture; and

30. Accidental Injuries For Which a Third Party May Be Liable

As more fully explained in Section II concerning Subrogation and Reimbursement, no benefits will be paid to you or your Eligible Dependent for expenses incurred due to an accidental injury for which a third party may be liable unless there is a signed Subrogation Agreement with the Fund. Under the terms of the Subrogation Agreement you, your Dependent, and each attorney representing you or your Dependent must agree that any amounts recovered from a third party relating to the accidental injury will first be used to repay the Fund the total of all benefits paid by the Fund relating to the accidental injury.

Claims Review & Appeal Procedures

Your Right to Receive an Explanation of and to Ask for Review of an Adverse Benefit Determination

You or your provider must file claims for Fund Medical Benefits with Michiana Area Electrical Workers' Claim Processing Office. Claims for other benefits (such as death benefits) are filed with the Fund Office.

If you have questions about decisions made on claims or requests for Medical benefits, you can address them by calling one of The Claim Processing Office's Customer Service Representatives. Their telephone number is in the top right hand corner of the first page of the Explanation of Benefits sent to you by the Fund and also in the Fund's notice to you that a claim has not been approved.

If you have questions about decisions made on claims of requests for other Fund benefits, you should address them by telephone to one of the Fund Office's claims representatives. Their telephone number is (517) 321-7502.

Types of Claims Covered. For purposes of the procedures set forth below, the following terms are used to define health claims:

- **Urgent Health Claims**: claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;
- **Pre-Service Health Claims**: for example, pre-certification of a hospital stay or predetermination of dental coverage;
- **Post-Service Health Claims**: for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician; and
- **Concurrent Claims**: claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by Plan amendment or Plan termination.
- **Rescission of Coverage**: retroactive cancellation of coverage.

Initial Submission of Claims. Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, medical, and prescription drug claims should be submitted to the Claims Processing Office, and all other claims for benefits (including eligibility claims) should be submitted to the Fund Office.

Notice That Additional Information is Needed to Claim

After the claim is submitted, the Fund deadline to provide notice to Claimant that the claim is incomplete (with explanation of additional information is necessary to process claim) is:

- For Urgent Health Claims – 24 hours after receiving improper claim.
- For Pre-Service health claims – 5 days after receiving improper claim.

➢ After receipt of notice from the Fund that the claim is incomplete, the Claimant's deadline to supply the Fund the information requested to complete claim is:

- For Urgent Health Claims – 48 hours after receiving notice.
- For Pre-Service Health Claims – 45 days after receiving notice.
- For Post-Service Health Claims – 45 days after receiving notice.
- For Disability Claims – 45 days after receiving notice.

Avoiding Conflicts of Interest. The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

Initial Decision On A Claim

(a) Additional Evidence:

(1) The Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), below, to give the Claimant a reasonable opportunity to respond prior to that date; and

(2) Before the Fund can issue an initial benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), to give the claimant a reasonable opportunity to respond prior to that date.

(b) The Fund deadline for making an initial decision on a claim is:

- **For Urgent Health Claims** – As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim; or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier.
- **For Pre-Service Health Claims** – 15 days after receiving the initial claim. A 15-day extension is permitted if the Plan needs more information and it has provided notice of same to the Claimant during the initial 15 day period. Fund deadline for responding is tolled while awaiting requested information from the Claimant.
- **For Post-Service Health Claims** – 30 days after receiving the initial claim. A 15-day extension is permitted if the Plan needs more information and has provided notice of same to the Claimant during the initial 30 day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.

- **For Disability Claims** – 45 days after receiving the initial claim. A 30-day extension is permitted if the Plan needs more information and has provided proper notice of same to the Claimant. An additional 30-day extension is permitted if the Plan needs more information and has provided notice of same to the Claimant during the first 30-day extension. The Fund deadline for responding is tolled while awaiting additional information from Claimant.

