

Important Contact Information as of June 1, 2013

<u>CALL</u>	<u>FOR</u>	<u>PHONE NUMBER</u>	<u>WEBSITE</u>
Fund Office	Medical and disability claim questions	1-800-323-7268	www.lineco.org disponible en Español
<div style="border: 1px solid black; padding: 5px;"> Mailing Address: 2000 Springer Drive Lombard, IL 60148 </div>	Eligibility questions		
	Write to the Trustees		
	Appeals		
Blue Cross Blue Shield	Find PPO hospitals and doctors	1-800-810-BLUE (2583)	www.bcbsil.com
Medical Cost Management	Pre-certification of all hospital admissions (except for mental health and substance abuse)	1-800-323-7268 Ask for MCM	
	Enroll in Prenatal Care Program		
ValueOptions	Member Assistance Program	1-800-332-2191	www.lineco.org (follow link)
	Mental health provider network		
	Pre-certification of inpatient, residential, partial inpatient and intensive outpatient treatment, psychological testing and electroconvulsive therapy.		
Express Scripts	Prescription Drug Program	1-877-327-0568	www.express-scripts.com
CuraScript/Accredo	Specialty drugs	1-866-848-9870	www.express-scripts.com
Dental Network of America	Dental preferred provider network (PPO)	1-866-522-6758	www.dnoa.com
Vision Service Plan (VSP)	Vision program and preferred vision providers	1-800-877-7195	www.vsp.com
HearPO	Hearing aid discount program	1-888-HEARING (432-7464)	www.hearpo.com
Lineco HRA	HRA program for employees of participating employers	1-877-282-8665	www.lineco.org (follow link)

ATTENTION NEW PARTICIPANTS!

Submit a completed Family Enrollment Card, along with your marriage certificate to enroll your spouse and birth certificates to enroll your children. If necessary, the divorce decree and court orders pertaining to medical coverage for a child, as soon as you become eligible. **You can obtain a Family Enrollment Card by calling the Fund Office or by going to Lineco's website. You only need to complete this form *ONCE* unless there is a change in your family status (such as a marriage, divorce or birth).** NOTE: Before any claims can be paid for a dependent(s), a certified copy of these certificate(s) MUST be on file at the Fund Office.

TABLE OF CONTENTS

INTRODUCTION	3
SCHEDULE OF BENEFITS	5
ELIGIBILITY FOR ACTIVE EMPLOYEES	9
Definitions Applicable to Eligibility	9
Initial Eligibility Requirements	9
Continuing Eligibility	10
Continuing Eligibility Through Working.....	10
Eligibility Chart.....	11
Continuing Eligibility by Making Short-Hours Self-Payments.....	11
Continuing Eligibility Through COBRA Self-Payments	12
Other Eligibility Provisions	12
Eligibility During Disability.....	12
Eligibility During Military Service.....	13
Family Medical Leave Act (FMLA).....	14
JATC School Eligibility	14
Eligibility for Weekly Income Benefits.....	14
Reciprocity.....	14
Utility Employees.....	14
Surviving Dependent Eligibility.....	14
Termination of Eligibility.....	16
Termination of Employee Benefits.....	16
Termination of Dependent Benefits.....	17
31-Day Termination Rule.....	17
COBRA COVERAGE	19
RETIREE COVERAGE	23
COBRA Coverage for Retirees	23
Eligibility for Retiree Benefits	23
Postponing or Suspending Retiree Benefits for Your Spouse	24
Dropping Spousal Coverage	24
Retirees Eligible for VA Benefits.....	24
Retiree Benefits Coverage	25
Self-Payment Rules for Retiree Benefits.....	26
Benefits for Surviving Dependents of Retirees	26
Termination of Retiree Benefits	27
INSURANCE BENEFITS	29
Life Insurance.....	29
Accidental Death & Dismemberment Insurance.....	30
WEEKLY INCOME BENEFIT	31
GENERAL RULES GOVERNING MEDICAL BENEFITS	33
Blue Card/Blue Cross Blue Shield PPO Network	33
ValueOptions Provider Network for Mental Health and Substance Abuse.....	33
Hospital Pre-Certification Program.....	33
Prenatal Care Program.....	34
Mental Health and Substance Abuse Pre-Certification Program	34
Deductibles	35

Hospital Pre-Certification Noncompliance Deductible	35
Calendar Year Deductibles.....	35
Emergency Room Deductible	36
Plan Payment Percentages/Out-of-Pocket limits.....	36
Maximum Benefits	36
MEDICAL BENEFITS.....	37
Benefits for Preventive Care	37
Other Covered Medical Expenses	38
Diagnostic X-Ray and Lab Benefit.....	44
Provisions Governing Hospice Care.....	45
Extension of Medical Benefits.....	46
PRESCRIPTION DRUG PROGRAMS	47
Retail Program.....	47
Mail Service Prescription Drug Program	49
LINECO MEMBER ASSISTANCE PROGRAM (MAP).....	51
DENTAL BENEFIT	52
VISION BENEFIT	59
LINECO HRA.....	61
HOW TO FILE CLAIMS.....	63
WHAT THE PLAN DOES NOT COVER (Exclusions and Limitations)	64
OTHER LIMITATIONS ON YOUR BENEFITS	69
Subrogation and Repayment Agreement.....	69
Payment of Benefits for Compensated Injuries	70
Coordination of Benefits (C.O.B.).....	71
GENERAL PLAN PROVISIONS AND INFORMATION.....	75
Definitions	75
Claim and Appeal Procedures	79
Examinations	83
Workers’ Compensation Not Affected	83
Plan Discontinuation or Termination	83
False or Inaccurate Information	83
Fund’s Right to Recover Overpayments.....	83
Release of Information.....	84
Certificates of Coverage	84
Women’s Health and Cancer Rights Act.....	84
Notice of Privacy Practices	84
Your Rights Under ERISA	88
Information About Your Plan	89
PARTICIPATING NECA CHAPTERS AND LOCAL UNIONS	91
BOARD OF TRUSTEES AND FUND PROFESSIONALS.....	92

An Important Note About Reciprocity

If you want Lineco to be your home fund when you travel outside of Lineco’s jurisdiction, you should register with the Electronic Reciprocal Transfer System (ERTS) at any IBEW Local Union office. You cannot be given proper credit for your reciprocity hours until you register with ERTS.

INTRODUCTION

To All Plan Participants From the Board of Trustees

We are pleased to provide you with this updated Summary Plan Description booklet which explains your Line Construction Benefit Plan (Lineco) benefits and provides other important information about your Plan. This booklet includes changes and improvements that have been made to your Plan since the previous booklet was printed. Both you and your spouse should read this booklet and keep it for future reference.

Lineco was established in 1963 to provide health and welfare benefits to the IBEW and NECA men and women working in the outside electrical construction industry. It is a multi-employer plan managed jointly by IBEW Union and NECA Employer representatives. We hope this booklet is helpful in understanding your Plan.

Sincerely,

Board of Trustees
Line Construction Benefit Fund

A complete list of the Board of Trustees starts on page 93.

To Contact the Fund

To write to the Board of Trustees, send your letter to: Board of Trustees, Line Construction Benefit Fund at the address shown on the inside front cover.

To write to the Fund Office, send your letter to: Line Construction Benefit Fund at the address shown on the inside front cover.

Trustee Interpretation, Authority and Right

The Board of Trustees has full authority to interpret the Plan, all Plan documents, rules and procedures. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious.

The Trustees have the authority to change the eligibility rules and other provisions of the Plan, to amend, increase, decrease or eliminate benefits, and to terminate the Plan, in whole or in part, at any time. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them. Benefits under this Plan will be paid only when the Board of Trustees or persons delegated by them decide, in their sole discretion, that the participant or beneficiary is entitled to benefits. The Trustees may adopt such rules as they feel are necessary, desirable, or appropriate in the exercise of their fiduciary duty, and they may change these rules and procedures at any time.

The right to change or eliminate any and all aspects of benefits provided for eligible retirees and their dependents is a right specifically reserved to the Trustees, since the Retiree Benefits are not accrued or vested benefits. The Trustees may reduce Retiree Benefits, increase self-payments for the benefits, or completely terminate such benefits at any time. Such a change will be effective even though an employee has already become an eligible retiree.

The Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participants and beneficiaries.

Information About This Summary Plan Description

This booklet is intended to give you a summary of the benefits and provisions of the Plan Document which sets forth the Plan of Benefits adopted by the Trustees. If there is any discrepancy between the information in this summary and the provisions of the Plan Document, the provisions of the Plan Document will take precedence.

No employer or union nor any representative of any employer or union, in such capacity, is authorized to interpret this Plan nor can any such person act as agent of the Trustees. If you wish any information regarding this Plan, such information must be communicated to you in writing signed on behalf of the full Board of Trustees either by the Trustees or, if authorized by the Trustees in writing, signed by the Fund Administrator.

This booklet may not accurately describe benefits to which you may currently be entitled. Notices of any changes will be sent to each known participant's last known address within the time required by applicable regulations. However, changes may take effect before you are notified of a change. Before incurring any non-emergency expense, contact the Fund Office to confirm your current entitlement to coverage.

To Get the Most Out of Your Plan

Visit the Lineco website: www.lineco.org	<ul style="list-style-type: none"> • View your eligibility, hours and dependent information. • View claims history and explanation of benefits. • Download change of address and family enrollment forms. • Follow links to important Preferred Providers.
Use Preferred Providers	<ul style="list-style-type: none"> • For medical conditions, use hospitals and doctors in the Blue Cross Blue Shield Blue Card PPO Network. • For substance abuse and mental or nervous disorders, use facilities and doctors in the ValueOptions Provider Network. • Use dentists in the Dental Network of America. • Use vision care providers in the VSP network. • Use hearing care providers in the HearPO network.
Call for Pre-Certification	<ul style="list-style-type: none"> • Call ValueOptions for pre-certification of the following mental health services: inpatient, residential, partial inpatient and intensive outpatient treatment, psychological testing and electroconvulsive therapy • Call Medical Cost Management (MCM) for pre-certification of all medical/surgical hospital admissions.
Use the Mail Service Rx	See page 49 for more information.
Take advantage of the MAP	Call the Lineco Member Assistance Program (MAP) for free, confidential counseling and referral for a wide range of personal, emotional, work/family problems. The MAP is run by ValueOptions.
Participate in the Prenatal Care Program	Female employees and spouses who participate in Medical Cost Management's prenatal program can earn a \$250 gift card.
File claims correctly and on time.	Follow the procedures described in <i>How to File Claims</i> on page 63.

SCHEDULE OF BENEFITS

All Plan payments, deductibles, maximums and limitations apply to each person separately except where stated otherwise.

BENEFITS FOR ELIGIBLE EMPLOYEES ONLY (NOT PROVIDED FOR UTILITY EMPLOYEES)		
INSURANCE BENEFITS (see pages 29-30)		
Life insurance	\$20,000	
Accidental death & dismemberment insurance	\$20,000	
WEEKLY INCOME BENEFIT for non-occupational disabilities only (see pages 31-32)		
Amount of weekly benefit	\$400	
Maximum weeks payable per period of disability	26 weeks	
<i>Benefits start on the first day of a disability due to an accidental injury. For an illness, benefits start on the earlier of the first day of an inpatient hospital stay or the eighth day of disability.</i>		
BENEFITS FOR ELIGIBLE EMPLOYEES, RETIREES AND DEPENDENTS		
MEDICAL BENEFIT (see pages 33-46)		
Calendar Year Maximum Benefit	CY 2013 = \$2,000,000 <i>(No maximum starting 1/1/14)</i>	
Deductibles		
Individual calendar year deductible	\$300	
Family calendar year deductible (2 or more family members)	\$600	
Hospital pre-certification noncompliance deductible per admission, in addition to the calendar year deductible	\$250	
Emergency room deductible for each occurrence of hospital emergency room treatment (waived if admitted)	\$100	
Plan Payment Percentages <i>After satisfaction of deductible(s) and before satisfaction of the person's or family's out-of-pocket limit. (See Special Benefits and Limitations below for exceptions and additional limitations.)</i>		
	Blue Cross Blue Shield In-Network	Out-of-Network
Covered Medical Expenses (unless stated otherwise)	80%	70%
Emergency Room (services for an emergency as defined on page 77)	80%	80%

