

January 1, 2017 Summary Plan Description Booklet Wisconsin Electrical Employees Health and Welfare Plan

For More Information
Or Further Assistance Please Call the Plan Office At

1 (608) 276-9111 OR 1 (800) 422-2128

Or Write:

Wisconsin Electrical Employees Health and Welfare Plan

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Business Hours: Monday through Friday 7:00 a.m. — 5:00 p.m.

The Board of Trustees is pleased to provide this summary of the benefits provided by the Wisconsin Electrical Employees Health and Welfare Plan ("Plan" or "Health and Welfare Plan Rules and Regulations") as of January 1, 2017 in a booklet that is easy to read and understand—one that provides you with the necessary information when you need it.

As there have been several changes and clarifications to the Plan since the last booklet was printed, you and your dependents should read this booklet carefully so you understand the eligibility and benefits of the Plan.

YOU MUST SUBMIT PROOF OF ALL CLAIMS WITHIN ONE YEAR (LOSS OF TIME CLAIMS SIX MONTHS) OF THE DATE THE EXPENSES ARE INCURRED. FAILURE TO SUBMIT CLAIMS WITHIN THE ONE YEAR PERIOD WILL RESULT IN A DENIAL. NO BENEFITS WILL BE PAID ON CLAIMS RECEIVED (PLAN OFFICE DATE STAMPED) MORE THAN ONE YEAR AFTER THE DATE EXPENSES ARE INCURRED.

Remember, you, your spouse or your Dependents, or the provider, should contact the Fund Office to verify eligibility and benefits. Providers may contact the Fund Office to verify eligibility only. This booklet is not a guarantee of benefits, but is an overview of your benefit package. Benefits are subject to review and approval upon receipt of the claim.

Fill out the enrollment card that is enclosed in the middle of the booklet and return it to the Fund Office as soon as possible so we may update our records. Our service to you depends on the information only you can provide to us. Thank you for your cooperation.

Additional Information

The Board of Trustees establishes the Health and Welfare Plan Rules and Regulations. By majority vote, the Board of Trustees can amend, modify or delete the terms, conditions or benefits of the Plan or discontinue all or part of the Plan, whenever, in their sole discretion conditions so warrant. The Board of Trustees makes final decisions regarding any questions or application of the Health and Welfare Plan Rules and Regulations.

The Health and Welfare Plan Rules and Regulations, as amended or restated from time to time, shall be the controlling document. This booklet is intended only as a summary of the Health and Welfare Plan Rules and Regulations and is not meant to interpret, extend or change the provisions expressed in the Health and Welfare Plan Rules and Regulations in any way. If any of the terms of this booklet and the Health and Welfare Plan Rules and Regulations are in conflict or discrepancy between the wording here and the actual provisions of the Health and Welfare Plan Rules and Regulations, the terms of the Health and Welfare Plan Rules and Regulations shall be followed.

The Board of Trustees will be the sole judge of the interpretation of the Plan, this booklet, or any other provisions relating to the operation of the Plan. Decisions of the Trustees shall be final and binding on all persons dealing with the Plan, except to the extent that such decision may be ruled to be arbitrary or capricious. No agent, representative, officer or other individual from a Union or Employer has the authority to speak for the Trustees or to act contrary to the written terms of the Health and Welfare Plan Rules and Regulations.



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ELECTRICAL
EMPLOYEES
HEALTH
AND
WELFARE
PLAN**



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Introduction

The benefits described in this booklet are available to you through your participation in the Wisconsin Electrical Employees Health and Welfare Plan. These benefits are designed to provide you and your Dependents with protection and peace of mind when you need it most.

Together these benefits help:

1. Hospital, Physician and other medical or optional benefit bills.
2. Replace your paycheck when illness or injury prevents you from working.
3. Protect your family if you should die.

Please read the remainder of this booklet carefully, so that you and your family fully understand what is covered and how to receive benefits. Terms which are capitalized in this booklet generally refer to defined terms in the Health and Welfare Plan Rules and Regulations.

Eligibility for Benefits

In order to be eligible for coverage you must be an Active Employee, which is a person who is actively employed by an Employer that makes contributions to the Plan on the employee's behalf. You may also be eligible under Self-Payment or Continuation of Coverage (COBRA) provisions of the Plan. An owner of an unincorporated entity, including a sole proprietor or a partner in a partnership, cannot be an Active Employee under the Fund.

Benefits

Active Employees, including Self-Pay Active Employees, are covered for medical, short-term disability, long-term disability, death and accidental death and dismemberment benefits. Optional Dental and Vision benefits are elected by your Union or your Employer.

Self-Pay Disabled Employees are covered for medical, death and accidental death and dismemberment benefits. If your Union or your Employer were covered for Optional Dental and/or Vision benefits while you were an Active Employee, you may continue to be covered for those benefits.

COBRA Participants may elect coverage for medical benefits only or medical benefits and all Optional Benefits (dental and/or vision) they were covered under on the date of the Qualifying Event. Disability, death and accidental death and dismemberment benefits are not available to COBRA Participants.

Retired Employees are covered for medical and death benefits as described beginning on page 40.

Eligibility

Active Hourly Employee Initial Eligibility

If you are a new hourly employee, you will become eligible on the first day of the calendar month following receipt by the Fund Office of Employer or reciprocity contributions for 300 work hours within a 12-consecutive month period.

Example: You begin working April 1st. Your Employer makes contributions to the Plan for 300 hours for the work months of April and May, which are received by the Fund Office in May and June. Your coverage under this Plan will begin on July 1st.

INTRODUCTION

ELIGIBILITY FOR
BENEFITS

BENEFITS

ELIGIBILITY

ACTIVE HOURLY
EMPLOYEE
INITIAL
ELIGIBILITY



As an alternative, an Active Hourly Employee may elect to purchase initial eligibility when he first becomes employed in a position for which an Employer is required to contribute to the Plan. An Employee electing this alternative must satisfy all the following requirements:

1. The Employee's home local union is one of the participating local unions in the Fund.
2. The Employee pays two months of premiums no later than the fifteenth day of the month prior to the month for which coverage is intended.
3. The Employee enrolls in the Plan within 30 days of beginning work in a position with an Employer for which an Employer is required to contribute to the Plan, but no later than the 15th day of the month prior to the month for which coverage is intended.

An Employee who does not satisfy these requirements is only eligible to elect participation under the standard Initial Eligibility rules. An Employee has only one opportunity to establish eligibility under this Special Eligibility rule.

Example: Your Employer is required to begin making contributions on your behalf to the Plan effective November 1. You wish to purchase initial eligibility on November 1. The Fund Office must receive your enrollment card and your initial payment equal to two months of premiums no later than October 15. An Employee satisfying these requirements will be eligible for coverage for November and December.

Continued Eligibility

The contributions received from Employers that you work for (either locally or on reciprocity) are applied to the second month of Health and Welfare Plan coverage following the month the contribution is received by the Fund Office. Example: You work in December, the contributions (hours) are received by the Fund Office in January and are applied to provide Health and Welfare Plan coverage for March.

Active Hourly Employee Reinstatement of Eligibility

An Active Hourly Employee's dollar bank will not be forfeited as long as the employee is available for work and is on the books located at your local Union office. An Active Hourly Employee who has his dollar bank credits cancelled due to termination of coverage and returns to Covered Employment within 12 months of termination will have any cancelled dollar bank credits reinstated effective the first day of the calendar month following the month in which the Fund Office receives contributions from a participating Employer or through reciprocity for at least 150 hours in a 12-consecutive month period. An Active Hourly Employee who was terminated and becomes reinstated will have his Flexible Benefit Account reinstated on the same date that dollar bank credits are reinstated.

Active Hourly Employee Continued Eligibility

After becoming eligible, you will continue to be eligible as long as your dollar bank contains enough money to pay for 1 month's coverage, unless you are terminated for a reason which causes you to lose your dollar bank.

Whenever you are credited with more contributions than those needed to provide 1 month's coverage, excess money is added to your dollar bank accumulation. If contributions received during a given month are for less than the prevailing rate (determined by the Board of Trustees) needed for 1 month's coverage, excess credit in your dollar bank will be used to give you coverage.

If you die with a balance in your dollar bank account, the balance will be used by your surviving Dependent spouse and children to continue coverage. If your surviving spouse remarries, your Dependent child marries or is no longer eligible as a Dependent, or they become covered under another group health plan, coverage will stop. They will then be eligible to continue coverage under COBRA. If you have no spouse or Dependent child at the time of your death, any remaining funds in your dollar bank will be forfeited.

Reciprocity

The Fund is a participating trust fund in the Electrical Industry Health and Welfare Fund Reciprocal Agreement. If you are an Active Hourly Employee who leaves employment, covered by the Plan for



employment, covered by another fund in the Reciprocal Agreement (“reciprocal plan”), you may elect to continue Plan coverage. To do so, you must register in the Electronic Reciprocal Transfer System (ERTS) and inform the hiring hall of the local union where you are being referred for employment that you are registered in the ERTS system. You will then receive credit in your dollar bank for the contribution amount the Plan receives from the reciprocal plan. Your benefits are limited to those set forth in the applicable reciprocity agreement.

Active Hourly Employee of Newly Organized Employers

When an Employer becomes newly organized by one of the Unions participating in the Plan, the Active Hourly Employees of the newly organized Employer must elect how to be considered for eligibility to participate in the Plan. The employees may elect to be considered under the normal Initial Eligibility rules described on page 1 or under the rules outlined below. This election must be made at the time participation is negotiated and whichever option is elected applies to all employees in the group. If the employee was covered by his employer’s group health plan on the date his employer becomes organized, the employee will be credited with premiums for the two months prior to his Employer’s participation in the Plan. The employee must repay the Fund the two months of premiums in full within 12 months of the start of coverage.

Active Employer Staff Employee

A special rule applies to an Active Employer Staff Employee who is covered by his/her spouse’s employer sponsored group health insurance plan. An Active Employer Staff Employee may waive coverage with the Plan by completing and sending a Waiver Form to the Fund Office within 30 days of becoming eligible. If an Active Employer Staff Employee waives coverage, he or she can elect to enroll in the Plan at a later date if any of the following requirements described below are satisfied. In such cases, the effective date of coverage will be the first day of the first calendar month following receipt of the written request and enrollment form.

1. The Active Employer Staff Employees loses other coverage, provided he submits a written request to the Fund Office and completes an enrollment form prepared by the Fund Office within 30 days of the date the other coverage terminates.
2. The Active Employer Staff Employee or his Dependent loses coverage under Medicaid or the State Children’s Health Insurance Program (“SCHIP”), provided he submits a written request to the Fund Office and completes an enrollment form prepared by the Fund Office within 60 days of the date the coverage terminates.
3. The Active Employer Staff Employee or his Dependent becomes eligible for assistance through Medicaid or SCHIP for coverage under this Plan, provided he submits a written request to the Fund Office and completes an enrollment form prepared by the Fund Office within 60 days of becoming eligible for such assistance.

Subject to rules adopted by the Trustees, the office staff of any Employer is eligible to participate in this Plan. Active Employer Staff Employees employed by the Employer will become eligible on the first day of the calendar month following date of hire and payment of 2 months’ contributions by the Employer before the month for which coverage is intended.

If you or your Employer terminate participation for any reason, you are not eligible for reinstatement for 1 year.

The Employer shall have no obligation to contribute to the Plan on behalf of the following classifications(s) of Non-Bargaining Employees (NBU).

1. All NBU employees who customarily work fewer than 25 hours per week in any calendar month.
2. All seasonal NBU employees. A seasonal employee is an employee who works 7 or fewer months per calendar year for the Employer and who is expected to work 1,000 or fewer hours in the calendar year.

The Employer recognizes and agrees that a NBU employee who customarily begins working 25 or more hours per week per month or a seasonal NBU employee who works greater than 7 months and is expected to work at least 1,000 hours will no longer be in the excluded class and the Employer shall make a contribution on such employee’s behalf for coverage under the Plan. The Employer agrees that it will

**ACTIVE HOURLY
EMPLOYEE OF
NEWLY
ORGANIZED
EMPLOYEES**

**ACTIVE
EMPLOYER
STAFF
EMPLOYEE**



maintain records of hours worked on behalf of the above Employees for purposes of confirming the Employee's qualification under the applicable class as described above.

Opt Out for Spouses Covered Under High-Deductible Plans

If a Dependent spouse is covered under their employer's high-deductible health plan in conjunction with a Health Savings Account ("HSA"), they will have the option of opting out of coverage under the Plan, provided the spouse supplies proof of their employer-sponsored HSA coverage to the Plan Office and signs a form stating that they understand that they are opting out of coverage under this Plan. The spouse's coverage under this Plan will terminate at the end of the last day of the month during which a completed and signed election form is received by the Plan Office. The election will automatically renew each year until the spouse reinstates coverage. No Flexible Benefit Account reimbursements can be made on the Dependent spouse's behalf.

A spouse who has opted out of this Plan's coverage may later reinstate their spousal coverage by submitting proof that their coverage under her employer-sponsored HSA has terminated and continues to qualify as a Dependent under the Plan. Once the spouse has filed for reinstatement, their spousal coverage under this Plan will be effective on the first day of the month following the date proof of coverage and proof of termination are provided to the Plan Office. The spouse's coverage under this Plan will not be reinstated unless and until their employer-sponsored HSA coverage has terminated.

Termination of Active Employee Coverage

Active Employee coverage will terminate:

1. The last day of the month that an Active Hourly Employee's dollar bank account no longer contains enough credits to provide 1 month's coverage;
2. The last day of the month following the month that an Active Employer Staff Employee's employment terminates;
3. The end of the last period for which any required contributions have been made for an Active Employer Staff Employee;
4. The date the Plan is discontinued;
5. 31 days after you enter the Military Service of the United States on full-time, active duty;
6. If you participate in, assist, or conceal any scheme, artifice, plan or conduct by an Employer intended to defraud the Plan by paying contributions less than those due, your eligibility and benefits will terminate on the last day of the month that your participation, assistance or concealment begins or is discovered, whichever is earlier. All amounts credited to your account for eligibility will be forfeited to the Plan when your eligibility terminates. If you have knowledge of such conduct, scheme or plan, or knowledge that an Employer is not paying all contributions due and do not report all known information to the Board of Trustees, you will lose eligibility under this provision. Contributions made after you lose eligibility will not be credited to your account, until you demonstrate, to the satisfaction of the Board of Trustees, that you are no longer participating in or assisting in any actions by an Employer to defraud the Plan and you have reported all information and knowledge of such to the Board of Trustees. Generally, this is not an event for which COBRA continuation coverage is available.
7. If you are an Active Hourly Employee and you start work in covered employment for an Employer not making contributions to this Plan and not subject to a written agreement to make contributions to this Plan, your eligibility and benefits will terminate on the last day of the month that such employment began or is discovered, whichever is earlier. Your Flexible Benefit Account will also be forfeited at that time.
8. If you are an Active Hourly Employee and you continue work, of any kind, for a former contributing Employer that you worked for prior to the Employer dropping out of the Plan, and the Employer is no longer obligated to contribute to the Plan under the terms of a written agreement or under the National Labor Relations Act during a period of bargaining, you will have your eligibility and benefits terminated on the last day of the month in which the Employer's obligation to make contributions ends. The Board of Trustees shall, under the appeal process, have discretion to make all findings of fact and conclusions

**OPT OUT FOR
SPOUSES
COVERED
UNDER HIGH-
DEDUCTIBLE
PLANS**

**TERMINATION
OF ACTIVE
EMPLOYEE
COVERAGE**



if you lose coverage under this section. If you lose eligibility under this section, you cannot self-pay as an Active Self-Pay Employee, Disabled Employee or Retiree. Also, the Employer's complete withdrawal is not an event for which COBRA continuation coverage is available. Your Flexible Benefit Account will also be forfeited at that time.

9. Death;

10. The date of a withdrawal as described on page 6. Your Flexible Benefit Account will also be forfeited at that time.

Active Hourly Employee Self-Pay

If credit in your dollar bank is no longer sufficient to provide coverage, you may elect to continue coverage by making self-payments for coverages in effect at the time of termination of eligibility in place of COBRA for 36 consecutive months maximum as long as you remain available for work through the Local Union's referral system and waive electing coverage under COBRA. A COBRA coverage waiver will also be requested from a spouse and any adult dependent child. Or, you may elect to continue coverage under COBRA. You will receive notice from the Fund Office of the contribution amounts due.

Disabled Self-Pay

If you are an Active Employee and you become Totally and Permanently Disabled, you can continue coverage by self payment after using up credits in your dollar bank account. You may elect medical, death and accidental death and dismemberment benefits, or medical, death, accidental death and dismemberment and all Optional Benefits that you were covered for on the date you became Totally and Permanently Disabled. Self-Pay Disabled employees will not be entitled to Loss of Time benefits. When you are age 55 or over and become covered under Medicare or when your spouse turns age 65, you will automatically be transferred to a Retiree class.

Generally, Totally and Permanently Disabled means the complete inability due solely to Bodily Injury or illness to perform every duty of your regular and customary work, as determined by entitlement to a Social Security Disability Award or by the Board of Trustees in accordance with standards consistently applied. After 2 years, you will be considered Totally and Permanently Disabled if you are unable to perform any occupation or employment you are qualified for by education, training or experience determined by the Board of Trustees. The Board of Trustees may require evidence of continued entitlement to such Social Security Disability Award or evidence of continued disability at your expense.

Surviving Dependents Self-Pay

Your surviving Dependents can elect to continue coverage after your death and credits in your dollar bank account have been used. Your surviving Dependents may elect medical benefits only or medical and **all** Optional Benefits that you were covered for on the date of your death, except death, accidental death and dismemberment and weekly disability benefits. If your Dependent spouse re-marries or becomes covered under another health plan or if your Dependent children are no longer considered eligible Dependents by the Plan, their coverage will terminate and they can continue coverage under COBRA for 36 months.

Self-Payment Contribution Due Date

Self-payment contributions are due the 15th day of the month prior to the month for which coverage is intended (i.e., January self-payment is due December 15th), with a 5 day grace period. If self-payments are not received on time, coverage will be terminated as of the last day of the month for which contributions were timely made. Any self-pay Participant whose contribution is returned due to non-sufficient funds will be charged a \$25 penalty and must make the next six months payments by guaranteed funds.

Termination of Self-Pay Coverage

The coverage of any Eligible Individual continuing Plan coverage under Active Employee Self-Pay, Disabled Employee Self-Pay, or Surviving Dependents Self-Pay will terminate on the earliest of the following dates:

1. The last day of the month for which the required timely self-payment has been made;

ACTIVE HOURLY
EMPLOYEE
SELF-PAY

DISABLED
SELF-PAY

SURVIVING
DEPENDENTS
SELF-PAY

SELF-PAYMENT
CONTRIBUTION
DUE DATE

TERMINATION
OF SELF-PAY
COVERAGE



2. Death;
3. The date the Plan is discontinued;
4. The date of a withdrawal as described on page 6.

In addition, in the case of Surviving Dependents Self-Pay, surviving Dependents will lose coverage as of the date a Dependent child's coverage would otherwise end, or the date the Dependent spouse remarries or becomes covered under any other group health plan.

In addition, in the case of Active Employee Self-Pay, coverage will end also on the last day of the month for which the self-pay period has been exhausted, the last day of the month the Employee becomes covered as an employee under any other group health plan, or the date coverage would otherwise terminate.

In addition, in the case of a Disabled Self-Pay Employee, coverage will also terminate on the last day of the month the Disabled Self-Pay Employee is no longer Totally and Permanently Disabled, the last day of the month in which he becomes covered under another group health plan as an employee, or the date the Self-Pay Employee is entitled to Medicare or when your Dependent spouse becomes age 65. In the event of termination of coverage due to entitlement to Medicare, the Employee can make a one-time election to continue coverage under the Plan for the Employee and Dependents as a self-payment for retirees.

Withdrawal

A withdrawal occurs when an Employer's Collective Bargaining Agreement ceases to require contributions to the Plan for Active Employees or the Employer otherwise ceases to be required to make contributions to the Plan. A withdrawal also can occur when a local union negotiates health benefit coverage for a substantial number of its members from a source other than the Plan.