Adverse Benefit Determination. Notice of an adverse benefit determination will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- the internal rule or similar guideline relied upon in denying the claim;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of available internal appeal process and how to initiate the external review process for an adverse benefit determination which involves a medical condition of the claimant for which the timeframe for completion of the internal appeal would jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function;
- if applicable, a statement of the Claimant's right to bring a civil action after further denial on appeal or external appeal; and
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272, or the Michigan Office of Financial and Insurance Regulation, MiCHAP, P.O. Box 30220, Lansing, Michigan 48909, (877) 999-6442.

- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.

Effective for claims for disability benefits filed on or after April 1, 2018, the written statement shall be provided in a culturally and linguistically appropriate manner pursuant to the applicable Department of Labor regulations and also include an explanation for disagreeing or agreeing with or not following:

- The views presented by the Claimant to the Plan of the health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
- A disability determination made by the Social Security Administration regarding the Claimant presented to the Plan by the Claimant.

Internal Appeals

(a) Adverse Benefit Determinations. A Claimant may appeal any Adverse Benefit Determination received. An Adverse Benefit Determination means any of the following:

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan;
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
- failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or
- rescission of coverage.

(b) Submission of Internal Appeals. An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the Claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal appeal.

The Plan will continue to provide coverage for an ongoing course of treatment pending the outcome of an internal appeal.

The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Appeals should be submitted as follows:

- **Appeals Regarding Benefits Administered by the Claims Processing Office:** For those claims administered by the Claims Processing Office, submit an initial appeal of a benefit denial to the address set forth on the benefit denial. If the Claims Processing Office denies this appeal, you may submit a second appeal to the Fund Office.
- **Appeals Regarding Benefits Not Administered by the Claims Processing Offices:** For those claims not administered by the Claims Processing Office, submit appeals to the Fund Office.

(c) Time for Submitting Internal Appeals. A Claimant must appeal a benefit denial within the following time limits:

- For Urgent Health Claims – 180 days after receiving denial.
- For Pre-Service Health Claims – 180 days after receiving denial.
- For Post-Service Health Claims – 180 days after receiving denial. In addition, for those claims administered by the Claims Processing Offices, the second appeal to Trustees must be made within 30 days of the of the Claims Processing Office appeal denial.
- For Concurrent Claims – Claimant must be given enough time to appeal decision before termination effective.
- For Disability Claims – 180 days after receiving denial.

ALL APPEALS MUST BE TIMELY SUBMITTED. A CLAIMANT WHO DOES NOT TIMELY SUBMIT AN APPEAL WAIVES HIS/HER RIGHT TO HAVE THE BENEFIT CLAIM SUBSEQUENTLY REVIEWED ON INTERNAL APPEAL, ON EXTERNAL REVIEW, OR IN A COURT OF LAW.

ANY LAWSUIT AGAINST THE FUND MUST BE BROUGHT IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF INDIANA. THE LAWSUIT MUST BE FILED WITHIN TWELVE (12) MONTHS AFTER THE CLAIMANT IS NOTIFIED OF AN ADVERSE BENEFIT DECISION ON REVIEW.

(d) Notice of Decision on Internal Appeal.

The notice of a decision on appeal will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- the internal rule or similar guideline relied upon in denying the claim;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, if applicable),
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of the external review process, including information regarding how to initiate the external review process;
- a statement of the Claimant's right to bring a civil action after a further denial on appeal or external appeal, if applicable; and
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272, or the Michigan Office of Financial and Insurance Regulation, MiCHAP, P.O. Box 30220, Lansing, Michigan 48909, (877) 999-6442.

Effective for claims for disability benefits filed on or after April 1, 2018, any notice of an adverse benefit determination on appeal shall be provided in a culturally and linguistically appropriate manner pursuant to the applicable Department of Labor regulations and also include a discussion of the decision explaining the basis for disagreeing or agreeing with or not following:

- The views presented by the Claimant to the Plan of the health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
- A disability determination made by the Social Security Administration regarding the Claimant presented to the Plan by the Claimant.