	Blue Cross Blue Shield In-Network	Out-of-Network
Prescription Drugs (not purchased through the Mail Service Program)	80%	n/a
Chiropractic Care	50%	50%
<i>The Blue Cross network does not apply to persons for whom Medicare is primary. Medicare-primary individuals must use providers that participate in Medicare.</i>		
Out-of-Pocket Limits		
<i>Amounts applied to out-of-pocket limits include out-of-pocket payments made for a person's 20% and 30% co-pay share of covered medical expenses except for deductibles, chiropractic care, hearing care, non-surgical TMJ treatment and jaw surgery.</i>		
Per person		\$1,500
Per family		\$3,000
Per person, if Medicare is the person's primary plan		\$1,125
Special Benefits and Limitations		
<i>Unless stated otherwise, the Plan payment percentages for the following types of treatment are the percentages shown under Plan Payment Percentages above.</i>		
Acupuncture (see page 38)		12 visits per calendar year
Chiropractic Care <i>Out-of-pocket limit does not apply.</i>		50% to \$600 per calendar year
Hearing Care (exams, tests and hearing aids) (see page 40) <i>Deductible does not apply.</i>		80% to \$2,500 every 60 months (every 24 months for children)
Home Nursing Care (see page 41)		\$5,000 per calendar year
Hospice Care (see page 41)		\$20,000 per lifetime
Mental/Nervous and Substance Abuse <i>Pre-certification required for inpatient, residential, partial inpatient and intensive outpatient treatment, psychological testing and electroconvulsive therapy.</i>		same as medical/surgical: 80% in-network, 70% out-of-network after deductible
Non-Surgical TMJ Treatment (see page 44) <i>Out-of-pocket limit does not apply.</i>		\$1,000 per lifetime
	Blue Cross Blue Shield In-Network	Out-of-Network
Preventive Care (<i>described on pages 37-38</i>)	100% <i>Deductible does not apply.</i>	70% <i>Deductible applies.</i>
Doctors' Professional Fees for routine physical examinations (no deductible)		100% up to \$125 per calendar year, regular benefits thereafter
Outpatient Diagnostic X-Ray and Lab (including tests for illnesses and injuries)		100% up to \$150 per calendar year, regular benefits after

TMJ/Jaw Surgery that is out-of-network or not pre-certified (see page 42) <i>Out-of-pocket limit does not apply.</i>	\$3,000 per lifetime
Skilled Nursing Facility care (see page 43)	30 days per calendar year
PRESCRIPTION DRUG PROGRAMS (see pages 47-50)	
	PARTICIPANT PAYS
Retail (up to 30-day supply)	
Participant co-pay percentage <i>The retail drug program is part of the regular Medical Benefit. The Medical Benefit's calendar year deductible and out-of-pocket limit apply.</i>	20%
Medicare-primary participants <i>No deductible applies. No benefits for drugs purchased at non-participating pharmacies.</i>	20% until \$1,000 prescription drug out-of-pocket limit is met
Mail (up to 90-day supply) <i>If Lineco is secondary to any other plan that provides coverage for prescription drugs, the person for whom Lineco is secondary cannot use the Mail Service program.</i>	
Generic Drugs	\$10
Formulary (Preferred) Drugs	\$20
Non-Formulary Drugs	\$35
Specialty Drugs <i>Must be purchased through CuraScript/Accredo even when administered in doctor's office. Subject to 30-day supply limit per prescription that may be extended on a case-by-case basis. (See page 47.)</i>	1/3 mail-order co-pay
<i>For Medicare-primary individuals, use of the mail-service for a maintenance medication is mandatory after the original supply plus one refill.</i>	
All prescriptions- If a brand is chosen over an available generic	Difference in cost plus applicable coinsurance/deductible
LINECO MEMBER ASSISTANCE PROGRAM (see page 51)	
<i>The Lineco Member Assistance Program (MAP) is administered by ValueOptions and provides confidential, counseling, education and referral services to you and your eligible family members. You can receive MAP counseling services free for up to 6 face-to-face office visits per problem.</i>	There are no deductibles, co-payments or claim forms involved. 6 FREE VISITS PROVIDED PER PROBLEM.

DENTAL BENEFIT (see pages 52-58)	
Deductible per calendar year per person <i>Does not apply to preventive care.</i>	\$100
Maximum benefit per person per calendar year	\$2,000
Plan payment percentage	80%*
Orthodontia lifetime maximum <i>For dependent children only. Orthodontia benefits do not apply to \$2,000 annual dental maximum.</i>	\$2,000

* Exception: Anesthesia for children ages 6 through 12 is payable at 50%. See No. 4 on page 55 for details.

VISION BENEFIT (see pages 59-60)		
	PLAN PAYS	
	VSP Doctor	Out-of-Network
Vision exam - every calendar year	Covered in full	Up to \$35
Frame - every two calendar years	Covered up to \$115 retail value	Up to \$35
Lenses - every calendar year:		
Single vision	Covered in full	Up to \$30/pair
Lined bifocal	Covered in full	Up to \$40/pair
Lined trifocal	Covered in full	Up to \$55/pair
Contacts, including exam, fitting, evaluation and lenses	Covered in full	Up to \$100/pair
<i>If you use a VSP doctor and select eyewear that costs more than the amount allowed by VSP, you will pay an additional (discounted) charge to the VSP doctor.</i>		

ELIGIBILITY FOR ACTIVE EMPLOYEES

This section describes the eligibility rules that apply to active employees. If you are a utility employee, you should also see page 14.

The rules governing COBRA coverage start on page 19 and the retiree eligibility section starts on page 23.

Definitions Applicable to Eligibility

Bargaining Unit Employee - An employee who is a member of a collective bargaining unit represented by a union and who is a full-time employee of a contributing employer.

Non-Bargaining Unit Employee - An employee who is not a member of any collective bargaining unit represented by a union and who is a full-time employee of a contributing employer or of the Fund.

Benefit Month - A period of one calendar month during which a person is covered under the Plan because he has met the applicable eligibility requirements during the corresponding work month.

Credited Hour - A credited hour is:

- Any hour worked by an employee for which an employer contribution is required under the terms of a collective bargaining agreement;
- With respect to a non-bargaining unit employee, any hour worked by such an employee for which an employer contribution is made under the terms of the employer's participation agreement with the Trustees;
- Any hour of work credited to an employee under the eligibility during disability provisions;
- Any hour of work received or due from another welfare fund having a reciprocity agreement with this Fund;
- Any hour credited to an employee while on active military duty (see page 13); and
- Any hour credited to an employee while he is attending a JATC-sponsored school (see page 14).

Work Month - A period of one calendar month during which a person meets the applicable eligibility requirements necessary to provide benefit coverage during the corresponding benefit month.

Initial Eligibility Requirements

Bargaining Unit Employees - If you are a bargaining unit employee, you will become initially eligible on the first day of the benefit month corresponding to the work month in which you first accumulate at least 125 credited hours of employment for which an employer is required to make a contribution to the Fund on your behalf. For example, if your employer makes contributions for you for at least 125 credited hours for work performed in January, your coverage will start on March 1.

Non-Bargaining Unit Employees - If you are a non-bargaining unit employee, you will become initially eligible on the first day of the benefit month corresponding to the work month for which your employer makes contributions to the Fund on your behalf under the terms of a participation agreement with the Trustees. (These contributions are reported at the same time and in a manner similar to the report covering bargaining unit employees.) For example, if your employer makes the required con-

tribution for you for work performed in January, your coverage will start on March 1.

Dependents - If you have dependents on the date your coverage starts, their coverage will start on that same date. If you don't have any dependents on the date your coverage starts but later acquire one or more dependents while you are eligible, their coverage will start on the date they become your dependents.

Continuing Eligibility

Once you become eligible, you and your dependents will remain eligible if you meet the requirements described in this section. The minimum credited hour requirement for continuing eligibility during a benefit month is 125 hours per month.

The following table shows how work months correspond to benefit months.

Work Months and Corresponding Benefit Months

<u>125 Credited Hours in</u>	<u>Make You Eligible in</u>
<i>This Work Month</i>	<i>This Benefit Month</i>
November	January
December	February
January	March
February	April
March	May
April	June
May.....	July
June	August
July.....	September
August.....	October
September	November
October.....	December

Continuing Eligibility Through Working

You will remain eligible during a benefit month if:

- **125-Hour Rule** - You have at least 125 credited hours from working during the corresponding work month;

or

- **The Rollback Rule** - You have an average of 125 credited hours going back for a period of up to twelve (12) months.

For example: Suppose you start work in August and work 160 hours in August, which provides coverage in October. Then you only work 100 hours in September. Even though you didn't work at least 125 hours in September, you have a total of 260 hours during August and September, giving you an average of more than 125 hours for the two months. Therefore, you will be covered in November.

The Rollback Rule is not an hour bank. Hours do not accumulate for use at any time in the future. Instead, your hours for the current work month are added to the prior month's hours, and then to the prior two months' hours, and then to the prior three months' hours and so on, rolling back up to twelve months, to see if you have an average of 125 hours per month during any period under review. Hours more than a year prior to the current work month are not taken into account. The following chart also shows how the Rollback Rule works.

Eligibility Chart

To use the chart below, first find the benefit month you are interested in, then follow the row across the chart. You will be eligible in that benefit month, if you meet ANY of the requirements shown in that row.

Benefit Month	125 Hours in	250 Hours in	375 Hours in	500 Hours in	625 Hours in	750 Hours in	875 Hours in	1,000 Hours in	1,125 Hours in	1,250 Hours in	1,375 Hours in	1,500 Hours in
Mar	Jan	Dec-Jan	Nov-Jan	Oct-Jan	Sep-Jan	Aug-Jan	Jul-Jan	Jun-Jan	May-Jan	Apr-Jan	Mar-Jan	Feb-Jan
Apr	Feb	Jan-Feb	Dec-Feb	Nov-Feb	Oct-Feb	Sep-Feb	Aug-Feb	Jul-Feb	Jun-Feb	May-Feb	Apr-Feb	Mar-Feb
May	Mar	Feb-Mar	Jan-Mar	Dec-Mar	Nov-Mar	Oct-Mar	Sep-Mar	Aug-Mar	Jul-Mar	Jun-Mar	May-Mar	Apr-Mar
Jun	Apr	Mar-Apr	Feb-Apr	Jan-Apr	Dec-Apr	Nov-Apr	Oct-Apr	Sep-Apr	Aug-Apr	Jul-Apr	Jun-Apr	May-Apr
Jul	May	Apr-May	Mar-May	Feb-May	Jan-May	Dec-May	Nov-May	Oct-May	Sep-May	Aug-May	Jul-May	Jun-May
Aug	Jun	May-Jun	Apr-Jun	Mar-Jun	Feb-Jun	Jan-Jun	Dec-Jun	Nov-Jun	Oct-Jun	Sep-Jun	Aug-Jun	Jul-Jun
Sep	Jul	Jun-Jul	May-Jul	Apr-Jul	Mar-Jul	Feb-Jul	Jan-Jul	Dec-Jul	Nov-Jul	Oct-Jul	Sep-Jul	Aug-Jul
Oct	Aug	Jul-Aug	Jun-Aug	May-Aug	Apr-Aug	Mar-Aug	Feb-Aug	Jan-Aug	Dec-Aug	Nov-Aug	Oct-Aug	Sep-Aug
Nov	Sep	Aug-Sep	Jul-Sep	Jun-Sep	May-Sep	Apr-Sep	Mar-Sep	Feb-Sep	Jan-Sep	Dec-Sep	Nov-Sep	Oct-Sep
Dec	Oct	Sep-Oct	Aug-Oct	Jul-Oct	Jun-Oct	May-Oct	Apr-Oct	Mar-Oct	Feb-Oct	Jan-Oct	Dec-Oct	Nov-Oct
Jan	Nov	Oct-Nov	Sep-Nov	Aug-Nov	Jul-Nov	Jun-Nov	May-Nov	Apr-Nov	Mar-Nov	Feb-Nov	Jan-Nov	Dec-Nov
Feb	Dec	Nov-Dec	Oct-Dec	Sep-Dec	Aug-Dec	Jul-Dec	Jun-Dec	May-Dec	Apr-Dec	Mar-Dec	Feb-Dec	Jan-Dec

Continuing Eligibility by Making Short-Hours Self-Payments

If you do not have sufficient hours in a work month to satisfy the 125-Hour Rule, and if your previous hours are not sufficient to satisfy the Rollback Rule, you can make a short-hours self-payment to continue your eligibility in the corresponding benefit month (but you will not be eligible for Weekly Income Benefits while you are making short-hours self-payments). The amount of your payment will be determined by deducting your credited hours in the work month from 160 hours, and multiplying the difference times the current employer contribution rate. The Rollback Rule will not be taken into account when determining the amount needed.