When a withdrawal occurs, all current and former Active Employees of that Employer and their Dependents are withdrawn from the Plan. Additionally, persons who are on a continuation of coverage, including retirees and self-payments, through service with a withdrawn Employer shall have that continuation coverage terminate.

An Active Hourly Employee who continues to be employed by an Employer that was a contributing Employer to the Fund but has since dropped out of the Fund will not be permitted to self-pay after the date his eligibility is terminated. He may be eligible for reinstatement by following the initial eligibility requirements for Active Hourly Employees or the special eligibility requirements for Newly Organized Employees. An Employer withdrawal from the Fund is not an event for which COBRA continuation coverage is available.

The withdrawal will occur on the last day of the second month, after the month in which the last contribution was required and paid by the Employer.

A withdrawal results in termination of eligibility for Plan benefits and will cancel all dollar bank accruals and Flexible Benefit Account accruals.

Prohibition of Rescissions

The Plan will not rescind the coverage of benefits provided under the medical and prescription drug components of the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan, and in other instances that may be prescribed under guidance from the Internal Revenue Service.

For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage that has a retroactive effect. However, the following examples of a retroactive cancellation or discontinuance of coverage are not considered rescissions:

1. A cancellation or discontinuance of coverage retroactive to the date an individual terminated employment if the cancellation or discontinuance is attributable to a delay in administrative



recordkeeping and if the individual did not pay any premiums for the coverage after the date of termination.

2. A cancellation or discontinuance of coverage that is effective retroactively if the cancellation or discontinuance is attributable to an individual's failure to pay required premiums or contributions toward the cost of coverage.
3. A cancellation or discontinuance of coverage retroactive to the date of divorce if the employee or former spouse failed to timely pay the required COBRA premiums for the former spouse's coverage.

The Plan will provide each Participant who will be affected by a rescission at least 30 days advanced written notice before Plan coverage can be rescinded. A rescission is considered a type of adverse benefit determination, as defined under Department of Labor regulations.

Dollar Bank Transfers

Subject to the following rules, an Active Hourly Employee may voluntarily transfer a portion of his or her dollar bank credits to the dollar bank account of another Active Hourly Employee or self-payment of a Self-Pay Active Employee who becomes Totally and Permanently Disabled or to an Active Employer Staff Employee.

1. **Employees Transferring Dollar Banks.** An Active Hourly Employee may transfer dollar bank credits one month at a time to another Active Hourly Employee or Active Employer Staff Employee, up to a lifetime maximum of three months to the same employee. Dollar bank transfers must be for a full month's payment.

In order to make a dollar bank transfer, the transferring Active Hourly Employee must have at least six months eligibility left in his or her dollar bank after making a dollar bank transfer.

The transferring Active Hourly Employee must also complete and sign all necessary forms waiving all rights and claims arising out of the transfer of credits from the dollar bank and confirming that he or she has not received, and will not receive, a payment or other consideration of any kind in exchange for the dollar bank transfer.

2. **Employees Receiving Transfers.** At the time of the transfer, the employee receiving a dollar bank transfer must have lost eligibility under the Fund as an Active Hourly Employee, Disabled Self-Pay Active Hourly Employee or an Active Staff Employee as a result of a catastrophic illness, and for an Active Hourly Employee, must have insufficient dollar bank credits to continue eligibility without making a self-payment. However, an employee who has lost coverage under paragraphs 6, 7 or 8 of the Termination of Active Employee Coverage rule on page 4 cannot receive a dollar bank transfer. For purposes of this provision, catastrophic illness means an injury or illness that the Trustees or their delegates determine, in their discretion, incapacitates this employee and creates a financial hardship, or an injury or illness that incapacitates a Dependent of this employee if it results in this employee being required to terminate employment or reduce his or her hours of employment for an extended period of time to care for the Dependent. The employee must submit medical proof or other documentation to evidence the catastrophic illness. The employee receiving dollar bank credits may receive a transfer of no more than one month's premium per month from all sources.

Dependents' Eligibility

The Plan defines an Eligible Employee's eligible Dependents as follows:

1. The Participant's spouse, pursuant to a marriage that was lawfully licensed and performed between two individuals, unless the Participant and spouse are legally separated under the terms of a legal separation agreement which does not require the Participant to provide health coverage to the spouse;
2. Your natural born child, legally adopted child and child placed for adoption from birth until the end of the calendar month in which the child attains age 26;

DOLLAR BANK
TRANSFERS

DEPENDENTS
ELIGIBILITY



3. Your unmarried step-child, foster child or child whose custody is court-ordered from birth until the end of the calendar year in which such individual turns 19 or until the end of the calendar month in which the individual attains age 26 if attending a post-secondary school as a full-time student, provided either:
 - (a) The child (1) is younger than you, (2) maintains a parent-child relationship with you, (3) does not provide more than half his or her financial support during the calendar year and (4) has the same residence as you for more than half the calendar year (except for temporary absences, such as attending school); or
 - (b) You provide over one half of the child's support for the calendar year and the child is not your "qualifying child" (as defined under Internal Revenue Code section 152) or the "qualifying child" of another taxpayer.

A "full-time student" means a person who is attending a post-secondary accredited college, university, graduate or vocational school on a full-time basis, as defined by such institution. Full-time student status must be submitted into the Plan annually.

4. Your unmarried child who is incapable of self-sustaining employment because of mental retardation or physical handicap (Totally and Permanently Disabled as defined and approved by SSA evidence) who becomes so incapable prior to the date coverage would otherwise terminate will continue to be covered beyond the limiting ages, provided the child is dependent upon you for over half the child's annual support and maintenance and has the same principal residence as you or is not considered a "qualifying child" or the employee of another taxpayer. Notification and satisfactory proof of the incapacity must be sent to the Fund Office within 31 days of the date the child's coverage would otherwise terminate and thereafter upon request.

Except for certain exceptions for an adopted child, the child must be a U.S. citizen or a resident of the U.S., Canada or Mexico. There are somewhat complicated rules defining a dependent child who does not live with the Participant, including children of divorced Employees. Contact the Fund Office for more information.

If your child is also an Eligible Employee covered under this Plan or the plan of another employer, such child will not be considered your eligible Dependent. However, this rule does not apply to a natural or adopted child or a child placed for adoption. A Dependent who qualifies as an Active Employee will be considered a new Participant for purposes of the Plan's calendar year and specific benefit maximums, deductible and out-of-pocket expenses.

All Eligible Employees must complete an enrollment card listing all Dependents to be covered by the Plan. As Dependents are added, a new enrollment card must be completed. No claims are considered for payment on a Dependent until an enrollment card is on file. In addition to losing coverage when an Eligible Employee's coverage ends, a Dependent will also lose coverage on the earliest of the date the Dependent no longer meets the above definition, the date a Dependent step-child, foster child or child whose custody is court-ordered marries or the date the Dependent enters full-time active duty with U.S. armed forces. A Dependent spouse will also lose coverage on the date he or she enters full-time active duty with the U.S. armed forces.

A Participant is responsible for confirming that individuals are properly enrolled as Dependent children. Proof of dependency status may be required from time to time by the Board of Trustees.

Effective on and after January 1, 2010, if a Dependent, described in paragraph 3 above, who is covered under the Plan and who has full-time student status before the first day of a medically necessary leave of absence from a post-secondary school because of a serious injury or illness, Plan coverage will not terminate for such Dependent due to such leave before the date that is the earlier of (1) the one-year anniversary of the date on which the medically necessary leave of absence began, or (2) the date on which such dependent's coverage under the Plan would otherwise terminate. To be eligible for this extended coverage, the Participant must provide the Plan with written certification from the Dependent's treating physician that the leave of absence from school is medically necessary and is as a result of a serious illness or injury. Contact the Fund Office for additional information on coverage under this provision.



Qualified Medical Child Support Orders (QMCSOs)

The Plan complies with all Qualified Medical Child Support Orders (QMCSOs) or National Medical Child Support Notices. A QMCSO is a court order, under family or child support laws that may require a parent to enroll his or her children in his or her employer's medical plan. The QMCSO may also require benefits to be assigned to a child, to a custodial parent, or to a legal guardian. QMCSOs can be sent to the Plan Administrator listed on page 44. A Participant or Dependent can also request a copy of the Plan's QMCSO procedures from the Plan Administrator and receive a copy at no charge.

Self-Payment for COBRA

A Qualified Beneficiary (an Eligible Employee or Dependent who, on the day before a Qualifying Event is covered under the Plan) may continue coverage for maximum periods, by making election to do so with the Fund Office and making self-payment contributions. The amount of the monthly self-payment contribution is established by the Board of Trustees.

This is described in more detail on pages 47-50.

Family and Medical Leave Act ("FMLA")

The Family and Medical Leave Act of 1993 ("FMLA") enables you, if you qualify, to take an unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent or child. The FMLA also allows you, if you qualify, to take an unpaid leave to care for a spouse, parent or child who was seriously injured or became ill in the line of duty while serving in the uniformed services as defined in USERRA. The FMLA requires certain Employers to maintain health care coverage during the leave period. If you qualify and take an FMLA leave, your benefits are protected. If you think that this law may apply to you, please contact your Employer. All disputes over eligibility and coverage under FMLA are between you and your Employer.

Death Benefit for Covered Employees Only

The Death Benefit and Accidental Death and Dismemberment Benefit are provided through a group insurance contract which sets forth the terms of this insurance coverage. You may examine or obtain a copy of the contracts by contacting the Fund Office. All benefits payable under the contract, limitations and exclusions and claims filing and appeals procedures are described in more detail in a separate booklet from the insurance company. This also is called a Certificate of Coverage. Contact the Fund Office for a copy.

If you are an Active Hourly Employee, Active Employer Staff Employee, Retiree or Early Retiree, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee, you are covered for Death Benefits by the Plan. Payment will be made to the person you designate as your Beneficiary. (Contact the Fund Office for a new Beneficiary designation form to change your designation.) If you die while still a Participant and prior to your 65th birthday, your Beneficiary will receive a lump sum payment of \$10,000. If you die while still a Participant and between your 65th birthday and 70th birthday, your beneficiary will receive a lump sum payment of \$6,500. If you die while still a Participant on or after your 70th birthday, your Beneficiary will receive a lump sum payment of \$5,000. If you die without having designated a Beneficiary or if your designated beneficiary has died, then the benefit will be paid in equal shares to the first surviving class of the classes listed in order as follows: 1) your spouse, 2) your children, 3) your parents, 4) your siblings, and 5) your estate.

Accidental Death and Dismemberment for Covered Employees Only

If you are an Active Hourly Employee, Active Employer Staff Employee, Self-Pay Active Hourly Employee (under age 65) or Self-Pay Disabled Employee (under age 65) you are covered for Accidental Death and Dismemberment Benefits with the Plan. Upon retirement no Accidental Death and Dismemberment Benefits are available.

If you are an Eligible Employee and die or suffer Bodily Injury as a result of an Accident prior to your 65th birthday, or you are age 65 and over while working under a Collective Bargaining Agreement, you will be paid (in addition to any other amounts due under this Plan) in accordance with the following schedule:

QUALIFIED
MEDICAL
CHILD
SUPPORT
ORDERS
(QMCSOs)

SELF-
PAYMENT FOR
COBRA

FAMILY AND
MEDICAL
LEAVE ACT
("FMLA")

DEATH
BENEFIT FOR
COVERED
EMPLOYEES
ONLY

ACCIDENTAL
DEATH AND
DISMEMBERMENT
FOR COVERED
EMPLOYEES ONLY



	Under 65	65 – 69	70 and over
1. Loss of Life	\$10,000	\$6,500	\$5,000
2. Loss of both hands, both feet, both eyes or any two such members	\$10,000	\$6,500	\$5,000
3. Loss of one hand, one foot or one eye	\$5,000	\$3,250	\$2,500

Loss of a hand or foot means complete severance through or above the wrist or ankle joint and loss of eye means irrecoverable loss of the entire sight. If more than one type of loss occurs, the amount provided for the greatest loss will be paid. These benefits are payable for both work related and non-work related Injuries.

Loss of Time or Short-Term Disability Benefits for Covered Employees Only

If you suffer a disability from a non-work related Injury or illness, you can receive \$500 per week for 26 weeks, or one-seventh of the weekly benefit for each day of disability. You must be under the care of a licensed Physician (M.D., D.C., D.P.M., or D.O.) and unable to work because of such Injury or illness. Payments begin the 1st day in the event of an Injury or inpatient hospitalization and the 8th day in the event of illness. This is taxable income and a W-2 will be mailed to you.

If you have consecutive disabilities, they will be treated as separate disabilities only if:

- a) You are available to return to work after the first disability for at least 2 weeks of full-time employment; or
- b) The two disabilities are due to entirely unrelated causes and you are available to resume work for at least one day.

You must file a claim within six months of the date the disability began. Disability forms may be obtained from the Fund Office or on our website at www.weebf.org. The Plan reserves the right to require your physician to provide documentation at least every four weeks to confirm you remain disabled, in order to continue to receive Loss of Time benefits. No Loss of Time benefits are payable for any period for which you fail to provide an acceptable physician certification of disability.

If you are disabled, premiums will be deducted monthly from your account to provide coverage. In addition, 3 hours premium per day will be credited to your account (disability credits), up to a maximum of 90 days during any one disability period. You can collect disability credits for a work related injury and/or accident, however, you cannot collect the disability payment of \$500 per week, unless a Workman's Compensation Agreement is signed and received by the Fund Office. If you are collecting unemployment compensation you are not eligible to collect the \$500/week short-term disability benefit or disability credits at the same time. Please contact the Fund Office directly for this form.

If you are a disabled Employer Staff Employee you must provide certification from an officer of your Employer that you are not receiving a salary while disabled.

If benefits are payable under Loss of Time benefits and under a long-term disability or other source maintained by the Plan, any disability income benefits payable under Loss of Time benefits shall be reduced (that is, offset) by the amount of any payments payable from the other sources. If any payment is made to or for you by the Plan under Loss of Time benefits and also paid under another source, the Plan will have the right to suspend or withhold payment of incurred claims and to reduce any future payments due to you and/or your Dependents (including payments of medical benefits) by the amount of any overpaid disability amount and by an amount incurred by the Plan in pursuing the overpayment. The Plan will also have the right to reduce the amount of your dollar bank to recover any overpaid disability amount until the Plan has recovered the full amount.



Long-Term Disability Benefit for Covered Employees Only

The Plan provides a disability benefit if you suffer a disability from a non-work related injury or illness and you exhaust your 26-week period of Loss of Time Benefits under the Plan. You must have worked at least 450 hours in a 6-month period before becoming disabled in order to be eligible for this disability benefit. Subject to the terms of the insurance contract funding this benefit, benefits could continue for two years, or possibly longer, provided that the insurance company determines that you are disabled. A more detailed explanation of the benefit, its eligibility provisions, limitations and exclusions and claims filing and appeal procedures is found in a separate booklet that will be provided to you or that is available by contacting the Fund Office. The terms of this separate booklet and the insurance contract control in the event there are any inconsistencies between it and the above summary.

Medical Benefits

You and your Dependents are covered for Hospital, doctor and other medical benefits for accidental Bodily Injury or illness. Payment is made for, Covered Charges, which means any Medically Necessary and Reasonable service or supply for which benefits are provided under the Plan. Covered Charges include only Usual, Customary and Reasonable (UCR) charges for items described in the Plan. A Covered Charge is incurred at the time the service is rendered or the item is provided for which a charge is made. The term Covered Charges does not mean that all Covered Charges will be paid. Payments will be made only for Covered Charges up to the maximum benefit amount allowed by the Plan, and only according to any other limitations that may apply. Payments based on the UCR amount as determined by the Plan shall constitute the Plan's full and final payment. For the Hospital or medical care, service or supply provided by a PPO Hospital, PPO Physician or PPO provider, the UCR amount will not exceed the prearranged fee established under the PPO. Charges made by a Physician, Hospital or other provider in excess of UCR are the responsibility of the patient. All benefits are subject to the deductible and co-payment percentage, unless otherwise stated.

Covered Physician

An individual holding an unlimited license to practice medicine and surgery as a physician as recognized by the state in which he practices, provided he is acting within the scope of his license. To the extent that benefits are provided and while practicing within the scope of his license, the term "Physician" includes a Medical Doctor (M.D.), Osteopath (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Podiatrist (D.P.M.), Chiropractor (D.C.), Licensed Clinical Psychologist (Ph.D.) or Optician (O.D.). It does not include any practitioner not specifically designated. However, to the extent required by federal law and guidance, if the practitioner's service is covered under the Plan, the Plan will not discriminate based on a practitioner's license if the practitioner is licensed to provide the services in the state where they are performed and the practitioner is acting in the scope of the license.

The following is only a summary of covered medical expenses for Eligible Individuals. You should read the remaining portions of this Summary Plan Description to be aware of all limitations and restrictions on your benefits.

Deductible and Co-Payments

Lifetime Maximum Unlimited

Calendar Year Deductible The deductible amount is the dollar amount of Covered Charges an Eligible Individual must pay out-of-pocket during a calendar year before the Plan pays benefits, unless otherwise noted. The deductible is \$500 per Eligible Individual per calendar year or \$1,500 per family. The family deductible is satisfied when three persons have incurred \$500 in Covered Charges during the calendar year. The deductible does not apply to routine (well-baby) nursery care, routine physical examinations, preventive care, required second surgical opinions, Hearing Benefits, vision benefits or dental benefits. Covered Charges by a PPO Provider are paid to satisfy the deductible and Out-of-Pocket maximum for PPO provider expenses and the Covered Charges for Non-PPO Providers are applied to satisfy the calendar year Deductible and Out-of-Pocket maximums for Non-PPO Providers.

LONG-TERM
DISABILITY
BENEFIT FOR
COVERED
EMPLOYEES ONLY

MEDICAL BENEFITS

COVERED
PHYSICIAN

DEDUCTIBLE AND
CO-PAYMENTS



Co-payment Percentage **Covered Charges by a PPO Provider.** After satisfaction of the deductible, the Plan will generally pay 90% of the Usual Customary and Reasonable Covered Charges by a PPO Provider until the calendar year out-of-pocket maximum is reached. The calendar year out-of-pocket expense limit for PPO Providers per Eligible Individual is \$1,000 and \$3,000 per family. The Eligible Individual's portion of the co-payment percentage represents the amount applied to the out-of-pocket expense maximum.

And

Out-of-Pocket Maximum **Covered Charges by a Non-PPO Provider.** After satisfaction of the deductible, the Plan will generally pay 70% of Usual Customary and Reasonable Covered Charges by a Non-PPO Provider until the calendar year out-of-pocket maximum is reached. (Exception: for Covered Charges incurred for emergency services for treatment of a Medical Emergency provided by a Non PPO Hospital, the Plan will pay 90% of such charges) The calendar year out-of-pocket maximum for Non-PPO Providers is \$3,000 per Eligible Individual and \$9,000 per family. The Eligible Individual's portion of the co-payment percentage represents the amount applied to the out-of-pocket expense maximum.

PPO and Pharmacy Networks

At present, the Plan provides a Preferred Provider Organization (PPO) Network option for care rendered at Hospitals and by Physicians and certain other health care providers. The name, address and phone number of the PPO Network is found on page 64. A PPO Network Organization negotiates with physicians, hospitals, clinics, etc. to provide medical care and services at a lower cost to you and to the Plan. While you are not required to use a PPO provider, use of a PPO provider should save you and the Plan money.

The Plan provides a Pharmacy Network where prescription drugs must be obtained.

Hospital and Physician PPO Network

You can determine whether a Hospital, Physician or other provider participates in the PPO Hospital and Physician Network by calling the PPO Hotline listed on page 64. A list of PPO Hospitals, Physicians and other providers can be verified by calling the customer service number or by accessing their website listed on page 64. The Plan has incentives when you use a provider in the PPO Network - see above co-payment.

It is very important that you (and your covered Dependents) show your I.D. card whenever you receive any type of health care. The I.D. card provides information on both the Plan and the PPO Network. If you need I.D. cards, contact the Fund Office at the number on page 64.