The Fund deadline for deciding an appeal of a benefit denial and notifying the Claimant of its decision is:

- For Urgent Health Claims – 72 hours after receiving appeal.
- For Pre-Service Health Claims:
  - Benefits administered by THE CLAIMS PROCESSING OFFICE – THE CLAIMS PROCESSING OFFICE shall decide the initial appeal, and inform the Claimant of its decision 15 days after receiving appeal. A second appeal to the Trustees must be filed within 30 days of receipt of the THE CLAIMS PROCESSING OFFICE appeal denial. The Trustees shall decide this appeal within 15 days.
  - Benefits not administered by THE CLAIMS PROCESSING OFFICE – The Trustees shall decide the appeal 30 days after receiving the appeal.
- For Post-Service Health Claims:
  - Benefits administered by THE CLAIMS PROCESSING OFFICE – THE CLAIMS PROCESSING OFFICE shall decide the initial appeal, and inform the Claimant of its decision 30 days after receiving appeal. A second appeal to the Trustees must be filed within 30 days of receipt of the THE CLAIMS PROCESSING OFFICE appeal denial. The Trustees shall decide this appeal at a Board Meeting.*

- Benefits not administered by THE CLAIMS PROCESSING OFFICE – The Trustees shall decide the appeal at a Board Meeting.*

- For Concurrent Claims – Prior to termination of previously approved course of treatment.
- For Disability Claims – The Trustees shall decide the appeal at a Board Meeting.*

  * Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third Board Meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees decision on appeal no later than five days after the decision is made.

Effective for claims for disability benefits filed on or after April 1, 2018,

- Prior to the date the Plan issues an adverse benefit determination on an appeal of a disability benefit claim, the Trustees shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or any other person making the benefit determination (or at the direction of the Plan or any other person) in connection with the Claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date; and

- Prior to the date the Plan can issue an adverse benefit determination on an appeal of a disability benefit claim based on a new or additional rationale, the Trustees shall provide the Claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claim a reasonable opportunity to respond prior to that date.

Deemed Exhaustion of Internal Claims and Appeals Processes

- If the Plan fails to adhere to all of the requirements in this Section VII with respect to a claim, the Claimant is deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under this Section VII. The Claimant is also entitled to pursue any available remedies under Section 502(a) of ERISA, or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.
- Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.
- The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.
- If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

Discretion of Trustees. The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

Limitations of Actions. For adverse benefit denials not subject to external review, no action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal. For adverse benefit denials subject to external review, a request for external review must be made within the time limitations provided in this Section VII. If a Claimant does not abide by these time limitations, he/she waives his/her right to any further review of an adverse determination, including waiving his/her right to have the determination reviewed in a court of law.

EXTERNAL REVIEW PROCESS

Eligibility for External Review. The external review process applies to any final internal adverse benefit determination that involves: (1) medical judgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or legal interpretation without any use of medical judgment), or (2) a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time). Weekly disability benefits are not subject to external review. A denial, reduction, or termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

Request for External Review. A Claimant must file a request for an external review with the Fund within four (4) months after receipt of a notice of the final internal appeal. If he/she fails to do so, he/she waives the right to an external review or review in a court of law. The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an external review.

Preliminary Review. Within five business days following the receipt of the external review request, the Fund must complete a preliminary review of the request to determine whether:

(a) The Claimant is or was covered under the Plan at the time the health care item or service was requested or provided;
(b) The final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;
(c) The Claimant has exhausted the Plan's internal appeal process; and
(d) The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Fund must issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-ESBS (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete and the Fund must allow a Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization

(a) The Fund must assign an independent review organization (IRO) to conduct the external review.

(b) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the IRO within ten business days additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Fund. Upon receipt of such information, the Fund may reconsider its final internal decision on appeal, but such reconsideration will not delay the external review. If the Fund decides to provide coverage, within one business day after such decision the Fund must provide written notice of same to the Claimant and the IRO and the IRO must then terminate the external review.

