EIT Benefits

Electrical Insurance Trustees (EIT Benefit Funds) is pleased to provide you with this Summary Plan Description (SPD or handbook) describing the health care and welfare benefits available to eligible participants as of January 1, 2008.

The SPD provides information about the plan provisions governing your health care benefits — including eligibility, coverage levels and plan guidelines. Consider this SPD, which is available in print and online at www.fundoffice.org, to be your primary reference guide for your benefits — the first place to turn when you have a question about your benefits or your rights as a plan participant.

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About this Handbook

This Summary Plan Description (SPD or handbook) explains how you become eligible for coverage and how coverage can be lost — and describes the health care and welfare benefits available as of January 1, 2008 to participants in the Electrical Insurance Trustees (EIT) Health & Welfare Plan that applies to you. To understand the plan, you must read the whole SPD. This SPD also serves as the official plan document, and supersedes and replaces any prior SPD and Summaries of Material Modification previously provided by EIT for the plans of benefits described in it. If you need more information, you may examine copies of the applicable collective bargaining agreement and other related documents at the Fund Office.

If You Have Questions

If you have questions about the information in this handbook, contact the claims administrators for the plans in question or call the Fund Office at 1-312-782-5442.

See the *Contact Information* section of this handbook for claims administrator names and other contact information.

The benefits and other principal provisions described in this handbook are effective only if you are eligible for coverage, become covered and remain covered according to the provisions of the applicable benefit plan.

Benefits are contingent upon the financial adequacy of the plan to which employer contributions are made. Benefits under the plan will be paid only when the Trustees, or persons delegated by them to make such decisions, decide in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the plan. The Trustees have the authority and unconditionally reserve the right, in their sole and unrestricted discretion, to change, amend or end the plan at any time, or from time to time, for any reason.

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

Overview of the Handbook

This handbook is designed to help you understand how your benefits work. It is divided into sections describing each benefit plan, as shown in the table of contents. For details about a specific plan, refer to that section. There, you'll find another table of contents to help you find what you're looking for in that section.

Health Care Benefits

Benefits as of January 1, 2008 include:

- Medical
- Behavioral Health/Substance Abuse
- Prescription Drug
- Dental
- Vision

Disability Benefits (not available for Participatory Plan participants)

Benefits as of January 1, 2008 include:

- Short-Term Disability
- Long-Term Disability

*Insurance Benefits**

Benefits as of January 1, 2008 include:

- Basic Life Insurance (formerly called Death Benefits)
- Accidental Death & Dismemberment (AD&D)

* Insurance benefits for Participatory Plan participants include Basic Life Insurance and Accidental Death benefits.

Each benefit is described in this handbook. The handbook also includes important information regarding:

- What to do when certain family/life or job changes occur,
- Eligibility for benefits,
- How to file a claim under the benefit plans, and
- Certain legal rights you have as a plan participant.

If You Need Help Understanding this Handbook

This handbook contains a summary of your plan rights and benefits under the EIT Health & Welfare Plan that applies to you. If you have difficulty understanding any part of this handbook, contact the Fund Office. You may also call the claims administrators for the individual plans of benefits for assistance (see the *Contact Information* section of this handbook for claims administrator names and other contact information).

What Happens If...

EIT benefits are designed to help and support you during family/life and job changes, expected and unexpected. This section gives you information on your benefits and outlines the steps you should take when certain events occur.

In This Section **See Page**

Family/Life Changes

This section describes what you should do if you experience family or life changes such as getting married, becoming a parent — or in the event you or your covered dependent loses eligibility or dies.

If I Marry

Health Care

In the case of a marriage, you may want to add dependents to your health care coverage, such as your new spouse and any stepchildren. If your spouse is already covered as a participant under the plan, he or she can be covered as a dependent, too. (See "Participation" in the *Health Care* section for more information about eligibility requirements for you and your dependents.)

Contact the Fund Office to make benefit changes and provide the following documentation or information as applicable:

Eligible Dependents	What You Must Do to Add Dependents
Lawful spouse	You must provide: • A copy of the marriage certificate, which has been certified by the state in which you were married. • A certified copy of your spouse's birth certificate, his or her Social Security number, and all insurance information to assist in the coordination of benefits.
Unmarried stepchildren under the age of 19	See "Participation" in the *Health Care* section for details about eligibility requirements for dependent children. To enroll eligible new dependents, you must: • Provide a certified copy of the child's birth certificate and a letter from you requesting coverage for the stepchild. • Include information on any other health care coverage the child has, including the policyholder's name and Social Security number, policy name, policy number and mailing address. If there is no other health care coverage, indicate this in your letter.

Important Note!

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

Eligible Dependents	What You Must Do to Add Dependents
Unmarried children under the age of 23 if full-time students	In addition to the documentation noted above, if your new dependent is age 19 through age 22 and a full-time student, you must provide verification of student status and full-time enrollment every term, semester, trimester, etc. Verification includes a letter from the school's Registrar's office indicating full-time student status and dates of the term. (Eligibility continues for 120 days after the last day of full-time attendance.) **Note:** Health care coverage under the plan ends on the dependent's 23rd birthday regardless of full-time student status. See "Participation" in the *Health Care* section for details about eligibility requirements for dependent children.
Children ages 19 and older if physically or mentally disabled	In addition to the documentation noted above, if your new dependent is age 19 or older and disabled, you will have to provide proof of disability (based on medical evidence) and financial dependence. You have 31 days before your child turns age 19 (or age 23 if covered as a full-time student) to apply for continuation of dependent benefits. Proof of disability and financial dependence may also be requested on an ongoing basis. See "Participation" in the *Health Care* section for more information about dependent benefits for physically or mentally disabled children and the definition of disabled.

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

Life Insurance and Accidental Death Benefits

You may wish to contact the Fund Office to update your beneficiary designation for your Life Insurance and Accidental Death benefit coverage. Your beneficiary designation applies to both the Basic Life Insurance and the Accidental Death benefit. You may change your beneficiary at any time by filing a new beneficiary designation form with the Fund Office. Forms must be received by the Fund Office during your lifetime in order to be valid.

If I Legally Separate or Divorce

If you get divorced or legally separated, contact the Fund Office to make benefit changes or update your beneficiary forms.

Health Care

You Are Responsible…

If you do not notify the Fund Office of your divorce or legal separation and the plan pays benefits for an ineligible dependent, you *must* reimburse the plan for any such benefits paid.

The health care coverage of your ex-spouse and any stepchildren will end at the time of your divorce or legal separation. Upon termination of coverage, your ex-spouse and stepchildren will be notified of their COBRA rights.

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

It is your responsibility, as the participant, to provide the Fund Office with a copy of the final entered Order of Dissolution of marriage. If you do not notify the Fund Office of your divorce or legal separation and the plan pays benefits for an ineligible dependent (e.g., an ex-spouse or stepchild) you must reimburse the plan for any such benefits paid. See “Overpayment” in the *Health Care* section.

Life Insurance and Accidental Death Benefits

To ensure benefits are paid as you want if you should die, you may want to update your beneficiary designations for these benefits. Contact the Fund Office for new beneficiary designation forms. Forms must be received by the Fund Office during your lifetime in order to be valid.

If I Become a Parent

Family leave benefits may be available during and after a pregnancy or adoption, or if your employer continues to make required contributions to the plan. If you do not provide notice, your coverage would end when a shortage of hours occurs. For more information, see “Family Medical Leave Act (FMLA)” in the *Health Care* section.

Health Care

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

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

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

Life Insurance and Accidental Death Benefits

You may wish to contact the Fund Office to update your beneficiary designation for your Life Insurance and Accidental Death benefit coverage. Your beneficiary designation applies to both the Basic Life Insurance and the Accidental Death benefit. You may change your beneficiary at any time by filing a new beneficiary designation form. Forms must be received by the Fund Office during your lifetime in order to be valid.

If My Dependent Loses Eligibility

Health Care

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

- Reaching age 19 (or age 23 if he or she is a full-time student living with you and financially dependent on you),
- Loss of student status after reaching age 19,
- Marriage, or
- Your divorce or legal separation.

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

Divorce or Legal Separation

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

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

It is your responsibility, as the participant, to provide the Fund Office with a copy of the final entered Order of Dissolution of marriage. If you do not notify the Fund Office of your divorce or legal separation and the plan pays benefits for an ineligible dependent (e.g., an ex-spouse or stepchild) you must reimburse the plan for any such benefits paid. See "Overpayment" in the *Health Care* section.

Important Note!

If you do not notify the Fund Office of your divorce or legal separation and the plan pays benefits for an ineligible dependent, you *must* reimburse the plan for any such benefits paid.

If I Die

Health Care

If you die, your surviving spouse will remain eligible for health care coverage for 90 days, whether or not he or she is entitled to Medicare. Your eligible dependent children will also remain eligible for health care coverage for 90 days. If your child stops attending school during this time, he or she is eligible for 120 days of health care coverage from the last day of full-time attendance (not to exceed a total of 90 days or past his or her 23rd birthday).

Your spouse and eligible dependent children may then apply for and continue health care coverage under COBRA for up to 36 months by paying the applicable premium. See “Continuing Coverage” in the *Health Care* section for more information about COBRA.

Life Insurance and Accidental Death Benefits

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

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

If My Dependent Dies

If a covered dependent dies, you should consider the following:

- Cancel dependent health care coverage, if appropriate.
- Update your beneficiary designations for Life Insurance or Accidental Death benefits coverage.

Job-Related Changes

This section describes what you should do if you experience job-related changes such as becoming a new participant or your employment terminates.

If I'm a New Participant

Health Care

You are eligible for benefits beginning on the first day of the month after your employer makes contributions to the plan on your behalf and is accepted by the Trustees as a participating employer. You also must be employed full-time, working at least 30 hours per week. New employees must work for the participating employer full-time for 90 days and then will be eligible on the first day of the following month after they complete 90 days.

When you receive your insurance acknowledgement, you will be asked to submit a certified copy of your birth certificate.

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

Once you are eligible for benefits, you can also choose to cover your dependents. Eligible dependents and the documentation or information you must provide include:

Eligible Dependents	What You Must Do to Add Dependents
Lawful spouse	You must provide: • A copy of the marriage certificate, which has been certified by the state in which you were married, *and* • A certified copy of the spouse's birth certificate, his or her Social Security number, and all insurance information to assist in the coordination of benefits.
Natural born unmarried children under the age of 19	See "Participation" in the *Health Care* section for details about eligibility requirements for dependent children. To enroll natural born children, you must provide a certified copy of the birth certificate or paternity test. These documents must list the eligible participant as one of the biological parents.

Important Note!

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

Eligible Dependents	What You Must Do to Add Dependents
Unmarried stepchildren under the age of 19	To enroll stepchildren, you must: • Provide a certified copy of the child's birth certificate and a letter from you requesting health care coverage for the stepchild. • Include information on any other coverage the child has, including the policyholder's name and Social Security number, policy name, policy number and mailing address. If there is no other coverage, indicate this in your letter. See "Participation" in the *Health Care* section for details about eligibility requirements for dependent children.
Adopted children (or children placed in your home for legal adoption) under the age of 19	Provide a finalized copy of the adoption papers (in English) or an interim order through the courts.
Unmarried children under the age of 23 if full-time students	In addition to the documentation noted above, if your dependent child is age 19 through age 22 and a full-time student, you must provide verification of student status and full-time enrollment every term, semester, trimester, etc. Verification includes a letter from the school's Registrar's office indicating full-time student status and dates of the term. (Eligibility continues for 120 days after the last day of full-time attendance.) **Note:** Health care coverage stops on the dependent's 23rd birthday regardless of full-time student status. See "Participation" in the *Health Care* section for details about eligibility requirements for dependent children.
Children ages 19 and older if physically or mentally disabled	In addition to the documentation noted above, if your dependent child is age 19 or older and disabled, you will have to provide proof of disability (based on medical evidence) and financial dependence. You have 31 days before your child turns age 19 (or age 23 if covered as a full-time student) to apply for continuation of dependent benefits. Proof of disability and financial dependence may also be requested on an ongoing basis. See "Participation" in the *Health Care* section for more information about dependent benefits for physically or mentally disabled children and the definition of disabled.