Pharmacy Network

The Plan has entered into an arrangement with a Pharmacy Network to secure discounts on prescription drugs when you have prescription filled at a pharmacy participating in this Network. You should receive a separate information package from the Pharmacy Network, along with a separate prescription drug I.D. card. Call the Pharmacy Network toll-free number listed on page 64 for information about participating pharmacies in your area. (Note, Walmart Pharmacy has not been a covered pharmacy since August 1, 2003.)

When prescriptions for covered prescription drugs or medicines for you or your covered Dependent are filled at a Network pharmacy, you should present your separate Pharmacy Network I.D. card to the pharmacist.

In the event you lose your Pharmacy Network I.D. card or have a question as to whether a prescription drug is covered, you should contact the Fund Office or Pharmacy Network at the address and phone number on page 64.

Precertification

All planned inpatient Hospital visits must be precertified by the Plan's utilization review service. Precertification is not necessary for emergency or maternity admissions. However, maternity admissions with complications must be reported to the utilization review service within 48 hours or the next business day. The Plan can limit the cost of coverage to an outpatient basis if the utilization review service finds



inpatient care not to be medically necessary. The name and number for the current utilization review service is on page 64.

Hospital Benefits

1. Room and board up to the semi-private room rate charged by the Hospital for the level of care rendered.
2. Routine nursery care of a newborn child.
3. Hospital charges for confinement in an Intensive Care Unit.
4. Hospital miscellaneous charges for services and supplies provided during confinement as a registered bed Inpatient, when room and board benefits payable, excluding charges for private duty nurse; anesthetics, but not including their administration; and whole blood or blood plasma, if not replaced, and the cost of its administration.
5. Professional ambulance service. The maximum allowable per trip Covered Charge on which the Plan will base its payment is \$600.
6. Professional air ambulance service, for emergency transportation to a Hospital or for transferring between Hospitals, provided the Physician certifies that an Eligible Individual's condition requires specialized treatment at another Hospital and the condition requires transportation by air ambulance to the Hospital. The maximum allowable per trip Covered Charge on which the Plan will base its payment is \$7,000.
7. When confined as a registered Inpatient for Mental, Nervous or Emotional Disorders, payment will be made for expenses incurred for Inpatient confinement, residential treatment facility, or partial hospitalization.
8. When confined as a registered Inpatient for Substance Abuse, the Plan will cover expenses incurred for Inpatient confinement, residential treatment facility or for partial hospitalization.

Note: Partial hospitalization means continuous treatment of a Mental, Nervous or Emotional Disorder or Substance Abuse for at least 3 hours, but no more than 12 hours in a 24 hour period. Family counseling rendered by a Physician is covered during such hospitalization.

Skilled Nursing Facility Benefits

1. Room and board charges and charges for services in connection with room occupancy up to the average semi-private room rate.
2. Use of special treatment rooms; x-rays and lab work; Physical, Occupational or Speech Therapy; oxygen and other gas therapy; drugs, biological, solutions, dressings and casts, but no other supplies; other Medically Necessary and Reasonable services and supplies charged and furnished by the Skilled Nursing Facility, excluding services of a private duty nurse or Physician.
3. Benefits are payable up to 60 days during any one period of confinement provided:
 - (a) Confinement follows at least 3 consecutive days of Inpatient Hospital confinement, while covered under this Plan;
 - (b) Confinement begins within 24 hours after Hospital discharge date; and
 - (c) A Physician certifies confinement and services are necessary to the continued treatment by the Physicians of the Injury or illness.
4. Successive confinements for the same condition will be considered 1 period of confinement unless separated by a period of at least 90 days during which the patient is not confined.

HOSPITAL
BENEFITS

SKILLED
NURSING
FACILITY
BENEFITS



5. Benefits excluded on page 31 #10 are excluded under this section.

Hospital Outpatient Benefits

Hospital charges incurred for medical services or supplies provided by that Hospital during outpatient care of an Eligible Individual, resulting from accidental Bodily Injury, surgery, or Medical Emergency provided services and supplies are rendered within 72 hours of the onset of the accidental Bodily Injury or Medical Emergency, and excluding services of a private duty nurse, Physician and routine physical examinations. Charges for medical services and supplies provided during Outpatient surgery are considered Covered Charges if the charges are made by a Licensed Ambulatory Surgical Center.

Pregnancy Benefits

1. Charges incurred by an Eligible Individual, as a result of pregnancy, childbirth or a related medical condition, if covered by the Plan at the time of delivery. Physician's obstetrical services, including pre-natal and post-natal care payable under the Usual, Customary and Reasonable tables adopted by the Trustees.
2. Expenses for care received in a licensed birthing center, for treatment of childbirth.
3. Pursuant to Federal law, the Plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. Federal law, however, does not generally prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable.) Providers are not required to obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours.)
4. The Plan will cover the obstetrical services, including pre-natal care, delivery and post-natal care, or a Certified Nurse Midwife ("CNM"), if the Eligible Individual is covered by the Plan at the time of delivery and the CNM meets all of the following requirement: (a) the midwife is certified as a CNM by the American College of Nurse Midwives and licensed as a CNM by the Board of Nursing in the State of Wisconsin; (b) the CNM is practicing in collaboration with an obstetrician who is available to assume responsibility at any time during the pregnancy or post-natal process; and (c) the birth occurs at a Hospital.

If the total Covered Charges for the services of a CNM and a Physician exceed the amount which would have been incurred if the entire maternity process had been handled by a Physician, the Plan's maximum benefit is limited to the amount which would have been paid if care throughout the entire process had been handled by the Physician. Services are payable under the Usual, Customary and Reasonable tables adopted by the Trustees.

Surgery—Anesthesia

Covered Charges for surgical and anesthesia services are payable based on Usual, Customary and Reasonable tables adopted by the Trustees for the procedure performed, subject to the second opinion and focused surgical review requirement of the Plan. The maximum surgical amount payable will include the surgery charge and the charge for allowable follow-up care.

1. Surgeon charges.
2. Assistant surgeon charges at 25% of the allowable benefit for the surgeon.
3. Physician's assistant (P.A.) charges when acting in the stead of an assistant surgeon, and when an assistant surgeon is allowed, at 15% of the allowable benefit for the surgeon.
4. Anesthesiologist or nurse anesthetists.

HOSPITAL
OUTPATIENT
BENEFITS

PREGNANCY
BENEFITS

SURGERY-
ANESTHESIA



Reconstructive Surgery

Reconstructive surgery following a mastectomy is covered under the Plan. Federal law (the Women's Health and Cancer Rights Act of 1998) requires a group health plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy. Coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthetic devices and treatment of physical complications at all stages of the mastectomy, including lymphedemas (swelling associated with removal of lymph nodes).

These benefits will be provided subject to the same deductibles, co-payments and limitations applicable to other medical and surgical benefits provided under this Plan. No benefits are payable for elective procedures. See Exclusions, page 32 #40.

Oral Surgery

Covered Charges for oral surgery and anesthesia services are payable based on Usual, Customary and Reasonable tables adopted by the Trustees for the procedure performed, subject to the second opinion and focused surgical review requirement of the Plan. The maximum surgical amount payable will include the surgery charge and the charge for allowable follow-up care.

1. Repair or alleviation of damage to sound natural teeth caused by Injury sustained while covered by this Plan.
2. Removal of partially or completely unerupted impacted teeth.
3. Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when pathological examination requires.
4. Removal of apex of tooth root, "apicoectomy", not including root canal.
5. Removal of exostoses, "growth of the jaw and hard palate".
6. Treatment of fractures of facial bones.
7. External incision and drainage of cellulitis.
8. Incision of accessory sinuses, salivary glands, or ducts.
9. Surgical treatment for the correction of temporomandibular joint dysfunction (TMJ/TMD).
10. Gingivectomy, excision of loose gum tissue to eliminate infection.
11. Alveolectomy, the leveling of structures supporting teeth for the purpose of fitting dentures.
12. Frenectomy, the cutting of the tissue in the middle of the tongue (frenulum), which is usually done to prevent tongue tie conditions.
13. Osseous surgery.

Second Opinion and Focused Surgical Review

You are required to get a confirming second opinion for the following surgical procedures:

1. Breast reduction.

RECONSTRUCTIVE
SURGERY

ORAL SURGERY

SECOND
OPINION AND
FOCUSED
SURGICAL
REVIEW



2. Osteotomy.
3. Temporomandibular joint dysfunctions.

You are required to get a focused surgical review for the following procedures. To get a focused surgical review you must contact the Plan's utilization review service and they will determine if a second opinion is required, if alternative treatment can obtain necessary results, or if surgery is approved.

1. Adenoidectomy.
2. Bunionectomy.
3. Carotid endarterectomy.
4. Carpal tunnel.
5. Cholecystectomy (gall bladder).
6. Coronary angiography.
7. Coronary artery bypass graft.
8. Dilation and curettage (D&C).
9. Dilation and curettage (D&C) and pelvic laparoscopy.
10. Hammertoe repair.
11. Hemorrhoidectomy.
12. Hysterectomy.
13. Knee arthroscopy.
14. Laminectomy (lumbar).
15. Pelvic laparoscopy.
16. Septorhinoplasty.
17. Spinal fusion.
18. Tonsillectomy and/or adenoidectomy.
19. Tympanostomy tube insertion.
20. Pain management injections (example, knee, back, shoulder).

A second opinion must be obtained from a surgeon licensed in the appropriate surgical specialty and not affiliated with the Physician or surgeon who initially recommended the surgery. If the Plan requires it, the cost of a second and third opinion will be paid 100% by the Plan with no deductible. If you are required to get a focused surgical review and/or a second opinion and you fail to do so, the covered charges for the surgeon and all other related Physician's charges will be reduced by 20% and this reduction is not applied to your deductible or co-payment percentage.

Gastric Bypass Surgery

Covered Charges for gastric bypass surgery as a direct result of Morbid Obesity, as defined by the Plan, will be covered up to a maximum of one such surgery per lifetime when all of the Plan's requirements are



satisfied. The lifetime maximum applies to all direct or indirect charges that the Eligible Individual incurs on account of the gastric bypass surgery, including but not limited to, charges made to the Eligible Individual by a Hospital, the surgical fees for the performance of the procedure, presurgical psychological examination performed in connection with the surgery, pre and postoperative visits, anesthesia services, and treatment of health issues and complications that may arise from the surgery.

You are required to get gastric bypass surgery precertified by the Plan's Utilization Review Provider and approved by the Plan in writing before receiving services. Coverage is subject to the Plan's exclusions and limitations. Contact the Fund Office for the Plan's definition of Morbid Obesity before investigating gastric bypass surgery.

Radiotherapy

The Plan will pay Covered Charges for radiotherapy, including the use of x-ray, radium, cobalt and other radioactive substances.

Diagnostic X-Ray and Laboratory

The Plan will pay Covered Charges for necessary x-ray and laboratory examination for diagnosis of an accidental Bodily Injury or illness, including allergy testing, basal metabolism determination, audiograms, electrocardiograms, and initial diagnostic testing.

Asbestosis Screening

The Plan will pay Covered Charges for one breathing test and x-ray analysis for detection of asbestosis per Eligible Employee or Retiree per lifetime.

Medical Services

1. Daily Physician visits when confined in a Hospital or Skilled Nursing Facility as an Inpatient, and when room and board benefits are payable.
2. Daily Physician visits for Substance Abuse when confined in a Substance Abuse Facility as an Inpatient, and when room and board benefits are payable.
3. Office visits and consultations and Physician visits at other covered locations.
4. Virtual Physician consultation programs sponsored by the Trustees are paid by the Plan at 100%, such as Life Health Online.
5. The following benefits are available for Physician's charges and charges by non-physician providers (as identified in the Plan) at state-licensed clinics for outpatient treatment of:
 - (a) Mental, Nervous or Emotional Disorders, including family counseling.
 - (b) Substance Abuse, including family counseling.
6. Physician's charges for treatment of an accidental Bodily Injury or Medical Emergency, provided treatment is rendered within 72 hours of the onset.

Durable Medical Equipment, Appliances and Nursing Care

1. Rental of a wheel chair, hospital bed, oxygen equipment and other similar durable medical equipment required for therapeutic use and not normally utilized for everyday use. The Board of Trustees may authorize purchase instead of rental. Like all covered charges, rental of equipment is subject to determination of medical necessity and reasonable rental of same equipment may not be covered even though prescribed by a Physician.

RADIOTHERAPY

DIAGNOSTIC X-RAY
AND LABORATORY

ASBESTOSIS
SCREENING

MEDICAL SERVICES

DURABLE MEDICAL
EQUIPMENT,
APPLIANCES AND
NURSING CARE



2. Prosthetic devices and replacement or repair, including artificial arms, legs and accessories, artificial eyes, initial prosthetic implants due to malignancy or benign tumor removal. Benefits are payable for fitting, adjusting and repair, but not for maintenance of the prosthetic's hardware. The Plan will limit its payment to one such prosthetic device per limb per 60-month period plus any adjustments. Coverage is excluded for implantable and/or inflatable prostheses and replacement of breast implants unless the breast implant is provided in conjunction with the reconstruction of a breast on which a mastectomy has been performed due to a malignancy (see page 15), surgery and reconstruction of the other breast to produce a symmetrical appearance, or prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.
3. Casts, splints, trusses, braces, crutches and surgical dressings.
4. Custom fitted orthotics, leg braces including attached shoes, arm and back braces, and cervical collars prescribed by a Physician, for a diagnosis not excluded by the Plan if cast impressions and range of motion testing performed. Payable up to a \$10,000 threshold per Eligible Individual. Once the threshold is reached, benefits are payable at 50% by the Plan and 50% by the Eligible Individual. Custom-fitted orthotics prescribed by a Physician for treatment of a chronic conditions of the foot (for example, plantar fasciitis) are covered up to a maximum benefit of \$500 per Eligible Individual per five-year period. Cast impressions and range of motion testing must be performed for the orthotics to be covered by the Plan.
5. Oxygen; insulin pumps following successful completion of 30-day trial period per Eligible Individual in a 2-year period.
6. The Plan will pay for Covered Charges of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) on a part-time or intermittent basis. However, services for a nurse that ordinarily lives in your home or in your Dependent's home or is a member of your immediate family will not be covered.
7. Breast pumps — one per child after child birth.

Home Health Care

At times it may be more appropriate to receive medical care at a private residence (not necessarily your own residence) by or through a Home Health Care Agency which meets Medicare requirements. Under certain conditions, Home Health Care expenses will be paid by the Plan.

The Plan will allow benefits for a Home Health Care visit up to 4 hours per day if the maximum weekly benefit is less than the weekly cost of care in a Skilled Nursing Facility.

In order to be covered, the expenses must be incurred under a Home Health Care plan, established and approved by your attending Physician. The treatment plan must be reviewed every 2 months by your Physician; however, a longer interval may be acceptable if approved by your Physician and this Plan.

The Physician must certify that Inpatient confinement in a Hospital or Skilled Nursing Facility would be required if Home Health Care is not provided. Also the Physician must certify that the necessary care cannot be provided by any other properly trained person of the household without endangering your life or impairing your condition.

The following expenses will be covered under a Home Health Care plan that meets the necessary requirements:

1. The evaluation of the need for and development of a plan by a registered nurse (RN), medical social worker (MSW) or the attending Physician.
2. Part-time or intermittent care by a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN) or licensed physiotherapist.
3. Part-time or intermittent care of a home health aide, under the supervision of a registered nurse (RN) or a medical social worker (MSW).



4. Physical, Respiratory, Occupational, Rehabilitation, or Speech therapy.
5. Medical supplies or services provided by or through the Home Health Agency, drugs and medication prescribed by a Physician, and laboratory services by or on behalf of a Hospital, if necessary, to the extent the items would have been covered if the patient had been Inpatient confined.
6. Nutrition counseling provided by or under the supervision of a registered dietician where such services are Medically Necessary and Reasonable as part of the Home Health Care plan.

The Plan will not pay benefits for:

1. Massage therapy, personal training or other general fitness services.
2. Routine housekeeping chores, which are not necessary to prevent or postpone hospitalization, or similar services which would increase the amount of time required for the visit.
3. Services or supplies that would not be paid if confined as an Inpatient in a Hospital or Skilled Nursing Facility.
4. Personal custodial care that can be provided by a family member or relative.

Hospice Care

The Plan will pay for expenses for Hospice Care if your attending Physician certifies that you or your Dependent has a life expectancy of less than 6 months. The Hospice must be an organization, agency or facility licensed by the state in which it is headquartered or accredited by a national accrediting organization or recognized as a hospice program by the U.S. Department of Health and Human Services and meets the certification requirements of Medicare.

Hospice Care, including pain management, is palliative and supportive medical, health care and other services provided to Terminally III Patients to meet special physical and emotional needs as part of dying so a Hospital patient may remain at home, to the maximum extent possible, with home-like Inpatient care utilized only if and while it is necessary.

The Plan will pay Covered Charges for:

1. Hospice Care, not to exceed Hospital benefits, for Inpatient confinement.
2. Home Hospice Care furnished in a private residence (not necessarily the residence of the Eligible Individual), including:
 - (a) home health aide;
 - (b) registered nurse (RN) or licensed practical nurse (LPN);
 - (c) physical and respiratory therapy;
 - (d) nutrition counseling and special meals; and
 - (e) licensed or certified social worker for medical social services rendered for a maximum of 6 visits.
3. The Plan will pay for 8 days of Inpatient care for Respite Care per lifetime. Respite Care is care furnished when confined as an Inpatient so your family may have relief from the stress of care at home.

Occupational, Physical and Speech Therapy

The Plan will pay for Occupational, Physical and Speech Therapy by a qualified and licensed therapist when prescribed by your Physician and when significant improvement can be obtained. The Plan will initially allow up to 3 consecutive months of therapy, and any additional need for therapy must be certified by your

HOSPICE CARE

OCCUPATIONAL,
PHYSICAL AND
SPEECH THERAPY



attending Physician to be Medically Necessary and Reasonable. The Plan will not pay for expenses to maintain functions at the current level or when no further significant practical improvement can be expected or when it is prescribed instead of non-medical treatment, such as exercise or an excluded diagnosis. Speech Therapy will be covered to restore patient's functional ability to prior levels. Following covered surgery, therapy to correct temporomandibular joint dysfunction (TMJ/TMD) and/or pain problems will be covered the same as other therapy listed above. Refer to chiropractic benefits below for additional exclusions, and limitations on therapists.

Transplants

The Plan will cover the expenses only if you or one of your covered Dependents is the recipient of a cornea, kidney/pancreas, liver, autologous or allogenic bone marrow, kidney, heart, or a heart/lung human-to-human transplant. The transplant and all phases of related transplant care, including, but not limited to treatments, procedures, services, supplies and medicines provided in connection with admission, surgery and post-transplant care, must be performed at a provider which participates in the Transplant Network adopted or approved by the Board of Trustees at the time such transplant care is rendered. Pre-Transplant evaluation may be performed at a Network provider or outside the Transplant Network provided that such evaluation is monitored by and coordinated with the Plan's utilization review service. The Transplant Network is a network of facilities with which the Trustees have contracted for reduced rates and differs from the PPO Network. **No benefits are payable for transplants performed outside the Transplant Network.** The Plan will cover up to \$5,000 for a transplant recipient's travel expenses per Eligible Individual per lifetime. Travel expenses are for the transplant recipient only to and from a provider participating in the Transplant Network in conjunction with the transplant will be covered. Travel expenses means ambulance, air ambulance or other professional transportation for the transplant recipient, including the recipient's travel by regularly scheduled airline or railroad to and from the Transplant Network provider.

No benefits are payable for donor expenses, except for available coverage for donor expenses as set forth as part of an all-inclusive discounted case rate charged by a provider in the Transplant Network retained by the Trustees where such expenses do not increase the case rate.

Contact the Fund Office at the phone number listed on page 64 if you require more information on this transplant benefit.

Chiropractic

Chiropractic benefits are subject to the Deductible for scheduled charges. No chiropractic services rendered to a Dependent child under age ten are covered by the Plan. Benefits are limited to the following services and maximums for the treatment of spinal maladjustments:

1. Initial office visit including routine examination, patient history (new patient or new condition)
2. Follow-up visit-manipulation, one per visit
3. Follow-up visit-one therapy per visit
4. Diagnostic X-ray—one per Eligible Individual per calendar year

The maximum number of follow-up visits will be 30 per Eligible Individual per calendar year. No other benefits are payable for services rendered by a Chiropractor, including orthotics.