(c) Within five business days after the date of assignment, the Fund will provide to the IRO documents and any information considered in making the final decision on internal appeal, but failure to do so will not delay the conduct of the external review. If the Fund fails to timely provide this information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination and notice of such decision will be provided by the IRO to the Claimant and Fund within one business day.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1) The Claimant's medical records;
2) The attending health care professional's recommendation;
3) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider;

4) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(e) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and deliver its decision to the Claimant and the Fund.

(f) The IRO's decision notice will contain:

1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
2) the date the IRO received the assignment and the date of the IRO decision;
3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
6) A statement that judicial review may be available to the Claimant; and
7) Current contact information, including phone number, for any applicable state office of health insurance consumer assistance or ombudsman established under PHS Act §2793.

(g) The external reviewer's decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law. The Plan must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(h) The IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, Fund, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Expedited External Review

A Claimant can make a request for an expedited external review at the time the Claimant receives:

(a) An adverse benefit determination which involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

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

Immediately upon receipt of the request for expedited external review, the Fund must take the steps for Preliminary Review outlined above under the standard external review procedures and immediately send the notification of such review to the claimant.
Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO as outlined above. The Plan must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The Plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation to the Claimant and the Fund.

Discretion of Trustees. The Trustees have full discretionary authority to determine eligibility for benefits, interpret Plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

Limitations of Actions. No action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on External Review. In the event a Claimant does not bring an action within such 180 days, he/she waives his/her right to any further review of an adverse determination in a court of law.

ANY LAWSUIT AGAINST THE FUND MUST BE BROUGHT IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF INDIANA. THE LAWSUIT MUST BE FILED WITHIN TWELVE (12) MONTHS AFTER THE CLAIMANT IS NOTIFIED OF AN ADVERSE DECISION ON REVIEW.

If You Have Any Questions About These Review Procedures, Please Contact The Fund Office.

Claim Review Procedure for Other Benefits

The Plan's review procedure for these claims has a one-step appeal process. It is triggered when the Plan provides you with a written adverse benefit determination, which must be done within one hundred eighty (180) calendar days of the Plan's receipt of your claim. The Trustees will decide your request no later than its first regular meeting that is at least thirty (30) days after the Trustees receive your appeal. The written determination that you receive as a result of your Level 1 request for review will be the final determination involving your claim for benefits.

Please send your written request to:

Michiana Area Electrical Workers'
Claim Processing Office - Appeals
P.O. Box 4963
Troy, MI 48099-4963

If you disagree with the Plan's determination, or a determination is not issued by the time required, or the procedures for review are not followed by the Plan, you have the right to bring a civil lawsuit under ERISA Section 502(a) to try to obtain the benefits that you have requested. **ANY LAWSUIT AGAINST THE FUND MUST BE BROUGHT IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF INDIANA. THE LAWSUIT MUST BE FILED WITHIN TWELVE (12) MONTHS AFTER THE CLAIMANT IS NOTIFIED OF AN ADVERSE DECISION ON REVIEW.**

Here is What To Do:

1. Notify the Fund Office in writing that you wish to have your claim reviewed by the Board of Trustees. If you wish, you may request a hearing before the Trustees.

2. Your written request for a review (or a hearing if applicable) must be submitted within sixty (60) days after you receive this denial notice.

3. Include in your written request all the facts regarding your claim as well as the reasons(s) you feel the original decision was incorrect.

   Upon your request, the Fund Office will assist you in gathering the pertinent data from Fund records to complete the information you need for review of your claim.

4. In the event you request a hearing, you can appear in person or choose a representative to appear for you before the Trustees.

   The Fund Office will notify you of the date, time and place to appear. In scheduling a hearing, every effort will be made to arrange a time that is convenient for you.

5. If you do not wish to make a personal appearance before the Board of Trustees, the Fund Office will present your written statement and other pertinent information on your behalf.

6. You will receive the Board of Trustee's decision in writing. The written notice will contain: the decision, reasons for the decision, and specific references to pertinent Plan provisions on which the decision was based.

7. The written decision will be sent to you: (a) within sixty (60) days after receipt of your written request for review or (b) within one hundred twenty (120) days if you requested a hearing.