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

Life Insurance and Accidental Death Benefits

You are eligible for benefits beginning on the first day of the month after your employer makes contributions to the plan on your behalf and is accepted by the Trustees as a contributing employer. You also must be employed full-time, working at least 30 hours per week. New employees must work for the participating employer full-time for 90 days and then will be eligible on the first day of the following month after they complete 90 days.

Dependents are not eligible for Life Insurance and Accidental Death benefits.

Designating a Beneficiary

Designate your beneficiaries for any Life Insurance or Accidental Death benefits by completing and returning the proper designation form. Your beneficiary designation applies to both the Basic Life Insurance and the Accidental Death benefit.

Beneficiary designation forms are available by contacting the Fund Office. You may change your beneficiary at any time by filing a new beneficiary designation form. Forms must be received by the Fund Office during your lifetime in order to be valid.

If I Terminate Employment

Health Care

If you terminate your employment with a contributing employer, your benefit coverage will end. However, you may be able to continue your health care benefit coverage — medical, prescription drug, dental, orthodontic, vision and hearing aid — for yourself and your eligible dependents for a limited period of time under COBRA. See “Continuing Coverage” in the *Health Care* section.

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

Life Insurance and Accidental Death Benefits

Life insurance and Accidental Death benefits coverage also will end the day you terminate employment. However, you may have the option to convert your Basic Life Insurance benefit to an individual life insurance policy if you terminate employment. Contact the Fund Office for more information.

Health Care

The Health & Welfare Plan provides you with comprehensive health care coverage that gives you and your eligible family members protection against the financial impact of covered medical, dental and other health care expenses.

In This Section **See Page**

Participation

This section describes how you and your eligible dependents can participate in health care benefits, including who is eligible, when health care coverage begins, maintaining health care coverage and when health care coverage ends.

Your Health Care Coverage at-a-Glance

The following table summarizes when participant health care coverage begins, continues, and ends. See the remainder of this "Participation" section for more details.

Health Care Coverage Begins…	Health Care Coverage Continues…	Health Care Coverage Ends…
Health care coverage begins on the first day of the month after you and your employer are accepted by the Trustees and your employer contributes to the plan on your behalf. New full-time employees must satisfy a 90-day waiting period to be eligible for coverage.	Your health care coverage continues as long as your employer continues to contribute to the plan on your behalf and you are working at least 30 hours per week.	Health care coverage ends if you fail to work at least 30 hours per week or your employer fails to contribute to the plan on your behalf.

Participant Eligibility

You are eligible for health care coverage under the plan beginning on the first day of the month after your employer makes contributions to the plan on your behalf and is accepted by the Trustees as a participating employer. You also must be employed full-time, working at least 30 hours per week.

New employees must work for a participating employer full-time for 90 days and then will be eligible on the first day of the following month after they complete 90 days.

Maintaining Your Coverage

Once you become eligible, you and your eligible dependents will continue health care coverage as long as you continue to work full-time (at least 30 hours per week) and your participating employer makes the required contributions to the plan on your behalf.

Dependent Eligibility

You can also choose to cover your eligible dependents for health care benefits under the plan. Eligible dependents and required documentation include the following. (See the "Definition of Dependent" and "Definition of Child" below for more information on who is considered to be an eligible dependent.)

Eligible Dependents	Documentation Requirements
Lawful spouse	Provide a copy of your marriage certificate. The certificate must have been certified by the state in which you were married.
Natural born unmarried children under the age of 19	Provide a certified copy of the birth certificate or paternity test. These documents must list the eligible particpant as one of the biological parents.
Unmarried stepchildren under the age of 19	Provide a copy of the child's birth certificate and a letter with information on any other coverage the child has, including the policyholder's name and Social Security number, policy name, policy number and mailing address. If there is no other coverage, indicate this in your letter.
Adopted children (or children placed in your home for legal adoption) under the age of 19	Provide a finalized copy of the adoption papers (in English) or an interim order through the courts.
Unmarried children under the age of 23 if full-time students	To be eligible, the child must be a full-time student as determined by the educational institution, must rely on you or your spouse for more than 50% of his or her financial support, and normally reside in your home. Once your child reaches age 19 through age 22, you must provide verification of student status every term, semester, trimester, etc. Verification includes a letter from the school's Registrar's office indicating full-time student status and dates of the term. Eligibility continues for 120 days after the last day of full-time attendance. Coverage stops on the dependent's 23rd birthday regardless of full-time student status.

Eligible Dependents	Documentation Requirements
Children ages 19 and older if physically or mentally disabled	To be eligible, the child must rely on you or your spouse for more than 50% of his or her financial support and normally reside in your home. The child is considered disabled if he or she is so severely impaired, physically or mentally, that he or she cannot perform in school or at work without assistance, and he or she is not capable of self-support. The impairment must be considered permanent or expected to last at least 12 months. The determination must be based on medical evidence. The child is not considered disabled if disability is solely due to alcoholism or drug addiction. You have 31 days before your child turns age 19 (or age 23 if covered as a full-time student) to apply for continuation of dependent benefits. You may have to provide proof of disability and financial dependence on an ongoing basis.

Definition of Children

"Children" means any one of the following individuals:

- Your legitimate child born of a valid marriage or your natural child who is not a legitimate child born of a valid marriage,
- A child, under age 19, who you legally adopt or who is placed in your home pending legal adoption, or
- A stepchild, which means a child of your current spouse who, prior to your marriage, was born to your spouse.

Definition of Dependent

"Dependent" means any one of the following individuals:

- Your lawful spouse
- Your unmarried child, provided that your child:
  - Is dependent on you for at least one-half of his or her support,
  - Lives with you for at least one-half of the calendar year, and
  - Is less than 19 years old or, if at least 19 but less than 23 years old, is a registered full-time student in an accredited secondary school, college, university, vocational or technical school.

- Your unmarried child who does not live with you, provided that:
  - Your child does not provide more than one-half of his or her own support,
  - Your child is your legitimate child born of a valid marriage,
  - Your child is in the custody of his or her other parent, from whom you are divorced or legally separated, and
  - Under a domestic relations order or a written agreement with the child's custodial parent, you are entitled to claim the child as a dependent for income tax purposes.
- Your unmarried child who does not live with you, if the plan is required by a Qualified Medical Child Support Order (QMCSO) to consider that child as an eligible dependent. Any benefits paid by the plan pursuant to a QMCSO, in reimbursement of expenses paid by the child's custodial parent or legal guardian, will be paid to the child's custodial parent or legal guardian.
- Your unmarried disabled child, provided that your child:
  - Is dependent on you for at least one-half of his or her support,
  - Lives with you for at least one-half of the calendar year, and
  - Is 19 years or older and became disabled prior to age 19. For purposes of this paragraph, "disabled" means that the child is unable to engage in any gainful activity without assistance by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more. The Trustees may require you to furnish proof of the child's continued disability from time to time, but not more often that once in a 12-month period. Coverage will terminate if the Trustees determine, based upon medical evidence, that the child is no longer disabled or if the child does not undergo an examination or furnish proof required by the Trustees.

If Both You and Your Spouse Are Covered Participants

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

Qualified Medical Child Support Order (QMCSO)

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

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

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

Cost of Coverage

Generally, your employer will pay all or a portion of the premium for health care coverage. You may pay a portion of the premium. Your employer will let you know the amount you have to pay, if anything.

When Coverage Begins

Benefit coverage begins on the first day of the month after you complete the eligibility requirements (see "Participant Eligibility" on page 17). Your dependents are eligible to join the plan on the same day you are eligible for coverage.

If you marry, your new spouse and your spouse's dependent children are eligible for coverage on your marriage date. For newborn eligible dependents, coverage begins on the date of birth. For adopted children, coverage begins as directed in the final adoption papers. For children placed in your home, coverage begins on the date verified in the interim order. See "Dependent Eligibility" on page 18 for more information.

Special Enrollment Periods

If you elected to waive coverage under this plan because you had other coverage, you may be able to enroll yourself or your dependents within 30 days of the date your coverage under the other plan ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents. You must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you do waive coverage, you will not be eligible to enroll until the next annual enrollment period, unless you experience one of the above special enrollment circumstances.

When You Have Other Coverage

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

See "Coordinating with Other Health Plans" below for the coordination rules that apply to this plan.

Prescription Drug Benefits

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

Coverage Under Another EIT Plan

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

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

Coordinating with Other Health Plans

Coordinating with COBRA

For information on how the plan coordinates with COBRA coverage, see "Continuing Coverage" on page 59.

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

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

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

Claims for Secondary Coverage

If the provider will not submit a claim for secondary coverage, it is *your* responsibility, as the participant, to file the claim in a timely manner.

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

1. The amount payable by a plan covering a person as an active employee will be determined first. Then, the benefits of a different plan covering the same person as a dependent are determined.
2. If a child is covered by more than one plan, or under this plan by both parents:
   - Primary coverage for a dependent child will be the plan of the person (participant or spouse) whose birth date (month and day) occurs first in the calendar year.
   - If the father and mother have the same birthday, the plan that has covered the child the longest will be primary.
   - If the other plan coordinates benefits based on the gender of the parents, the child's primary plan will be the male parent's primary plan.

   Primary coverage for a dependent child whose parents are separated or divorced will be determined in the following order:
   - The plan of the parent with legal custody of the child, or
   - If a court decree establishes financial responsibility for a child's health care expenses, the primary plan is the plan of the parent with that responsibility.
3. When none of these situations applies, the medical plan that has covered a person the longest will pay first.

It is the participant's responsibility to see that a claim for secondary coverage is filed in a timely manner. COB claims can be filed within one year of the date that the primary carrier either pays their portion or denies the claim.

Claims Administrators' Rights

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

Coordinating with Medicare

Integrating Benefits with Medicare

While you are actively employed, regardless of your age, the plan is primary to Medicare for you and your covered dependents. Benefits under the plan are determined before Medicare's benefits.

Medicare Coverage for Disabled Individuals

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

Medicare Coverage for Individuals with End-Stage Renal Disease

In all situations involving end-stage renal disease (ESRD), regardless of age or Medicare status, the plan is the primary payor of medical expenses for the first 30 months of entitlement to Medicare because of ESRD. After the first 30 months of ESRD entitlement, Medicare is the primary payor, and the plan is the secondary payor. Primary coverage ends 36 months after the month in which a patient has a successful kidney transplant.

Subrogation

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

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

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

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

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

Overpayment

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

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

If You Are on a Leave of Absence

Family Medical Leave Act (FMLA)

Coverage during FMLA or Military Leave

Health care coverage under the plan continues during your approved FMLA leave or military leave of absence.

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

- Birth and care of a newborn child
- Placement of a child with you for adoption or foster care
- Care of your spouse, child or parent with a serious health condition
- A serious health condition that prevents you from performing your job

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

To be eligible for FMLA, you must have worked at least 12 months for a participating employer.

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

Military Leave of Absence (Voluntary or Involuntary)

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

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

How to Continue Coverage if You Are Disabled

If you become disabled and are unable to work at least 30 hours per week, your coverage will continue during your disability as long as your employer continues to make the required contributions to the plan on your behalf.

When Coverage Ends

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

- You fail to work at least 30 hours per week,
- Your employer fails to make the required contributions to the plan on your behalf,
- You retire,
- You die,
- You become eligible under another plan administered by EIT, or
- The plan terminates, for any reason.

Your dependent coverage ends when the first of the following occurs:

- When your coverage ends (see the following table for information about continuing coverage for your spouse and eligible dependent children in the event of your death),
- For your spouse and any stepchildren, at the time of your legal divorce or legal separation,
- On your dependent's death,
- When your dependent child reaches the age limit, or
- You become eligible under another plan administered by EIT.

The following table summarizes situations in which coverage would normally end and what happens to your coverage in each situation.