If a registered physical therapist (RPT) is employed with, by, associated with, or in the same office with a chiropractor and renders services, these are payable under the above chiropractic benefits and not under the therapies benefit of the Plan. The number of visits to the registered physical therapist will count toward the 30 follow-up visits maximum.

TRANSPLANTS

CHIROPRACTIC



Routine Physical Examination and Preventive Care; Immunizations

The Plan will pay for routine physical examinations at 100% of U&C without payment of the deductible for services provided by a PPO provider. Services by a Non-PPO provider are payable by the Plan at 100% of UCR without payment of the deductible up to \$450 per calendar year and at 10% thereafter for the calendar year.

This benefit includes physician's charges for complete history and physical examination, well-child expenses for a Dependent child including charges for routine immunizations, and x-ray and laboratory charges such as electrocardiogram, blood count, chest x-ray, pap smear, routine mammogram, and preventative care services recommended by U.S. Preventative Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and the Health Resources and Services Administration, as required by federal regulations. For additional information on these recommended preventive care services you can visit the website:

www.healthcare.gov/

or contact the Fund Office. Physical exams for employment (such as a commercial driver's license or hazmat services) or recreational activity such as a pilot's license are not covered by this benefit.

Health Dynamics (Participants and Spouses)

The Plan will pay the entire cost of an annual comprehensive physical exam and consultation performed by a participating provider in the **Health Dynamics program** for an eligible Participant and Dependent spouse. Contact the Fund Office for a list of the **Health Dynamics** locations most convenient for you and your family. In any calendar year, any individual who utilizes this program is not eligible for benefits under the routine physical benefit described above.

Under the **Health Dynamics program** you will receive a computer-generated fitness and medical report providing test results and preventive care recommendations. If follow-up care is suggested, you will need to take the report to your primary care Physician for treatment and/or monitoring. **Health Dynamics** will maintain your records for annual comparison purposes. To avoid year-end scheduling problems, you are encouraged to schedule appointments (which will take about 2-1/2 hours) in the spring or summer.

Hearing Benefits

The Plan will pay up to \$1,500 per Eligible Individual per 3 year period for Hearing exams, Hearing Aids, Hearing Aid batteries and repairs. This benefit is not subject to the deductible or co-payment percentage of the Plan.

Alternative Care

The Trustees reserve the right to approve payment of benefits for alternative treatment on a case-by-case basis in accordance with guidelines adopted by the Trustees.

Prescription Drug Expense Benefits

The Plan has entered into an arrangement with a Pharmacy Network to secure discounts on prescription drugs. When you have a prescription drug or medicine filled at a pharmacy participating in the Network, you must use the separate prescription drug I.D. card. At that time, you must pay the pharmacist a co-payment for covered prescription drugs or medicines. The Plan will pay the remainder of the cost of covered prescription drugs and medicines.

Even though you may have other medical expenses paid by the Plan at 100% after satisfying the deductible and out-of-pocket maximum, you must continue to pay the prescription drug co-payment when a prescription is filled.

A covered prescription drug or medicine is one that requires a Physician's written prescription, whether for a pill, a liquid or an injectable substance (including birth control pills and contraceptive devices), subject to the

ROUTINE
PHYSICAL
EXAMINATION;
AND PREVENTIVE
CARE;
IMMUNIZATIONS

HEALTH
DYNAMICS
(PARTICIPANTS
AND SPOUSES)

HEARING
BENEFITS

ALTERNATIVE
CARE

PRESCRIPTION
DRUG EXPENSE
BENEFITS



Plan's exclusions and limitations listed on pages 30-33. It must be prescribed in accordance with and for a medical condition for which the U.S. Food and Drug Administration (FDA) has authorized its use. In order for an injectable drug or medicine to be covered, it must be one that would be covered under the Plan's medical benefits if administered by a physician or registered nurse. Insulin and diabetic supplies are NOT considered a covered prescription drug, and they are paid at a flat 80% by the Plan and 20% by the Eligible Individual and do not count toward the prescription drug out-of-pocket maximum. If a drug is not covered, you must pay the entire cost. The Plan will cover specialty drugs and medications (as determined and pre-authorized by the Plan's pharmacy network provider) as further described below.

Retail - You may receive up to a 30-day supply of medication from your local pharmacy with a co-payment of \$10 for generic drugs or \$50 for brand name drugs.

Mail Order - You may receive up to a 60-day supply from the Sav-Rx Mail Order for maintenance medications with a co-payment of \$10 for generic drugs (\$15 co-payment for 61-90 day supply) or \$50 for brand name drugs (\$75 co-payment for a 61-90 day supply). Remember, you must have your physician write the prescription for a 60-day supply to take advantage of this benefit.

"Walk-In" Mail Order Available at Walgreens - You may receive up to a 60-day supply of maintenance medications at your local Walgreens for a co-payment of \$10 for generic drugs (\$15 co-payment for 61-90 day supply) or \$50 for brand name drugs (\$75 co-payment for a 61-90 day supply). Remember, you must have your physician write the prescription for a 60-day supply to take advantage of this benefit.

Once the Plan has paid \$10,000 in pharmacy benefits from a PPO provider in a calendar year for an Eligible Individual for covered prescription drugs, the Plan will pay 50% of future covered prescription drug costs up to the calendar year out of pocket maximum for prescription drugs. The out-of-pocket maximum is adjusted each January 1 to allow the Plan to meet the maximum out of pocket as determined by the federal law. PPO prescription drug expenses count only toward the prescription drug out-of-pocket limit and not the major medical out-of-pocket limit.

Specialty Drugs - The Plan will cover specialty drugs and medications (as determined and pre-authorized by the Plan's pharmacy network provider) only for uses or diagnoses for which the drug or medication has been approved by the U.S. Food and Drug Administration (FDA). Eligible Individuals with a prescription covered under a manufacturer's coupon program will automatically be enrolled in the program. Use of the coupon results in a lower cost to the Plan and Eligible Individual. Coupon payments are not treated as the prescription drug co-payment, and are not applied to any deductible or the prescription drug out-of-pocket maximum. The list of medications can be changed from time to time. Coverage for non-FDA approved uses will be denied.

If you go to an Out-of-Network pharmacy or do not present your I.D. card at a Network pharmacy, you must pay for the entire cost of the prescription at the pharmacy and submit your receipt along with a claim form to the Pharmacy Network at the address found on page 64. Claim forms can be obtained by contacting the Pharmacy Network.

Smoking Cessation

The Plan provides a calendar year maximum of two 90-day supplies of smoking cessation medications, provided the Eligible Individual has a prescription from a Physician and they are purchased at a participating PPO pharmacy.

The Plan first provides a 90-day trial period of over-the-counter smoking cessation products, such as nicotine patch, lozenge or gum, used singly or in combination. Benefits will be provided by the Plan at 100% of UCR. A 90-day approval of generic prescription smoking cessation products, such as Buproban and generic Zyban, is available following failure, intolerance, allergy, or contraindication to the over-the-counter products. The Plan will provide benefits at 100% of UCR. A 90-day approval of brand name prescription smoking cessation products, such as Chantix and Nicotrol, following an Eligible Individual's demonstrated intolerance and/or allergic reaction to over-the-counter and generic prescription products. The Plan will provide benefits at 100% of UCR.

Also, 4 tobacco counseling sessions of 10 minutes from a PPO provider per calendar year in conjunction with a maximum of 2 calendar year smoking cessation attempts. These counseling sessions are not subject to deductible and paid by the Plan at 100% of UCR.



Retirees, Early Retirees and their Dependents covered by this Plan will be ineligible for the Plan's Prescription Drug Benefit Program and prescription drug benefit reimbursement under the Flexible Benefit Account Program effective on the date of enrollment in a Medicare Part D plan.

Peer Review

The Board of Trustees has the right to submit claims to peer review to determine appropriateness of treatment for the diagnosis, to determine if charges are Medically Necessary and Reasonable, and determine if charges are Usual, Customary and Reasonable. Medical charges can be denied if the peer review process and appeal to the Board of Trustees determine the charges are unreasonable or for services which are not Medically Necessary and Reasonable or accepted as Usual, Customary and Reasonable for the condition.

Optional Benefits

The Plan provides Optional Benefits for Preventive Dental, Comprehensive Dental and Vision Care, Supplemental Unemployment, or a Flexible Benefit Account which must be elected through your collective bargaining agreement. Optional Benefits, other than the Flexible Benefit Account program, are not available to Retirees or Early Retirees or their Dependents. The following is a summary of Optional Benefits which you may be covered under if such has been elected through your collective bargaining agreement.

Optional Benefits will terminate on the earliest of the following dates:

1. The date coverage would otherwise terminate under the Plan;
2. The date the Eligible Individual becomes covered as a Retiree or Early Retiree (except Flexible Benefit Account benefits); or
3. The date the Employer or Union terminates participation in the Optional Benefit.

Optional Benefits are subject to the General Exclusions and Limitations and Coordination of Benefits provisions of the Plan.

Optional Preventive Dental Benefits

Benefits are not subject to a deductible or co-payment percentage, and the Plan will cover:

1. Oral exams including cleaning and scaling—no more than twice in a calendar year (generally 6-month checkups).
2. Cleaning—oral prophylaxis up to twice in a calendar year—one topical fluoride treatment and one application of tooth sealants per back molars for Dependents under age 16 each calendar year.
3. X-rays limited to one set of bite-wing x-rays in a 6-month period and one set of full-mouth x-rays in a 36-month period.
4. Certain space maintainers (fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost teeth for Dependent children under age 19.

Limitations and Exclusions

In addition to the General Exclusions and Limitations of the Plan, no benefits are payable under Optional Preventive Dental for:

1. Services and supplies not listed above;
2. Expenses for services or supplies that are not necessary according to or do not meet accepted standards of dental practice; and

PEER REVIEW

OPTIONAL
BENEFITS

OPTIONAL
PREVENTIVE
DENTAL
BENEFITS

LIMITATIONS
AND
EXCLUSIONS



3. Treatment by other than a legally qualified dentist (D.D.S. or D.M.D.), except charges for cleaning performed by a licensed dental hygienist under the supervision and direction of a dentist.

Optional Comprehensive Dental Benefits

Optional Comprehensive Dental Benefits are not subject to a deductible and are divided into the following 4 types:

1. Preventive - reimbursed 100% of the covered benefit
2. Basic - reimbursed 80% of the covered benefit
3. Major - reimbursed 80% of the covered benefit
4. Orthodontic - reimbursed 50% of the first \$1,400 of covered charges and 100% of the next \$1,800 per Eligible Individual per lifetime.

The maximum benefits payable per Eligible Individual is:

1. Basic and Major - \$1,700 per Eligible Individual per calendar year (does not apply to Eligible Individuals through the end of the Calendar Year in which the person reaches age 19).
2. Orthodontic - \$2,500 per Eligible Individual per lifetime.

The following is a summary of the covered dental expenses.

Preventive

1. Oral exams including cleaning and scaling—no more than twice in a calendar year (generally 6-month checkups).
2. Cleaning—oral prophylaxis up to twice in a calendar year—one topical fluoride treatment and one application of tooth sealants per back molars for Dependents under age 16 each calendar year.
3. X-rays limited to one set of bite-wing x-rays in a 6-month period and one set of full-mouth x-rays in a 36-month period.
4. Certain space maintainers (fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost teeth for Dependent children under age 19.

Basic

1. Periodontal
2. Oral surgery or extractions
3. Restorative or fillings
4. Endodontic treatment, including root canal therapy
5. Local anesthetic (e.g., Novocain), and when Medically Necessary and administered in connection with oral or dental surgery, general anesthetics
6. Repair or recementing of crowns, inlays, onlays, bridgework or dentures
7. Relining or rebasing of dentures more than 6 months after installation or replacement, but not more than once every 36 months



Limitations to Basic Services are:

1. If anterior teeth can be satisfactorily restored with synthetic materials and posterior teeth can adequately be restored with amalgam, payment will be made based on such.
2. Veneers posterior to maxillary first molars or mandibular second bicuspids are considered optional and are not considered covered services.

Major

1. Cast restorations—gold restorations; crowns and jackets when teeth cannot be restored with other materials.
2. Prosthodontics—construction, placement or repair of fixed bridges, partial and complete dentures.
 - (a) Initial installation of fixed bridgework to replace missing natural teeth (including inlays and crowns as abutments, except periodontal splinting).
 - (b) Initial installation (including precision attachments and adjustment during the 6-month period following installation) of partial or full removable dentures.
 - (c) Replacement of existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:
 - (i) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or
 - (ii) the existing denture or bridgework was installed at least 5 years prior to its replacement under this Plan or any other group plan, unless no payment was received and the existing denture or bridgework cannot be made serviceable; or
 - (iii) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

Normally dentures will be replaced by dentures but if a professionally adequate result can be achieved with bridgework only, the bridgework will be covered.

- (d) Inlays, implements, onlays, fillings, or crown restorations to restore diseased teeth and implants.

Limitations to Major Services are:

1. If adequate retention and aesthetics can be obtained using only gold for a crown, payment will be made toward the cost of a more extensive procedure at the gold rate.
2. Porcelain gold, porcelain veneer and acrylic veneer precious metal crown over vital teeth are not covered for children under age 12.
3. Veneers on crown posterior to maxillary first molars or mandibular second bicuspids are optional, and are not covered.
4. Appliances for the replacement of the same natural teeth are a benefit only once in a 5 year period.
5. Temporary partial dentures are a benefit only when anterior teeth are missing.
6. Specialized techniques, precious metals for removable appliances, precision attachments, personalization and characterization are optional, and are not covered. Allowance for standard procedures will be made toward the cost of a more complex procedure.



7. Fixed bridges and/or cast partials are not a benefit for children under age 16.
8. A posterior fixed bridge is not covered when done in connection with a removable appliance in the same arch.
9. Oral surgery is not covered under the Dental Coverage of your Plan, it is covered under the Medical Coverage shown on page 15.

Orthodontic

Orthodontic procedures and treatment consisting of appliance therapy and surgical therapy (the surgical repositioning of the jaw, facial bones and/or teeth to correct malocclusion).

The maximum amount payable for expenses for orthodontic treatment will not exceed \$100 for a person whose initial expense for treatment is incurred less than 3 months prior to the date of termination of coverage.

Limitations and Exclusions

In addition to the General Exclusions and Limitations of the Plan, no benefits are payable under Optional Comprehensive Dental for:

1. Services and supplies not listed above;
2. Expenses for services or supplies that are not necessary according to or do not meet accepted standards of dental practice;
3. Treatment by other than a legally qualified dentist (D.D.S. or D.M.D.), except charges for cleaning performed by a licensed dental hygienist under the supervision and direction of a dentist;
4. Treatment due to injury to natural teeth as a result of an accident—benefits are paid under Medical Benefits;
5. Correction of congenital, developmental or acquired malformations;
6. Treatment for temporomandibular joint dysfunction (TMJ/TMD);
7. Procedures necessary to alter occlusion or vertical dimension or restoration of tooth structure lost through attrition;
8. Hypnosis;
9. Pre-medication;
10. Treatment solely for cosmetic reasons;
11. Prescription drugs;
12. Hospital charges, including Hospital visits;
13. Charges for completion of forms;
14. Charges for lost or stolen appliances; and
15. Experimental treatment and services.



Extended Dental Benefits

No benefits are payable for any covered dental expenses incurred after termination of coverage, except as follows:

1. Expenses for a prosthetic device, including bridgework, will be covered only if the impressions were taken and abutment teeth fully prepared while covered under this Plan, provided the prosthetic device is installed or delivered to the person within 2 calendar months following termination of coverage.
2. Expenses for a crown will be covered only if the tooth was prepared for the crown while covered under this Plan, and the crown is installed within 2 calendar months following termination of coverage.
3. Expenses for root canal therapy will be covered if the tooth was opened while covered under this Plan, and treatment is completed within 2 months following termination of coverage.

Optional Vision Benefits

Optional Vision Benefits are not subject to a deductible or co-payment percentage and benefits are paid up to a maximum of \$300 per Eligible Individual per calendar year for a vision exam, glasses, frames, corrective lenses, charges in connection with radial keratotomy, LASIK surgery and other surgical procedures to correct refractive errors of the eyes. The \$300 maximum benefit does not apply to a person through the end of the calendar year in which the person reaches age 19. Such person is eligible for one exam and a choice of one set of glasses (standard lenses and frames) or one set of non-disposable contact lenses or a one-year supply of disposable contact lenses.

Reimbursement will not be made available for professional services or materials connected with:

- (a) orthoptics or vision training;
- (b) subnormal vision aids;
- (c) plano (non-prescription) lenses;
- (d) Medical or surgical treatment of the eyes;
- (e) Any eye examination required by an Employer as a condition of employment; and
- (f) Swimming or skiing goggles.

Flexible Benefit Account Reimbursement Program

1. **Overview.** The purpose for the Flexible Benefit Account is to provide Participants with a tax free source for paying deductibles, co-payments, self-payments and a number of other medical expenses that are not covered under the regular Plan provisions or by any other source. The Flexible Benefit Account is a health reimbursement arrangement.
2. **Funding.** The Plan will establish an individual Flexible Benefit Account for each Participant. A Participant's account will be funded from the Employer's contributions made to the Plan on behalf of the Participant. (If a Participant is working under a reciprocity agreement, the first \$1.00 of each hourly reciprocal contribution will be allocated to the Participant's Flexible Benefit Account.) This dollar bank transfer must be made within 30 days of the date that the Participant's Local Union begins participating in the Flexible Benefit Account program.
3. **Benefits.** Flexible Benefit Account payments are available to reimburse a Participant for out of pocket expenses, *i.e.*, co-payments and deductibles. A Participant may also apply assets in his Flexible Benefit Account to continue Plan coverage if there are insufficient credits in his dollar bank. Further, a Participant may obtain reimbursement from his Flexible Benefit Account for the following:
 - vision and dental benefits not covered by the Plan's vision or dental programs (even if the Participant does not participate in the Plan's vision or dental programs);

EXTENDED
DENTAL
BENEFITS

OPTIONAL VISION
BENEFITS

FLEXIBLE
BENEFIT
ACCOUNT
REIMBURSEMENT
PROGRAM



- medical expenses that are only partially covered by the Plan's major medical expense program (or that are listed below) but not expenses for which reimbursement can be made from another source, such as spousal coverage, other Health Reimbursement Accounts ("HRAs"), Veterans Affairs ("VA"), Medicare, other medical assistance, HRAs and HSAs.;
- acupuncture;
- guide dogs for blind or deaf persons;
- smoking cessation programs;
- hearing examinations and hearing aids;
- surgery or laser treatments to correct vision;
- weight loss programs, but not food or dietary supplements nor health club memberships or expenses;
- over-the-counter medications (except insulin), if a prescription for such medication is provided; and
- breast feeding supplies that help with lactation.

Flexible Benefit Account benefits will be paid by deducting assets from a Participant's Flexible Benefit Account. Benefits will only be available to the extent of the assets in a Participant's Flexible Benefit Account.

4. **Filing Procedure.** A Participant must submit a claim form along with evidence identifying the reimbursement amount (e.g., an explanation of benefit form). All explanation of benefit forms must be submitted when filing for benefits from the Flexible Benefit Account. A Participant must submit the form and evidence within 12 months of the date the claim was incurred. Only claims incurred after the Flexible Benefit Account is adopted for a Local Union may be submitted. A charge is incurred at the time the service is rendered or the item is purchased. In addition, a charge is deemed incurred when an advance payment is made for orthodontic services, provided satisfactory substantiation of the payment is provided to the Fund Office to the extent permitted by applicable law. Except where an individual's Flexible Benefit Account is forfeited as described below, a former or retired Participant with an Account balance is eligible to use his or her Account for reimbursable expenses. The Participant does not need to be eligible for regular Plan benefits when the Covered Expense is incurred, the reimbursement request is submitted or received or when the check is issued.

The total amount of claims submitted at one time must equal at least \$100. The Plan will issue Flexible Benefit reimbursement checks weekly or as soon as administratively feasible. The Plan will annually reimburse Participants whose claims do not exceed \$100. The Flexible Benefit Account will not issue partial payments. Amounts not spent in a calendar year remain available in later years.