Additional Rules Governing Short-Hours Self-Payments

- You are only entitled to a self-pay period if you are an active employee who is already covered under the Plan when your hours shortage occurs. You cannot make a self-payment to establish or re-establish initial eligibility, nor can you pay for any period on or after the date you leave the Plan (for example, if you begin work for a non-contributing employer).
- You can make up to six (6) consecutive monthly self-payments. An additional 6-month self-pay period will be allowed only if you return to covered employment and re-establish your eligibility based on employer contributions. There is no annual or lifetime limit on the number of non-consecutive 6-month self-pay periods you are allowed.

- A short-hours self-payment is generally counted and applied in the same way as employer contributions, but no more than 125 hours will be credited to you for any one month (even if you paid for more than 125 hours). Eligibility based on these payments provides the same benefits as eligibility based on employer contributions, except, you are not eligible for Weekly Income Benefits while making short-hours self-payments.
- The Fund Office will send a self-payment notice to you at your last known address, telling you how much your self-payment will be and when it is due. While the Fund Office will attempt to notify you when a self-payment is due, it is your responsibility to keep track of your credited hours and make any required self-payments on time regardless of Fund Office notification.
- Payments must be postmarked by the 15th day of the benefit month. For example, a payment for the work month of October is due by December 15 (October hours earn eligibility in December). No exceptions will be allowed.
- Self-payments will not be refunded unless the Fund receives valid hours from your employer.
- You must maintain continuous eligibility after making your first self-payment. If you fail to make a self-payment on time, you cannot make up the payment and this will result in your coverage being terminated. In such case, you can make COBRA self-payments (see the following section).
- You can also elect COBRA if you make 6 consecutive short-hours self-payments and are still unable to re-establish eligibility through working.

Continuing Eligibility Through COBRA Self-Payments

You and your dependents have the right to be offered an opportunity to make self-payments for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called “COBRA coverage.” The rules governing COBRA coverage start on page 19.

Other Eligibility Provisions

Eligibility During Disability

Disability Hours

If you become totally disabled and satisfy the requirements below, you will be credited with disability hours during your period of disability at the rate of eight (8) hours per day, Monday thru Friday. Disability hours will be granted until the end of your disability, however, the maximum period of time eligibility can be continued using disability hours is twelve (12) consecutive months.

Three-Rule Requirement

You will be eligible for disability hours only if you meet all three (3) of the following rules:

1. You must be eligible (from working) on the date your disability starts. You are not entitled to disability hours for a disability that begins while you are maintaining your eligibility by making short-hours or COBRA self-payments; AND
2. You must be eligible (from work hours) for the benefit month immediately following the month in which you became disabled; AND
3. You must have worked enough hours and have been credited with sufficient disability hours in the work month in which you became disabled to satisfy the Plan’s continuing eligibility rules.

Short hours self-payment(s) do not count toward satisfaction of these rules.

Additional Rules Governing Eligibility During Disability

- These provisions apply to non-work-related disabilities. They also apply to work-related disabilities if you become disabled on the job while you are working for an employer who is making contributions to the Fund under a collective bargaining agreement or participation agreement, or if you are an employee of the Fund and become disabled on the job. If you become disabled on the job while working for an employer who is not signatory to a collective bargaining agreement or participation agreement, or other than while on the job for the Fund, you will not be eligible for disability hours.
- The maximum period that your eligibility will be continued under these rules is 12 benefit months. However, if your eligibility is continued under this provision and you return to employment for a contributing employer before the expiration of 12 benefit months, your eligibility will be continued for the rest of the benefit month in which you return to work on a continuous full-time basis and for the next two succeeding benefit months. This permits your eligibility to be continued without interruption while you are earning future eligibility because of your return to work.
- If you qualify for disability hours and if you recover in the same month in which your total disability began, you will be eligible in the benefit month related to the work month in which you were totally disabled, provided you would have been eligible under the Plan if you had worked full-time for a contributing employer during your period of total disability.
- If you are covered under this provision for the allowed 12 months and are still disabled and unable to go back to work, or if you recover from your total disability but there is no work available in your jurisdiction, you may be entitled to continue coverage by making COBRA self-payments (see *COBRA Coverage* starting on page 19).
- If you recover after receiving disability hours and you do not go to work for an employer contributing to Lineco, your coverage will terminate on the date you are no longer disabled or the date your coverage terminates under the continuing eligibility rules of the Plan, unless you elect and make correct and on-time COBRA self-payments.
- If you die while you are covered under these provisions and you have not accumulated any further eligibility, your dependents will be covered for three (3) more months starting with the first day of the month following the month in which you die. After the 3-month period, your dependents may be entitled to continue coverage by making COBRA self-payments.

Eligibility During Military Service

If you leave employment with a contributing employer to enter active duty in the uniformed services of the United States, your eligibility will either be frozen or you can make self-payments to continue coverage for your dependents.

Eligibility Freeze - The default option is a freeze of your accumulated credited hours during your period of active duty. After your release from active duty under circumstances entitling you to re-employment under Federal law, your eligibility and accumulated credited hours will be reinstated on the date you return to work with a contributing employer, provided your return to work is within the time prescribed by Federal law.

Self-Payments - You and your eligible family members are also entitled to make self-payments for continued coverage for up to 24 months, regardless of any coverage provided by the military or government. The payment amounts, rules and provisions for continued coverage during military leave are very similar to COBRA coverage. This Plan will pay primary benefits before the military/ government pays except for service-related disabilities.

Credited Hours During Short-Term Service - The following provision applies if you perform active duty in the military service for 30 days or less, provided you meet ONE of the following conditions:

- You must be eligible from working in the month in which your military duty starts; OR
- You must have earned at least 125 credited hours from working in the month immediately preceding the month in which your military duty starts.

If you meet one of the above requirements, you will be credited with up to a maximum of eight credited hours per business day while you are performing the active military duty. These credited hours may be used for the purpose of satisfying the continuing eligibility requirements as though the hours had been earned from working.

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

Family Medical Leave Act (FMLA)

If you are entitled to leave under the Family and Medical Leave Act, your eligibility will be continued for up to the maximum period required by Federal law (usually twelve weeks) upon receipt of a copy of appropriate certification from your employer and a record of the approved leave time.

JATC School Eligibility

If you attend a Joint Apprenticeship Training Committee-sponsored school, you will receive credit at the rate of eight hours per day, up to a maximum of 120 credited hours during your lifetime. You will only receive credit for JATC school if you would otherwise have been working in covered employment. If your JATC class does not prevent you from working in covered employment, you will not receive credit for those hours.

Eligibility for Weekly Income Benefits

The eligibility rules governing the Weekly Income Benefits are explained on page 31.

Reciprocity

Lineco is signatory to the International Brotherhood of Electrical Workers Reciprocal Agreement. The purpose of the reciprocity agreement is to permit you to retain eligibility when contributions are made for you to another IBEW welfare fund. **If you want Lineco to be your home fund when you travel outside of Lineco's jurisdiction, you should register online with Electronic Reciprocal Transfer System (ERTS) at any IBEW Local Union, and advise that Local Union(s) Fund Office in whose jurisdiction you are working to send your contributions to Lineco.**

Utility Employees

You are considered a "utility employee" if you are employed under a collective bargaining agreement or participation agreement by an employer who is designated as a "utility" by the Trustees, or a member of that utility's board of directors. The utility must contribute to Lineco at the rate of 174 hours per month for each of its employees who are paid for at least 125 hours per month.

Eligibility - Your eligibility is determined on a month-to-month basis. You will be eligible during each month that your employer makes a correct and timely contribution to Lineco. The Rollback Rule and the eligibility during disability rules do not apply, nor can you make short-hours self-payments, but you will be entitled to COBRA coverage if you or a dependent has a qualifying event. When you re-

tire, your months of eligibility will be counted toward meeting the eligibility requirements for Retiree Benefits.

Benefits - The benefits provided to eligible utility employees and their dependents are the same benefits provided to non-utility employees and dependents, except that the insurance benefits (life insurance and AD&D insurance) and the Weekly Loss of Time Benefit are not provided.

Surviving Dependent Eligibility

If you die while you are an eligible employee who is NOT making COBRA self-payments, coverage under the Plan for your surviving dependents may be continued according to the rules explained below.

- Your surviving dependents may be entitled to an automatic continuation of coverage as follows:
 - ~ If you were covered under the eligibility during disability provisions at the time of your death, your dependents will continue to be covered for three months starting with the first day of the month following the month in which you die; or
 - ~ If you were not covered under the eligibility during disability provisions at the time of your death, your dependents will continue to be covered through the end of the benefit month for which you had earned eligibility before your death.
 - ~ After that, your spouse can continue coverage for herself and your children either by making COBRA self-payments, or by making surviving dependent self-payments. If your spouse chooses to make COBRA self-payments, she will not be entitled to make surviving dependent self-payments at any future date. Similarly, if she chooses the surviving dependent self-payment option, she will lose the right to elect COBRA coverage at any future date.

If you are not survived by your spouse, your children's coverage can be continued under COBRA coverage.

If you die while making COBRA self-payments for yourself and your dependents, your surviving dependent spouse may be entitled to make COBRA self-payments according to the COBRA coverage rules and subject to the following additional rules:

- COBRA self-payments may be made for up to a maximum of 36 months, minus the number of self-payments you had made before your death; and
- If your surviving spouse dies while she is making COBRA self-payments for herself and any dependent children, the children (or their guardian) can make COBRA self-payments for up to 36 months, minus the number of self-payments made by you and by your spouse prior to your respective deaths, unless coverage terminates earlier according to the termination rules on page 17.

COBRA Coverage for Surviving Dependents - If your surviving spouse chooses this option, the rules governing COBRA coverage (starting on page 19) will apply.

Surviving Dependent Self-Payments for Spouses Under Age 62 - If your surviving spouse is under age 62, she can make self-payments to continue coverage for herself and any of your surviving dependent children in accordance with the following rules:

1. Your spouse will have a choice of the electing medical/prescription benefits only, or medical/prescription with dental and vision benefits.
2. The amount of the monthly self-payment is determined by the Trustees and may be changed at any time.

3. Your spouse must make her first self-payment on or before the date on which a self-payment to maintain continuous coverage is due. There must be no lapse in coverage.
4. Additional payments must be postmarked no later than the 15th day of the month before the benefit month in which she is paying. Payments postmarked after the 15th will not be accepted.
5. If your spouse fails to make a self-payment on or before the date it is due, her eligibility and the eligibility of any of your surviving dependent children will terminate at the end of the benefit month for which she had already paid. She will not be allowed to make future self-payments.
6. Once a self-payment has been accepted by the Fund Office, it will not be returned.
7. Your spouse can continue to make self-payments until she reaches age 62, remarries, or becomes covered under another group health care plan.
8. When your spouse becomes age 62, her coverage under the active employee Plan will terminate and she will then be able to make self-payments for the Plan's Retiree Benefits.
9. If your spouse doesn't elect to make surviving dependent self-payments when she is first entitled to do so, she will not be permitted to make self-payments at any future date.

Surviving Spouses Age 62 or Older - If your spouse is age 62 or older when your death occurs, she will be entitled to elect Lineco's Retiree Benefits. See *Benefits for Surviving Dependents of Retirees* on page 26 for additional information.

Coverage for Your Surviving Children - Coverage for your surviving dependent children will continue as long as your spouse's coverage remains in effect, provided they continue to meet the Plan's definition of a dependent. Coverage for your children will terminate if your surviving spouse's coverage under this provision terminates for any reason—for example, if she remarries, becomes covered under another group health care plan, fails to make a timely self-payment, or dies. The same rules apply if your spouse continues to make self-payments for Retiree Benefits when she becomes age 62.

TERMINATION OF ELIGIBILITY

Termination of Employee Benefits

You will cease to be eligible for benefit coverage under the Plan if any of following events occurs:

- The Trustees terminate this Plan of Benefits;
- You enter the armed forces of any country on a full-time basis;
- You fail to meet either the 125-hour rule or the rollback rule for continuing eligibility (your coverage will terminate at the end of the last day of the benefit month corresponding to the last work month for which you did meet the continuing eligibility requirements);
- Your coverage is being continued under the eligibility during disability provisions but you fail to meet the requirements in those provisions;
- You are making short-hours self-payments but you fail to make a correct and on-time self-payment;
- 31 days have passed since your group's contract expiration date (see *31-Day Termination Rule* starting on page 17); or
- Your death.

You may be entitled to elect COBRA coverage if your eligibility as an active employee terminates.

See the *COBRA Coverage* section starting on page 19 for more information.

If your eligibility terminates due to your retirement, you may be eligible to continue your coverage under Lineco's Retiree Benefits. See the *Retiree Coverage* section starting on page 23.