8. You may, at your own expense, have legal representation at any stage of these review procedures. You must completely exhaust these Claims Review and Appeal Procedures before undertaking any legal action.

In reviewing your claim, every effort will be made by the Trustees to handle interpretations of the Plan and claim disputes in a consistent and equitable manner.

In addition, the Trustees will make every effort to assure that you receive a full and fair review if your claim is denied.

SECTION VIII

STATEMENT OF PARTICIPANT'S RIGHTS

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

As a participant in the Michiana Area Electrical Workers' Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

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

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA

continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen [18] months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal Court. In such case, the Court may require the Plan Administrator to provide the materials and pay you up to one hundred ten dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that 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, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if

you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION IX

OTHER IMPORTANT INFORMATION

The Trustees Interpret the Plan

Under the Trust Agreement creating the Welfare Fund, and the terms of this Plan, the Board of Trustees have the sole authority and the sole discretation to interpret the Trust Agreement and the Plan and to make final determinations regarding any application for benefits and the interpretation of the Plan and any administrative rules adopted by the Trustees. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties to the Trust, and the Welfare Plan provides, that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Any interpretation of the Plan's provisions rests solely with the Board of Trustees. Benefits under this Plan will be paid only if the Trustees decide, in their discretion, that the applicant is entitled to them. **No employer or union**, nor any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board nor can an employer or union act as an agent of the Board of Trustees.

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

The Plan Can be Changed

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

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

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

Your Plan is Tax Exempt

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

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

The Trustees are well aware of these advantages and will take whatever steps are necessary to keep your Plan "Qualified" as a tax exempt Trust under Internal Revenue Service rules.

Right to Receive and Release Necessary Information

To determine the applicability of and to implement the terms of this Plan or the similar terms of any other plan, the Fund will not without consent or notice and signed authorization, release to or obtain from any insurance company or other organization or individual, any information, with respect to any covered person, which is considered individually identifiable protected health information unless such information is deemed necessary for payment of claims. Any covered person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

Right of Recovery

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

1. Any individual to whom or from whom such payments were made; or

2. Any insurance company, hospital, physician or any other organization.

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

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which are prescribed herein effective at the time of payment. If no such designation or provision is then effective, the indemnity will be payable to the estate of the Employee. Any other accrued indemnities unpaid at the Employee's death may, at the option of the Trustees, be paid either to the beneficiary or to the estate.

Subject to any written direction of the Employee, all or a portion of any indemnities provided by the Fund for services rendered by a hospital, nursing, medical, surgical, dental or vision service may, at the Trustees' option, and unless the Employee requests otherwise in writing no later than the time for filing proof of loss, be paid directly to the hospital or provider of services.

WOMEN'S HEALTH AND CANCER RIGHTS

The Trustees of your Health and Welfare Fund are issuing this annual notice in compliance with the Women's and Cancer Rights Act of 1998. Your Health and Welfare Plan already provides the benefits required by this new law. You have a right to this notice, and the Trustees are providing the notice for your information so that you may be assured that you are treated in accordance with federal law if the need arises.

The Federal law requires that all health care plans that provide medical and surgical benefits for mastectomies provide, participants and beneficiaries receiving mastectomy benefits and who elect mastectomy related breast reconstruction with coverage for the following:

- **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 physical complications of all stages of mastectomy including lymph edemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.**

The Fund has provided coverage for mastectomies for a number of years. As part of this coverage, the Plan also covered the procedures necessary to effect reconstruction of the breast on which the mastectomy was performed, as well as the cost of prostheses and physical complications of all stages of mastectomy, including lymph

edemas, as recommended by the attending physician of any patient receiving Plan benefits in connection with the mastectomy and in consultation with the patient. The Plan also covers any surgery and reconstruction of the other breast to achieve a symmetrical appearance.

Name of the Plan

The Plan is the Michiana Area Electrical Workers' Health & Welfare Fund.