Forfeiture of Flexible Benefit Account. A Participant's Flexible Benefit Account will be forfeited to the Plan in the following circumstances:

- **Upon Death.** Upon a Participant's death, the entire balance of the Account will become available to the Participant's eligible Dependents. The Participant's eligible Dependents may request reimbursement from the Account until the Account balance is zero, the Account is forfeited for the reasons below, or the Plan ends. If there are no surviving Dependents, the balance will be forfeited to the Plan.
- **Forfeiture of Inactive Account.** A Participant's Flexible Benefit Account will be forfeited if there is no account activity (no contributions to or benefits paid from) for five consecutive calendar years or for accounts holding \$400 or less an entire calendar year.
- **Forfeiture of Account Due to Opt-Out.** If you or, upon your death, your eligible Dependent elects to opt out of the Flexible Benefit Account (as described below), the balance will be forfeited to the Plan.



- **Forfeiture Due to Non-Contributory Employment.** Your Account will be terminated and forfeited to the Plan if you perform work with a non-contributing employer that would qualify as Covered Employment if it had been performed for a contributing Employer within the jurisdiction of the Plan. However, if you return to covered employment with a contributing Employer your Flexible Benefit Account can be reinstated on the same date dollar bank credits are reinstated as described on page 2.

Opting-Out of the Flexible Benefit Account

You will be given an opportunity to opt-out of the Flexible Benefit Account and waive future reimbursements from the Account at the following times:

- Annually, while you remain covered under the Plan;
- Upon termination of eligibility for Plan coverage;
- Upon becoming eligible for Retiree coverage; and
- Upon notification you sign up for a subsidized plan under the Affordable Care Act ("PPACA" or "ACA") marketplace.

Additionally, upon your death, your eligible Dependents will be given an opportunity to opt-out of Flexible Benefit Account coverage and waive future reimbursements from your Account.

If you or, upon your death, your eligible Dependents elect to opt-out of your Flexible Benefit Account, any amounts remaining in the Account will be forfeited to the Plan. Your Account will not be reinstated if you subsequently elect to reenroll in the Flexible Benefit Account. Any contributions to the Flexible Benefit Account received on your behalf after you opt-out will be forfeited to the Plan.

Coordination of Benefits. For purposes of coordination of benefits, the Flexible Benefit Account is not considered a group health plan and will not be taken into account when determining other benefits payable under this Plan or any other plan, except for Medicare. The use of benefits under the Flexible Benefit Account program may be restricted under some circumstances for active Employees or their Dependents who are enrolled in Medicare.

Retirees, Early Retirees and their Dependents covered by this Plan will be ineligible for the Plan's Prescription Drug Benefit Program and prescription drug benefit reimbursement under the Flexible Benefit Account Program effective on the date of enrollment in a Medicare Part D plan.

Supplemental Unemployment Benefits ("SUB")

1. **Overview.** The Plan's SUB feature is intended to provide an eligible Participant who has involuntarily terminated employment with a \$250 weekly benefit during a period in which the Participant qualifies for unemployment benefits. SUB payments are subject to state and federal income tax withholding.
2. **Eligibility.** To qualify for a SUB payment during the first six weeks of unemployment, the Participant must submit a state unemployment compensation receipt to the Plan. The Participant must submit the receipt within 30 days after he receives it.

After the sixth week of unemployment, the Participant must timely submit both a state unemployment receipt and evidence that he has signed Book One or taken other action to obtain employment through his Local Union's employment referral process. SUB payments may also be available following exhaustion of state unemployment benefits in certain situations.

Participants must elect SUB pay as soon as they qualify for payments. If you qualify to receive SUB benefits but fail to submit a request for benefits, you will still be subject to taxation on the amount that would have been paid if you had requested benefits at the time you qualified.

3. **Funding.** Before a SUB account can be established, a Participant's Local Union and Employer must agree to modify the collective bargaining agreement to redirect eight percent of the Participant's defined contribution pension plan contribution to an individual SUB account that the Plan will establish on behalf



of the Participant. Once the SUB account reaches \$4,500, the employer contributions will again be made to the Participant's defined contribution pension plan account.

All earnings on a Participant's SUB account assets will be credited to the Participant's account (reduced by expenses the Plan incurs administering the SUB program). The Plan will pay a single \$300 holiday benefit to Participants after October for any calendar year in which the Participant's SUB account exceeds \$5,500.

4. **Benefit Duration.** Weekly benefits will be paid to an eligible Participant until there is less than \$250 in the Participant's SUB account.
5. **Death and Retirement.** Upon retirement, a Participant's SUB account will be transferred to his Flexible Benefit Account or, if a Flexible Benefit Account is not maintained for the Participant, to his dollar bank. If a Participant dies before his SUB account is exhausted, the assets remaining in the SUB account will be transferred on behalf of the Participant's surviving spouse and other dependents to the Participant's Flexible Benefit Account or, if a Flexible Benefit Account is not maintained for the Participant, to the Participant's dollar bank. Any asset that cannot be transferred following death will be forfeited.

The Plan will forfeit the SUB account of an inactive Participant. A Participant is considered inactive if no contribution is made to the Plan on his behalf for 24 consecutive months. The forfeiture will occur after two consecutive Plan Years. The Plan will transfer SUB account assets of an inactive employee to the employee's Flexible Benefit Account or if not maintained, to the Participant's dollar bank at the time the forfeiture would otherwise occur.

The SUB is not a pension benefit; the benefit does not vest.

General Exclusions and Limitations

The General Exclusions and Limitations apply to all Plan benefits, including Optional Benefits. If any services or supplies are not particularly addressed in the Restated Health and Welfare Plan Rules and Regulations, whether as an exclusion or covered expense, it is not to be assumed that such services or supplies are covered under this Plan. The Plan shall not provide benefits for any expenses directly or indirectly related to the following:

1. If, with respect to an accidental Bodily Injury or illness, an Eligible Individual is entitled, or could have been entitled if proper application had been made, to any medical benefits paid by, reimbursed by or provided by or under the authority of any government or any governmental agency, such benefit shall discharge the obligation of this Plan as though and to the extent such benefit had been paid hereunder, but no claim will be denied solely because treatment or services are rendered in a Hospital owned or operated by a State or political subdivision thereof;
2. Any charge under more than one type of coverage, unless specifically provided otherwise;
3. If the Eligible Individual is not obligated to pay, is not billed or would not have been billed except for the fact that the person was covered under this Plan; however, to the extent required by law the Plan will reimburse a Veterans Administration Hospital for care of a non-military service connected disability;
4. Medical services or supplies unless such service or supply is provided for the treatment or diagnosis of an accidental Bodily Injury or illness and is prescribed by, or made at the direction of a Physician, except when such charges are provided as a benefit under the Plan (e.g., routine physical examinations and related charges);
5. Accidental Bodily Injury or illness resulting from and arising out of or occurring in the course of any employment or occupation for wages, compensation or profit, including work performed outside the Eligible Individual's regular trade for an employer who should have been covered under Workers' Compensation except for Death Benefit and Accidental Death and Dismemberment Benefits;
6. Hearing aid or the fitting thereof except as described on page 21;
7. Eye examination or refractions, eye glasses, contact lenses or fitting of eye glasses or contact lenses, except as provided in Optional Vision Benefits;



8. Medical benefits for dental services and supplies, except for oral surgery as described on page 15, and Optional Preventive Dental Benefits and Optional Comprehensive Dental Benefits;
9. Cosmetic, plastic or reconstructive surgery for developmental malformations (except initial plastic, cosmetic or reconstructive surgery due to a condition caused by a malignancy or removal of a benign tumor), or as the result of earlier cosmetic, plastic or reconstructive surgery, unless the surgery is necessary for the repair or alleviation of damage resulting from a disability caused by Bodily Injuries sustained by an Eligible Individual and charges are incurred within 1 year of the Bodily Injury and while coverage as afforded by the Plan is in effect with respect to such individual; or the surgery is necessary because of a congenital disease or anomaly of a Dependent child which has resulted in a functional defect;
10. Custodial Care, medical care or treatment and services or supplies for which charges are made by a nursing home, rest home, convalescent home, or similar establishment;
11. Accidental Bodily Injury or illness resulting from any act of war, armed invasion or aggression which shall have occurred after the effective date of coverage;
12. Accidental Bodily Injury or illness incurred while in service in the Armed Forces of any country;
13. Accidental Bodily Injury or illness resulting from any release of nuclear energy, except when being used solely for medical treatment of an illness or Bodily Injury of the Eligible Individual under direction and prescription of a Physician;
14. Accidental Bodily Injury or illness resulting from or occurring during the commission or attempted commission of a criminal act by an Eligible Individual except that losses resulting from acts of domestic violence will be covered;
15. Replacement or repair of any prosthetic device, except once in a 5 year period, unless due to the patient's pathological changes or normal growth and is Medically Necessary and Reasonable;
16. Milieu therapy or recreational therapy; or Naprapathy therapy;
17. Orthopedic shoes, or supportive devices for the feet, such as arch supports, heel lifts, orthotics, except for the benefit for orthotics on page 18;
18. Confinement, treatment, services, medications or prescription drugs provided for or in connection with a surrogate pregnancy (including, but not limited to, pre-natal, delivery and post-natal expenses of the mother, the host (surrogate) mother or child) or for or in connection with infertility, restoration of fertility or the promotion of conception, including, but not limited to artificial insemination, in-vitro fertilization, gamete intra fallopian tube procedures or revision of surgically induced infertility;
19. Over-the-counter birth control pills and contraceptive devices, except as required by PPACA, genetic counseling or confinements, treatment, services, medications, or prescription drugs for sexual impotency.
20. Rental and/or purchase of humidifiers, air conditioners, exercise equipment, whirlpools, hot tubs, health spa or club, athletic club, or swimming pools, whether or not prescribed by a Physician;
21. Charges incurred prior to the individual's effective date of coverage;
22. Transsexual surgery;
23. Private duty nursing care, medical care or treatment, performance of surgical procedures, or physical therapy, when those services are rendered by a professional that ordinarily resides in the Eligible Individual's home or who is a member of the Eligible Individual's immediate family;
24. Callus or corn paring, toenail trimming or excision for toenail trimming, treatment of chronic conditions of the foot, such as weak or fallen arches, flat or pronated foot metatarsalgia (plantar fasciitis) or foot strain;



25. Weight loss or physical fitness programs, weight loss clinics, Cardiac Rehab Phase III, or obesity, except for gastric bypass surgery to treat Morbid Obesity and limited to a lifetime maximum of one surgery;
26. Non-surgical treatment or services rendered in connection with disturbance of the temporomandibular joint (TMJ/TMD dysfunction/pain syndrome);
27. Marital counseling;
28. Orthoptics or vision training;
29. Speech Therapy that is not for correction of a pathological functional disorder;
30. Laetrile, enzymes and food supplements;
31. Pre-Menstrual Syndrome (PMS);
32. Chelation therapy;
33. Experimental and investigative treatment procedures, facility, equipment, supplies or drugs, including prescription drugs that are not approved by the FDA for the use for which the drug is prescribed, except that, to the extent required by PPACA, the Plan will not deny any Qualified Individual the right to participate in an Approved Clinical Trial; deny, limit or impose additional conditions on the coverage of Routine Patient Costs for items and services furnished with participation in the Approved Clinical Trial and will not discriminate against a Qualified Individual who participates in such Clinical Trial. Qualified Individuals must use a PPO Provider if the PPO Provider is participating in an Approved Clinical Trial.
34. Insulin pumps (before 30 day trial use period has expired), blood pressure kits, monitoring devices and other similar devices, other than pacemakers, which can be permanently implanted;
35. Travel expenses of Eligible Individual, except as provided for transplant recipient, or Physician;
36. Preparing medical reports or itemized bills;
37. Telephone consultations, except as described on page 17;
38. Wigs, artificial hairpieces;
39. Acupuncture;
40. Elective procedures (e.g., mastectomies, abortions);
41. Personal convenience items, education materials, etc.
42. Expenses for grandchildren or children of Dependent children;
43. Court ordered classes or treatments;
44. Lamaze classes;
45. Vocation rehabilitation;
46. All transplants, except those listed on page 20 of the Medical Benefits section.
47. Donor expenses related to transplants, except for available coverage as part of an inclusive case rate provided in the transplant network;
48. Non-surgical treatment of hemorrhoids (obliteration);
49. Drug testing required by an employer for employment;



50. Stop smoking substances and devices, programs and clinics regardless of whether prescribed by a Physician unless otherwise covered under the preventive care services or the Prescription Drug Benefit section page 22;
51. Massage therapy, self-help and stress management, and exercise stress testing and perceptual therapy;
52. Occupational Therapy which retrains an individual for a job or career, Physical Therapy or Speech Therapy, except as provided by the Plan;
53. Biofeedback;
54. Hypnosis;
55. For or relating to any special education rendered to any Eligible Individual. This limitation applies regardless of the type of education, the purposes of the education, the recommendation of the attending physician or the qualifications of the individual(s) rendering the special education. This limitation shall include, but is not limited to, programs for monitoring and management of pain, including biofeedback, and nutritional and dietary counseling or therapy;
56. Sales taxes; and
57. Virtual colonoscopies.
58. For and relating to programs for monitoring and management of pain unless determined by the Plan, in consultation with its medical review firm as necessary, to be the appropriate prescribed course of treatment for the diagnosis rendered and Medically Necessary and Reasonable.

Coordination of Benefits

Your Plan is designed to provide reimbursement for covered medical, dental and vision expenses. It is the intention of the Trustees that you should never receive in excess of 100% of your covered expenses. If you are also covered under another health plan, you may not recover more than your actual covered expenses.

If the other plan does not have a coordination of benefits provision, then the other plan will pay first up to its allowable limits. Only after such payment will this Plan be liable.

If the other plan also has a coordination of benefits provision, the coverage as an employee pays first and coverage as a dependent pays second. Notwithstanding anything to the contrary, if the Eligible Individual is also a Medicare beneficiary and, under Medicare rules, Medicare pays second to the plan covering the Eligible Individual as a dependent and pays before the plan covering the Eligible Individual as other than a dependent (such as a retiree), the plan covering the Eligible Individual as a dependent pays before the plan covering the Eligible Individual as other than a dependent (retiree).

In the case of children, the plan insuring the parent whose birthday occurs earlier in the calendar year pays first.

In the event of divorce or legal separation, the plan covering the child as a dependent of the natural parent who has responsibility for health care under a court order will be the primary plan and will pay first. If there is no court order, usually the plan covering the natural parent who has custody or, if joint custody, primary physical placement of the child pays first. In the event of joint custody and there is no court order, the plan insuring the parent whose birthday occurs earlier in the calendar year pays first.

For purposes of coordinating benefits, this Plan will not consider charges as Allowable Expenses for services that would have been provided under an HMO (Health Maintenance Organization) program had the individual used the participating providers and required HMO procedures for receiving treatment (within or outside the applicable service area). If your Dependents have primary HMO coverage, they should use such coverage for their benefits, as this Plan is not obligated to pay for such when they elect, on their own, to use a non-HMO provider.



The benefits of a plan which covers the Eligible Individual as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that Eligible Individual as a laid off or retired employee (or as that employee's dependent). The benefits of a Plan covering the Eligible Individual as an Employee or as the dependent of an Employee will pay before a Plan covering the individual under COBRA Continuation Coverage or any other right of continuation coverage provided under federal or state law.

This Plan's Order of Determination will be followed, regardless of another plan's compliance, and this Plan will be secondary in all cases where its Order of Determination specifies it is secondary. If the plans do not agree on Order of Determination this Plan will subordinate benefits with any payments received from the other plan when this Plan determines it is secondary.

When another plan is maintained by the employer of an Eligible Individual who is also covered by this Plan and the other plan attempts to disregard industry-wide coordination of benefit provisions by adopting a provision that excludes or limits the other plan's benefits to a person covered by this Plan, the arrangement of the other plan is considered by this Plan to have no force or effect. This Plan will coordinate its benefits with the benefits that would have been provided by the other plan if that Provision did not exist.

In the event this Plan makes an overpayment due to your failure to report other coverage or for any other reasons, the Trustees have the right to recover the amount of the overpayment from you.

If you request a copy of an explanation of benefits ("EOB") noting the amount paid on a specific charge, other than the EOB automatically provided when payment is made, you will be charged for the copy.

Coordination With Medicare

This Plan will be primary over Medicare for Active Employees who are age 65 or older and the spouse age 65 or older of an Active Employee.

This Plan will be primary over Medicare for disabled individuals for services furnished, regardless of entitlement or potential entitlement to Medicare if the Eligible Individual is under age 65, an Active Employee or Dependent of an Active Employee, and entitled or potentially entitled to Medicare as a disabled beneficiary other than as an ESRD beneficiary.

This Plan will pay benefits regardless if an Eligible Individual is entitled to Medicare as an ESRD (End Stage Renal Disease) beneficiary, and not more than 30 months has elapsed since the earliest of the following:

1. The fourth month after the Eligible Individual began a regular course of renal dialysis (or the first month of dialysis if the Eligible Individual has taken a course in self-dialysis training before the third month of dialysis and expects to give himself dialysis treatments);
2. The month the Eligible Individual received a kidney transplant;
3. The month the Eligible Individual was admitted to the Hospital in anticipation of a kidney transplant that was performed within the next 2 months; or
4. The second month before the month the kidney transplant was performed, if performed more than 2 months after admission.

This Plan will be secondary to Medicare in all other cases and Allowable Expenses shall be reduced so the sum of benefits paid between this Plan and Medicare shall not exceed the total amount of the Allowable Expense.

The term "Allowable Expense" for Medicare Coordination of Benefits is the Usual, Customary and Reasonable charge as determined by the Plan, which is for medical care and treatment of the type and kind covered by both Medicare and the Plan. Charges made by Physicians who do not accept assignment of benefits from Medicare may not exceed the limiting charge provided for under federal law.

Eligible Individuals are responsible for enrolling in Part A and Part B of Medicare. If an Eligible Individual fails to enroll, this Plan will coordinate with Medicare benefits and if this Plan is determined to pay second, will reduce its benefits regardless of whether the Eligible Individual has enrolled for Medicare benefits. At



present, there is no cost for Part A, which provides hospital benefits. Part B covers such items as doctors' services. The government makes a monthly charge for Part B. If an Eligible Individual wants information about Medicare enrollment, contact the local Social Security office (at least two months before the Individual's 65th birthday, if possible).

Retirees, Early Retirees and their Dependents covered by this Plan will be ineligible for the Plan's Prescription Drug Benefit Program and prescription drug benefit reimbursement under the Flexible Benefit Account Program effective on the date of enrollment in a Medicare Part D plan other than an Employer Group Waiver Plan ("EGWP") sponsored by a CMS approved administrator and adopted by the Trustees from time to time.

Subrogation and Reimbursement

The Plan is not designed to pay expenses covered by another person or party who may have caused harm to you or your Dependents. Examples of this type of situation include an automobile accident or a product liability case. If such a situation arises, call the Fund Office.

The Plan shall be subrogated to all rights of recovery of a Participant, his or her parent(s) and dependent(s) or a representative, guardian or trustee of the Participant, his or her parent(s) and Dependent(s) (collectively the "Claimant"), relating to any claim paid or obliged to be paid by the Plan. The subrogation rights applies on a priority, first dollar basis to any recovery received by or payable to or on behalf of the Claimant by suit, settlement or otherwise. This right applies to any recovery, regardless of whether it is a partial or full recovery or whether the Claimant is made whole, from any source making a payment for the injury, illness or conditions relating to the claim. It further applies, regardless of whether the source admits it is liable. Possible sources include, but are not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, financial responsibility, uninsured or underinsured insurance coverages, as well as medical reimbursement coverage purchased by the Claimant or by any responsible party.