Termination of Dependent Benefits

A dependent of yours will cease to be eligible for benefit coverage under the Plan if any of the following events occurs:

- The Trustees terminate this Plan of Benefits;
- The Trustees terminate dependent benefits under this Plan;
- You cease to be eligible for benefit coverage for reasons other than your death;
- Your dependent enters the armed forces of any country on a full-time basis;
- With respect to your spouse:
 - ~ Your spouse becomes covered under the Plan as an employee; or
 - ~ You and your spouse divorce or legally separate; or
- With respect to a child, the child no longer meets the Plan's definition of a dependent child;
- In the event of your death:
 - ~ When the eligibility you earned prior to your death expires; or
 - ~ If your eligibility was being maintained under the eligibility during disability provisions, three full benefit months have passed since your death occurred.

Your surviving spouse may be entitled to make surviving dependent self-payments to continue coverage for herself and your surviving dependent children (see the *Surviving Dependent Eligibility* section starting on page 15 for more information). Surviving dependent coverage will terminate if any of the following events occurs:

- ~ Any of the events above occurs;
- ~ Your surviving spouse fails to make a correct and on-time self-payment;
- ~ Your surviving spouse attains age 62 (coverage terminates on the first of the month after her 62nd birthday and she will then be offered the opportunity to elect Retiree Benefits);
- ~ Your surviving spouse becomes covered under another health care plan;
- ~ With respect to a surviving child, the date the child ceases to meet this Plan's definition of a dependent child; or
- ~ Your surviving spouse remarries.

If coverage terminates for one of your dependents, he or she may be entitled to elect COBRA coverage. See the *COBRA Coverage* section starting on page 19 for more information.

31-Day Termination Rule

Regardless of the termination provisions stated above, all eligibility for benefits for participants (employees or dependents) will terminate after the 31st day following the date on which a collective bargaining agreement (CBA) which requires contributions to Lineco for those participants is not succeeded by another CBA which requires such contributions to Lineco, called the group's contract expiration date.

For employees who are not covered by a CBA but who are participants in Lineco as a result of a written participation agreement between their employer and the Trustees, the eligibility of all such participants (employees and dependents) will terminate after the 31st day following the expiration of the participation agreement or its termination by the Trustees, called the group's contract expiration date.

An employee who is eligible for benefits on his group's contract expiration date by reason of employer contributions obligated pursuant to a CBA or participation agreement cannot make self-payments to maintain eligibility. However, an employee who is making COBRA self-payments to Lineco on his group's contract expiration date may continue to make self-payments if the employer discontinues group health coverage for that group after termination of the employer's Lineco contract. (Any additional self-payments must be made in accordance with the Plan's self-payment rules.) If, however, the group becomes covered under another group plan, Lineco will not accept self-payments for coverage after the contract expiration date. In that case the new plan would become responsible. Short-hours self-payments cannot be made after the group's contract expiration date.

Retirees Not Affected by 31-Day Rule - Retirees who are maintaining their eligibility by self-payments are not affected by the 31-Day Termination Rule as long as they make self-payments in accordance with the retiree self-payment rules.

COBRA COVERAGE

Under the COBRA coverage rules, qualifying individuals can make self-payments for continued Plan coverage (called COBRA Coverage). COBRA self-payments are different from short-hours self-payments in that with COBRA you pay for benefit months (coverage months) while short-hours self-payments (pages 11-12) are for eligibility (work months).

You and/or your dependents can make COBRA self-payments for 18 months if your coverage terminates due to a reduction in your hours or termination of your employment (including your retirement).

Your dependents can make COBRA self-payments for 36 months if their coverage terminates due to your death, your divorce or legal separation from your spouse, or a child's failure to meet the definition of a dependent (for example when the child reaches the age limit for coverage under the Plan).

Qualifying Events/Maximum Coverage Period

- You and/or your dependents can elect COBRA coverage and make self-payments for the coverage for up to 18 months after coverage terminates if the coverage terminates due to one of the following events (called "qualifying events"):

- ~ A reduction in your hours; or
- ~ Termination of your employment (which includes retirement).

If you or a covered dependent is disabled (as defined by the Social Security Administration for the purpose of Social Security disability benefits) on the date of one of the qualifying events listed above, or if you or a covered dependent becomes so disabled within 60 days after an 18-month COBRA period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. The COBRA self-payment may be higher for the extra eleven (11) months of coverage for the family. Also, you must notify the Fund Office within 60 days of such a determination by the Social Security Administration and within the initial 18-month period, and within 30 days of the date Social Security determines that the person is no longer disabled.

- Your dependents can elect COBRA coverage and make self-payments for the coverage for up to 36 months after coverage terminates if their coverage terminates due to one of the following events (called "qualifying events"):

- ~ Your divorce or legal separation from your spouse;
- ~ A child's failure to meet the definition of a dependent; or
- ~ Your death.

Multiple Qualifying Events - If your dependents are covered under COBRA during an 18-month maximum coverage period due to your termination of employment or reduction in hours and a second qualifying event (such as divorce or a child losing dependent status) occurs, your spouse or the child is entitled to elect COBRA coverage for up to a maximum of 36 months minus the number of months of COBRA coverage already received under the 18-month continuation. Only a person who was your dependent on the date of your termination of employment or reduction in hours is entitled to make an election for this extended period. Exception: If a child is born to you (employee), adopted by you or placed with you for adoption during the first 18-month continuation period, that child will have the same election rights when a second qualifying event occurs as those of a person who was your dependent on the day before the first qualifying event.

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

COBRA Coverage During Military Service - Refer to *Eligibility During Military Service* on page 13.

Special Medicare Entitlement Rule - A special rule provides that if you (the covered employee) become entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of hours, the period of coverage for your spouse and dependent children will be 36 months measured from the date of your Medicare entitlement, or 18 months from the date you lose coverage because of a reduction in hours or termination of employment, whichever is longer.

Benefit Options Under COBRA Coverage

If you or a dependent elect COBRA coverage, you will have a choice of electing medical/prescription benefits only, or medical/prescription with dental and vision benefits. Life insurance is also available as an option if you elect medical/prescription/dental/vision. (This option is only for employees whose reduction in hours or termination of employment is due to reasons other than retirement, and only the employee is eligible for life insurance.) AD&D insurance and Weekly Income Benefits are not provided under COBRA coverage. You cannot change your coverage option after you have elected COBRA.

You must be enrolled in Medicare Part B if you are eligible for Medicare when your COBRA coverage begins.

Notification Responsibilities

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

Your employer must notify the Fund Office within 30 days of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notice of your election rights as soon as possible, you or the affected dependent should notify the Fund Office any time a qualifying event occurs.

Reminder - So that the Fund Office can give proper notification when coverage terminates, please be sure the Fund Office always has the current mailing address for you and all your covered dependents. You can notify the Fund Office about an address change by telephone or on the Lineco website (see the inside front cover).

Self-Payment Procedures and Rules

1. When the Fund Office is notified of a qualifying event, you and/or your dependents will be sent an election notice that explains COBRA coverage election rights, the due dates, the amount of the self-payments, the benefit options that can be elected, etc.
2. An election form will be sent along with the election notice. This is the form you or a depend-

ent fill in and send back to the Fund Office if you want to elect COBRA coverage.

3. The person electing COBRA coverage has 60 days after he is sent the election notice or 60 days after his coverage would terminate, whichever is later, to send back the completed election form. (However, it is strongly recommended that the form be sent back as soon as possible.) An election of COBRA coverage is considered to be made on the date of the postmark on the returned election form.
4. If the election form is not mailed back to the Fund Office within the allowable period, you and/or your dependents will be considered to have waived your right to COBRA coverage.
5. After the filled-in election form is returned to the Fund Office, the Fund Office will send the person electing the coverage a packet of payment coupons. A coupon should accompany each self-payment that is made.
6. A person electing COBRA coverage has 45 days after the date of the mailing postmark on the signed election form to make his initial payment. (However, it is strongly recommended that the payment be made as soon as possible so that a number of months won't have to be paid for all at once.) You will not be considered to be eligible until the on-time payment is received.
7. COBRA self-payments must be made monthly. After the initial self-payment, each subsequent monthly self-payment is due by the first day of the benefit month for which the self-payment is being made. A self-payment will be considered on time if it is received by the Fund Office within 30 days of the due date.
8. If a self-payment is not made within the time allowed, COBRA coverage for all affected family members will terminate. The self-payment may not be made up nor may coverage be reinstated by making future self-payments.
9. The amounts of the monthly self-payments are determined by the Trustees based on Federal regulations. The amounts are subject to change.
10. Once a self-payment has been accepted by the Fund Office, it will not be returned.
11. If you, the employee, make COBRA self-payments because of reduced hours, you will be credited with 125 credited hours in the work month corresponding to the benefit month for which you make the self-payment. These hours will be considered credited hours under the continuing eligibility rules.

Additional Rules Governing COBRA Coverage

- COBRA coverage may be elected for a person who is entitled to Medicare on his election date, however, if the person *becomes* covered under Medicare *after* he has elected COBRA coverage, the person's COBRA coverage will terminate. (Note: You must be enrolled in Medicare Part B if you are eligible for Medicare when your COBRA coverage begins.)
- COBRA coverage may be elected for a person who is covered under another group health care plan; however, if the person *becomes* covered under another group health care plan *after* he has elected COBRA coverage, the person's COBRA coverage will terminate unless the person has a preexisting condition that would cause benefits to be excluded or limited under the other plan.
- Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage. If you elect COBRA coverage for yourself and your

dependents, your election is binding on your dependents. If you don't elect COBRA coverage for your dependents when they are entitled to COBRA coverage, your dependent spouse has the right to elect COBRA coverage for herself and any children, or the children may elect independently.

- You do not have to show that you or your dependents are insurable in order to elect COBRA coverage.

Termination of COBRA Coverage

COBRA coverage for a person will be terminated before the end of the applicable maximum coverage period when the first of the following events occurs:

- A correct and on-time self-payment is not made to the Fund;
- The Line Construction Benefit Fund no longer provides group health coverage to any employees;
- The person has been receiving extended COBRA coverage for up to an additional 11 months due to his or another family member's disability, and the Social Security Administration has determined that the previously disabled person is no longer disabled;
- The person becomes covered under another group health plan. Exception: This termination rule will not apply if the person has a preexisting medical condition that would cause benefits to be excluded or limited under the other Plan; or
- The person becomes entitled to Medicare.

RETIREE COVERAGE

You have a choice of two ways to continue coverage under the Plan for yourself and your dependents when you retire:

- **COBRA Coverage** - You may be entitled to make COBRA self-payments for up to 18 months; OR
- **Retiree Benefits** - You can make self-payments for Retiree Benefits as long as you meet the eligibility requirements and make on-time self-payments.

COBRA Coverage for Retirees

Retirement is a qualifying event under COBRA coverage. When you retire, you may be entitled to make self-payments for up to 18 months for continued Plan coverage under the COBRA coverage rules. **If you are receiving pension benefits and elect COBRA coverage, you CANNOT get into the Retiree Benefits plan later, regardless of the length of your COBRA coverage period.**

Medicare entitlement is a terminating event under COBRA coverage. A person who becomes eligible for Medicare while making COBRA payments will lose the right to make any additional payments for COBRA coverage.

If your death occurs while making COBRA self-payments, your surviving dependents may be entitled to continue making COBRA self-payments up to a maximum of 36 months starting with the month you first began making COBRA self-payments due to your retirement.

For more information, see *COBRA Coverage* starting on page 19.

Eligibility for Retiree Benefits

To be eligible to make self-payments for Retiree Benefits, you must meet **ALL** of the following requirements:

Early and Normal Retirements

- You must be at least age 55; AND
- You must be retired from any and all employment in the electrical industry or any organization affiliated with the electrical industry (does not apply to working as an electrical inspector, or as an instructor in an apprenticeship program recognized by the IBEW or NECA); AND
- You must be receiving retirement benefits either from a plan negotiated or sponsored by the IBEW, from a qualified pension plan sponsored by a contributing employer, or from Social Security; AND
- You must be eligible for Lineco benefits on the day immediately preceding the effective date of your Lineco Retiree Benefits; AND
- You must have been eligible for coverage under Lineco due to work hours for 48 of the 60 months preceding the effective date of your Lineco Retiree Benefits. For the purpose of this requirement, “work hours” include hours worked for which your employer made contributions,

The privilege of making self-payments by either you or your spouse to maintain eligibility for Retiree Benefits is not an “accrued benefit.” The right to change, reduce or eliminate any and all aspects of benefits provided for retirees and their dependents, including the right to increase the retiree self-payment rate, is a right specifically reserved to the Trustees.

disability hours credited to you by the Fund, and hours for which you made short-hours self-pays. The 48 coverage months do not have to be consecutive. In addition:

- ~ No more than six (6) consecutive months immediately preceding the effective date of your Lineco Retiree Benefits can be COBRA coverage months; and
- ~ Out of the 48 coverage months, no more than twelve (12) can be due to COBRA self-payments, UNLESS you were eligible under Lineco for 96 of the 120 months immediately prior to the start of your Lineco Retiree Benefits.