Health Care Coverage Ends…	However, Health Care Coverage May Continue if…
If you fail to work at least 30 hours per week	You apply for COBRA continuation of coverage (see "Continuing Coverage" on page 59).
If you die	You are survived by a spouse and/or other eligible dependents. Coverage continues for 90 days for your surviving spouse, regardless of whether or not he or she is entitled to Medicare. Eligible dependent children also remain eligible for 90 days. If your child stops attending school during this time, he or she is eligible for 120 days of coverage from the last day of full-time school (not to exceed a total of 90 days or past his or her 23rd birthday). Coverage then ends unless your dependents apply for and pay COBRA continuation of coverage (see "Continuing Coverage" on page 59).
If you retire	You apply for COBRA continuation of coverage (see "Continuing Coverage" on page 59).
If the plan is discontinued	No further coverage.

The Trustees will make every effort to notify you by mail if you lose coverage for any reason. The notice will be sent to the address on file at the Fund Office. Be sure to notify the Fund Office in writing if you or any covered dependent has a change of address.

Medical Benefits

The medical benefits available to you under the plan help you pay for covered medical care and protect you from the financial impact of catastrophic expenses.

Your Medical Benefits at-a-Glance

You can visit any licensed physician or other covered provider you select. In general, the plan pays a percentage of the charges for medically necessary covered services after you have met your deductible. When you use a PPO network provider, you will receive the highest level of benefits available through the plan (see "Using Your Medical Benefits" on page 31 for more information on PPO providers).

Medical Benefits			
	In-Network	***Out-of-Network***	***Out-of-Area***
Annual calendar year deductible	$300 per person. $600 per family.	$600 per person. $1,200 per family.	
	Note: An additional $200 penalty applies if the utilization review organization is not notified or does not certify hospital admissions and extensions.		
Coinsurance and copays	After deductible is satisfied, you pay $25 office visit copays for in-network care, plus 10% of covered charges for services.	Plan pays 80% of PPO negotiated rates after deductible; you pay 20%, plus any amount above the negotiated rate.	Plan pays 80% of usual and customary (U&C) charges after deductible; you pay 20%, plus any amount above U&C charges.
Annual calendar year out-of-pocket maximum	$3,000.	$6,000.	
	Includes deductible, but excludes copays and behavioral health/substance abuse expenses.		
Lifetime maximum benefit	$2 million per person; separate $40,000 per person for substance abuse treatment.		

Medical Benefits			
	In-Network	***Out-of-Network***	***Out-of-Area***
Wellness benefits	• Plan pays for one annual physical per person, up to $75 (charges in excess of $75 will be applied to the calendar year deductible and paid based on the applicable percentage, as noted in "Coinsurance and copays" above). • Plan pays 90% of PPO negotiated rates in-network or 80% of U&C charges out-of-network for one annual coronary artery scan per person upon physician's referral. • Plan pays for immunizations for children up to age 19 at 100% of PPO negotiated rates, or 90% for individuals age 19 or older. • No deductible applies. **Note:** Regardless of age, if you use an out-of-network provider, you pay 20% of PPO negotiated rates (or U&C charges for out-of-area), *plus* any amount over the PPO negotiated rate.		
Physician office visits	$25 copay per visit.	Plan pays 80% of PPO negotiated rates. You pay 20%, plus any amount over the PPO negotiated rates.	Plan pays 80% of U&C. You pay 20%, plus any amount over U&C charges.
	• You may use any licensed physician; copays are not applied to calendar year deductible or out-of-pocket maximum. • Deductible applies.		
Hospital services: inpatient, outpatient and diagnostic tests	Plan pays 90% of PPO negotiated rates after deductible.	Plan pays 80% of PPO negotiated rates after deductible. You pay 20%, plus any amount over the negotiated rates.	Plan pays 80% of U&C charges after deductible. You pay 20%, plus any amount over U&C charges.
	Note: The utilization review organization must be notified of non-emergency hospital admissions at least three days before treatment or within 48 hours following an emergency admission or penalties may apply.		

Medical Benefits			
	In-Network	***Out-of-Network***	***Out-of-Area***
Behavioral health/substance abuse benefits (not included in out-of-pocket maximum)	• Inpatient care covered at 100%. • Outpatient care covered at 100% after $25 copay.	$100 annual deductible per person if out-of-network services are used (separate from other calendar year medical deductible); then plan pays 80% of U&C charges.	
	• There is no referral requirement; participants may access outpatient treatment directly for up to 30 visits per calendar year. • Treatment limited to 30 inpatient days and 30 outpatient visits per person per year unless additional days/visits are approved as medically necessary.		
Chiropractic and naprapathic services	• Plan pays 90% of PPO negotiated rates.	• Plan pays 80% of PPO negotiated rates. You pay 20% plus any amount above the negotiated rates.	
	• Plan pays up to the first $3,000 in covered expenses per calendar year. • No deductible applies.		
Hearing aid benefits	• Annual calendar year benefit: $475 (includes exam benefit) • **Exam:** Plan pays up to $75; one visit per year per person • **Instrument:** Plan pays 80% of the first $500 of U&C charges for a hearing aid instrument each year. • No deductible applies.		
Home health care and hospice services	Plan pays 90% of PPO negotiated rates.	Plan pays 80% of PPO negotiated rates. You pay 20% plus any amount above the negotiated rates.	
	• Deductible applies. • A medical necessity review is required.		
Occupational therapy	Plan pays 90% of PPO negotiated rates.	Plan pays 80% of PPO negotiated rates. You pay 20% plus any amount above the negotiated rates.	
	• Plan pays up to the first $3,000 in covered expenses per person per calendar year. • A medical necessity review is required if expenses exceed $3,000 per person per calendar year. • No deductible applies.		

Medical Benefits			
	In-Network	***Out-of-Network***	***Out-of-Area***
Physical therapy	Plan pays 90% of PPO negotiated rates.	Plan pays 80% of PPO negotiated rates. You pay 20% plus any amount above the negotiated rates.	
	• Plan pays up to the first $3,000 in covered expenses per person per calendar year. • A medical necessity review is required if expenses exceed $3,000 per person per calendar year. • No deductible applies.		
Speech therapy benefits	Plan pays 90% of PPO negotiated rates.	Plan pays 80% of PPO negotiated rates. You pay 20% plus any amount above the negotiated rates.	
	• Plan pays up to the first $3,000 in covered expenses per person per calendar year. • A medical necessity review is required if expenses exceed $3,000 per person per calendar year. • No deductible applies.		
Other covered services: • Emergency care • Durable medical equipment • Prosthetic devices • Casts and splints	Plan pays 90% of PPO negotiated rates after deductible.	Plan pays 80% of PPO negotiated fees after deductible. You pay 20% plus any amount above the negotiated rates.	Plan pays 80% of U&C charges after deductible. You pay 20% plus any amount above U&C charges.
Ambulance service	80% of billed charges after deductible.		

Using Your Medical Benefits

You can visit any licensed physician or other covered provider you select. In general, you pay the least for provider services if you use one of the plan's PPO network providers. For hospital services, such as inpatient, outpatient and diagnostic tests, the amount you pay differs depending on if you visit a PPO network provider or a non-PPO network (or "out-of-network") provider. If you visit a PPO provider, the plan pays 90% of PPO negotiated rates for covered expenses after you pay the deductible, then you pay 10%. If you visit a non-PPO provider, you generally pay 20% of PPO negotiated rates after the deductible, plus all charges above the PPO negotiated rates. Your maximum out-of-pocket cost in any year is $3,000 for PPO network providers and $6,000 for out-of-network providers. Charges by out-of-network providers above negotiated rates do not count toward the deductible or out-of-pocket maximum.

I.D. Cards

If you've lost or misplaced your I.D. card, contact Blue Cross/Blue Shield (BCBS) at 1-800-862-3386 for a replacement I.D. card.

In-Network Care

When you receive care from in-network providers, you pay the full cost of services until you meet your annual deductible. After you meet the deductible, you pay a $25 copay for office visits and 10% of covered charges for any services received during your office visit. Once you reach the out-of-pocket maximum, you continue to pay your $25 office visit copay and the plan pays 100% for additional covered expenses for the remainder of the calendar year.

If your in-network provider refers you to a specialist, he or she typically refers you to another in-network provider. However, it is your responsibility to confirm that the specialist participates in the Blue Cross/Blue Shield (BCBS) PPO network.

For a directory of PPO providers, visit www.bcbsil.com or call BCBS at 1-800-810-2583. You may also contact your physician directly to confirm whether he or she participates in the BCBS PPO network.

Out-of-Network Care

Since out-of-network providers have not agreed to charge PPO negotiated rates, they may charge any amount for services or supplies — which can cost you more. If you receive care from an out-of-network provider, you pay the full cost of services until you meet your annual deductible. After you meet the deductible, the plan generally pays 80% of what the negotiated rate would have been had you used a network provider. You are responsible for paying 20% of the negotiated rate *plus* all charges above the negotiated rate. Charges by out-of-network providers above negotiated rates do not count toward the deductible or out-of-pocket maximum. With out-of-network providers, you have to pay the provider, file claim forms and then wait for reimbursement.

Out-of-Area Care

If you live 10 miles or more from an in-network provider, you can receive health care coverage from the plan of up to 80% of U&C charges after you meet the deductible. You pay 20%, plus any amount above U&C charges. If you are out-of-area, any amount you pay above U&C does not apply to your deductible or out-of-pocket maximum.

The 10-mile radius is based on the address that the Fund Office has on file for you at the time of treatment.

Out-of-Network Emergency Care

In an emergency, you or your dependents should seek treatment from the closest physician or hospital. You will receive health care coverage of up to 80% of U&C charges after you meet the deductible.

Any follow-up treatment that you or your dependent receives after discharge is no longer considered emergency treatment. That means you or your dependent will receive out-of-network benefit levels if the provider you see is not an in-network provider. It is your responsibility to verify that any provider you see for follow-up care after emergency treatment is an in-network provider or you will pay 20% of the PPO negotiated rate plus any amount above the negotiated rate.

Participating Provider Option (PPO)

A PPO provider is a member of a network of providers that has agreed to provide services at lower costs to network participants. By using one of the plan's PPO network (or "in-network") providers you receive a higher level of coverage with a lower out-of-pocket cost than if you use a non-PPO (out-of-network) provider. When you use a PPO provider, the plan pays 90% of covered expenses and you pay 10%. If you live within 10 miles of a network provider but you visit a non-PPO provider, the plan pays 80% and you pay 20% plus any amount above the negotiated rate. If you live more than 10 miles away from all PPO network providers, out-of-area benefits are available; the plan pays 80% and you pay 20%. For a list of the plan's PPO network providers, log onto www.bcbsil.com.

Paying for Your Care

Annual Deductible

For most services, you must satisfy a deductible before the plan begins to pay benefits. The calendar year in-network deductible is $300 per person, up to a maximum of $600 per family. The out-of-network deductible is $600 per person, up to a maximum of $1,200 per family. A separate $100 calendar year deductible applies to out-of-network behavioral health and substance abuse treatments (see "Behavioral Health and Substance Abuse Benefits" on page 45).

Coinsurance and Copays

Once you satisfy the deductible the plan pays 90% of PPO negotiated rates for most covered in-network services; you pay 10%. For most covered out-of-network services, the plan pays 80% of PPO negotiated rates; you pay 20%, plus any amount above the PPO negotiated rate.

Copays for in-network office visits are $25, and do not apply to your annual out-of-pocket maximum.

Annual Out-of-Pocket Maximum

The plan limits the amount you have to pay for covered medical expenses in any calendar year. Your annual maximum in-network out-of-pocket expense is $3,000 per family. Your annual maximum out-of-pocket expense for services you receive outside of the PPO network is $6,000 per family. After you reach the out-of-pocket maximum, the plan pays 100% of the remaining covered expenses for the rest of the year.

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

- Amounts in excess of PPO negotiated rates or U&C charges (for the definition of usual and customary, see the "Glossary" on page 63),
- Office visit copays,
- Behavioral health and substance abuse treatment expenses,
- Prescription drug expenses, or
- Claims paid by third parties.

New deductible and out-of-pocket requirements apply each January 1 for the remainder of the calendar year.

Lifetime Maximum

The plan's lifetime maximum benefit for most covered medical expenses is $2 million per person. Substance abuse treatment has a separate $40,000 lifetime maximum.