In addition to its subrogation rights, the Plan is granted a right of reimbursement from any recovery from any source, including a partial or full recovery, and regardless of whether it is by suit, settlement or otherwise or whether the Claimant is made whole. Consistent with this right, the Claimant shall first reimburse the Plan on a priority basis for the full amount of all payments the Plan made or may be obliged to make for the claim. This means, for example, that if a covered person has claims, such as medical or loss of time, as a result of an accident for which the Plan pays or would pay benefits, the Plan is entitled to be reimbursed in full first from any recovery the covered person makes from any source relating to the accident. Once the Plan makes or is obligated to make payments on behalf of the Claimant, the Plan is granted, and the Claimant consents to, an equitable lien by agreement or constructive trust on the proceeds of any payment, settlement or judgment received by the Claimant from any source.

The Plan disavows any claims the Claimant may make under the common fund doctrine. This means the Plan will not be responsible for any of the Claimant's attorneys' fees or costs incurred in seeking a recovery unless the Plan has agreed, in writing, to pay such fees or costs.

In situations where a Claimant has been asked to complete a Subrogation and Reimbursement Agreement in a form acceptable to the Trustees, the Fund Office may suspend the processing and payment of any claims that relate to the incident or condition to which the Plan relates until the signed Subrogation and Reimbursement Agreement is received by the Fund Office. In accepting benefits from the Plan, the Claimant agrees that any and all amounts recovered will be applied first to reimburse the Plan. In addition, if requested in writing by the Trustees or the Plan's representatives, the Claimant or the Claimant's authorized representative shall take action as necessary or appropriate to recover any and all payments the Plan made or is obliged to make. If the Claimant does not, the Plan will be entitled to exercise its rights in the Claimant's name.

The Claimant shall not do anything to impair, release, discharge or prejudice the Plan's rights to subrogation and reimbursement. The Claimant shall assist and cooperate with the Plan's representatives and shall do everything needed to allow the Plan to enforce these rights. The Claimant shall hold in trust for the Plan's benefit that portion of the total recovery from any source which is due for any claim paid or obliged to be paid by the Plan. The Claimant shall reimburse the Plan immediately upon recovery.

The Claimant must provide the Plan with a copy of any judgment, settlement agreement or other document obtained in connection with the recovery. Any claim that is first received by the Plan after a recovery,



regardless of when a claim is incurred, is the Claimant's responsibility and is paid by the Claimant and not the Plan to the extent of the Claimant's net recovery. If the Plan inadvertently provides benefits for such a claim, the Claimant is obligated to repay the Plan to the extent of the Claimant's net recovery.

If you or your agent receive a recovery from any source but do not reimburse the Plan, the Plan shall have the right to reduce future benefits on the claims you and your eligible dependents submit or reduce the amount of the dollar bank until the Plan has recovered the full amount allowed under the Plan's subrogation and reimbursement provision. The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests through any appropriate legal or equitable remedy, including but not limited to the initiation of a collection action under ERISA or applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any Claimant for recovery from any reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

The Trustees of the Plan may waive the above right to subrogation and reimbursement if they determine that doing so is in the best interest of the Plan and its Participants.

Work-Related Injury or Sickness

The Plan does not provide benefits for loss of time or medical care for work-related injuries or sickness. A Participant should apply for payment of benefits from Workers' Compensation and, if denied, appeal the denial. If the appeal results in a determination that the injury or sickness was not work-related, the Participant should submit any claims to the Plan along with a copy of the appeal denial letter. During a Workers Compensation appeal, the Plan may advance payment of benefit on an interim basis provided the Participant agrees in writing to repay 100% of these benefits from any recovery.

Claims/Terms for Filing a Claim and Payment of Claims

Disability claims must be filed within 6 months of the date the disability began. All other claims must be filed within one year of the date the expenses are incurred. No benefits will be paid on bills or claims received (Plan Office date stamped) more than one year after the date the expense was incurred.

The Plan will pay benefits directly to the Eligible Individual, unless a signed and dated authorization to pay benefits to the provider of the service or another individual or entity is received with the claim. The Trustees reserve the right to make payments directly to the Eligible Individual without regard to a signed authorization or assignment directing payment to the provider. The Trustees require an Eligible Individual to complete and file all claim forms approved by the Trustees and to furnish all pertinent information and documents requested by the Trustees, including enrollment materials, required to properly process and pay claims before a payment is made on an Eligible Individual's behalf.

All claims submitted must be honest, accurate and as complete as possible. If the Trustees find there has been intentional falsification or any document submitted in support of a claim by forgery or intentionally inaccurate information or any other fraudulent means whatsoever, coverage can be terminated and/or the claim may be denied. If coverage is terminated, the coverage will be that of the Eligible Employee and Dependents who are related to the person submitting the false or fraudulent claim.

Claims should be filed at the Fund Office at the address on page 64.

The Plan and Board of Trustees, in making decisions on claims and on appeal, will apply the terms of the Plan and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with these documents, and where appropriate, applied consistently with respect to similarly situated claimants. Also, the Plan and Trustees will take into account all information you submit in making decisions on claims and on appeal. The Trustees will review all claims and appeals impartially and without conflicts of interest.

You may name a representative to act on your behalf. To do so, you must notify the Plan in writing of the representative's name, address and telephone number.



MEDICAL, DENTAL OR VISION BENEFIT CLAIMS AND APPEAL PROCEDURE

(1) **Claim Denial.** The length of time required to process the claim depends upon the type of claim. A claim can fall into one of the following categories:

1. **Pre-service claim** - A Pre-service claim is one that requires pre-approval before services are performed under the terms of the Plan of benefits. The requirements for preauthorization or preapproval are described elsewhere in the Summary Plan Description (page 12-13). Your Pre-service claims will be decided within 15 days of receipt by the Plan. If the Plan determines that an extension of this time is necessary, the claim will be decided within 30 days of receipt (unless the period is tolled while the Plan waits for information it requested from you). You will be notified of the need for an extension within 15 days of receipt of the claim and the reasons why the extension is needed.

If the Plan needs more information from you to process the claim, you will have 45 days to provide the needed information to the Plan. If you do not provide the information requested, your claim will be denied. If you provide the requested information, the Plan will issue its decision within 15 days of the date you submit such information.

Urgent Care claim - An Urgent Care claim is a pre-service claim that must be processed quickly to prevent serious jeopardy to you or your Dependent's life or health. Urgent Care claims also include those claims that, in the opinion of your doctor, would subject you to severe pain that cannot be managed without the care or treatment requested under the claim. Effective July 1, 2011, your Urgent Care claims will be processed within 24 hours after receipt by the Plan.

If the Plan needs more information from you to process the claim, you will have 48 hours to provide the necessary information. The Plan then has 48 hours to decide the claim after receiving this information. An Urgent Care claim to extend Concurrent Care (described below) will be decided within 24 hours (if you make the claim at least 24 hours before treatment expires).

If your Urgent Care claim is filed improperly, then you will be notified by telephone, told how to correct it and given a chance to correct it within 24 hours. If you do not provide the information requested, or do not properly refile the claim, the Plan will have to decide the claim on the information it has, and your claim may be denied. Due to the nature of an Urgent Care claim, you may be notified of a decision via telephone. This will be followed by a written notice of the same information within three days of the oral notice.

2. **Post-service claim** - A Post-service claim is any other type of claim under the Plan, such as a payment for covered services after a doctor visit and whenever you have already received the treatment or supply for which payment is now being requested. You will be notified if your claim is denied within 30 days after receipt of the claim by the Plan. If the Plan determines that an extension of this time is necessary to decide the claim, the claim will be decided within 45 days of receipt (unless the period is tolled while the Plan waits for information it requested from you). You will be notified of the need for an extension within 30 days of receipt of the claim and the reasons why the extension is needed.

If the Plan needs more information from you to process the claim, you will have 45 days to provide the needed information to the Plan. If you do not provide the information requested, your claim will be denied. If you provide the requested information, the Plan will issue its decision within 15 days of the date you submit such information.

3. **Concurrent Care claim** - A Concurrent Care claim is one for which the Plan is requested to approve, or has already approved and is requested to extend such approval, for coverage of an ongoing course of treatment to be provided over a period of time or a certain number of treatments. If the Plan determines that course of treatment will be stopped or reduced before the previously approved number of treatments or period of time expires, you will be notified within a sufficient amount of time to allow an appeal before the Plan stops or reduces coverage for the ongoing treatment. If you request that a Concurrent Care treatment be extended beyond the initially determined time, your claim will be decided no later than 24 hours after your claim is received by the Plan (if you make the claim at least 24 hours before the period or number of treatments expires).



- (2) **Notice of Claim Denial.** If all or part of your claim is denied, you will receive a written explanation that includes information sufficient to identify your claim, describes the specific reason for the denial (including the denial code and its corresponding meaning), the specific provisions of the Plan document on which the decision was based, any additional information necessary to reconsider your claim (and the reasons why that information is necessary). Additionally, the notice will include a provision stating that diagnosis and treatment codes (as well as their corresponding meanings) are available upon request. The notice also will include the Plan's appeal procedures and the time limits for use of those procedures and will advise you of your right to bring an action under ERISA or to request an external review by an independent review organization if you decide to appeal and your appeal is denied.

If the Plan relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, etc., or a statement that it was relied upon and is available upon request and free of charge. Additionally, if the Plan based its decision on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the scientific or clinical judgment related to your condition or a statement that such an explanation is available upon request and free of charge. If the Plan received the advice of any medical or vocational expert with respect to your claim, the Plan will identify the expert upon your request.

- (3) **Appeal Procedure.** If your claim is not an Urgent Care claim and is denied, you (or your authorized representative) may, within 180 days from receipt of the denial, request a review by writing to the Board of Trustees. If you are appealing an Urgent Care claim denial, you may do so orally by calling the Fund Office at 1-800-422-2128 or 1-608-276-9111 or in writing. Your written appeal should state the reason for your appeal. You (or your authorized representative) may receive, upon request and free of charge, reasonable access to and copies of any documents relevant to your claim and may submit issues and comments in writing. In addition, you shall receive copies of any new or additional information considered, relied upon, or generated during the appeal as well as any new or additional rationale for the denial, if any.

The Board of Trustees will determine all requests for review for claims that were denied on the basis of the Plan's eligibility rules.

If the Trustees review your appeal, the amount of time the Trustees have to issue a decision after receiving your appeal will depend on the type of claim.

1. **Pre-service claims** - Appeals of Pre-service claims will be decided within 30 days after the Trustees or their authorized Committee receive the appeal.

Urgent Care claims - Appeals of Urgent Care claims will be decided within 72 hours after the Trustees or their authorized Committee receive the appeal. You may appeal denials of Urgent Care claims either orally by calling the Fund Office at 1-800-422-2128 or 1-608-276-9111 or in writing. All information necessary to decide the appeal may be transmitted via telephone, facsimile or other available method.

2. **Post-service claims** - Appeals of Post-service claims will be decided at the next quarterly meeting of the Trustees or their authorized Committee immediately following the receipt of your appeal unless your appeal was received by the Trustees within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will receive a decision no later than the third quarterly meeting, and you will be notified in writing of the need for the extension, why the extension is needed, and when a decision is expected. The Trustees will send you a notice of this decision within 5 days of the decision.
3. **Concurrent Care claims** - Appeals of Concurrent Care claims are governed by the provisions above for Urgent Care, Pre-service or Post-service claims, whichever applies to the particular claim.

- (4) **Notice of Appeal Denial.** If all or part of your claim is denied on appeal, you will receive a written explanation that includes information sufficient to identify the claim and that describes the specific reason for the denial (including the denial codes and their corresponding meanings), the specific provisions of the Plan document on which the decision was based, a discussion of the Trustees' decision, any additional information necessary to reconsider your claim (and why that information is necessary), notice that you may receive on request access to and free copies of documents and records relevant to your claim, a provision stating that diagnosis and treatment codes (and their



corresponding meanings) are available upon request, and a statement of your right to bring a lawsuit under ERISA or to request an external review by an independent review organization.

If the Trustees relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, guideline or protocol, or a statement that it was relied upon and is available upon request and free of charge. If the Trustees based their decision on a medical claim on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the scientific or clinical judgment related to your condition or a statement that such an explanation is available upon request and free of charge. If the initial decision on a medical claim was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination (but not a subordinate of such person). In reviewing a denied medical claim, the Trustees will not automatically presume that the Plan's initial decision was correct. Rather, the medical claim will be reviewed independently based on all information you provided to the Trustees, including any new information that you provide that was not reviewed during the Plan's initial decision.

If your claim is denied, in whole or in part, you are not required to appeal the decision to the Board of Trustees. Similarly, if your appeal is denied, in whole or in part, you are not required to request an external review. However, it is important to note that you must exhaust your administrative remedies by appealing the denial of your claim for benefits to the Board of Trustees before you have the right to request an external review or to file suit in state or federal court under section 502(a) of ERISA. Failure to exhaust these administrative remedies will result in the loss of your right to request an external review or file a lawsuit, as described in the ERISA Rights statement in the SPD. Notwithstanding the above, if the Plan fails to adhere to all new claims and appeals requirements, you will be deemed to have exhausted this claim appeals process and may seek an external review or file a lawsuit, unless the Plan's failure is de minimis. If a claim has been submitted for appeal and denied, no lawsuit or other action against the Plan or Trustees may be filed after 12 months from the date the appellant has been given written notice of the decision.

- (5) **External Review Procedure.** If your appeal is denied, in whole or in part, you have the right to have the decision reviewed by an independent review organization. The Plan offers this right in accordance with and to the extent required by available guidance issued by the Departments of Labor and Health & Human Services and the Internal Revenue Service. You (or your authorized representative) may, within 4 months from receipt of the appeal denial, request an external review from an independent review organization by writing to the Board of Trustees. Your written request should state the reason for your request. You may submit copies of evidence supporting your request for review. The Board of Trustees will determine whether the request is eligible for external review. Only claim denials involving a medical judgment or a rescission of coverage are eligible for external review.

Loss of Time or Short-Term Disability Benefit Claims and Appeal Procedure

- (1) **Claim Denial.** All claims by Participants for benefits under the Plan shall be filed in writing on forms provided by the Trustees. If a claim for benefits is denied, in whole or in part (or benefits are reduced or terminated), you will receive a written explanation of the reason(s) it was denied within 45 days after the claim has been received by the Fund Office. If the claim is denied, you will receive a written explanation that describes the specific reason for the denial, the specific provisions of the Plan document on which the decision was based, any additional information necessary to reconsider the claim, the Plan's appeal procedures, and also the right to bring an action under ERISA if the claimant decides to appeal and that appeal is denied. If additional time is required because of special circumstances, you will be notified in writing of the reason for the delay within the 45-day period and the date that the Plan expects to issue a final decision. You will have at least 45 days to provide the information. A decision will be made with respect to the claim within 30 days of the deadline or the date that you respond. If circumstances warrant, a final extension of up to 30 days may be utilized.
- (2) **Appeal Procedure.** You can appeal the claim denial to the Board of Trustees within 180 days from receipt of the denial.

The written appeal must include all the facts regarding the claim as well as the reason(s) you believe the denial was incorrect. You will receive, if requested, reasonable access to and copies of documents relevant to the claim at no charge. You may submit issues and comments in writing, and documents,



relating to the claim. You may name a representative to act on your behalf by notifying the Plan in writing of the representative's name, address, and telephone number.

The Board of Trustees (or its authorized committee) will follow the same appeal procedure for Loss of Time Benefits as is followed for Medical Post-service claims (pages 37-39).

Optional Supplemental Unemployment Benefits (SUB)

The Board of Trustees (or its authorized committee) will follow the same claims filing and appeal procedures for SUB Benefits as is followed for Medical Benefit Post-service claims (pages 37-39).

Overpayment of Benefits

In the event any payment is made by the Plan to or for an individual (e.g., a Participant, Dependent or provider) who is not entitled to such payment or the full amount of such payment, the Plan can suspend or withhold payment of claims and reduce future payments due to such person and/or, if applicable, his dependents by the amount of any erroneous payment and by the amount incurred by the Plan in pursuing the overpayment. The Plan and Trustees in their sole judgment, may take other actions to recover the erroneous payments and other amounts, including, but not limited to, commencing a restitution action under ERISA or reducing the amount of the Participant's dollar bank until the Plan has recovered the full amount.

Submission of Falsified or Fraudulent Claims

All claims, enrollment forms and any other information submitted or provided to the Fund, directly or indirectly, shall be accurate and complete. If the Board of Trustees finds, at any time, that false or inaccurate information has been submitted or provided to the Fund, directly or indirectly, in support of a claim, the claim shall be denied. The Trustees shall have the right to offset an amount improperly paid as discussed above and/or to terminate coverage for the Eligible Individual and Eligible Individual's covered family members.

Retiree Benefits

Eligibility for Benefits

In order to be eligible for coverage you must be, or have previously been, actively employed by an Employer that makes contributions to the Plan on your behalf. You may also be eligible under Self-Payment provisions of the Plan. If you are covered by the Plan under COBRA Continuation Coverage, you must become eligible again for coverage as an Active Employee.

To qualify as an Early Retiree, you must be covered by the Plan as an Active Employee, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee, be at least 55 years of age, cease from working in the industry, and advise the Fund Office in writing that you are an Early Retiree. An Early Retiree may, prior to age 65, again establish eligibility as an Active Employee as described on page 2.

To qualify as a Retiree you must be covered by the Plan as an Active Employee, Self-Pay Active Hourly Employee or an Early Retiree and be at least 65 years of age. Individuals retiring should contact the Social Security Administration at least 30 days in advance of their 65th birthday.

A Self-Pay Disabled Employee will be eligible as a Retiree upon the Employee's entitlement to Medicare Parts A and B.

Participants should notify the Fund Office at 1(800) 422-2128 prior to the effective date of their retirement.

Coverage as a Retiree or Early Retiree is not considered an accrued benefit.

OPTIONAL
SUPPLEMENTAL
UNEMPLOYMENT
BENEFITS

OVERPAYMENT
OF BENEFITS

SUBMISSION OF
FALSIFIED OR
FRAUDULENT
CLAIMS

RETIRED
BENEFITS

ELIGIBILITY FOR
BENEFITS



Retiree Self-Pay

If you are at least age 55 and under age 65 and not working in the industry, or age 65 or older, you may continue coverage, after using credits in your account, by making required self-payments.

Retiree classifications are:

1. Single on Medicare;
2. Yourself and 1 Dependent (spouse or child)—1 of you on Medicare and the other not on Medicare;
3. Yourself only, not on Medicare;
4. Yourself and 2 or more Dependents (e.g., spouse and child or two children)—1 of you on Medicare and all others not on Medicare;
5. Yourself and your Dependent spouse, both on Medicare;
6. Yourself, Dependent spouse and/or Dependent child or children, none on Medicare; and
7. Yourself, Dependent spouse and/or Dependent child or children, all on Medicare.

Self-Payment Contribution Due Date

Self-payment contributions are due the 15th day of the month prior to the month for which coverage is intended (for example, the January self-payment is due December 15th), with a 5 day grace period. If self-payments are not received on time, coverage will be terminated as of the last day of the month for which contributions were timely made.

Termination of Self-Pay Coverage

Subject to a Dependent's eligibility to continue coverage under the Surviving Dependents Self-Pay Plan or under COBRA, the coverage of any Eligible Individual continuing Plan coverage under the Retiree Self-Pay Program will terminate on the earliest of the following dates:

1. The last day of the month for which the required timely self-payment has been made;
2. Death;
3. The date the Plan is discontinued;
4. Withdrawal as described on page 6. In addition, if your Dependent is covered, coverage for the Dependent will also terminate on one of the dates described on pages 7-8.

Medical Benefits

Retiree medical benefits are the same as the medical benefits described for all other Plan Participants, except where limited by coordination with Medicare described below.

Death Benefits

If you are a Retiree or Early Retiree, you are covered for Death Benefits with the Plan. If you die while still a Participant and prior to your 65th birthday, your Beneficiary will receive a lump sum payment of \$10,000. If you die while still a Participant and between your 65th birthday and your 70th birthday, your beneficiary will receive a lump payment of \$6,500. If you die while still a Participant on or after your 70th birthday, your beneficiary will receive a lump sum payment of \$5,000. If you die without having designated a Beneficiary or if your designated beneficiary has died, then the benefit will be paid in equal shares to the first surviving class of the classes listed in order as follows: (1) your spouse, (2) your children, (3) your parents, (4) your siblings, and (5) your estate.