Type of Plan

This Plan provides Health Care Benefits for expense due to hospitalization, surgery, and medical treatment. It may from time to time also provide benefits for vision or dental care. This Plan also provides benefits for Death, Accidental Dismemberment and Weekly Accident and Sickness (Loss of Time). This Plan is classified as an "employee welfare benefit plan" under federal law.

Type of Plan Administration

The Plan is administered and maintained by the Board of Trustees which is the Plan Administrator for purposes of federal law. The Trustees have selected a professional employee benefits administrative firm as the Administrative Manager of the Plan. The Administrative Manager is responsible for carrying out the Trustees' policy decisions, recordkeeping, accounting and paying most benefits subject to the Plan Document.

Name and Address of Administrative Manager

TIC International Corporation
6525 Centurion Drive
Lansing, Michigan 48917
Telephone: (517) 321-7502
Fax: (517) 321-7508
Toll Free: (877) 244-9473

Name of Each Trustee

Trustees can and do change periodically. The current Trustees are:

Management Trustees	Union Trustees
Roger Dosmann, Chairman	Stanley Miles, Secretary
Thomas Cioch	Christopher Grove
Daniel Schmidtendorff	Mike Leda
Matt LaFree, Alternate	Dustin Hansen, Alternate

Parties to the Collective Bargaining Agreement

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

The parties to the collective bargaining agreement are:

International Brotherhood of Electrical Workers Local 153
and
The Northern Indiana Chapter of the National Electrical Contractors Association, Inc.

and those Employers which execute an individual collective bargaining or non bargaining participation agreement with the Union. Upon written request to the Administrative Manager, Participants and Beneficiaries may obtain information as to the address of a particular Employer and whether that Employer is required to pay contributions to this Plan.

Service Providers

Michiana Electrical Workers'
Claim Processing Office
P.O. Box 4963
Troy, MI 48099-4963

Anthem, Inc.
220 Virginia Avenue
Indianapolis, IN 46204

Humana Claims Office
Attention: Pharmacy Department
P.O. Box 14601
Lexington, KY 40512-4601

Humana (Medicare Participants)
P.O. Box 14168
Lexington, KY 40512-4168

Internal Revenue Service
Employer and Plan Identification Numbers

The Employer Identification Number (EIN) issued to the Board of Trustees is 35-6073323 and the Plan Number is 501.

Agent for Service of Legal Process

Richard B. Urda, Jr.
Attorney at Law
205 West Jefferson Blvd.
Suite 210
South Bend, IN 46601
(574) 234-2161
(574) 233-6533 FAX
rurdapc@gmail.com

Service of legal process may also be made upon any Plan Trustee.

Eligibility Requirements

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

Sources of Trust Fund Income

Sources of Trust Fund income include Employer contributions, Employee self-payment of contributions and investment earnings. All Employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining or non-bargaining participation agreements between the Union and an Employer Association or those Employers who are not members of or represented by an Association but who execute an individual collective bargaining agreement or non-bargaining participation agreement with the Union.
The agreements specify the amount of contribution, due date of Employer contributions, type of work for which contributions are payable and the geographic area covered by the labor contract.

Method of Funding Benefits

Benefits payable under this Plan are self-funded and paid directly from the accumulated assets of the Trust Fund. A portion of Fund assets are also allocated for reserves to meet future liabilities and to carry out the objectives of the Plan.

Fiscal Year of the Plan

The financial records of this Plan are based on a fiscal year which begins May 1 and ends April 30.

The Plan May be Terminated

Although the Trustees do not foresee that the Plan will be terminated, the Trust Agreement provides that termination may occur when:

1. The Trustees determine that the Trust Fund assets are not adequate to carry out the purpose for which the Welfare Fund is intended; or

2. There is no longer a collective bargaining agreement or other written agreement in effect that requires Employer contributions to be made to the Trust Fund and negotiations for extension thereof have ceased.

The Trustees are obligated to use the Trust Assets for payment of expenses incurred up to the date of termination and expenses related to the termination as their first priority. Remaining assets, if any, must be used to continue Plan benefits after the Plan termination date for those persons eligible when the Plan was terminated.

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