Know Which Services Need Precertification

Before you receive medical care, make sure you're following the correct procedures so you will receive the highest level of benefits for those services. See "Medical Service Advisory" on page 34 and "Precertification" under "Medical Service Advisory" on page 34 for details.

Information You Need to Provide

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

- Name, address and telephone number of the attending and/or admitting physician,
- Name of the hospital/location where the admission has been scheduled,
- Scheduled admission date, and
- Preliminary diagnosis or reason for the admission.

Behavioral Health and Substance Abuse Care

For behavioral health and substance abuse care, all inpatient services and treatment must be precertified, whether provided in-network or out-of-network. Additional days or visits (above the 30-day or 30-visit limit) also must be approved by the behavioral health and substance abuse claims administrator as medically necessary. See "Behavioral Health and Substance Abuse Benefits" on page 45 for specific coverage information for this type of care.

After Treatment

File a Claim if Necessary

After you've seen your provider, remember to file a claim if necessary. See "Filing a Claim" on page 58.

Medical Service Advisory

Important Note!

Failure to precertify when needed may result in certain penalties and/or a reduction in benefits.

The utilization review process helps you receive the appropriate levels of care in the proper setting and for an appropriate length of time. The BCBS Medical Service Advisory (MSA), the plan's utilization review organization, must certify in advance any:

- Hospital stays,
- Certain services which follow hospital stays, and
- Alternative courses of inpatient treatment from what was initially approved.

This helps ensure that your treatment is medically necessary. It also helps to keep your health care costs under control. Failure to precertify may result in certain penalties and/or a reduction in benefits.

You, a family member or your physician must notify the BCBS MSA, at 1-800-635-1928, at least three days before a scheduled procedure or within 48 hours following an emergency admission or when you:

- Are admitted to a hospital,
- Need an extension to a hospital stay,
- Have outpatient therapies in excess of $3,000 per person per year,
- Need durable medical equipment,
- Need home health care,
- Need hospice care, or
- Need skilled nursing facilities.

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

- Name, address and telephone number of the attending and/or admitting physician,
- Name of the hospital/location where the admission has been scheduled,
- Scheduled admission date, and
- Preliminary diagnosis or reason for the admission.

The utilization review organization will review the medical information provided and may follow up with your physician. Keep in mind, the utilization review organization may determine that the services to be provided are not medically necessary. (Services must be considered medically necessary to be covered by the plan.)

Precertification

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

- At least three days before treatment for non-emergency hospital admissions, or
- Within 48 hours following an emergency admission.

If you do not precertify when required, the following penalties and benefit limits apply:

- You pay a **$200 penalty** for failure to precertify a hospital admission, and
- Your room and board expenses may be covered at **50% of the PPO negotiated rates** for not precertifying an admission or for any admission reviewed but not approved.

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

Certifying Additional Days

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

Hospital Stays for Childbirth

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

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

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

Case Management

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

Centers of Excellence

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

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

Qualified procedures include:

- Combination heart/bilateral lung,
- Heart,
- Liver,
- Pancreas,
- Pancreas/kidney, and
- Single or bilateral lung.

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

Covered Medical Expenses

Generally, the plan pays 90% of PPO negotiated rates after the deductible for covered medically necessary services provided in-network. For non-PPO services, the plan usually pays 80% of PPO negotiated rates. If you use an out-of-area hospital or physician, the plan generally pays 80% of U&C fees after the deductible.

Covered services include:

- Semiprivate hospital room and board, routine nursing services and ancillary charges
- Intensive or cardiac care services
- Cardiac rehabilitation, including Phase 1 and Phase 2 services started within six months of release from an inpatient confinement (excludes programs primarily for exercise such as Phase 3 services)
- Medical services and supplies, including anesthesia and its administration
- X-rays, laboratory tests and other diagnostic services
- Physicians' charges for medical care and treatment, including surgery
- Transportation charges from the place where a disability began to the closest facility or hospital equipped to furnish special treatment (transportation includes professional ambulance service or air ambulance)
- Charges for treatment by a licensed physical, occupational or speech therapist
- Charges for treatment of morbid obesity (for the definition of morbid obesity, see the "Glossary" on page 63)
- Artificial limbs or eyes
- Orthotic devices including casts, splints, trusses, crutches and braces. Excludes dental braces and over-the-counter orthotics
- Oxygen and rental of equipment to administer it

- Rental, or purchase at the option of the plan, of durable medical equipment, including glucose and apnea monitoring devices, transneuromuscular stimulators, wheelchairs, manually operated hospital beds and oxygen machines (excludes sports equipment, convenience items like wheelchair lifts, extended warranties, repairs and consumable items; e.g., air cleaners, air purifiers, vacuum systems and filters)
- Dental care, artificial tooth implants and x-rays needed because of an accidental injury to sound and healthy natural teeth; restorative dental care needed due to chemical, x-ray or surgical treatment of mouth cancer; or the rare congenital condition amelogenesis imperfecta
- Syringes for anything other than diabetes, which are covered under prescription drug benefits
- Tuberculosis vaccines
- Mastectomy procedures including:
  - Reconstruction of the breast on which the mastectomy has been performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas
- Midwife services at a hospital or home delivery
- Services rendered by:
  - Nurse practitioners
  - Clinical nurse specialists
  - Physician assistants
- Vision therapy

Additional Medical Benefits

Other services, treatment and supplies covered by the plan include the following:

Wellness Benefits

Wellness benefits are designed to encourage preventive treatment and routine exams that can detect problems early.

Routine Physical Exam

You and your covered dependents may receive a routine physical exam once per year. The plan pays the first $75 of the physician's fees per covered person, per year (any charge in excess of $75 will be applied to the calendar year deductible and paid at the applicable in-network or out-of-network rate).

Note: Services must be billed as a physical exam to be covered as a wellness benefit.

Coronary Artery Scan

You or your covered dependents may obtain a coronary artery scan to detect calcification once a year upon a physician's referral. The plan will pay 90% of PPO negotiated rates if you use an in-network provider, or 80% of U&C if you use an out-of-network provider.

Immunizations

Immunizations for children up to age 19 are covered at 100% if you use an in-network provider. The plan also covers flu shots for participants and covered dependents at 100% of PPO negotiated rates. Immunizations for individuals age 19 or older are covered at the applicable in-network or out-of-network rate.

See "Your Medical Benefits at-a-Glance" under "Medical Benefits" on page 27 for other information about the coinsurance that may apply to wellness benefits.

Members Assistance Program (MAP)

The MAP provides counseling and education for covered participants and dependents for up to three sessions per presenting issue at no charge.

For general information about the services provided, call the MAP at the number listed in the *Contact Information* section.

Behavioral Health and Substance Abuse Benefits

See "Behavioral Health and Substance Abuse Benefits" on page 45.

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

The plan covers the initial assessment process, treatment and maintenance medication for Attention-Deficit Disorder (ADD) and Attention-Deficit Hyperactivity Disorder (ADHD). You must follow the behavioral health and substance abuse precertification requirements for any inpatient treatment and for approval of days/visits in excess of 30 for medical necessity. (See "Behavioral Health and Substance Abuse Benefits" on page 45.)

Chiropractic Benefits

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

The plan pays 90% of up to $3,000 (combined limit for chiropractic and naprapathic care) of PPO negotiated rates per person per calendar year. No deductible applies.

Hearing Aid Benefits

The plan covers medically necessary hearing aid-related expenses.

You must visit a Board-certified otologist or otolaryngologist when you need hearing aid care. You will be reimbursed for part of the expense of hearing exams and hearing aid instruments (receipts must accompany claim forms). For hearing aid instruments, the prescription must include the name, model number, battery power and frequency response.

The plan pays benefits for the following expenses:

- Charges for a hearing exam performed by a legally qualified otologist or otolaryngologist, up to $75 per calendar year
- Charges for a hearing aid instrument prescribed by a legally qualified otologist or otolaryngologist, up to 80% of the first $500 of U&C charges each year

No deductible applies.

In addition to the types of expenses listed in "Medical Expenses Not Covered" on page 41, the plan does *not* cover the following hearing aid expenses:

- Exams not performed and hearing aid instruments not prescribed by a legally qualified otologist or otolaryngologist
- Replacement of lost or stolen hearing aid instruments
- Batteries or repair of hearing aid instruments

Home Health Care Benefits

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

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

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

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

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

Hospice Care Benefits

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

- Care is provided by a hospice care organization, hospital or skilled nursing/inpatient rehabilitation facility,
- The attending physician statement indicates the life expectancy to be six months or less, and
- Care is reviewed and certified in advance as medically necessary by the utilization review organization.

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

The following hospice care benefits are *not* covered:

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

Physical and Occupational Therapy Benefits

Physical and occupational therapy benefits cover expenses for restoring physical capabilities lost due to an accident or illness. Benefits are available per condition per year for each type of therapy.

Physical therapy is covered by the plan if:

- Treatment is ordered by a physician,
- Treatment is performed by a licensed physical therapist using physical means, hydrotherapy or biomechanical and neurophysiological principles, and
- Services are expected to allow the participant or covered dependent to regain physical capabilities lost due to an accident or illness.

Occupational therapy is covered by the plan if:

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

The plan pays 90% of PPO negotiated rates for the treatment if you use an in-network provider — or 80% of PPO negotiated rates if you use an out-of-network provider — up to $3,000 for each type of therapy per person per calendar year. No deductible applies. If more than $3,000 in expenses is requested for physical or occupational therapy, a medical necessity review will be required. Coverage will be discontinued if significant progress is not made within a usual and predictable period of time, or if progress stops or becomes minimal.

Speech Therapy Benefits

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

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

The plan pays 90% of PPO negotiated rates if you use an in-network provider for the treatment — or 80% of U&C if you use an out-of-network provider — up to $3,000 per person per calendar year. No deductible applies. If more than $3,000 in expenses is requested, a medical necessity review will be required. Coverage will be discontinued if significant progress is not made within a reasonable and predictable period of time, or if progress stops or becomes minimal.

Medical Expenses Not Covered

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

- Deductibles and amounts in excess of PPO negotiated rates and U&C charges
- Copays and the annual out-of-pocket maximum
- Expenses over the lifetime maximum benefit of $2 million per person
- Expenses over the substance abuse lifetime maximum benefit of $40,000 per person
- Expenses for services that, in the judgment of the claims administrator, are not medically necessary
- Expenses incurred after coverage has ended
- Expenses to treat a participant's illness or injury arising from any electrical work and any other paid work; expenses for a dependent paid or payable under any Workers' Compensation law (whether performed for pay or not) and any other paid work
- Medical expenses incurred while you or a dependent is not under the care of a licensed physician, surgeon or licensed midwife
- Charges for outpatient therapy or counseling unless provided directly and personally by a psychiatrist, licensed psychologist, licensed clinical social worker or substance abuse counselor authorized by the appropriate behavioral health and substance abuse review organization
- Maternity expenses for anyone not a covered participant or lawful wife of a participant (maternity expenses for **dependent children will *not* be covered** by the plan)

- Charges for marriage counseling
- Premarital exams
- Dental services covered under a separate plan of dental benefits (see "Covered Expenses" on page 53)
- Cosmetic, plastic or reconstructive surgery unless needed to:
  - Correct the effects of an injury if the surgery is performed in the year of the injury or the next year,
  - Improve a congenital deformity, or
  - Improve a deformity resulting from disease or medically necessary surgery.