If you retire before your employer has participated in Lineco for at least 60 months, the Plan will look at your last 60 months of employment with that employer, including the months prior to the employer's Lineco participation date, in order to determine whether you meet the 48-month requirement.

Disability Retirements

- You must be receiving disability retirement benefits either from a plan negotiated or sponsored by the IBEW, from a qualified pension plan sponsored by a contributing employer, or from Social Security; AND
- You must be eligible for coverage under Lineco on the day immediately preceding the date your disability pension becomes effective.

Postponing or Suspending Retiree Benefits for Your Spouse

You can postpone Retiree Benefits coverage for your spouse if your spouse has employer-provided group health coverage. You can also suspend Retiree Benefits coverage for your spouse if, after you retire and elect spousal coverage, your spouse becomes eligible under another employer-provided plan. During the time your spouse has other coverage, you will only need to pay the single rate for Retiree Benefits for yourself, provided you have no other covered dependents. When your spouse's coverage terminates (ex., your spouse retires), you can begin paying the higher rate for both you and your spouse.

If you want to postpone/suspend coverage for your spouse, you must provide proof of your spouse's other coverage to the Fund Office. To reinstate spousal coverage, you must submit proof the other coverage has ended. Proof must be submitted within 30 days after the other coverage terminates.

Your spouse's Lineco coverage cannot be reinstated unless and until her other coverage terminates.

The postponement and suspension rules do not apply to retirees—they are only for spouses. However, if a retiree has a dependent child who is also covered by the spouse's plan, Retiree Benefits coverage for that child can be postponed or suspended, and later reinstated, along with the spouse's.

Dropping Spousal Coverage

Retirees are also permitted to drop spousal coverage. This opt-out for a spouse will be valid only if the spouse signs a written acknowledgement that Lineco coverage will never become available again.

Retirees Eligible for VA Benefits

A retired employee who is eligible for coverage through the Veterans Administration (VA) may opt out of Lineco Retiree Benefits for himself while maintaining Lineco Retiree Benefits for his spouse (at the single coverage rate). The retiree can opt back into the Retiree Benefits program later.

Retiree Benefits Coverage

You have a choice of making self-payments for medical and prescription drug benefits only, or medical/prescription plus dental and vision benefits.

- Retiree Benefits do not include Weekly Income Benefits, life insurance or AD&D insurance. (Nor are you entitled to any coverage under the eligibility during disability rules once you retire.)
- Prescription drug benefits for retirees and their dependents are the same prescription drug benefits provided to active participants until they become eligible for Medicare. When a retiree or dependent becomes eligible for Medicare, that person's prescription drug coverage will be provided under the special program for Medicare-primary participants (described on page 48), and the person's Medical Benefit out-of-pocket limit will be reduced to \$1,125 per calendar year.
- Otherwise, your benefit coverage is the same as that currently provided to active eligible employees and their dependents.

Once you select an option you cannot change it except during the first 30 days after your original coverage election. The only exception is that if you originally elect dental and vision coverage, you can later drop those coverages. However, the change will be permanent—if you drop dental and vision coverage you cannot re-elect it at a later date.

The benefits provided to retirees may be changed at any time by the Trustees.

In the event of your death, your spouse may continue making self-payments for the option she is covered under when your death occurs.

Coordination of Benefits With Medicare

If you and/or your spouse are eligible to participate in Medicare, Lineco's benefits will be calculated as though benefits under Medicare Part A and Part B have been paid, whether or not you are actually enrolled in both Parts. You and your spouse should enroll in both Medicare Part A and Part B when eligible to do so. For more information see *C.O.B. With Medicare* starting on page 73.

Medicare Part D Prescription Drug Plans

Medicare prescription drug coverage is available to everyone with Medicare. This coverage is separate from any coverage provided by Lineco. You must pay a monthly premium to a private plan approved by Medicare in order to get Part D coverage.

Medicare-eligible retirees (and Medicare-eligible spouses of retirees) have the option of dropping Lineco's prescription drug coverage and switching to a Medicare Part D plan. However, most participants will NOT benefit by doing so, and Lineco is NOT encouraging anyone to switch to Part D. If you elect a Part D plan, you can still make payments for Lineco's Retiree Benefits. In this case, Lineco will provide you with hospital and physician benefits—but not prescription drug benefits. Your self-payment amount to Lineco will NOT be lower if you elect a Part D plan. You can get back into Lineco's prescription drug program later if you drop your Part D plan.

You cannot choose dual coverage. Lineco will not coordinate its prescription drug benefits with a Part D plan. You and your spouse can be covered under different drug plans.

You must inform the Lineco Fund Office if you or a Medicare-eligible dependent chooses Part D coverage. If you do not provide timely notification, and Lineco continues to pay your drug expenses, you will have to repay Lineco for the amount it paid.

Self-Payment Rules for Retiree Benefits

- You must make your first self-payment on or before the date on which a self-payment to maintain continuous coverage is due. There must be no lapse in coverage between active employee coverage and Retiree Benefits coverage.
- The monthly self-payment amount is determined by the Trustees and may change at any time. Self-payment amounts for retirees are based on the retiree's dependent status and Medicare eligibility.
- Self-payments must be received by the Fund Office no later than the 15th day of the month preceding the benefit month for which you are paying. (Ex., your payment for March must be received by Feb. 15th) Lineco offers secure direct-debit to make ongoing retiree self-payments.
- Note that in the example above, the self-payment will be credited to your account as hours in the work month of January—the work month corresponding to the March benefit month.
- If you fail to make a self-payment on or before the due date, your eligibility for Retiree Benefits will terminate at the end of the benefit month for which you have already paid. You will not be allowed to make any future self-payments.
- Once a self-payment has been accepted by the Fund Office, it will not be returned.
- If you die while making self-payments for Retiree Benefits, your surviving spouse can continue Retiree Benefits coverage for herself and any dependent children by making self-payments as explained in the following section.

You can make your Retiree Benefits self-payments by automatic withdrawal from your personal bank account or your Lineco HRA (if applicable). Contact the Fund Office for more information about this service.

Benefits for Surviving Dependents of Retirees

If your death occurs while making self-payments for Retiree Benefits for yourself and your dependents, your surviving spouse can continue to make self-payments for Retiree Benefits for herself and any dependent children, subject to the following rules:

- The self-payments must be made according to the provisions of *Self-Payment Rules for Retiree Benefits* (page 26) as though the self-payments were being made by you.
- Your surviving spouse can continue to make self-payments until the earlier of the date on which she remarries or dies unless coverage terminates earlier according to the *Termination of Dependent Benefits* rules on page 17.
- If you have no surviving spouse, or if your spouse dies while making self-payments for continued Retiree Benefits, your surviving dependent children or a legal guardian can make self-payments for continued Retiree Benefits on behalf of the children, subject to the following rules:
 - ~ Self-payments may be made on behalf of the children for a maximum of 36 months, less any self-payments made by you before your death and/or any self-payments made by your surviving spouse before her death. If you/your spouse already made 36 self-payments for Retiree Benefits, no self-payments may be made by or on behalf of the children.
 - ~ The self-payments must be made according to the same rules and time limits as self-payments made by you.
 - ~ Benefits for a surviving dependent child will terminate before the termination of the allowable maximum coverage period on the date the child fails to meet the Plan's definition of a dependent, unless coverage terminates earlier according to the following termination rules.

- If upon your death you are eligible for Retiree Benefits but your spouse is not (because you had previously suspended, postponed or dropped her coverage), she will have the option of electing Retiree Benefits coverage for herself (and any of your qualifying dependent children), provided she does so within 90 days following your death.

Termination of Retiree Benefits

Retirees - You will NOT be eligible for the Plan's Retiree Benefits if any of the following events occur:

- The Trustees terminate this Plan of Benefits;
- The Trustees terminate Plan benefits for retirees;
- You fail to make a proper and on- time self-payment;
- You go to work for an employer in the electrical industry who is not required to make contributions on your behalf to an IBEW-NECA-sponsored health and welfare fund (benefits will terminate on the last day of the month before your industry employment begins); or
- The date of your death.

Dependents - A dependent of yours will NOT be eligible for the Plan's Retiree Benefits if any of the following events occur:

- Your eligibility for Plan coverage terminates for any reason other than your death;
- The Trustees terminate Plan benefits for dependents of retirees;
- The dependent enters the armed forces of any country on a full-time basis;
- The dependent ceases to meet this Plan's definition of a dependent, except that a divorced or legally separated spouse of an eligible retiree can make COBRA self-payments for the lesser of 36 months or until the spouse attains age 65;
- In the event of your death, at the end of the month in which your death occurred.

Your surviving spouse may be entitled to continue her coverage by making surviving dependent self-payments to continue coverage for herself and your surviving dependent children (see the *Benefits for Surviving Dependents of Retirees* section starting on page 26 for more information). Surviving dependent coverage will terminate if any of the following events occurs:

- ~ The dependent fails to make a correct and on-time self-payment;
- ~ The dependent fails to meet the Plan's definition of a dependent;
- ~ With respect to the surviving spouse, if she remarries; or
- ~ With respect to a child, if your surviving spouse dies.

If your spouse predeceases a child who is still eligible for coverage under the Plan (for example, because he has not reached age 26), self-payments can continue to be made by or on behalf of that child. Your child's Retiree Benefits coverage can continue until any of the following events occurs:

- ~ A correct and on-time self-payment fails to be made by or on behalf of the child;
- ~ The child ceases to meet the Plan's definition of a dependent; or
- ~ The expiration of the allowable maximum coverage period to which the child is entitled (the maximum coverage period is 36 months minus any months of Retiree Benefits coverage before your and your spouse's death).

This page is intentionally blank.

INSURANCE BENEFITS

Life Insurance

Life insurance is available only for eligible employees who are not utility employees. Life insurance is not provided for retirees or dependents. An employee whose reduction in hours or termination of employment is due to reasons other than retirement will have the option of continuing his life insurance coverage under COBRA.

The amount of your life insurance is \$20,000. If you die while you are eligible for this benefit, your life insurance is payable to your beneficiary regardless of the cause of death.

Your Beneficiary - Be sure that the person you want to receive your life insurance has been named as your beneficiary and is on file in the Fund Office. You can do this by filling in the beneficiary section of the Family Enrollment Card and sending it to the Fund Office. You can get a Family Enrollment Card by calling the Fund Office or by completing and returning the form online on Lineco's website (see the inside front cover for Lineco's telephone number and web address).

If you name more than one beneficiary and don't state how much each is to get, the beneficiaries will share equally.

Be sure that the person you want to receive your life insurance has been named as your beneficiary and is on file in the Fund Office.

If you haven't named a beneficiary or if your named beneficiary dies before you, your life insurance will be paid to the first of the following successive classes of survivors: your spouse; your children; your parents; your brothers and sisters; or your estate. If there is more than one survivor in the class payment is made to, the survivors in that class will share equally.

You can change your beneficiary at any time. Just submit a new beneficiary designation (on a Family Enrollment Card) and send it to the Fund Office during your lifetime. (To be valid, the change of beneficiary must be received by the Fund Office while you are still living.)

Waiver of Premium - If you become totally disabled and unable to work, your life insurance may be continued at no cost to you. You must meet all of the following conditions to have your life insurance continued under this provision: (1) You must have been actively employed by a contributing employer within the 90-day period immediately preceding the date your total disability started. (2) You must be totally disabled and thereby completely and continuously prevented from engaging in any occupation or employment for wages, compensation or profit. (Notification of a total disability determination from the Social Security Administration is sufficient evidence to establish eligibility for this provision.) (3) Your disability must occur prior to your retirement. (4) Your total disability must last for at least nine months. (5) You must provide the insurance company with acceptable medical proof that your disability is presumably permanent. The proof must be furnished while you are still covered under the Plan and after you have been disabled for at least nine months and before your disability has lasted for twelve months. (6) Each year afterwards you must provide proof that you remain disabled. This proof is to be submitted during the three-month period preceding the anniversary date of your disability. (7) Your life insurance will be continued on a year-to-year basis as long as you are disabled. When your disability ends or if you fail to comply with the above proof requirements, your life insurance will no longer be continued.