RETIREE
SELF-PAY

SELF-PAYMENT
CONTRIBUTION
DUE DATE

TERMINATION OF
SELF-PAY
COVERAGE

MEDICAL
BENEFITS

DEATH BENEFITS



Accidental Death & Dismemberment Benefits

Accidental death and dismemberment benefits are not available to Early Retirees or Retired Participants.

Optional Dental and Vision Benefits

Optional dental and vision benefits are not available to Early Retirees, Retirees, or their Dependents.

Prescription Drug Benefits

With the availability of Medicare Part D prescription drug coverage, the Plan continues to provide prescription drug benefits to Retirees and their eligible Dependents who are also eligible for Medicare. In the event a Retiree or a Dependent of a Retiree enrolls in a Medicare Part D program other than the Employer Group Waiver Plan ("EGWP") sponsored by a government approved administrator and adopted by the Trustees, the Plan will terminate coverage for prescription drugs for that individual effective with the Medicare Part D enrollment date.

Coordination With Medicare

Coordination of benefits with Medicare is described on pages 34-35.

Limitation

In the event the Trustees determine that Fund economic conditions warrant such action, the Trustees reserve the right to take action to reduce or modify coverage for Early Retirees and Retirees, including coverage for Dependents, to increase Self-Payments for such coverage, or to completely terminate all or any part of such coverage, at any time and at their sole discretion.

Important Information About the Plan

Plan Administration

Name of Plan. Wisconsin Electrical Employees Health and Welfare Plan.

Type of Plan. This multiemployer group health plan is maintained for the purpose of providing medical, weekly disability, transitional disability, death, accidental death and dismemberment, and optional preventive dental, optional comprehensive dental and optional vision benefits.

Plan Sponsor and Plan Administrator. A Board of Trustees is the Plan Sponsor and the Plan Administrator and the Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of an equal number of employer and employee representatives, selected by the Employers and the Unions which have entered into Collective Bargaining Agreements that relate to the Plan. As of January 2017, the Trustees of the Plan are:

Employee Trustees

SEAN FRANK
IBEW LOCAL UNION 127
3030 39TH AVENUE
KENOSHA WI 53144

DON ALLEN
IBEW LOCAL UNION 158
2970 GREENBRIAR ROAD
GREEN BAY WI 54311

MICHAEL GRASSY
IBEW LOCAL UNION 159
4903 COMMERCE COURT
MCFARLAND, WI 53558

DEAN MILLER
IBEW LOCAL UNION 388
5224 HEFFRON COURT
STEVENS POINT WI 54481

CHRIS GULBRANDSON
IBEW LOCAL UNION 430
1840 SYCAMORE AVENUE
RACINE WI 53406

GREG YOUNG
IBEW LOCAL UNION 577
1024 S LAWE STREET
APPLETON WI 54915

ACCIDENTAL DEATH
&
DISMEMBERMENT
BENEFITS

OPTIONAL DENTAL
AND VISION
BENEFITS

PRESCRIPTION
DRUG BENEFITS

COORDINATION
WITH MEDICARE

LIMITATION

IMPORTANT
INFORMATION
ABOUT THE PLAN

PLAN
ADMINISTRATION



LEO SOKOLIK
IBEW LOCAL UNION 890
17 SOUTH RIVER STREET
JANESVILLE WI 53548

MARK LAUER
IBEW LOCAL UNION 14
9480 HWY 53
FALL CREEK WI 54742

Employer Trustees

LOYAL O'LEARY
WISCONSIN CHAPTER NECA
2200 KILGUST ROAD
MADISON WI 53713

MARK HADY
JH LAMB, LLC
610 UNION STREET
WATERTOWN WI 53098

ROBERT VAN ERT
VAN ERT ELECTRIC
7019 W STEWART AVENUE
WAUSAU WI 54401

RUSS TIMMERS
VAN ERT ELECTRIC
2000 PROGRESS WAY
KAUKAUNA, WI 54130

JOHN GERLACH
NEI ELECTRIC
605 INDUSTRIAL PARKWAY
ST. CROIX FALLS, WI 54024

JOHN DESENS
WESTPHAL & COMPANY, INC.
14 MARCH COURT
MADISON, WI 53718

DAN MURPHY
ROBERT NICKLES ELECTRIC
4269 ARGOSY COURT
MADISON WI 53714

JIM ELAND II
ELAND ELECTRIC CORP.
3154 HOLMGREN WAY
GREEN BAY WI 54304

Trustee Address and Telephone Numbers. If you wish to contact the Board of Trustees, you may use the address and telephone numbers below:

Board of Trustees
Wisconsin Electrical Employees Health and Welfare Plan
2730 Dairy Drive, Suite 101
Madison, Wisconsin 53718
(608) 276-9111 or (800) 422-2128
Monday through Friday 7:00 a.m. to 5:00 p.m.

A complete list of the employers and employee organizations sponsoring the Plan may be examined at this address. A Plan Participant or beneficiary may obtain a copy of this list for a reasonable charge by writing to the Trustees at this address. In addition, upon written request to the Trustees at this address, a Plan Participant or beneficiary may obtain information as to whether a particular employer or employee organization is a sponsor including the sponsor's address.

Type of Administration.

The Board of Trustees has delegated administrative responsibilities to the Plan's Administrative Office or Fund Office. The Administrative Manager is the Chief Executive Officer of the Wisconsin Electrical Health and Welfare Fund Office, LLC.

Wisconsin Electrical Employees Health and Welfare Plan
2730 Dairy Drive, Suite 101
Madison, WI 53718
(608) 276-9111 or (800) 422-2128
Monday through Friday 7:00 a.m. to 5:00 p.m.



The Plan's Administrative Office has been designated as the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal document should be served upon the Plan at the following address:

Wisconsin Electrical Employees Health and Welfare Plan
c/o Administrative Manager
2730 Dairy Drive, Suite 101
Madison, WI 53718

In addition, service of legal process may be made upon any member of the Board of Trustees listed above at the address of the Wisconsin Electrical Employees Health and Welfare Plan or such documents may also be served upon any individual Trustee.

Identification Numbers. The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 39-1651543. The Plan Number assigned by the Board of Trustees is 501.

Plan Year. For purposes of maintaining the Plan's records, the fiscal year of the Plan ends on the last day of December each and every year.

Collective Bargaining Agreements. This Plan is maintained pursuant to one or more Collective Bargaining Agreements. Plan Participants and beneficiaries may examine these Collective Bargaining Agreements at the Plan Administrative Office address listed above and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees.

Funding Medium. Benefits are provided from the Plan's assets which are accumulated under the provisions of the Collective Bargaining Agreement, Participation Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses.

Medical, prescription drug, weekly disability, optional preventive dental, optional comprehensive dental, optional vision, supplemental unemployment (SUB) benefits and flexible benefit account benefits are provided directly by the Plan. The Plan has entered into a contract with Standard Insurance Company to provide death and accidental death and dismemberment benefits and with Northwestern Mutual Life Insurance Company (NML) to provide long-term disability benefits. The Plan has entered into a contract with the Union Labor Life Insurance Company to provide excess stop-loss coverage for certain claims.

The complete Wisconsin Electrical Employees Health and Welfare Plan and copies of the insurance contracts are available for review, upon request, at the Plan Administrative Office.

Rights to Trust Assets. No employee shall have any right to, or interest in, any assets of the Plan upon termination of his employment or otherwise, except as provided from time to time under this Plan, and then only to the extent of the benefits payable under the Plan to such employee out of the assets of the Plan. All payments of benefits as provided for in this Plan shall be made solely out of the assets of the Plan and none of the fiduciaries shall be liable therefor in any manner.

Disclaimer. None of the benefits provided by the Health and Welfare Plan Rules and Regulations other than death, accidental death and dismemberment benefits and transitional disability are insured by any contract of insurance other than through a stop-loss insurance contract and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amounts in the Plan collected and available for such purpose.

Contribution Source. Contributions to the Plan are made by Employers in accordance with Collective Bargaining Agreements between the Union and the Employer, Participation Agreements between the Employer and the Plan in accordance with the Trust Agreement, and in some instances by direct employee and/or beneficiary payments. The amount of the Employer contribution is determined by the provisions of the Collective Bargaining Agreement or Participation Agreement.

Plan Information

Eligibility. The Plans requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described on pages 1-8 of this booklet.



Plan Termination. The Board of Trustees intends to continue the Health and Welfare Plan indefinitely. However, in the event the obligations of all Employers to make contributions to the Plan shall terminate or the Plan otherwise terminates, the Trustees shall determine the disposition of any assets in the Trust remaining after all expenses of the Plan have been paid; provided that any such distribution shall be made only for the benefit of former Participants and for the purposes set forth in the Plan.

Amendment and Termination. In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program of benefits for all Eligible Employees, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time, by majority vote to increase, decrease, change or eliminate benefits, eligibility, rules or other Plan provisions as necessary.

Non-Guarantee of Employment. Nothing contained in this Plan shall be construed as a contract of employment between any Employer and any employee, or as a right of any employee to be continued in the employment of any Employer, or as a limitation of the right of any Employer to discharge any of its employees, with or without cause.

Board of Trustees' Discretion and Authority

Under the documents creating the Plan, the Trustees have sole and absolute discretion and authority to make final determinations regarding any application for benefits, including eligibility for participation, or other benefits available under the Plan, the interpretation of the Plan, Summary Plan Description and Agreement and Declaration of Trust, and any administrative rules adopted by the Trustees. To the extent any such duties are delegated to others, the Trustees retain the right to ultimately decide all appeals, in the Trustees' sole and absolute discretion. Benefits under this Plan will be paid only if and when the Board of Trustees or persons to whom such decision making authority has been delegated by the Trustees, in their sole discretion, decide the participant or beneficiary is entitled to benefits under the terms of the Plan. Any exercise by the Trustees of their discretionary authority with respect to construction and interpretation of the Plan, the Summary Plan Description, and the Trust or eligibility for benefits are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. All questions or controversies of whatsoever character arising in any manner or between any parties or persons in connection with the Plan or Summary Plan Description or its operation, whether as to any claim for benefits, as to the construction of the language of the Plan or this Summary Plan Description or any rules and regulations adopted by the Trustees, or as to any writing, decision, instrument, or account in connection with the operation of the Plan or the Summary Plan Description or otherwise, shall be submitted to the Board of Trustees for decision. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner and the Trustees' decisions will be awarded judicial deference in any subsequent court or administrative proceedings.

The Board of Trustees determines the benefits provided in accordance with all Plan provisions. Any required self-payment contributions may vary depending on the benefits provided and other factors.

The Trustees have the authority and retain the right, by written amendment to the Plan, to change, add, or delete benefits, self-payment contribution rates, eligibility rules, or any other provisions relating to the operation of the Fund or discontinue all or part of this Plan whenever, in their sole discretion, conditions so warrant. If the Plan is amended or modified, you will be notified in writing.

The Trustees also retain the exclusive right to interpret coverage and benefit provisions of the Fund.

Prohibition Against Assignment to Providers

A Participant, or Beneficiary may not assign any right under the Plan or statutory right under applicable law to a provider of services or supplies. A Participant or Beneficiary may not designate a provider of services or supplies as a Beneficiary under the Plan. The prohibition against assignment of such rights includes, but is not limited to, the right to:

- Claim benefits in accordance with Plan procedures and/or federal law (unless the provider has been named the authorized representative to act on behalf of the Participant or Beneficiary);
- Commence legal action against the Plan, Trustees, Fund, its agents, or employees (unless the provider has been named the authorized representative to act on behalf of the Participant or Beneficiary);

BOARD OF
TRUSTEES'
DISCRETION AND
AUTHORITY

PROHIBITION
AGAINST
ASSIGNMENT TO
PROVIDERS



- Request Plan documents or other instruments under which the Plan is established or operated (unless the provider has been named the authorized representative to act on behalf of the Participant or Beneficiary);
- Request any other information that a Participant or Beneficiary as defined in Section 102 of ERISA may be entitled to receive upon written request to the Plan Administrator; and
- Any and all other rights afforded a Participant or Beneficiary under the Plan, Restated Trust Agreement, federal law, and state law.

This provision does not have the effect of prohibiting the claims administrator or the Trustees from mailing payment of benefits under the Plan directly to a provider of services or supplies, to any organization or to any person as is needed to properly carry out the provisions of the Plan.

Your Rights and Protections Under ERISA

As a Participant in the Plan, you are entitled certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About the Plan and Benefits

1. Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all Plan documents, including Health and Welfare Plan Rules and Regulations, insurance contracts, collective bargaining agreements, participation agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for such copies.
3. 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 the summary annual report.

Continue Group Health Plan Coverage

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

You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

If your claim for welfare benefits is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

YOUR RIGHTS
AND
PROTECTIONS
UNDER ERISA

RECEIVE
INFORMATION
ABOUT THE
PLAN AND
BENEFITS

CONTINUE
GROUP
HEALTH PLAN
COVERAGE

PRUDENT
ACTIONS BY
PLAN
FIDUCIARIES

ENFORCE
YOUR RIGHTS



Under ERISA, there are steps you can take to enforce the rights listed above. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (866-444-3272).

Continue Your Coverage through COBRA - General Notice

NOTICE TO COVERED EMPLOYEES AND FAMILY MEMBERS ABOUT COBRA CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

Continuation Coverage. A federal law known as "COBRA" (Consolidated Omnibus Budget Reconciliation Act of 1985), requires that group health plans offer "covered employees" and their families the opportunity for a temporary extension of health coverage ("continuation coverage") in certain instances ("qualifying events") where coverage under the plan would otherwise end. To receive this continuation coverage, the covered employee, dependent spouse or child(ren) must pay the monthly contributions directly to the Fund. This notice is intended to inform you of your rights and obligations regarding COBRA continuation coverage. You should take the time to read this notice carefully. The term "covered employees" will include any individual who is or was provided coverage because of performance of services for one or more employers maintaining the Plan, including partners, independent contractors and other self-employed individuals.

Eighteen (18) Month Continuation. If you are a covered employee, dependent spouse or child covered under the Plan and your group health coverage terminates due to any of the following reasons, called qualifying events, then you will have the right to elect continuation coverage for a maximum of 18 months after the loss of coverage from the qualifying event occurs:

1. A reduction in the covered employee's hours of employment; or
2. Termination of a covered employee's employment (for reasons other than gross misconduct); or
3. The covered employee's retirement; or
4. The date the covered employee enters the Military Service of the United States on full-time active duty.

For persons with dollar bank accounts the 18 months of continuation coverage begins to run from the date of loss of dollar bank eligibility.

If you are a covered employee, dependent spouse or child and disabled (as determined by the Social Security Administration) or become disabled (as determined by Social Security) at any time during the first 60 days of COBRA continuation coverage due to a qualifying event involving termination of employment, or a reduction in hours, the 18 month continuation period may be extended an additional 11 months for all qualified beneficiaries. Your Employer must notify the Plan Administrator of these types of Qualifying Events.

ASSISTANCE WITH
YOUR QUESTIONS

CONTINUE YOUR
COVERAGE THROUGH
COBRA - GENERAL
NOTICE



If the covered employee does not elect continuation coverage, the covered employee's dependent spouse and each eligible adult dependent child will have a separate right to elect it. The covered employee or dependent spouse may elect to continue coverage for minor children. THEREFORE, IT IS IMPORTANT THAT THE COVERED EMPLOYEE, DEPENDENT SPOUSE AND ALL CHILDREN READ THIS NOTICE.

Thirty-Six (36) Month Continuation. If you are the spouse or dependent child of a covered employee and you lose group health coverage under the Plan for one of the following reasons (also qualifying events), you will have the right to elect continuation coverage for a maximum of 36 months after the qualifying event occurs:

1. The death of the covered employee;
2. Divorce or legal separation from the covered employee; or
3. The covered employee becomes entitled to Medicare.

A dependent child of a covered employee who loses group health coverage under the Plan because the dependent ceases to be a "dependent child" as defined on pages 7-8 will have the right to elect continuation coverage for a maximum of 36 months after the qualifying event occurs.

If an Employee is entitled to Medicare at termination of employment the Employee's covered dependents will be entitled to continue coverage for up to 36 months from the date of Medicare entitlement or 18 months from the termination of employment, whichever is longer.

Multiple Qualifying Events. An 18-month period of continuation coverage may be extended to a period of up to 36 months for a covered employee's spouse or dependent child if a second qualifying event occurs within the first 18-month period. For example, if a covered employee's spouse is on continuation coverage for 18 months due to the termination of a covered employee's employment, and during the 18-month period the former employee dies, the spouse will be eligible to extend his or her coverage for up to 36 months from the date of the loss of coverage resulting from the first qualifying event. COBRA continuation coverage cannot extend beyond 36 months from the date coverage is lost from the first qualifying event, and it may end before the 18- or 36-month period expires, as explained later in this notice.

Continuation After Bankruptcy of Employer Under Current Law. A retiree or surviving spouse of a covered employee who loses coverage because the employer has filed for bankruptcy under Title 11 of the United States Code may continue coverage for life for himself and his dependents. If the retiree dies during continuation coverage, covered dependents can continue for an additional 36 months after the death of the retiree. Coverage may end before the maximum period expires as explained later in this notice.

Other Continuation Rights. The maximum period of continuation coverage may be reduced by any period of extended coverage otherwise provided by the Plan.

A child born to or placed for adoption with a covered employee while the employee is maintaining COBRA continuation coverage can be added to the COBRA coverage. Complete a new enrollment card adding the dependent in accordance with the Plan's rates directly after the birth or placement.

What Health Coverage May Be Continued? You are eligible to continue only those medical and Optional Dental and Vision Benefits for which you were covered at termination. If you were covered under medical plus other health benefits, you may elect to continue either medical benefits only or the full package of benefits (excluding death, accidental death and dismemberment and disability benefits). Within the limitations noted above, you will have the opportunity to change health plan coverages in the same manner as covered employees.

How Much Will the Benefits Cost? Any person who elects to continue coverage under the Plan must pay the full cost of the coverage (including both the share you now pay, if any, and the share the Employer now pays), plus any additional amounts allowed by law.

Termination of Continuation Coverage. Under the law, continuation coverage may be terminated before the end of the maximum period of coverage on the following dates:

1. The date the Plan is terminated;



2. The first day of the month for which your contribution for COBRA continuation coverage is not paid on time;
3. The date after the election date that coverage is obtained under another employer maintained group health plan, as an employee, dependent spouse or child of an employee;
4. The date after the individual's election date that he or she becomes entitled to Medicare; or
5. The date the covered employee's employer ceases providing any group health plan to any employee.

If you do not elect continuation coverage, your group health coverage will end. THE PLAN DOES NOT PROVIDE A MEDICAL CONVERSION OPTION AT THIS TIME.

Procedures to Elect Continuation Coverage.

1. In the case of death of the covered employee, termination of employment, reduction in hours, termination of dollar bank eligibility, or entitlement to Medicare, which causes coverage to terminate, you and/or your dependents will receive information from the Plan concerning the continuation of coverage election provisions, including the self-payment rates. Notice to the Plan Administrator should be sent as described in Notice Procedures below.
2. In the case of divorce or legal separation or a dependent child who ceases to qualify as a dependent, the covered employee, spouse or dependent child must notify the Fund Office within 60 days of the event and they will receive information from the Plan concerning the continuation of coverage including the self-payment rates. If notice is not received within 60 days of the event, your dependent(s) will not be eligible for continuation coverage.

Loss of dependent status occurs when the individual no longer meets the definition of "Dependent" as described on pages 7-8.

Notice to the Fund Office should be sent as indicated below.