  For some conditions, photographs may be required for appraisal of medical necessity.
- Eye exams to prescribe or fit glasses (covered under a separate plan of vision benefits — see "Vision Benefits" on page 56)
- Treatment for infertility, including related prescribed drugs
- Charges for an experimental or investigational procedure or drug
- Confinement in other than an accredited hospital with 24-hour nursing care, and organized facilities for diagnosis and major surgery
- Treatment in a hospital operated by the federal government or a federal agency for a disability connected to military service
- Illness or injury resulting from any act of war or international armed conflict, participating in a riot or the commission of a criminal act
- Treatment for which there would be no charge if these benefits were not available
- Services provided by a relative or a person who ordinarily resides with you
- Services provided without charge or paid through any other plan
- Expenses that are reimbursable by Medicare
- Treatment of any intentionally self-inflicted injury (except in cases of mental illness)
- Broken appointments
- Prescribed drugs and medicine dispensed by a physician or licensed pharmacist and covered under a separate plan of prescription drug benefits (see "Prescription Drug Benefits" on page 48)
- Any court-ordered services or testing
- Nursing home or assisted living facilities and services
- Over-the-counter drugs or baby formulas
- Massage therapists
- Dietitian used for weight loss (except in cases of morbid obesity) and *all* weight loss programs
- Personal convenience items

- Nutritional supplements, dietary supplements, and food products for special dietary needs
- Acupuncture by a licensed acupuncturist
- Therapeutic devises and appliances, support garments or other non-medical items, regardless of their intended use
- Claims filed more than 365 days after the date the expense was incurred

Filing a Claim

In-network PPO providers will submit a claim directly to the claims administrator. However, if you need to submit the claim, call BCBS at 1-800-862-3386 for a Request for Benefit Payment form. Specify the type needed — general medical or hearing. For medical claims, you can complete the form and attach the bills that explain your treatment. Submit your claim forms to the address listed on the back of your BCBS card.

Filing Deadline

Claims must be filed within 365 days of the date they are incurred or reimbursement will be denied.

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

For treatment at a hospital, present your medical benefits identification card. If your provider is in the PPO network, you usually won't have to submit a claim — the PPO in-network provider will do it for you.

Important Note!

For the highest level of benefits, be sure to contact the utilization review organization at least three days before a non-emergency hospital admission or within 48 hours after an emergency admission (see "Medical Service Advisory" on page 34 for more information about the utilization review program).

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

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

The law requires that the following time frames apply to claims processing. If you file:

- **An urgent care claim** (involving threats to the patient's life or health): The claim must be decided as soon as possible considering the medical emergency, but no later than 72 hours after it is received (up to 48-hour extension).
- **A non-urgent pre-service claim** (for services requiring notification of the utilization review organization, e.g., hospitalization): The claim must be decided within 15 days after it is received (up to 15-day extension).
- **A non-urgent post-service claim** (after you have received services): The claim must be decided within 30 days after it is received (up to 15-day extension).

- **A concurrent care claim** (decision to reduce or terminate previously-approved benefits while you are under care): The claim must be decided sufficiently in advance to give you an opportunity to appeal and obtain a decision before the benefit is reduced or terminated.
- **Any other claim under the plan:** The claim must be decided within 90 days after it is received (up to 90-day extension).

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

Medical and Hearing Aid Claims

Generally no claim forms are required when you use a BCBS participating provider.

In most cases, participating providers agree to submit your claims for you. If the provider does not submit the claim, you may submit your claims directly to BCBS at the following address:

Blue Cross/Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680

For more information about appealing claims and additional claims review procedures, see "Claims Review and Appeals Procedures" in the *Rules, Regulations and Administrative Information* section. For additional contact information for claims administrators, see the *Contact Information* section.

Behavioral Health and Substance Abuse Benefits

The plan also provides benefits for covered behavioral health and substance abuse care. These types of care are administered by CIGNA Behavioral Health (CIGNA), separately from your medical benefits and must also be precertified by CIGNA before receiving services.

Your Behavioral Health and Substance Abuse Benefits at-a-Glance

Behavioral Health and Substance Abuse Benefits			
	In-Network	***Out-of-Network***	***Limits***
Deductible	No deductible.	$100 annual deductible per person.	Separate from medical deductible; applies for inpatient and outpatient out-of-network services.
Members Assistance Program (MAP)	1 to 3 sessions at no cost to participants.	No coverage.	
Inpatient care (hospital expenses include room and board, drug, x-ray, detoxification and lab and physician charges)*	Inpatient care covered at 100%.	Inpatient care covered at 80% of U&C charges.	Treatment limited to 30 inpatient days per person per year*/**, combined for both in- and out-of-network services.
Outpatient care*	Outpatient care covered at 100% after $25 copay per visit.	Outpatient care covered at 80% of U&C charges.	Treatment limited to 30 outpatient visits per person per year**, combined for both in and out-of-network services.

Behavioral Health and Substance Abuse Benefits			
	In-Network	***Out-of-Network***	***Limits***
Structured intensive outpatient substance abuse program***	Care covered at 100% after $25 copay per visit; $150 maximum out-of-pocket per program.	Care covered at 80% of U&C charges.	No limit other than $150 out-of-pocket maximum for in-network services per program.
Lifetime limit (combined for all in and out-of-network benefits)	**Behavioral health:** Included in $2 million medical benefit lifetime limit. **Substance abuse:** $40,000 per person.		
Precertification and review	Precertification is required for all inpatient services. Precertification is not required for outpatient services except for visits in excess of 30.	Precertification is required for all inpatient services. Precertification is not required for outpatient services except for visits in excess of 30. Failure to call within 24 hours of an admission will result in a reduction of coverage. Benefits will be payable at 50% of the out-of-network benefit levels	All coverage is subject to medical necessity **Emergency:** For an emergency admission, notification must be received within 48 hours to be covered at the in-network level.

* Lab and pharmacy management are covered under the behavioral health or substance abuse plans *only* when ordered by a psychologist or psychiatrist.

** Two partial hospitalization days or two residential treatment days are considered one inpatient day.

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

Using Your Behavioral Health and Substance Abuse Benefits

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

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

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

- The balance of the treatment period,
- 60 days, or
- Benefits are exhausted.

Behavioral Health Treatment

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

- Fitness to act as a custodial parent, or
- Diagnosis of a learning disability.

If you are covered under Medicare and Medicare is the primary payor, you are expected to seek treatment from a Medicare-approved provider. If you do not, the Fund will only consider 20% of your expense as eligible for reimbursement.

Substance Abuse Treatment

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

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

One Methadone treatment is considered one outpatient visit and is applied against the 30 visits available annually for substance abuse treatment.

Filing a Claim

All claims should be submitted to:

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

For more information about appealing claims and additional claims review procedures, see “Claims Review and Appeals Procedures” in the *Rules, Regulations and Administrative Information* section. For additional contact information for claims administrators, see the *Contact Information* section.

Filing Deadline

If you do not file a claim within 365 days of the date you incur an expense reimbursement will be denied.

Prescription Drug Benefits

You can buy prescription drugs at a low cost through any pharmacy that participates in the CVS/Caremark network or through a convenient mail-order program. The medical deductible and copay provisions do not apply to the prescription drug benefits.

Your Prescription Drug Benefits at-a-Glance

Prescription Drug Benefits	
Retail prescription drugs purchased through a network pharmacy (34-day supply)	• $5 copay for generic drugs. • $20 copay for preferred drugs. • $35 copay for brand-name and non-preferred drugs.
Mail-order prescription drugs (90-day supply)	• $10 copay for generic drugs. • $40 copay for preferred drugs. • $70 copay for brand-name and non-preferred drugs.
Prescription drugs purchased at a nonparticipating pharmacy	No coverage.

Prescription Drug Benefits and the Medical Plan

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

Using Your Prescription Drug Benefits

Retail Pharmacies

Important Note!

Always ask your pharmacy if it is a member of the CVS/Caremark network before filling a prescription. Prescriptions purchased at a nonparticipating pharmacy are *not* covered under this plan.

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

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

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

- $5 copay for generic drugs
- $20 copay for preferred drugs
- $35 copay for brand-name and non-preferred drugs

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

- Pay the full price of the prescription at the time of purchase,
- Have your pharmacist fill out a claim form, and
- Submit the claim form to the prescription drug claims administrator for reimbursement.

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

Mail-Order Prescriptions

If you take prescribed drugs on a long-term or continuing basis, you can obtain them by mail. When you purchase up to a 90-day supply of mail-order prescribed drugs and medications, the plan pays 100% after you pay a:

- $10 copay for generic drugs
- $40 copay for preferred drugs
- $70 copay for brand-name and non-preferred drugs

Your prescription will automatically be filled with a generic drug, unless your doctor has indicated otherwise on your prescription. New prescriptions generally take two to three days to process and fill. Refills take one to two days to process and fill. Shipping is free of charge, and takes 10 – 14 days for standard delivery. You can choose two-day or next-day shipping; however, it will still take one to three days for your order to be processed before it is shipped. If delivery is delayed for any reason, your order will not be reprocessed until 15 days from the original shipping date.

For further information, order forms and pre-addressed envelopes, contact CVS/Caremark at the number listed in the *Contact Information* section.

Covered Expenses

Covered drugs include:

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

Call CVS/Caremark at the number listed in the *Contact Information* section to determine whether or not a new drug is covered.

Expenses Not Covered

The following are not covered under the plan:

- Contraceptive devices, regardless of the purpose for which they are prescribed (Oral contraceptives are covered, but skin implant contraceptives such as Norplant are not.)
- Fertility drugs
- Drugs or medications lawfully obtainable without a prescription, except insulin
- Therapeutic devices and appliances, support garments or other nonmedical items, regardless of their intended use
- Drugs labeled “Caution: Limited by federal law to investigational use” or experimental drugs, even though a charge is made to the individual
- Charges for the administration of prescription drugs or injectable insulin
- Drugs taken by or administered to an individual in whole or in part while an inpatient in a hospital or other health care facility licensed for dispensing pharmaceuticals
- A quantity in excess of the number specified by the prescriber for a 34-day supply (90-day for mail-order)
- Any refill dispensed more than one year after the date of the prescription
- Prescription drugs that may be properly received without charge under local, state or federal programs, including Workers’ Compensation
- Renova (Tretinoin)
- Lifestyle drugs such as drugs treating weight loss (except in the case of morbid obesity) and hair loss. Drugs prescribed for erectile dysfunction (ED) in excess of six doses per month
- Prescriptions purchased at a nonparticipating pharmacy
- Expenses for drugs obtained through another medical or prescription drug plan (no coordination of benefits)
- Claims filed more than one year after the date the expense was incurred

Filing a Claim

Filing Deadline

If you do not file a claim within 365 days of the date you incur an expense, reimbursement will be denied.

If you do not have your prescription drug card when you make a retail purchase, you must pay for the prescription when purchased and have the pharmacist fill out a CVS/Caremark claim form. You must then submit your claim to:

CVS/Caremark
P.O. Box 52116
Phoenix, AZ 85072

For more information about appealing claims and additional claims review procedures, see “Claims Review and Appeals Procedures” in the *Rules, Regulations and Administrative Information* section. For additional contact information for claims administrators, see the *Contact Information* section.

Dental Benefits

The BlueCare® Freedom Dental PPO program allows you and/or your eligible dependent(s) the freedom to choose any licensed dentist when you need dental care. You will maximize your dental benefits when you access a contracting general or specialty dentist through the BlueCare® *Dental PPO Network*. Advantages of using the BlueCare *Dental PPO Network are*:

- Reduced out-of-pocket costs due to discounted fees
- No balance billing
- No referral needed for specialty dentists
- Contracting dentists will submit claims for you

Your ***dental benefits remain the same*** whether you select a dentist from within or outside the network; services are covered at the same benefit level. However, if you choose to receive services from a dentist outside of the network, the plan will pay a percentage of the charges for covered services, based on usual and customary (U&C) charges, up to a maximum annual or lifetime benefit depending on the services received.

When your dependent needs orthodontic care, treatment must begin before age 16.

Your Dental Benefits at a Glance

Dental Benefits	In-Network	Out-of-Network
Maximum annual benefit	$1,200 per covered family member (excluding orthodontic).	$1,200 per covered family member (excluding orthodontic).
Annual calendar year deductible	No deductible applies.	No deductible applies.
Preventive care (two oral exams/year)	Plan pays 100% of PPO negotiated rates.	Plan pays 100% of U&C charges.
All non-orthodontic dental care	Plan pays 80% of eligible expenses, based on the PPO negotiated rate, up to the maximum annual benefit.	Plan pays 80% of eligible expenses, based on the U&C amount, up to the maximum annual benefit.
Orthodontic dental care	Plan pays 80% of U&C, up to a lifetime maximum of $2,000, for each eligible covered dependent.	Plan pays 80% of U&C, up to a lifetime maximum of $2,000, for each eligible covered dependent.