Conversion Privilege - If your life insurance is going to terminate because your eligibility for life insurance terminates, or because the group insurance policy terminates, you can convert your life insurance to an individual policy as follows: (1) You must pay the insurance premiums. (2) You can

convert to any type of individual life insurance policy customarily issued by the insurance company except term insurance, and no medical examination or proof of good health is required. (3) Your written application and first premium payment must be made within 31 days after termination of your eligibility for life insurance or termination of the group insurance policy. (4) If you die within the 31-day period allowed for conversions, your life insurance will be paid even if you haven't applied for conversion. (5) If your eligibility for life insurance terminates, you can convert up to, but not more than, the amount you had under the Plan. If the group insurance policy terminates, you can convert up to \$10,000 if you have been continuously eligible under the Plan for five or more years. However, the \$10,000 will be reduced by any amount of group life insurance for which you become eligible under any other group plan within 31 days of the policy termination.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Accidental Death and Dismemberment (AD&D) insurance is available only for eligible employees who are not utility employees. AD&D insurance is not provided for retirees, dependents or persons who are making COBRA self-payments.

AD&D insurance benefits are payable if you suffer any of the losses shown below. The loss must result from an accident that occurs to you while you are eligible for AD&D insurance and must occur within 90 days of the date of the accident.

Amount of Benefit - The full amount of your AD&D insurance is \$20,000. The amount payable for all losses resulting from any one accident cannot exceed this full amount. If you suffer any combination of the losses on the Table of Losses as the result of one accident, only one amount (the largest) is payable for all losses. The amount paid for accidental death (loss of life) is in addition to your life insurance benefit. For each of the following losses, the Plan will pay as follows:

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

Loss of	Benefit Amount
Life	Full Amount—Paid to your beneficiary
Two hands or two feet or sight of two eyes	Full Amount—Paid to you
One foot and sight of one eye	Full Amount—Paid to you
One hand and sight of one eye	Full Amount—Paid to you
One hand and one foot.....	Full Amount—Paid to you
One hand, one foot, or sight of one eye.....	One-half the Full Amount—Paid to you

Exclusions and Limitations (Losses Not Covered) - No AD&D insurance benefits will be paid for any loss: (1) which occurs more than 90 days after the date of the accident causing the loss; or (2) which results directly or wholly from or which is caused or contributed to by intentionally self-inflicted injury or suicide or attempted suicide, while sane or insane; disease, medical or surgical treatment, ptomaines, bacterial infections, or bodily or mental infirmity; or war or any act of war (whether declared or undeclared).

WEEKLY INCOME BENEFIT

Weekly Income Benefits are available only for eligible employees who are not utility employees. Weekly Income Benefits are not provided for retirees, dependents or persons who are making COBRA self-payments, or employees who are making short-hours self-payments.

Weekly Income Benefits are designed to help replace lost wages when you are totally disabled and unable to work. No Weekly Income Benefits are payable for any period of time during which you are able to work.

Eligibility for Weekly Income Benefits

To be eligible for Weekly Income Benefits, you must meet all the following requirements:

- You must be eligible for Plan benefits from worked hours on the date your disability begins. However, if your disability begins while eligible under the Plan not from worked hours (e.g., if COBRA or self-payments), this benefit will not begin until the date you become eligible due to worked hours. Any applicable waiting period will begin on your disability date.
- You must have been actively employed by a contributing employer within 15 days prior to the date your disability began.
- A doctor must certify that you are totally disabled as a result of a non-occupational accidental bodily injury or sickness and be completely unable to perform each and every duty of your occupation or employment.

Amount of Benefit

The weekly benefit is \$400 per week.

Benefits are paid on the basis of a regular five-day work week, Monday through Friday. If benefits are due you for a partial week, you will receive one-fifth of the weekly benefit for each day of disability. In accordance with Federal law, the Plan will withhold your share of any required taxes from each weekly payment. In addition, keep in mind that you must include the weekly benefits you receive as gross income and pay Federal income tax on them. Please check with a competent attorney or accountant for tax advice.

Period of Payment/When Benefits Start

Weekly benefits are payable for up to 26 weeks while you are totally disabled, but not for more than 26 weeks for any one continuous period of disability.

Weekly benefits will begin:

- On the first day of disability due to an accidental injury.
- For disabilities due to sickness:
 - ~ On the eighth day of disability if not hospitalized as an inpatient, or
 - ~ On the first day of an inpatient hospital stay if the admission was before the eighth day of sickness.

If a female employee is disabled due to maternity or a pregnancy-related condition, the disability will be treated as a disability due to sickness.

Disability does not begin until you are initially treated or examined by a doctor.

Successive Periods of Disability

If you have a second period of disability due to the same diagnosis or cause, it will be considered part of the previous period of disability, subject to the same 26-week maximum payment period, unless you return to full-time work and re-establish eligibility due to work hours.

If you have a second disability with a new diagnosis and cause, you must re-satisfy the requirements in the *Eligibility for Weekly Income Benefits* section in order to qualify for a new benefit period.

If you have more than one period of disability due to the same accident, only the first period of disability will be considered as caused by an accident. All other periods of disability due to that accident will be considered as due to a sickness.

Weekly Income Benefits for Substance Abuse Treatment

Weekly Income Benefits are payable for eligible employees who are receiving pre-certified full-time inpatient/residential treatment, but not beyond the date the treatment program is completed. Benefits will not be paid for treatment that is not certified, or not provided in a hospital or a covered substance abuse treatment facility

Exclusions and Limitations

No weekly benefits are paid for a period of disability:

- Caused by a sickness or injury for which you are not under the direct care of a doctor as defined on page 76;
- For which you are or may be entitled to receive benefits in whole or in part under any Workers' Compensation law, Occupational Diseases law, Employer's Liability law or similar law;
- Sustained while performing any act or duty pertaining to any occupation or employment for remuneration or profit;
- Caused by substance abuse:
 - ~ If you are not undergoing covered inpatient treatment in a hospital or a covered substance abuse treatment facility;
 - ~ Beyond the date an inpatient course of treatment is completed; or
 - ~ If you do not complete the treatment program;
- Caused by military service; or
- Due to a non-covered cosmetic procedure.

GENERAL RULES GOVERNING MEDICAL BENEFITS

Blue Card/Blue Cross Blue Shield PPO Network

The Blue Card PPO Network is a network of hospitals and physicians throughout the United States that participate in their local Blue Cross Blue Shield PPO networks. Blue Card PPO providers will provide medical care to Lineco participants at negotiated rates. When you use Blue Card PPO hospitals and doctors for your medical care, you save money twice. First, because the rates charged by PPO providers are usually lower, and second, because the Plan will pay a higher percentage of your covered expenses. Please note that Blue Card providers are Lineco's preferred providers, but you are not required to use them—the choice of a hospital and a doctor is solely yours to make.

To find Blue Card PPO providers, go to www.bcbsil.com and follow the links. Or call 1-800-810-BLUE (2583).

Show your Blue Card I.D. card whenever you receive medical treatment, even if the treatment is provided by a non-network provider. **The Blue Card PPO does not apply to you if Medicare is your primary plan, and you will not receive a Blue Card I.D. card.** Instead, you should use providers that participate in Medicare.

ValueOptions Provider Network for Mental Health and Substance Abuse

The ValueOptions provider network is the Plan's preferred provider network (PPO) for treatment of substance abuse or mental or nervous disorders. The ValueOptions Provider Network is a nationwide network of mental health hospitals, treatment facilities, doctors and professional mental health practitioners.

To find ValueOptions providers, call 1-800-332-2191.

All ValueOptions network providers are covered, including Masters-level mental health providers such as social workers and counselors. Masters-level non-PPO providers are NOT covered. Although ValueOptions providers may also be in the Blue Cross Blue Shield network, the PPO level of benefits will only be paid for mental health and substance abuse treatment in the ValueOptions network.

Hospital Pre-Certification Program

The Hospital Pre-Certification Program is administered by Medical Cost Management (MCM). MCM will work with you and your doctor to help avoid unnecessary hospital days and ensure services rendered meet coverage guidelines under the terms of the Plan whenever possible. Of course, only you and your doctor make the decisions about your medical care and treatment. A \$250 deductible will apply to the covered medical expenses incurred during each hospitalization if the admission is not pre-certified.

For pre-certification of hospital admissions, call the Fund Office at 1-800-323-7268, 8:30 a.m.-4:30 p.m., CST and ask for Medical Cost Management (MCM).

A different pre-certification program applies to inpatient admissions and other types of treatment for substance abuse and mental or nervous disorders—see page 34 for more information.

How to Have Hospital Admissions Pre-Certified

To start the pre-certification process, you, your doctor or the hospital must call the Fund Office's toll-free number and ask for the MCM Hospital Pre-Certification personnel. Call BEFORE a non-emergency hospital admission. Call within two working days after an emergency admission. (Treat-

IMPORTANT: No matter who makes the call, it is your responsibility to see that the call is made.

ment in a hospital's emergency room does not require pre-certification unless the person is admitted to the as an inpatient.) For a maternity, call as soon as the pregnancy is confirmed (or during the first trimester) and again within twelve hours after delivery. Also call within two working days after an admission for any pregnancy-related conditions such as false labor, miscarriage, etc.

Who Can Call - Although it is best to have your doctor make the call—you, a family member, or the hospital can call the Fund Office to tell MCM about a hospitalization.

After the call has been made to MCM about a proposed hospital admission, you will be sent a letter explaining MCM's recommendations regarding pre-certification of the hospital stay under the terms of the Plan. This letter is your proof the Hospital Pre-Certification Program was contacted.

Pre-Certification is not a guarantee that the Plan will pay benefits for the treatment. The coverage available to you is also subject to the Plan's eligibility requirements and all applicable Plan limitations and provisions.

Alternate Methods of Treatment - There are certain types of procedures which can be performed or conditions which can be treated other than in a hospital. In such a case, MCM will discuss alternatives to hospital confinement with the patient and doctor. They may also be able to identify resources in your area that can provide alternative care.

Prenatal Care Program

Female employees/retirees and spouses are encouraged to participate in a special program provided by Medical Cost Management (MCM) designed to help reduce complications and premature births. Women will receive a \$250 gift card if they participate.

For more information, call 1-800-323-7268 and ask for MCM.

The goals of the Prenatal Care Program are a healthy pregnancy and delivery. Early education and adequate prenatal care throughout pregnancy can help achieve these goals. MCM's specially trained staff will perform a screening for high risk factors and will offer information, counseling and resources.

To participate, call as soon as a pregnancy is confirmed (in the first trimester) and call again by the first business day after delivery. (If the mother is not covered by Lineco in the first trimester but is eligible in the second trimester, then the initial contact must be made during the second trimester.) MCM will ask you to complete certain forms and provide updates on the progress of your pregnancy. You must complete any required forms and provide the information requested by MCM in order to qualify for the \$250 gift card.

Mental Health and Substance Abuse Pre-Certification Program

You or your doctor must call ValueOptions before you or a dependent incurs the following types of expenses for substance abuse or a mental or nervous disorder:

- Inpatient, residential and partial inpatient treatment
- Intensive outpatient treatment
- Psychological testing
- Electroconvulsive therapy

For mental health/substance abuse pre-certification, call ValueOptions at 1-800-332-2191.

ValueOptions will review the proposed treatment and advise you whether or not the treatment meets the Plan's criteria for being medically necessary and appropriate.

Although it is best to have your doctor make the call—you, a family member, or the hospital can call make the call to ValueOptions.

Medical Benefit Quick Facts		
Calendar Year Maximum Benefit	CY 2013 = \$2,000,000 <i>(No maximum starting 1/1/14)</i>	
Deductibles (MEMBER PAYS)		
Individual calendar year deductible	\$300	
Family calendar year deductible (2 or more family members)	\$600	
Hospital pre-certification noncompliance deductible per admission, in addition to the calendar year deductible	\$250	
Emergency room deductible for each occurrence of hospital emergency room treatment (waived if admitted)	\$100	
Plan Payment Percentages (LINECO PAYS) <i>After satisfaction of deductible(s) and before satisfaction of the person's or family's out-of-pocket limit. (See Special Benefits and Limitations below for exceptions and additional limitations.)</i>		
	Blue Cross Blue Shield In-Network	Out-of-Network
Covered Medical Expenses (unless stated otherwise)	80%	70%

Deductibles

Hospital Pre-Certification Noncompliance Deductible

If the Hospital Pre-Certification Program procedures explained above are not followed when a person is hospitalized, a \$250 deductible will apply to the covered medical expenses incurred for each such hospitalization in addition to the calendar year deductible. The noncompliance deductible will not apply to inpatient hospital care following a normal delivery lasting 48 hours or less, or inpatient hospital care following a Caesarean section lasting 96 hours or less. It will apply to other pregnancy-related confinements if MCM is not contacted as described above.