3. When the covered employee, dependent spouse or child is disabled (as determined by Social Security) any time during the first 60 days of COBRA continuation coverage elected due to a qualifying event involving termination of employment, termination of dollar bank eligibility, or reduction of your hours of employment, the covered employee, dependent spouse and child must notify the Fund Office within 60 days of the Social Security determination of disability and before the end of the initial 18-month period. If a disability ends within the 29-month period of COBRA continuation coverage, the Plan must be notified within 30 days of the date the disability ends. In addition, the disabled person must notify the Fund Administrator within 30 days of a determination that he or she is no longer disabled. Notices to the Fund Administrator should be sent as described in Notice Procedures below.
4. When the Fund Office is notified that a qualifying event has occurred, you will be sent an Election Form and other information regarding continuation coverage. You will have 60 days from the date your coverage terminates under the Plan, or, if later, 60 days from the date of the notice advising you of your election rights to make your decision. You do not have to show that you are insurable to obtain continuation coverage.
5. If you or your Dependents choose to waive COBRA coverage, a waiver of COBRA coverage will be effective on the date sent to the Fund Office. If you or your Dependents, during the election period, waive COBRA coverage, such waiver can be revoked at any time before the end of the election period. However, if the waiver is revoked, coverage will be effective on the date the revocation of waiver and election to continue is sent to the Fund Office.
6. The first payment (which must include contributions for all months since coverage terminated) must be received by the Fund Office within 45 days of the date COBRA coverage is elected.

Example: Coverage terminates January 31st and you elect coverage March 15th, your first payment is due April 29th and must include payment for February, March and April coverage.



Each subsequent payment is due the 1st day of the month for which coverage is intended and will be considered timely if received prior to or on the last day of the month for which coverage is intended.

Example: Using the above example, the monthly payment for May coverage is due May 1st and must be received no later than May 31st.

7. If payment is not received in time, coverage will be terminated. No eligibility will be verified nor will claims be paid until the correct and timely payment is received. If payment is returned due to non-sufficient funds, replacement payment must be received within the contribution due period, and if not received within such period, regardless of reason, payment will be considered not paid on a timely manner, and coverage will be terminated, with no right of reinstatement.

If you have any questions, please feel free to contact the Fund Office.

Notice Procedures – COBRA.

1. If the qualifying event is the divorce or legal separation of the covered employee and his or her spouse or a dependent child's loss of eligibility for coverage as a dependent, the covered employee, spouse or child (or their representative) must notify the Plan Administrator within 60 days after the qualifying event occurs.
2. A covered employee, spouse or child (or their representative) receiving continuation coverage for 18 months must notify the Plan Administrator of a second qualifying event or disability determination by the Social Security Administration within 60 days of the occurrence of the qualifying event or disability determination and before the initial 18-month period of coverage expires. In addition, the Plan Administrator must be notified of a determination by the Social Security Administration that a qualified beneficiary is no longer disabled within 30 days of the determination.
3. The notices described in this section must be sent to the Plan Administrator at Wisconsin Electrical Employees Health and Welfare Plan, 2730 Dairy Drive, Suite 101, Madison, WI 53718.
4. The notices must be in writing and must include sufficient information to enable the Plan Administrator to determine the following information:
 - the Plan,
 - the covered employee and qualified beneficiaries,
 - the qualifying event (or disability determination) and
 - the date on which the qualifying event or disability determination occurred.
5. A notice that does not contain all of the required information will not be considered sufficient notice. Failure to supplement the notice with the additional information necessary to meet the content requirements will result in the loss of the right to elect continuation coverage.

Current Addresses. In order to protect your family's rights, you must keep the Plan Administrator informed of the current addresses of all family members who are or may become Qualified Beneficiaries.

More Information. This notice may not fully describe continuation coverage or your other rights under the Plan. If you have any questions or want more complete information, please feel free to contact the Plan Administrator at the above address.

Military Service

"Military Service" means "service in the uniformed services" as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 or similar federal law, as amended from time to time ("USERRA"). An Eligible Employee who performs Military Service and has reemployment rights under USERRA will be considered on military leave of absence effective on the date of his or her absence to perform such Military Service. The following rules apply where an Active Employee qualifies for USERRA reemployment rights.



Military Service of Less Than 31 Days. Coverage under the Plan for the Eligible Employee and the employee's Dependents will continue through the 30th day of the leave at no cost to the employee or the employee's employer and will terminate on the 31st day of such military leave, subject to the continuation of health coverage provisions required by USERRA or provided for under the Plan, as further described below. Upon returning to work as an Active Employee or making himself available for employment, as provided for under USERRA, the employee, and his or her covered Dependents, will be immediately entitled to benefits as if he or she had been continuously employed during the Military Service.

Military Service of 31 Days or More. Coverage under the Plan for the employee and the employee's Dependents will continue through the 30th day of the leave and will terminate on the earlier of the 31st day of the military leave or the last day of the leave, subject to the continuation of health coverage provisions required by USERRA or provided for under the Plan, as further described below. Upon returning to employment as an Active Employee or making himself available for employment, as provided for under USERRA, the employee, and his or her covered Dependents, shall be immediately entitled to benefits as if he or she had been continuously employed during the Military Service, regardless of whether the employee continued coverage under the Plan during Military Service.

Effect on Dollar Bank and Staff Coverage. Any unused credits in an Active Hourly Employee's dollar bank or prepaid coverage of an Employer Staff Employee is to be preserved until such time as he or she is discharged from Military Service if he or she has reemployment rights under USERRA. If the Hourly Employee complies with the reemployment requirements of USERRA, the accumulated credits will be reinstated immediately. If the Hourly Employee does not comply with the reemployment requirements specified above, his accumulated credits shall be forfeited to the Plan. The Employer Staff Employee's prepaid coverage will be reinstated immediately if he returns to employment as specified above. If the above requirement is not met, all prepaid coverage shall be forfeited to the Plan.

If, upon reinstatement to the Plan after returning to employment or making himself available for employment, as specified under USERRA, the Employee has exhausted his or her Dollar Bank or prepaid account to pay for continuation coverage described below, the Employee will be required to make self-payments in an amount established by the Trustees from time to time so that his or her Dollar Bank or prepaid account returns to a level sufficient to maintain eligibility under the Plan.

Right of Continuation Coverage. If the employee fails to provide advance notice of his Military Service, the employee's coverage will terminate as of the 31st day of his military leave and the employee will not be eligible to continue coverage unless the failure to provide advance notice is excused by the Trustees, in their sole discretion. If the Trustees determine that the employee's failure to provide advance notice is excused, the employee may elect to continue coverage, in accordance with this section, retroactive to the date of his absence for Military Service, provided that the employee elects such coverage and pays all amounts required for the continuation coverage.

Upon the Plan's notification of an employee's reduction in hours due to a military leave of absence of 31 days or more, the employee will be provided with the required notice of continuation rights. The Board of Trustees will establish the amount of the monthly self-payment contribution for this continuation coverage, within the guidelines established by federal law. The procedures to elect and make self-payments for this continuation coverage will be the same as those for COBRA coverage and the available coverage for such employee and dependents will be the same as COBRA coverage provided the COBRA rules do not conflict with USERRA. If the employee does not elect continuation coverage and does not submit payment for all amounts required to continue coverage within the applicable time frame, the employee will lose the right to continue coverage under this section and such right will not be reinstated.

An Eligible Employee who takes a military leave of absence may continue coverage under the Plan for himself and for his eligible Dependents for a period of 24 consecutive months from the date the employee's military leave began or until he ceases to qualify for reemployment rights under USERRA (for example, the date the employee fails to timely return or make himself available for reemployment under USERRA after receiving his honorable discharge), whichever period is shorter. An election of continuation coverage under USERRA is treated by the Plan the same as an election under COBRA and continuation of coverage rights under COBRA are concurrent with the employee's election to continue coverage under USERRA. Continuation coverage may terminate before the expiration of the maximum period described above for any of the reasons set forth in herein.

Some provisions of COBRA provide more generous coverage rights than those available under USERRA (for example, COBRA provides for coverage in excess of 24 months in some circumstances), and vice versa (e.g., USERRA does not allow for termination of coverage where a qualified beneficiary obtains other group



health plan coverage after electing continuation coverage). An individual eligible for continuation coverage rights under both USERRA and COBRA shall be entitled to the most generous coverage provisions available under USERRA and COBRA during those periods during which the individual is eligible under both provisions.

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice

February 17, 2010

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Wisconsin Electrical Employees Health and Welfare Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1

Notice of PHI Uses and Disclosures

Required PHI uses and disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization or opportunity to agree or object to carry out treatment, payment and health care operations. When required by law, we will restrict disclosures to the Limited Data Set, or if necessary, to the minimum necessary information to accomplish the intended purpose. The Plan and its business associates (and any health insurers providing benefits to Plan Participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes



related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require your written authorization.

The Plan will obtain your authorization before releasing your PHI in those circumstances where the law or the Plan's privacy practices do not otherwise permit disclosure. For example, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you prepared by your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

1. the information is directly relevant to the family member or friend's involvement with your care or payment for that care; and
2. you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Additional rules and exceptions apply with family members. You may request additional information from the Plan.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.



3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.



Section 2

Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request.

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

The Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations purposes if you paid for these services in full, out of pocket.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set" for as long as the Plan maintains the PHI.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative



may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made as authorized by law. For example, the accounting will not include disclosures made: (1) to carry out treatment, payment or health care operations (including to business associates pursuant to a business associate agreement and to the Trustees as authorized by the Plan or the HIPAA privacy regulations) except as provided below; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

You may also request and receive an accounting of disclosures made for payment, treatment or health care operations during the prior three years for disclosures made as of January 1, 2014 for electronic health records acquired before January 1, 2009 or January 1, 2011 for electronic health records acquired on or after January 1, 2009.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes, notarized by a notary public;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3

The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (Participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that



date. If a privacy practice is changed, a revised version of this Notice will be provided to all Participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than a Limited Data Set, or if necessary, the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by Participants and excludes identifying information in accordance with HIPAA.

Section 4

Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5

Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at: 2730 Dairy Drive, Suite 101, Madison, Wisconsin 53718, 608-276-9111.



Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

To Receive More Information

We hope this booklet has answered your questions regarding the benefits provided by the Health and Welfare Plan. If you have any questions, we invite you to call us. We will be available to answer your questions during normal business hours on Monday through Friday 7:00 a.m. to 5:00 p.m. Our phone numbers are: (800) 422-2128 or (608) 276-9111.

If you wish to write to the Trustees, write to:

Board of Trustees
Wisconsin Electrical Employees Health and Welfare Plan
2730 Dairy Drive, Suite 101
Madison, WI 53718

Notice of Nondiscrimination and Accessibility Services

The Wisconsin Electrical Employees Health and Welfare Plan (the "Fund") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Fund provides the following services free of charge to qualifying individuals:

- Aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Plan Office.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

TO RECEIVE
MORE
INFORMATION

NOTICE OF NON-
DISCRIMINATION
AND
ACCESSIBILITY
SERVICES



ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-422-2128 or 1-608-276-9111.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-422-2128 or 1-608-276-9111.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-422-2128 or 1-608-276-9111。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-422-2128 or 1-608-276-9111.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-800-422-2128 or 1-608-276-9111-1).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-422-2128 or 1-608-276-9111.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-422-2128 or 1-608-276-9111 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-422-2128 or 1-608-276-9111.

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-422-2128 or 1-608-276-9111.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ອັດຕະໂນພາສາ, ໂດຍບໍ່ຄ່າ ຈຳນວນ ພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-422-2128 or 1-608-276-9111.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-422-2128 or 1-608-276-9111.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-422-2128 or 1-608-276-9111.

ध्यान दें: यदि आप □□□□ बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-422-2128 or 1-608-276-9111 पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-422-2128 or 1-608-276-9111.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-422-2128 or 1-608-276-9111.



Schedule of Benefits - Effective January 1, 2017

Death Benefit, Loss of Two Limbs and Accidental Death and Dismemberment:	
Under Age 65	\$ 10,000
Age 65-69	\$ 6,500
Age 70 & Over	\$ 5,000
Loss of Limb:	
Under Age 65	\$ 5,000
Age 65-69	\$ 3,250
Age 70 & Over	\$ 2,500
Short Term Disability	\$500 per week for 26 weeks
Long Term Disability (Transitional) (two years disabled own occupation, any occupation for the next three years, after five years must be unable to perform two daily living activities)	\$100 minimum/\$1,800 maximum per month
Medical Benefits	
Major Medical Calendar Year Deductible (PPO charges and non-PPO charges applied separately to satisfy deductible)	<u>PPO</u> <u>Non-PPO</u>
Individual	\$500 \$500
Family	\$1,500 \$1,500
Co-Payment Amount:	<u>Plan</u> <u>Participant</u>
PPO Covered Charges	90% 10%
Non-PPO Covered Charges	70% 30%
Medical Maximum Out of Pocket Expense Per Calendar Year (After Calendar Year Deductible)	<u>Individual</u> <u>Family</u>
PPO Covered Charges	\$1,000 \$3,000
Non-PPO Covered Charges	\$3,000 \$9,000
	<u>PPO</u> <u>Non-PPO</u>
Inpatient / Outpatient Hospital Benefits:	<u>PPO</u> <u>Non-PPO</u>
Inpatient Hospital (must be pre-certified)	90% 70%
Skilled Nursing (60 days maximum per confinement)	90% 70%
Surgery (subject to Usual and Customary Fee)	90% 70%
Second opinion required, no deductible or co-pay applied to second opinion	100% 100%
If no Second Opinion obtained	Surgeon and related Physician charges reduced 20% and not applied to deductible or co-payment percentage
Anesthesia (subject to Usual and Customary Fee)	90% 70%
Emergency Room	90% 90%
Urgent Care	90% 70%
Oral Surgery - see page 15 for list of approved surgeries	90% 70%
Diagnostic X-Ray and Laboratory	90% 70%
Imaging (CT/PET scans, MRIs)	90% 70%

**SCHEDULE OF
BENEFITS -
EFFECTIVE
JANUARY 1,
2017**



Physical, Occupational and Speech Therapy	90%	70%
Doctors Inpatient, Outpatient, Office Visits	90%	70%
Prenatal Care, Postnatal Care and Delivery Services	90%	70%
Certified Nurse Midwife	90%	70%
Home Health Care (limited to four hours/day)	90%	70%
Rehabilitation Services (limitations apply)	90%	70%
Orthotics (to \$10,000)**	90%	70%
**After \$10,000 threshold	50%	50%
Orthotics (\$500 maximum per five years for excluded diagnosis)	90%	70%
Durable Medical Equipment (prior approval required)	90%	70%
Hospice Care (life expectancy of six months)	90%	70%
Diabetes Counseling and Education	90%	70%
Inpatient M/N and Substance Abuse Counseling	90%	70%
Outpatient M/N and Substance Abuse Counseling	90%	70%
Hearing Benefit	No deductible or co-payment Maximum of \$1,500 paid at 100% per person, per three calendar years	
Routine Physical Exams (including Routine Well Baby Check-ups and Immunizations and pre-natal care visits per ACA guidelines)	No deductible or co-payment	
PPO	100% paid, no maximum	
Non-PPO	Plan pays 100% up to \$450 maximum per person, per calendar year; after \$450, Plan pays 10%	
OR		
Health Dynamics: One Comprehensive Physical (Adult Participant and Spouse, no children)	100% paid, one visit per person, per calendar year	
Gastric Bypass Surgery (prior approval required, subject to Usual and Customary Fee)	One procedure per lifetime	
Prosthetic Devices	One device per limb, per 60-month period, plus any adjustments	
Ambulance Service	Subject to deductible and co-payment	
Ground Ambulance (each occurrence)	\$ 600 maximum	
Air Ambulance (each occurrence)	\$ 7,000 maximum	
Transplants (Cornea, Kidney/Pancreas, Liver, Autologous or Allogenic Bone Marrow, Kidney, Heart, or a Heart/Lung Human to Human) (must be performed at a Provider Transplant Network Facility)	Subject to deductible and co-payment 90% 0%	
Chiropractic Benefits (30 visits per person, per calendar year; back-related adjustments only; must be over age 10)	Subject to deductible and co-payment	
Initial Visit	90%	70%
Manipulation - one per visit, per person	90%	70%
Therapy only - one per visit, per person	90%	70%
Diagnostic X-rays (one per person per calendar year)	90%	70%



Prescription	Drug	Expense
Sav-Rx (Prescription Card Service)		
Generic		\$10 Participant Co-pay per fill of 30 days Or \$15 Co-pay for 61-90 day fill
Brand Name		\$50 Participant Co-pay per fill of 30 days or \$75 Co-pay for 61-90 day fill
Diabetic Supplies and Insulin		Plan pays 80%, not subject to co-pay or Calendar Year Maximum
Smoking Cessation Program		Maximum - Two 90-day supplies of stop smoking medications per calendar year if Physician prescribed - must follow tiers in smoking program
Specialty Drugs must be prior approved by Prescription Card Service or obtained through Plan's specialty medication pharmacy where Covered Drugs that have manufacturers coupons available, otherwise not covered by the Plan		After Plan pays \$10,000, Plan pays 50% per calendar year of PPO prescription drug costs up to prescription drug out-of-pocket maximum/does not apply to major medical out-of-pocket maximum
Maximum Out-of-Pocket Expense Per Calendar Year		Out-of-pocket maximum for Covered Drugs received from a PPO Provider is \$5,650 (individual) and \$11,300 (family) as adjusted each January 1 as permitted by federal law
OPTIONAL VISION BENEFITS		
NOTE: For the Optional Vision Benefits listed below, individuals are considered Children through the end of the calendar year in which the individual reaches age 19		
Vision Benefits (includes eye exam, lenses, frames, contact lenses, tinting, coatings, bi-focal, tri-focal, etc.) (must be by prescription) and Radial Keratotomy		
Adults		No deductible or co-pay; \$300 maximum per person, per calendar year
Eligible Children		One vision exam with refraction and <u>one</u> of the following choices: One standard lenses and frames; or <ul style="list-style-type: none"> • One set of non-disposable contact lenses per calendar year; or • One-year supply of disposable contact lenses per calendar year



OPTIONAL PREVENTIVE DENTAL BENEFITS	
<p>Two Oral Exams per calendar year</p> <p>Two Cleanings per calendar year</p> <p>Two Bitewing X-rays every 6 months</p> <p>Full-Mouth X-ray every 36 months</p> <p>Intra-Oral X-rays</p> <p>Fluoride Treatment (under age 16 per calendar year)</p> <p>Sealants of Back Molars (under age 16 per calendar year)</p> <p>Certain Space Maintainers (premature lost teeth for children under age 19)</p>	<p>No deductible or co-pay, 100% paid</p>
<p>OPTIONAL COMPREHENSIVE DENTAL BENEFITS</p> <p>NOTE: For the Optional Comprehensive Dental Benefits listed below, individuals are considered Children through the end of the calendar year in which the individual reaches age 19</p>	
<p>Periodontal services, Oral Surgery, Extractions, Restorative, Fillings, Endodontic Treatment, Root Canal Therapy, Crowns, Inlays, Onlays, Dentures, Bridgework, Relining or Rebasing of Dentures and Implants</p> <p>*Includes the Preventive Dental Services listed above (for both Adults and Children)</p> <p>Adults</p> <p>Children</p> <p>Orthodontics (for both Adults and Children)</p>	<p>No deductible, 80% paid up to \$1,700 per person, per calendar year</p> <p>No deductible, 80% paid thereafter</p> <p>No deductible</p> <p>First \$1,400 paid at 50%</p> <p>Next \$1,800 paid at 100%</p>



Important Addresses and Telephone Numbers

Health & Welfare Fund Office, and for information about Life, Accidental Death and Dismemberment and Long-Term Disability

Wisconsin Electrical Employees Health & Welfare Fund
2730 Dairy Drive, Suite 101
Madison, WI 53718
(608) 276-9111 or (800) 422-2128
www.weebf.org or www.weebf.com

Hospital/Physician PPO Network

Anthem Blue Cross Blue Shield
P.O. Box 951254
Cleveland, OH 44193
Provider Locator: (800) 810-BLUE
Provider Eligibility/Benefits: (800) 676-BLUE
Member Eligibility/Benefits: (800) 422-2128
24/7 Nurse Line: (866) 670-1565
www.anthem.com

Anthem — Live Health Online
www.livehealthonline.com
(855) 603-7985

Utilization Review

SHPS / Carewise Health
9200 Shelbyville Rd., Ste. 400
Louisville, KY 40222
Precertification: (877) 298-5659

Pharmacy Network

SAV-RX
224 N. Park Avenue
Fremont, NE 68025
(800) 228-3108

Health Dynamics

www.healthdynamics.com

Preventative Program
www.hdhelpsu.com
password: hdhelpsu

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IMPORTANT
ADDRESSES
AND
TELEPHONE
NUMBERS