Using Your Dental Benefits

Dental benefits provide comprehensive coverage for preventive and other types of dental services, including orthodontia. When you need dental care, you must visit a licensed dentist. The plan pays a percentage of PPO or U&C charges for covered services, up to a maximum annual or lifetime benefit. You pay no deductible for dental benefits.

In-network dental benefits are available when you choose a provider that participates in the Blue Cross/Blue Shield (BCBS) BlueCare® Freedom Dental PPO Program. The benefit remains the same whether you use an in-network or out-of-network provider. However, in-network providers have agreed to accept a negotiated rate for their services.

Benefit Amounts

Preventive care: Preventive care is covered at 100% of PPO negotiated rates for in-network dentists or U&C charges for out-of-network dentists. Preventive services include two oral exams a year, including teeth cleaning, fluoride applications (up to 19 years of age) and dental x-rays (two bitewings per year and one full mouth x-ray every 36 months).

Other care: The plan pays 80% of the PPO negotiated rate for other covered dental care provided by in-network dentists (80% of U&C charges for out-of-network dentists).

Annual maximum (excluding orthodontic): The maximum amount the plan will pay *each calendar year* is $1,200 per person. When you or your covered dependents reach this limit, you are responsible for the full cost of any additional services received.

How the Orthodontic Benefit Works

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

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

- A full-time student,
- Unmarried,
- Financially dependent on you, and
- A resident in your household.

Benefit Amount

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

Cost

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

To receive your monthly reimbursements, you must:

- Continue to qualify as a plan participant, and
- Submit paid receipts from your orthodontist for your monthly payment.

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

Covered Expenses

Your dental benefits provide coverage at PPO negotiated rates or U&C charges for the following types of services:

- Two oral exams, including teeth cleaning and scaling, every calendar year; additional cleanings (up to four per year) to treat periodontal disease with a letter of medical necessity
- Fluoride applications up to age 19
- Application of dental sealant up to age 19
- Dental x-rays (bitewings limited to two per year; full mouth limited to once every 36 months)
- Extractions and oral surgery
- Fillings and inlays
- Crowns and initial installation of fixed bridgework
- Artificial tooth implants
- Treatment of diseases of the gums and tissue of the mouth
- Initial installation of removable partial or full dentures
- The addition of teeth to an existing removable partial or full denture or fixed bridgework, or its total replacement, if made necessary by drifting of anchor teeth
- Repair or recementing of crowns, inlays, bridgework or dentures
- Treatment for tooth damage that results from the grinding or biting of teeth (occlusal services)
- General anesthesia for dental procedures when medically necessary
- Orthodontia

Expenses Not Covered

Dental benefits do not cover:

- Expenses to treat a participant's illness or injury arising from any electrical work or any other paid work; expenses for a dependent paid or payable under any Workers' Compensation law (whether performed for pay or not) or any other paid work
- Treatment by someone other than a licensed dentist or physician (the plan will cover teeth cleaning by a licensed dental hygienist who is supervised by a dentist)
- Any work performed directly by a lab and billed to you without a prescription from a dentist, such as manufacture or repair of dentures, liners and other devices and appliances; services and supplies of any kind furnished directly by a lab
- Replacement of a lost or stolen prosthetic device
- Services and supplies that are solely for cosmetic reasons, such as bonding or whitening
- Services that are not medically necessary
- Treatment in a hospital operated by the federal government or a federal agency for a disability connected to military service
- Illness or injury resulting from any act of war or international armed conflict, participation in a riot or the commission of a criminal act
- Treatment for which there would be no charge if these benefits were not available
- Services provided by a relative or a person who ordinarily resides with you
- Services provided or paid through any other plan
- Treatment of any intentionally self-inflicted injury (except in cases of mental illness)
- Broken appointments
- Claims filed more than one year after the date the expense was incurred

Orthodontic Expenses Not Covered

- Expenses for participants other than eligible covered dependents
- Expenses for a dependent paid or payable under any Workers' Compensation law (whether performed for pay or not) or any other paid work
- Treatment by anyone who is not a licensed orthodontist or dentist
- Replacement of lost or stolen retainers
- Services or supplies furnished on or after the date your dependent turns age 16, unless those procedures began before age 16
- Services and supplies that are solely for cosmetic reasons
- Treatment for which there would be no charge if these benefits were not available
- Services provided by a relative or a person who ordinarily resides with you

- Services provided without charge or paid through any other plan
- Broken appointments
- Claims filed more than one year after the date the expense was incurred

Filing a Claim

In-network providers will file a claim for you. Out-of-network providers will usually file a claim for you; but if you are required to file a dental claim, call BCBS at 1-800-862-3386 to obtain a dental claim form. All dental claims should be submitted to:

Blue Cross/Blue Shield of Illinois
c/o DNoA
P.O. Box 23059
Belleville, IL 62223

Filing Deadline

If you do not file a claim within 365 days of the date you incur an expense, reimbursement will be denied.

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

For more information about appealing claims and additional claims review procedures, see “Claims Review and Appeals Procedures” in the *Rules, Regulations and Administrative Information* section. For additional contact information for claims administrators, see the *Contact Information* section.

Vision Benefits

Important Note!

Before you make an appointment, notify the provider that you are covered under VSP.

In-network vision benefits are provided by VSP (Vision Service Plan). However, you can visit any out-of network licensed optician, optometrist or ophthalmologist and receive a lesser out-of-network benefit.

Your Vision Benefits at a Glance

Vision Benefits		
	In-Network	***Out-of-Network***
Annual calendar year deductible	No deductible applies.	
Annual calendar year benefit maximum	Not applicable.	
Exam	After a $20 copay per exam, plan pays 100% on up to one exam per year.	After a $20 copay per exam, plan reimburses up to $45 on one exam per year.
Lenses (includes glasses and frames)	After $20 copay per pair, plan pays 100% (frame costs in excess of $31.25 are your responsibility, but discounted by 20%)	After a $20 copay per pair, plan reimburses up to specified limits depending on the type of lens and frame.
Contact lenses	**Participant:** Plan pays 100% of discounted prices up to $200 per pair per year. **Dependent:** Plan pays 100% of discounted prices up to $200 per year.	**Participant:** Plan reimburses up to $200 per pair per year. **Dependent:** Plan reimburses up to $200 per year.
Participant annual limits	Two sets of framed lenses or two sets of contact lenses or one of each.	
Dependent annual limits	One set of framed lenses or one set of contact lenses.	

Using Your Vision Benefits

You must visit a licensed optician, optometrist or ophthalmologist. You may choose to visit either in-network or out-of-network providers, but with in-network providers the cost savings can be substantial. For in-network services, the plan pays the cost of covered services after you pay a copay. For out-of-network services, you pay a copay, then you will be reimbursed for part of the expense of eye exams, frames and lenses. You pay no deductible.

You must submit claim forms within six months for non-VSP providers. When you submit claim forms, you must include receipts.

VSP Network Advantages

You and your covered dependents benefit when you use providers who participate in the VSP network (network providers) because:

- Network providers have agreed to accept pre-negotiated, discounted rates for their services. Since network providers charge discounted rates, you (and the Fund) save money when you use them.
- Network providers will file claims for you. When you go to a network provider, all you have to do is pay your $20 copay(s) (and any amount that exceeds specific maximums) and your provider will file a claim with VSP for reimbursement. There are no copays for contact lenses.
- You receive discounted prices on all your vision care needs, including those that are not covered by your plan, such as extra supplies and laser vision correction services.
- When you go to a non-network provider, you must pay for the services at the time you receive them and then file a claim with VSP. After any applicable copays, the plan will then reimburse you up to the scheduled amount. This amount will not be sufficient to pay for the entire cost of the eye examination or materials and you will not receive discounted prices.

Finding VSP Network Providers

VSP's network includes many providers; so your current provider may already be in the VSP network. To locate a VSP network provider, you can:

- Ask your provider if he/she participates in the VSP network
- Call VSP Member Services at 1-800-877-7195, Monday – Friday, 8:00 a.m. until 8:00 p.m.
- Visit their Web site at www.vsp.com for more information

Covered Expenses

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

- Complete vision analysis, including eye exam, refraction, visual therapy and case history
- Two sets of framed lenses or two sets of contact lenses (or one set of each) for a participant if required by a prescription. One set of framed lenses or contact lenses for a dependent if required by a prescription.

Expenses Not Covered

The plan does not cover:

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

Filing a Claim

Important Note!

If you see a non-VSP provider, you must file your claim(s), and the filing limit is six months from date of service.

No claim forms are required when you use a VSP participating provider. All claims are filed directly with VSP by the provider.

To submit a nonparticipating provider claim, you must contact VSP at 1-800-877-7195 to obtain a claim form. The reimbursement rate is significantly less than it would be if you used a VSP provider.

For more information about appealing claims and additional claims review procedures, see "Claims Review and Appeals Procedures" in the *Rules, Regulations and Administrative Information* section. For additional contact information for claims administrators, see the *Contact Information* section.

Continuing Coverage

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

Under COBRA, you and your covered dependents (or former dependents) have the right to continue medical, prescription drug, dental, orthodontic, vision and hearing aid coverage. Or you may elect to continue medical and prescription drug coverage only. You receive the same benefits as active employees for the option you choose. COBRA *does not extend* to Life Insurance.

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

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

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

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

Who Is Eligible for COBRA Coverage

You and your eligible dependents are eligible for COBRA.

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

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

How to Enroll for COBRA Coverage

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

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

If coverage is modified for active employees, COBRA coverage will also be modified. If you do not elect COBRA coverage within the 60 days described above, coverage will end and will not be reinstated.

You, your spouse and dependent children who lose coverage as a result of the COBRA qualifying event are qualified beneficiaries entitled to elect COBRA. A child born to, adopted by or placed for adoption with you during the period of COBRA coverage would also be a qualified beneficiary with a right to COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children.

In deciding to elect COBRA coverage, you should know that a failure to continue your group health coverage will affect your future rights under federal law as follows:

- You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of COBRA coverage may help you not have such a gap.
- You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not elect and maintain COBRA coverage for the maximum time available to you.
- You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you elect and maintain COBRA coverage for the maximum time available to you.

How Much COBRA Coverage Costs

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

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired individuals who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD I TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/.

How Long COBRA Coverage Lasts

COBRA coverage can continue up to 18, 29 or 36 months depending on the qualifying event. If more than one qualifying event applies, the maximum coverage period is 36 months total. The following chart shows when you and your dependents may continue health care coverage under COBRA and for how long.

	Maximum Period Coverage Can Continue		
COBRA Qualifying Event	**You**	**Spouse**	**Child**
You lose coverage because: • Your hours are reduced • Your employment ends for any reason (except gross misconduct)	18 months	18 months	18 months
You or your qualified dependent are disabled (as defined by Social Security) when you lose coverage	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your spouse divorce or become legally separated	N/A	36 months	36 months
You become entitled to Medicare*	N/A	36 months	36 months
Your child no longer qualifies as an eligible dependent	N/A	N/A	36 months

* If you become entitled to Medicare *before* your coverage ends, your spouse and any dependent children are entitled to elect COBRA coverage for up to the greater of 36 months from the date of Medicare entitlement, or 18 months from the date your coverage ends.

Additional Qualifying Events

The 18-month COBRA period may be extended to 36 months for your spouse and dependent children who are qualified beneficiaries if a second qualifying event (death, divorce, legal separation or a dependent child ceasing to be a dependent under the terms of the plan) occurs during the 18-month COBRA continuation period. However, this extension will only be allowed if the second event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. To be granted an extension, the qualified beneficiary must notify the Fund Office within 60 days of the second qualifying event.

Please note: Your Medicare entitlement (Part A, Part B or both) is considered a second qualifying event for your spouse and dependent children under the EIT plan.

Disability Extension

The 18-month COBRA continuation period may be extended by up to 11 months for a total of 29 months if a qualified beneficiary is determined by Social Security to be disabled at any time within 60 days of the start of the COBRA continuation period. This 11-month extension is available to all individuals who were qualified beneficiaries at the time of the initial termination or reduction in hours of employment. To be granted this extension, you must notify the Fund Office at 1-312-782-5442 within 60 days of the determination and within the 18-month COBRA continuation period. You must also provide a copy of the determination of disability notification from the Social Security Administration.