Calendar Year Deductibles

You are responsible for the first \$300 in covered medical expenses you and your dependents each incur during a year. After two or more persons in your family have incurred a total of \$600 in covered medical expenses applied toward calendar year deductibles in a year, the family deductible will be considered satisfied and no further deductibles will be required of your family for covered expenses incurred during the rest of that year.

If any part of a person's individual deductible is applied to covered medical expenses incurred during October, November, or December of a calendar year, that person's individual deductible for the following year will be reduced by the amount applied.

Deductibles are based on an accumulation period of one calendar year, and must be satisfied each year even if services for the same medical condition take place over a period of two or more years.

If two or more family members are injured in the same accident, only one deductible is applied each calendar year for all expenses resulting from that accident.

Emergency Room Deductible

A \$100 deductible applies to each occurrence of hospital emergency room treatment that does not directly result in a hospital admission, whether the treatment is for an accident or illness, whether the hospital is a PPO or non-PPO hospital. Emergency room deductibles are in addition to the regular calendar year deductible and do not apply to the out-of-pocket limits.

Plan Payment Percentages/Out-of-Pocket Limits

Payment Percentages - After you satisfy any applicable deductibles, the Plan usually pays 80% for covered in-network expenses and 70% for covered out-of-network expenses. You are responsible for the balance (this is called your “coinsurance”). Exceptions to the 80%/70% percentage amounts are listed on the Schedule of Benefits.

Out-of-Pocket Limits - Once the amounts of your out-of-pocket payments for your 20% and 30% coinsurance during a calendar year total \$1,500 (\$1,125 for persons whose primary plan is Medicare), the Plan will pay 100% of the covered medical expenses you incur during the remainder of that year.

If the amounts paid out-of-pocket for you and your family’s 20% and 30% coinsurance total \$3,000 during a calendar year, the Plan will pay 100% of the covered medical expenses incurred by you and your covered family members during the remainder of that year.

Exception: If an inpatient admission carries over into another calendar year, all the expenses incurred during both years for that hospital stay will count as though they had been incurred during the year in which the admission occurred.

Any out-of-pocket payments you make for the following do not count toward any individual or family maximum out-of-pocket limits:

- Deductibles and co-pays
- Non-surgical TMJ treatment, or non-precertified or out-of-network TMJ/jaw surgery
- Chiropractic care
- Non-covered expenses
- Hearing care

Expenses for non-surgical TMJ treatment, chiropractic care, hearing care and non-precertified or out-of-network TMJ/jaw surgery will NOT be paid at 100% even if your out-of-pocket limit has been met.

Maximum Benefits

A maximum benefit is the maximum amount of benefits the Plan will pay for a person for a particular type of treatment. Maximums apply even if the person’s eligibility is interrupted or if his status changes—for example, from dependent to employee status or vice versa, or from employee to retiree status. The amounts of the Plan’s maximum benefits are stated on the Schedule of Benefits.

MEDICAL BENEFITS

Benefits for Preventive Care

Lineco covers a wide range of preventive and wellness services designed to keep participants and dependents healthy. A summary of Lineco preventive coverage is included below:

Benefits for the preventive services will be paid as follows:

- Typically, the Plan will pay 100% with no deductible when you use a Blue Cross Blue Shield (BCBS) PPO provider. Out-of-network (non-PPO) services will be paid at 70% subject to the calendar year deductible.
- Childhood immunizations (under age 19) will be paid at 100% with no deductible, whether or not a PPO provider is billing for the service.
- Covered immunizations can also be obtained at a participating Express Scripts (ESI) pharmacy at no cost to you, and with no claims to file, if you show the pharmacist your ESI card.
- You can also use your ESI card to obtain the pharmacy products covered under this benefit, including products covered at 100% with no deductible.

The services covered under this benefit are based on the following recommendations and are subject to change (please consult the Lineco website for the most up to date recommendations):

- United States Preventive Services Task Force (services/items with a rating of A or B by this task force);
- Immunizations recommendation from the Advisory Committee on Immunization Practices and adopted by the Centers for Disease Control and Prevention; and
- With respect to infants, children, adolescents and women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Below are partial lists of the preventive services covered under this benefit. A complete list is available on the Lineco website or by calling the Fund Office.

CHILDREN		
AGES 0-2	AGES 2-18	IMMUNIZATIONS (0-18)
<ul style="list-style-type: none"> • Newborn screenings • Well-baby check-ups • Measurements • Developmental screenings • Lead screening • Metabolic screening • Hemoglobin test • TB test 	<ul style="list-style-type: none"> • Physician's exams • Measurements • Developmental screenings • Lead screening • Metabolic screening • Hemoglobin test • Autism screening • Behavioral assessment • TB test 	<ul style="list-style-type: none"> • Diphtheria, tetanus & pertussis • Hepatitis A • Hepatitis B • Human papillomavirus • Influenza • Influenza type B • Measles, mumps & rubella • Meningococcal • Pneumonia • Polio • Rotavirus • Varicella

ADULTS		
<p>ANNUALLY <u>Starting at Age 18</u></p> <ul style="list-style-type: none"> Well-woman visit Other routine exams⁽¹⁾ Pap test Pelvic exam Blood pressure check Cholesterol testing STD screening Routine tests incl. EKGs & blood & urine tests⁽²⁾ HIV screening <p><u>Starting at Age 40</u></p> <ul style="list-style-type: none"> Mammogram <p><u>Starting at Age 50</u></p> <ul style="list-style-type: none"> Occult blood test Colorectal cancer screening⁽³⁾ 	<p>ANNUALLY (cont.) <u>Starting at Age 65</u></p> <ul style="list-style-type: none"> Occult blood test Abdominal aneurysm screening <p>ONE PER LIFETIME IF NEEDED</p> <ul style="list-style-type: none"> Depression screening Diet counseling Bone density scan <p>OTHER, AS NEEDED</p> <ul style="list-style-type: none"> Tobacco use intervention⁽⁴⁾ Breastfeeding support⁽⁵⁾ FDA-approved female contraceptives⁽⁶⁾ Folic acid supplements⁽⁶⁾ Prenatal visits⁽⁷⁾ 	<p>IMMUNIZATIONS <u>As Prescribed</u></p> <ul style="list-style-type: none"> Hepatitis A Hepatitis B Human papillomavirus Influenza Measles, mumps & rubella Meningococcal Pneumonia Tetanus, diphtheria & pertussis Varicella Zoster

Go to www.lineco.org for more information about covered preventive services.

⁽¹⁾ The first \$125 for a routine exam per year is paid in full even if the provider out-of-network.

⁽²⁾ First \$150 per year will be paid under the Diagnostic X-Ray and Lab Benefit, whether in- or out-of-network. The excess will be considered under the regular provisions of the Medical Benefit subject to the deductible and coinsurance.

⁽³⁾ Plan covers tests and procedures within the age and frequency guidelines established by the American Cancer Society, including colorectal exams, flexible sigmoidoscopies, barium enemas, and colonoscopies.

⁽⁴⁾ Plan covers one tobacco use intervention session every 12 months and certain physician-prescribed tobacco cessation agents: Chantix limited to 180-day supply/12-month period, and other medications limited to 90-day supply during a 12-month period.

⁽⁵⁾ Breastfeeding support includes post-delivery breast pump rental, one lactation counseling session per pregnancy, and supplies as needed.

⁽⁶⁾ Written doctor's prescription is required.

⁽⁷⁾ Only routine prenatal visits are covered under the preventive benefit provisions. Delivery, prenatal lab, ultrasounds, abortions and high-risk pregnancy care services are covered under the regular major medical provisions of the Plan for female employees, retirees and spouses only—not for dependent children of any age.

Other Covered Medical Expenses

Unless otherwise specified, the following medical expenses are covered subject to the deductible, coinsurance and other limitations shown on the Schedule of Benefits. The amount payable is subject to the maximum benefits and limitations shown on the Schedule of Benefits and to all other limitations and exclusions that apply.

Only the actual allowable charges incurred for the following types of services and supplies which are medically necessary and, except where specifically stated otherwise, required in connection with the treatment of a person's injury or sickness will be considered for payment under the Medical Benefit. Only the amount of a charge that is allowable is considered a covered medical expense.

- Acupuncture** provided by a medical doctor or a licensed acupuncturist. Services by acupuncturists are limited to twelve (12) visits per calendar year per person. Coverage will be provided only for procedures involving the stimulation of anatomical points on the body using needles, pressure, electrical stimulation, heat, etc. (Medically necessary acupuncture administered by a med-

ical doctor (M.D., D.O.) or chiropractor (D.C.) is not subject to the 12-visit limit.)

The Plan does NOT cover acupuncture for smoking cessation.

2. **Ambulance** services only as follows:

- a. *Local ambulance* - Emergency local transportation by professional ambulance service other than air ambulance, limited to the first trip to and from a hospital for any one sickness and for all injuries sustained in any one accident; and
- b. *Long distance transportation* - If the attending doctor certifies that a person's disability requires specialized or unique treatment that isn't available in a local hospital, transportation to get the treatment is covered, subject to the following limitations: (1) the transportation must be by regularly scheduled commercial airline or railroad or by professional air ambulance; (2) the transportation may only be from the town where the injury or sickness occurred to the nearest hospital qualified to provide the special treatment (which may or may not be the hospital where the individual wants to be treated); (3) only the first trip to and from the hospital for any one sickness and for all injuries resulting from any one accident are covered; and (d) the transportation is limited to the United States or Canada.

Note: If you have no control over which ambulance service is used, the Plan will pay the related covered charges at 80%, even if the ambulance service is not in the PPO network.

3. **Anesthetics** and their administration.

4. **Autism assistance** - early detection and medically necessary and appropriate treatment of autism spectrum disorder (as defined on page 75) for children through age 5 years of age, as follows:

- a. Diagnosis and screening by a medical doctor (M.D. or D.O.) or psychologist. The Plan will also cover these services when provided by a Masters-level licensed behavioral health specialist participating in the ValueOptions network;
- b. Physical therapy by a licensed physical therapist, when ordered by an M.D., D.O. or psychologist;
- c. Occupational therapy by a licensed occupational therapist, when ordered by an M.D., D.O. or psychologist;
- d. Speech therapy by a licensed speech or language therapist, when ordered by an M.D., D.O. or psychologist (NOT subject to the regular \$90-per-visit and 50-visits-per-year speech therapy limits); and
- e. Office visits, therapy and counseling provided by when ordered by an M.D., D.O. or psychologist. The Plan will also cover these services when provided by a Masters-level licensed behavioral health specialist participating in the ValueOptions network.

Have your child's autism treatment reviewed in advance by ValueOptions so that you do not incur expenses that are not covered.

Notes:

- The treatment can be for the autism spectrum disorder itself or for a related physical, mental or nervous disorder.
- Lineco will NOT cover Applied Behavior Analysis or similar programs, or any inpatient, partial inpatient, residential, in-home or intensive therapies. See page 65 for additional autism-related exclusions.

5. **Bariatric (obesity) surgery** for an eligible employee, retiree or spouse, but only if ALL the following requirements are met:

- a. The patient must be at least 100 pounds over his medically desirable weight and have a Body Mass Index (BMI) of at least 40;
- b. The obesity must be threat to the patient's life due to the existence of complicating health factors such as diabetes, heart trouble, hypertension, etc.;
- c. Before the proposed surgery, the patient must have a documented history of at least six (6) consecutive months of physician-assisted attempts to reduce weight by more conservative measures (there must be at least seven office visits: the initial visit plus one monthly visit for 6 consecutive months during the 12-month period prior to the proposed surgery). There can be no more than two years between the end of the weight loss program and the surgery;
- d. The surgery must be performed in a Blue Cross PPO facility by a PPO physician/surgeon; and
- e. The patient has obtained prior authorization from the Fund Office.

Obesity surgery will be covered only once in a patient's lifetime. No benefits are payable for obesity surgery performed on dependent children.

6. Chiropractic care.

- 7. Diagnostic tests**, including x-rays, laboratory tests, and diagnostic imaging and tracing services (such as EKGs, MRIs, computerized scans, sonograms, mammograms, etc.) that are ordered by a doctor, including services of radiologists and pathologists.

Except as provided under the Plan's preventive care benefits, genetic testing is covered only if the tests are performed in connection with an actual treatment plan for a diagnosed illness.

Dental services - see *Dental Benefit* starting on page 52.