The disabled individual must also notify the Fund Office within 30 days of any final determination that such individual is no longer disabled.

When COBRA Coverage Ends

COBRA health care coverage will end before the maximum period described in the "Maximum Period Coverage Can Continue" chart in this "Continuing Coverage" section, if:

- Required premiums are not paid by the due date.
- You, your spouse or dependent becomes covered under another group health plan, including a Medicare plan, after you have made your COBRA election (this does not apply if the new plan has pre-existing condition limits affecting the covered person).
- You, your spouse or dependent become eligible for Medicare (this only affects the person with Medicare coverage).
- You, your spouse or dependent recover from disability during the 11-month extension period.
- EIT no longer provides health care coverage to any of its active employees.

COBRA coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

If your COBRA coverage terminates for any reason, it cannot be reinstated.

Notice and Election Procedures

To protect your family's rights, you should keep the appropriate parties informed of any changes in address, as follows:

- **Participant address:** If your address changes, you should notify the Fund Office.
- **Dependent address:** Also notify the Fund Office if your spouse or dependent(s) changes address (to an address other than your address).

If you have any questions or need to provide notice or make an election related to your COBRA rights, contact the Fund Office at 1-312-782-5442 Monday through Friday between 8:30 a.m. and 4:30 p.m. Central Time or write to:

EIT Benefit Funds
221 North La Salle Street, Suite 200
Chicago, Illinois 60601-1214

Glossary

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

Active Employee

A person who meets the definition of employee, who is actively at work or available for work for a contributing employer, and who is not a retiree.

Chiropractic and Naprapathic Care

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

Coinsurance

The percentage of covered expenses you must pay after you have met your annual deductible. For example, if you use an in-network provider, you pay 10% of the PPO negotiated rate for most medical procedures and the plan covers the remaining 90%.

Copay

A fee charged by the plan for certain health care services or care. For example, copays are charged at the time of a medical office visit or when you have prescriptions filled. This fee is usually a flat amount.

Cosmetic Surgery

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

Deductible

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

Durable Medical Equipment (DME)

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

Home Health Care (HHC)

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

Hospice Care

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

Industry Employment

The term "industry employment" means any period of employment in which a participant is engaged in any capacity, whether as an employee, sole proprietor, owner-operator, independent contractor, self-employed person or otherwise, within the trade and geographic jurisdiction of the Union.

In-Network (PPO Provider)

A health care service or supply furnished by a PPO network provider. In general, in-network services are covered at a higher benefit level than out-of-network services.

Investigational/Experimental

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

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

Lifetime Maximum

The total amount of benefits you can receive under the plan in your lifetime.

Medical Services Advisory (MSA)

Blue Cross/Blue Shield (BCBS) Medical Service Advisory is the organization responsible for precertifying or authorizing medical services received from a hospital or other inpatient facility (see "Medical Service Advisory" on page 34).

Medically Necessary (Medical Necessity)

Health care services and supplies that are:

- Determined by the claims administrator to be medically appropriate,
- Necessary to meet the basic health needs of the patient,
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the service or supply,
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations, or governmental agencies that are accepted by the claims administrator,
- Consistent with the diagnosis of the condition,

- Required for reasons other than the convenience of the patient or physician, and
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the sickness or condition for which their use is proposed, or
  - Safe with promising efficacy for treating a life-threatening sickness or condition in a clinically controlled research setting using a specific research protocol that meets standards equal to those defined by the National Institutes of Health.

Morbid Obesity

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

Occupational Therapy

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

Out-of-Area

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

Out-of-Network (Non-PPO Provider)

A medical care service or supply furnished by a provider that does not participate in the PPO network. In general, out-of-network services are covered at a lower benefit level than services from a PPO network provider.

Orthotic Devices

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

Out-of-Pocket Maximum

The most you pay out-of-pocket in a calendar year for eligible medical expenses. If your deductible plus coinsurance toward eligible expenses reaches the out-of-pocket maximum, the plan pays 100% for most additional covered expenses for the rest of the calendar year. (In-network office visit copays and amounts charged by out-of-network providers above negotiated rates or U&C charges do not count toward the out-of-pocket maximum.)

Participant

A person who is employed by an employer participating in the EIT benefits plan and for whom contributions are being received by EIT.

Participating Provider Option (PPO)

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

Physical Therapy

Physician-ordered treatment by a licensed physical therapist using physical means, hydrotherapy or biomechanical and neurophysiological principals.

Plan Administrator

The plan administrator controls and manages the operation and administration of the benefits and programs of a plan. The Trustees serve as the plan administrator for the Electrical Insurance Trustees (EIT) Health & Welfare Participatory Plan.

Preventive Care

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

Skilled Nursing Facility (SNF)

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

Speech Therapy

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

Timely Filing

The length of time in which a claim must be filed in order to receive benefits.

Usual and Customary (U&C) Charges

The charges considered appropriate in your geographic area for medically necessary services, treatments, supplies or drugs. You pay any charges over the U&C amount.

Welfare Fund

Refers to the assets held in trust for the EIT Health & Welfare Participatory Plan.

Life Insurance and Accidental Death Benefits

The plan provides you with Basic Life Insurance and Accidental Death coverage that gives you and your family protection against some of the financial hardships that can occur if you should die.

In addition to these benefits, your spouse may also be eligible for death benefits from Social Security.

More Information…

For definitions of terms that are often used in describing your benefits, be sure to review the "Glossary" at the end of this section and in the *Health Care* section of this SPD.

In This Section **See Page**

Participation

This section describes how you can participate in Life Insurance and Accidental Death benefits, including who is eligible, when Life Insurance and Accidental Death coverage begins, maintaining Life Insurance and Accidental Death coverage and when Life Insurance and Accidental Death coverage ends.

Participant Eligibility

If you are an active employee and you are eligible for health benefits, you are eligible for Life Insurance and Accidental Death benefits.

If you stop working in active employment or become ineligible for health benefits under the plan, your eligibility for Life Insurance and Accidental Death benefits will end. Once your eligibility for health benefits ends, you will not be eligible for Life Insurance and Accidental Death benefits until you resume coverage as an active employee under the plan.

See “Participant Eligibility” in the *Health Care* section for more information about health plan eligibility requirements.

When Coverage Begins

Benefit coverage begins on the first day of the month after you complete the eligibility requirements (see “Participant Eligibility” in the *Health Care* section).

When Coverage Ends

Coverage ends when you fail to meet eligibility requirements or if the plan is discontinued. The following table summarizes situations in which coverage would normally end and what happens to your coverage in each situation.

It is solely your responsibility to know when your coverage will end once your employment terminates. Notice of loss of coverage from the Fund Office is not an obligation of the Welfare Fund, its Trustees or the Fund Office.

Life Insurance and Accidental Death Coverage Ends…	However, Life Insurance and Accidental Death Coverage May Continue if…
If you fail to work at least 30 hours per week or contributions for coverage are not paid	No further coverage is available.
If the plan is discontinued	No further coverage is available.

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

Designating a Beneficiary

You may designate anyone you want as your beneficiary by completing and returning the beneficiary designation form available from the Fund Office. Your beneficiary designation applies to both Basic Life Insurance and the Accidental Death benefit. You may change your beneficiary designation at any time by filing a new beneficiary designation form with the Fund Office. Completed beneficiary designation forms must be received by the Fund Office during your lifetime.

If there is no designated beneficiary still surviving at the time of your death, your death benefit is divided equally among the then living members of the first surviving class listed below:

- Your spouse
- Your children
- Your parents
- Your estate

Other Benefits Payable on Death

Depending on your age and other circumstances, your spouse may also be eligible to receive death benefits from Social Security.

Filing a Claim

To collect the Life Insurance benefit, your designated beneficiary must advise the Fund Office of your death and obtain a claim form. The completed claim form must be filed with the Fund Office within 365 days of the date of your death. Your designated beneficiary must supply the Fund Office with information the Trustees require.

To receive Accidental Death benefits, your designated beneficiary needs to complete the following steps:

- Your designated beneficiary must complete and return the claim form within 365 days of the date of your death.
- He or she must also provide other information as requested by the Trustees.

Refer to “Claims Approval and Denial” in the *Rules, Regulations and Administrative Information* section for more claims information.

Life Insurance Benefits

If you die *from any cause* while an active employee and you are eligible for health benefits, the plan provides a Basic Life Insurance benefit.

The chart below summarizes the Life Insurance benefits offered under the plan. To fully understand how these benefits work, you should read the more detailed information that follows the chart.

Life Insurance Benefits	
When Coverage Begins	On the first day of the month after you become eligible for health benefits under this plan
When Benefits Are Payable	If you die while you are an active employee eligible for health benefits under this plan
What You Receive	Your designated beneficiary will receive $10,000.
How Long Benefits Last	Your designated beneficiary will receive a one-time lump-sum benefit payment.

Receiving Benefits

Your Basic Life Insurance benefit is paid to your designated beneficiary as a single lump-sum payment.

Conversion Privilege

If your Life Insurance coverage ends for any reason other than termination of the plan, you may purchase an individual life insurance policy from an insurance carrier designated by the Trustees, currently Fort Dearborn Life Insurance Company, without giving any evidence of insurability. Contact the Fund Office in advance for an application form and premium and coverage information.

To use this conversion privilege, a written application and payment of the first premium must be made to and received by Fort Dearborn Life Insurance Company within 31 days after termination of coverage. The individual policy issued will be of the form used by the insurance company for conversion of group life insurance at the time conversion is made. The effective date will be the date following the date coverage ends under the plan.

What's Not Covered

No exclusions apply under Basic Life Insurance coverage.

Accidental Death Benefits

If you die *because of an accident* while an active employee, the plan pays your designated beneficiary an Accidental Death benefit in addition to the Basic Life Insurance benefit.

The chart below summarizes the Accidental Death benefits offered under the plan. To fully understand how these benefits work, you should read the more detailed information that follows the chart.

Accidental Death Benefits	
When Coverage Begins	On the first day of the month after you become eligible for health benefits under this plan
When Benefits Are Payable	If, while you are eligible for this benefit, you die due to an accident
What You Receive	Your designated beneficiary will receive $5,000 in one lump-sum payment (in addition to your Basic Life Insurance benefit) if you die because of an accident.
How Long Benefits Last	Benefits are paid to your designated beneficiary in one lump-sum payment if you die as a result of an accident.
Other Benefits	Not applicable

Receiving Benefits

An Accidental Death benefit will be paid to your designated beneficiary if you die as a direct result of an accident and independent of all other causes within 90 days of the date of the accident. This Accidental Death benefit is in addition to any other life insurance (or death benefit) coverage you may have under a Local 134 benefit plan.

See “Designating a Beneficiary” on page 69 for details about beneficiaries for this benefit.

What’s Not Covered

Your Accidental Death benefit is not paid if death or dismemberment results from:

- Bacterial infections (except pyogenic infections that occur with or through an accidental cut or wound),
- Ptomaines,
- Bodily or mental infirmity or any other kind of disease,
- Suicide or attempted suicide,
- An act of war,
- Participation in a riot, or
- Commission of a felony.

Glossary

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

Active Employee

A person who meets the definition of employee, who is actively at work or available for work for a contributing employer, and who is not a retiree.

Rules, Regulations and Administrative Information

This section contains important administrative information about the benefit provided to you by the Electrical Insurance Trustees and described in this handbook. The information in this section applies to all of your benefits and includes details about your rights as provided under the Employee Retirement Income Security Act of 1974, as amended (ERISA). Although you may not need this information on a day-to-day basis, it is important for you to understand your rights and the procedures you need to follow should certain situations arise.

Your benefits are sponsored and administered by a joint labor-management Board of Trustees. The Fund Administrator assists the Board of Trustees in the administration of the Fund. The Fund Administrator and other personnel of the administration office are employees of the Fund Office.

In This Section **See Page**

Plan Documents

This Summary Plan Description (SPD or handbook) serves as the official plan document for the Electrical Insurance Trustees (EIT) Health & Welfare Participatory Plan, and supersedes and replaces any prior SPD and Summaries of Material Modification previously provided by EIT for the plans of benefits described in it. If you need more information, you may examine copies of the applicable collective bargaining agreement and other related documents at the Fund Office.

Your Rights Under ERISA

As a participant in the EIT Health & Welfare Participatory Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

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

ERISA provides that all plan participants shall be entitled to the following rights:

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

- Under COBRA, you may continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, you or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

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

Enforcement of Your Rights

- If your claim for a benefit is denied, in whole or in part, the plan administrator must give you a written explanation of the reason for the denial, and you can obtain copies of documents relating to the decision, without charge. You also have the right to have the plan administrator review and reconsider your claim, all within certain defined time schedules.
- Under ERISA, there are steps you can take to ensure the above rights. For instance, if you request materials from the plan administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.
- If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. You may also file suit in a federal court if you disagree with a decision, or the lack of a decision, concerning the qualified status of a medical child support order. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.
- The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), it may order you to pay these costs and fees.

Assistance with Your Questions

- If you have any questions about 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 contact 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

Your HIPAA Rights

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

The claims administrator promptly provides this certificate:

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

The certificate identifies:

- Who was covered under the plan,
- The period of coverage, and
- Any waiting periods.

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

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

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

Under HIPAA, if you have creditable coverage from another plan, you will receive a certificate of coverage that helps to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your new group health plan. You will be provided a certificate of creditable coverage, free of charge, from the Electrical Insurance Trustees Health & Welfare Participatory Plan or your health insurance insurer when:

- You lose coverage under the plan,
- You become entitled to elect COBRA continuation coverage, or
- Your COBRA continuation coverage ends.

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

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

EIT will assist you in obtaining a certificate of creditable coverage from your previous insurer if one is needed and you do not have one.

Claims Review and Appeals Procedures

In all circumstances relating to any claim or appeal for benefits under any plan, the plan administrator or claims administrator responsible for making a determination on the claim or appeal will have discretionary authority in making the determination, including but not limited to, interpreting and applying the terms and conditions of the plan, making any necessary factual determinations and determining eligibility under the plan. Benefits under the plan will be paid only when the Trustees, or persons delegated by them to make such decisions, decide in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the plan.

Health Care

The plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974, as amended (ERISA). The period of time the plan has to evaluate and respond to a claim begins on the date the claim is first filed with the applicable claims administrators.

Filing Claims

You may file claims for plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from BCBS. The notice will explain the reason for the denial and the review procedures.

An “authorized representative” means a person you authorize, in writing, to act on your behalf. The plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

If you have any questions regarding how to file or appeal a claim, contact the claims administrator. For more information on filing claims and claims administrator’s addresses, please see “Filing a Claim” in each applicable benefit plan section and the *Contact Information* section.

Appealing Denied Claims

If your claim is denied, in whole or in part, you may appeal the denial. You will receive a written notice explaining why and on which specific plan provisions the claim has been denied. The notice also will explain how to file an appeal. There are two levels to the appeals process, as described below: you must submit your first appeal to Blue Cross/Blue Shield (BCBS) within 180 days of the date of the initial BCBS non-favorable decision. If the BCBS appeal is not favorable, you may then request a second level of appeal with the Trustees within 180 days of the date of the BCBS non-favorable decision. You may choose to name an authorized representative to handle your appeal.

A first level appeal is decided by a BCBS review unit that did not conduct the initial review of your claim. The timelines for deciding appeals will differ based upon the type of claim you file.

A second level appeal is decided by the Board of Trustees after a full and fair review and is based upon the information submitted in the appeal and the terms of the plan. The timelines for deciding appeals will differ based upon the type of claim you file.

If your appeal is:

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

Note

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

The Trustees' decision on a second level appeal is final. If either you or your authorized representative still believes a claim for benefits has been improperly denied, you or your authorized representative may contact the plan administrator. You have the right to receive without charge, upon written request, reasonable access to any documents relied on in making this determination. Furthermore, if you believe the Trustees have erred in determining your rights under the Plan's provisions, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Besides having the right to appeal, you or your authorized representative can examine any documents, records and other information relevant to your denied claim. You can also submit, in writing, reasons why you think the claim should not be denied.

If your claim for benefits is denied, you can file suit in a state or federal court. However, you may not initiate any action at law or in equity to recover under the plan until you have exhausted the appeal rights described above and the plan benefits requested in that appeal have been denied in whole or in part.

Life Insurance/Accidental Death Benefits

Filing a Claim

If your claim is approved, you will receive all applicable benefits as soon as the Fund Office receives and approves all necessary documentation.

If your claim is denied, you will receive a written explanation from the Fund Office within 90 days from the time the application was received by the Trustees (or within 180 days if the Trustees notify you that additional time is needed for processing the application). This written notice includes:

- Specific reasons for the denial,
- References to the plan provisions on which the denial is based,

- Descriptions of any additional information you may have to provide and why it's needed,
- Explanations of the plan's claim review procedure including the steps to take if you or your beneficiary wish to appeal the decision, and
- A statement of your right to bring a civil action lawsuit under ERISA section 502(a) following a denial of your claim or review.

Appealing a Claim

You or an authorized representative may appeal any claim denial by filing a written request for a full and fair review by the Trustees. A request for a review must be filed within 180 days after you receive written notice of the denial. You may also review documents pertinent to the administration of the plan and submit written comments and issues outlining the basis of the appeal. You may have legal representation throughout the review procedure.

The review on appeal will take into account any information you submit, even if it was not submitted or considered as part of the initial determination. Upon request and free of charge, you will also be provided reasonable access to and copies of all documents, records, and information relevant to your claim.

The person filing the appeal may request a written answer, including specific reasons and references to pertinent plan provisions, within 60 days after the appeal is made (or within 120 days if special circumstances require additional time and the Trustees notify you that additional time is needed before the end of 60 days).

The Trustees will provide you written notification of the decision on an appeal, usually within 45 days of when it is received (within 90 days in special cases).

If your appeal is denied, the notification will:

- Include specific reasons for the denial,
- Refer to the specific plan provisions on which the determination is based,
- State that you are entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim,
- Describe any voluntary appeal procedures offered by the plan and state your right to bring civil action under federal law,
- Disclose any internal rule, guideline, protocol, or similar criterion relied on in making the adverse determination (or state that information will be provided free of charge upon request), and
- If the denial on appeal is based on a medical necessity, experimental treatment or similar exclusion, explain the scientific or clinical judgment for the adverse determination (or state that an explanation will be provided free of charge upon request).

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

Besides having the right to appeal, you or your authorized representative can examine any plan documents related to your claim. You can also submit, in writing, reasons why you think the claim should not be denied. If your claim for benefits is denied or ignored, you can file a suit in state or federal court, once you have exhausted all appeals and administrative remedies available under the plan.

Non-Assignment of Benefits

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

Change or Termination of the Plan

Although the Electrical Insurance Trustees intend to continue the plan indefinitely, the Trustees have the authority and unconditionally reserve the right, in their sole and unrestricted discretion, to change, amend or end the plan at any time, or from time to time, for any reason.

Changes may be made retroactively, if necessary, to qualify or maintain the benefits under the Internal Revenue Code or the Employee Retirement Income Security Act of 1974, as amended (ERISA). If the plan is amended or ends, you may not receive benefits as described in this handbook. However, you may be entitled to receive different benefits, or benefits under different conditions or no additional benefits.

Other Plan Details

This section contains other important information about the administration and funding of the benefit plans described in this handbook.

Plan Name

The official name of the plan is the Electrical Insurance Trustees Health & Welfare Participatory Plan. This SPD describes the health care benefits (medical, prescription drug, dental, orthodontic, vision and hearing aid) and the welfare benefits (sickness, life, and accidental death and dismemberment insurance) provided under the plan.

Plan Administrator and Sponsor

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

Electrical Insurance Trustees
221 North LaSalle Street, Suite 200
Chicago, IL 60601-1214
1-312-782-5442

Employer Identification Number

The employer identification number is 36-1033970.

Plan Number

The plan number is 501.

Agent for Legal Process

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

Sean P. Madix
Fund Administrator
221 North LaSalle Street, Suite 200
Chicago, Illinois 60601-1214

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

Trustees

The Trustees who authorize the plan benefits have authority to:

- Resolve questions concerning the plan,
- Make rules to implement the plan,
- Construe the plan terms, and
- Determine when plan benefits will be paid.

As of January 1, 2008, the Trustees are as follows:

Employer Trustees

William T. Divane, Jr.
Divane Bros. Electric Company
2424 North 25th Avenue
Franklin Park, Illinois 60131-3323
1-847-455-7143

Kevin M. O’Shea
Shamrock Electric Company Inc.
1281 East Brummel Avenue
Elk Grove Village, Illinois 60007
1-847-593-6070

I. Steven Diamond
Malko Electric
6200 Lincoln Avenue
Moton Grove, Illinois 60053-2851
1-847-291-9500

Kenneth Bauwens
Jamerson & Bauwens Electrical Contractors, Inc.
3055 MacArthur Blvd
Northbrook, Illinois 60002
1-847-291-2008

Michael R. Walsdorf
Advent Systems, Inc.
435 West Fullerton Avenue
Elmhurst, Illinois 60126-1404
1-630-279-7171

Union Trustees

Timothy Foley

Michael J. Caddigan

Lawrence J. Crawley

Samuel Evans

James T. North

600 West Washington Boulevard
Chicago, Illinois 60661-2490
1-312-454-1340

Discretion of Trustees and Fund Administrator

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

- Any claim for benefits,
- The construction of the language or meaning of the rules and regulations adopted by the Trustees,
- This SPD and any amendments thereto, and
- Any writing concerned with or provided in connection with the operation of the plan.

Benefits under the plan will be paid only when the Trustees, or persons delegated by them to make such decisions, decide in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the plan. The good faith decision of the Trustees or the Fund Administrator is binding upon anyone dealing with the plan or claiming any benefit under the plan.

Plan Funding

Coverage for you and your dependents under the plan is paid for by contributions from the participating employers. The amount of the contribution is established annually by an actuary. Your employer will let you know if you have to pay a portion. Assets are held in trust by the Trustees and disbursed by them.

Plan Year

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

For More Information

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

Attention: Fund Administrator
221 North LaSalle Street, Suite 200
Chicago, Illinois 60601-1214

You may also call 1-312-782-5442 for more information.

Contact Information

This section shows you where to go for questions about your benefits. For claims filing information and addresses, see "Filing a Claim" in the applicable benefit plan sections.

Claims Administrators

For…	Contact…	At…
Medical, Hearing Aid and Vision		
Medical benefit PPO network provider information, benefit information (including information about hearing aid benefits), forms and claim information	Blue Cross/Blue Shield of Illinois (BCBS)	1-800-862-3386 www.bcbsil.com
The Medical Services Advisory (MSA) Program (the plan's utilization review organization)	Blue Cross/Blue Shield of Illinois (BCBS)	1-800-635-1928* www.bcbsil.com
Vision services	Vision Service Plan (VSP)	1-800-877-7195 www.vsp.com
Behavioral Health and Substance Abuse		
Information on mental health and substance abuse benefits	CIGNA Behavioral Health	1-888-218-7210 www.cignabehavioral.com
The Members Assistance Program (MAP) counseling and education information	MAP (CIGNA Behavioral Health)	1-888-218-7210
Prescription Drug Information		
Prescription drug information, order forms and preaddressed envelopes for mail service	CVS/Caremark	1-800-566-5693 www.caremark.com P.O. Box 94467 Palatine, Illinois 60094
Dental and Orthodontia		
Dental and orthodontia benefit information, forms and claim information	Blue Cross/Blue Shield of Illinois (BCBS)	1-800-862-3386 www.bcbsil.com BlueCare® Freedom Dental PPO P.O. Box 23059 Belleville, Illinois 62223

For…	Contact…	At…
Life Insurance and Accidental Death Benefits		
Life insurance and accidental death benefit information, forms and claim information	EIT Fund Office	1-312-782-5442

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

Fund Office

Electrical Insurance Trustees (EIT)
221 North La Salle Street, Suite 200
Chicago, Illinois 60601-1214
1-312-782-5442