- 8. Dental treatment covered under the Medical Benefit**, limited to treatment of accidental injury to sound natural teeth, including the initial replacement of such teeth and necessary dental x-rays. The first treatment must be received within six months of the accident causing the injury.

9. Durable medical equipment as follows:

- a. *Appliances, and prostheses* (such as artificial limbs and eyes) to replace physical organs or parts of organs. Lineco will cover the initial prosthesis or appliance and up to two replacement prostheses or appliances during the individual's lifetime. Replacement prostheses will be covered only if the need for the replacement is certified as medically necessary by Medical Cost Management (MCM). Covered medical expenses also include breast prostheses following a mastectomy.
- b. *Oxygen* and rental of the equipment for the administration of oxygen.
- c. *Rental of a wheelchair*, a hospital-type bed, an iron lung or other similar therapeutic equipment that is medically necessary for treatment.
- d. *The first pair of contacts following cataract surgery*, or up to a maximum benefit of \$200 for the first pair of eyeglasses following cataract surgery.

- 10. Erectile dysfunction drugs following a radical nerve-sparing prostatectomy.** Coverage is limited to 10 tablets per month for the 12-month period immediately following the prostatectomy.

Refer to your HearPO brochure or call 1-888-HEARING (432-7464) for more information about the discounts available to Lineco participants for hearing aids and batteries.

- 11. Hearing exams, tests and hearing aid devices**, paid at 80%

(no deductible) up to a maximum benefit of \$2,500 every five years (60 months) for adults, and every two years (24 months) for children. Note that hearing aid replacement batteries are not covered under this benefit.

Note: You can receive significant discounts on hearing services, including hearing aids and batteries, through the HearPO network. Use of HearPO is voluntary under the Plan.

12. **Home nursing care** - part-time or intermittent nursing care provided by home health aides under the supervision of an R.N. (services of an R.N. or L.P.N. are covered if the patient's condition requires the professional services of a trained nurse) and medical supplies (other than drugs and biologicals) provided by the home health agency, up to a maximum benefit of \$5,000 per year, subject to the following requirements:

- a. The services and supplies must be provided by or through a licensed home health agency;
- b. A program of home nursing care must be established and approved in writing by the patient's doctor within seven days after termination of an inpatient hospital stay; and
- c. The doctor must certify that the home nursing care is for the same or related condition for which the patient was hospitalized and that proper and medically necessary treatment of the patient's condition would require hospital confinement in the absence of the services and supplies provided as part of the program of home nursing care.

Notes:

- No payment will be made for child care or housekeeping services.
- Contact the Fund Office before arranging home nursing care for anyone in your family.

13. **Hospice care**, subject to the rules in *Provisions Governing Hospice Care* starting on page 45.

14. **Hospital inpatient** services and supplies:

- a. Daily room and board, if semi-private or ward accommodations are used, and general duty nursing care, excluding professional services of doctors, private duty nurses or any individual nursing care, regardless of what it is called. If a private room is used, only the hospital's most common charge for a semi-private room is a covered medical expense.
- b. Other hospital services and supplies furnished to a person which are medically necessary and required for treatment of the person, excluding room and board, professional services of doctors and private duty nursing.

15. **Hospital outpatient, ambulatory surgical center, and urgent care facility** services and supplies for surgery or treatment of a non-occupational injury or illness.

Notes:

- Hospital emergency room services provided by an out-of-network hospital will be paid at the PPO payment percentage if the treatment was sought due to an emergency ("emergency" is defined on page 77).
- If a dentist recommends that a person have a dental procedure performed in a hospital (on an inpatient basis or outpatient basis) or in an ambulatory surgical center, a doctor who is an M.D. or D.O. must certify the medical necessity of having the procedure performed in such a setting. The doctor must submit a letter to the Fund Office prior to the treatment, giving the medical reasons the procedure should be performed in a hospital/ambulatory surgical center instead of the dentist's office. Be sure to contact the Fund Office for advance approval of any such treatment. (If only the dentist certifies the medical necessity, or if the doctor's let-

ter is not received before the treatment is performed, or if the Fund Office does not approve the treatment, the hospital or ambulatory surgical center expenses will not be paid.)

16. **Jaw surgery** (includes TMJ surgery), including hospital and doctors’/surgeons’ services, and other medically necessary services and supplies provided for or in connection with the surgery. Jaw surgery must be pre-certified by Medical Cost Management (MCM). If the surgery would otherwise have been covered but is not pre-certified by MCM, or is not performed by a BCBS PPO provider at a BCBS PPO facility, the maximum benefit payable for all covered expenses will be \$3,000 per person.

Note: No benefits of any kind are provided under the Dental Benefit for non-surgical treatment of TMJ.

Mail-order prescriptions - see page 49.

17. **Maternity** expenses for delivery in a hospital, and medically necessary services and supplies provided in connection with delivery in a birthing center or at home, including the services of a licensed midwife used instead of a doctor, and circumcision of a newborn male child during the first 30 days after birth.

Maternity benefits are not provided for children, except that the prenatal office visits are covered under the preventive benefit provisions for all females age 18 and older, including children.

Note About Length of Maternity Confinements - An eligible female employee, retiree or dependent spouse, and her newborn infant, are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarean section. (The attending provider may however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Cesarean section.) The Plan will provide benefits for the covered medical expenses incurred by an eligible female employee or dependent spouse during the prescribed time periods, subject to the applicable deductibles, payment percentages payable and maximum benefits shown on the Schedule of Benefits.

18. **Medical supplies**, such as:
- a. *Drugs and medicines* which may only be legally dispensed by a registered licensed pharmacist according to a doctor’s written prescription which includes the name of the drug, and certain diabetic supplies not requiring a doctor’s prescription. (Medications and supplies that can be dispensed without a written doctor’s prescription are not covered, even when there is a written doctor’s prescription.) Prescriptions may only be filled for up to a 90-day supply at one time. (Refer to *Prescription Drug Programs* starting on page 47 for more information about obtaining prescription drugs.)
 - b. *Whole blood* (if not donated or replaced) or blood plasma and the administration of such substances.
 - c. *Bandages, surgical dressings, casts, splints, trusses, crutches and orthopedic braces.*
 - d. *Surgical supplies*, including the first charge incurred for surgical supplies required to aid any impaired physical organ or part in its natural body function.
 - e. *Enteral or parenteral nutrition*, including its administration, provided that such services and supplies are: (1) administered in accordance with a treatment plan that has been approved and is being managed by MCM; (2) prescribed by a physician; (3) medically necessary to replace oral feeding in a patient who is unable to take oral nutrition as the result of sickness or accidental bodily injury; and (4) is the primary source of the patient’s nutrition.

- f. *Custom-made orthopedic shoes for diabetics* - Orthopedic or therapeutic shoes that are prescribed by a physician for treatment of a diabetic foot disease. The shoes must be custom-fitted by a podiatrist or other qualified individual. Covered expenses will be limited to the following each calendar year: (a) one pair of custom-molded shoes, including the inserts provided with the shoes, and up to two additional pairs of inserts; or (b) one pair of extra-depth shoes, not including the inserts provided with the shoes, and up to three additional pairs of inserts. In either case, a modification of the shoes may be covered instead of an allowable pair of inserts (other than the initial set).

19. **Mental/nervous disorders and substance abuse treatment**, subject to the following provisions:

- a. The ValueOptions provider network is the Plan's preferred provider network (PPO) for these conditions.
- b. The Plan covers Inpatient, intensive outpatient and regular outpatient treatment provided by a hospital, a covered substance abuse treatment facility, an M.D. or a licensed clinical psychologist. All ValueOptions network providers are covered, including Masters-level mental health providers such as social workers and counselors. Masters-level non-PPO providers are not covered.
- c. Pre-certification is required for inpatient, residential, partial inpatient and intensive outpatient treatment, psychological testing and electroconvulsive therapy. See page 33 for more information.

Call ValueOptions at 1-800-332-2191 to find network providers and to precertify your mental health or substance abuse treatment.

NOTE: If the Lineco Member Assistance Program (MAP) refers you to a MAP counselor for in-office counseling, your first six (6) visits will cost you nothing, regardless of the nature of the counseling. MAP counseling services are separate from the regular medical benefits provided by the Plan.

20. **Physical therapy** rendered by a registered physical therapist on an inpatient or outpatient basis, provided the therapy is recommended by the attending doctor.

21. **Physicians' (doctors') professional services**, rendered either in or out of a hospital for surgery and medical care and treatment. The Plan's definition of a doctor or physician is on page 76.

22. **Professional services of other covered providers**, such as services rendered by a physician's assistant, a certified registered nurse anesthetist (CRNA), a licensed nurse practitioner (LNP), or a surgical assistant, if such services are rendered within the scope of the provider's license.

With respect to charges by a physician (M.D., D.O., or D.P.M.) who is providing surgical assistance, the maximum allowable covered medical expense is 25% of the allowable surgeon's fee.

23. **Radiological services** and supplies for x-ray treatments, radon, radium and radioactive isotopes.

24. **Skilled nursing facility care**, including room and board and medically necessary services and supplies provided to a person in a skilled nursing facility for up to 30 days per year, subject to the following requirements:

- a. A doctor must certify that the confinement and nursing care are necessary for the patient's recuperation from an injury or sickness;
- b. The confinement must be preceded by at least three (3) consecutive days of a hospital stay for which Plan benefits are payable;
- c. The confinement must start within 3 days after termination of a hospital stay for which Plan benefits are payable or within 3 days after termination of a skilled nursing facility stay for which Plan benefits are payable;

- d. The skilled nursing facility stay must be due to the condition which required the previous hospital stay; and
 - e. The confinement must be provided in a facility which meets the following Plan's definition of a skilled nursing facility (page 78).
25. **Speech therapy** rendered by a qualified speech therapist pursuant to a medical doctor's written prescription. Coverage is limited to therapy:
- a. For a person who had normal speech and lost it as a result of sickness or accidental injury;
 - b. For a child after repair of a cleft palate; and
 - c. For a child due to a congenital medical defect or acute disease, including a hearing deficit caused by specifically diagnosed illnesses, cerebral palsy, or neurological disorder.

Note: The Plan excludes speech therapy for developmental delays, attention disorders, behavioral problems, psychosocial delays, verbal apraxia, or stuttering or stammering unless due to a specific disease or injury. The only exception is that speech therapy for autism spectrum disorders may be covered under No. 4 above.

Covered speech therapy expenses include up to 50 visits per calendar year, with a maximum allowable amount of \$90 per visit.

26. **TMJ non-surgical treatment**, including hospital and doctors' services, and other medically necessary services and supplies provided for or in connection with non-surgical treatment of TMJ, up to a \$1,000 lifetime maximum benefit payable per person. (The Plan's definition of TMJ is on page 79.)

Note: No benefits of any kind are provided under the Dental Benefit for non-surgical treatment of TMJ.

See No. 15 above for Lineco's rules governing surgical treatment of TMJ.

Vision services - see *Vision Benefit* starting on page 59.

Diagnostic X-Ray and Lab Benefit

The Plan pays the first \$150 of covered diagnostic x-ray and lab expenses you incur during a calendar year in full under the Diagnostic X-Ray and Lab Benefit. Any amount of covered expenses over \$150 during a year will be considered under the regular provisions of the Medical Benefit. Covered expenses under this benefit include the allowable charges incurred for outpatient x-rays, EKGs, MRIs, computerized scans, sonograms, mammograms, blood tests, urinalysis, and other tests that are consistent with prevailing medical standards and appropriate for the patient's age, sex and medical history. Covered expenses include interpretation of covered tests by a radiologist or pathologist. The services can be performed in a hospital outpatient department, an outpatient radiology center or laboratory, or at a doctor's office.

Not covered under this benefit are charges made for radiation therapy or charges made in connection with chiropractic care, non-surgical TMJ, non-precertified or out-of-network TMJ/jaw surgery, vision care, dental treatment, tests that are not consistent with prevailing medical standards, or any other type of treatment that is subject to special benefit limitations (see the Schedule of Benefits for the types of treatment subject to special benefit limitations.) Charges for certain types of treatments and conditions (such as obesity and cosmetic surgery) are also not covered (see *What the Plan Does Not Cover* starting on page 65).

For employees, retirees and their spouses, covered medical expenses also include diagnostic tests ordered for purposes of routine (preventive) health screening, provided the tests are appropriate for the patient's age, sex and medical history and are consistent with prevailing medical standards.

Provisions Governing Hospice Care

A hospice doctor, as well as a person's personal doctor if not a hospice doctor, must certify that a person's medical condition is terminal no later than two days after the person begins receiving hospice care. The patient can then elect hospice services from a specific hospice. Before any hospice care is provided, the election form must be submitted through the hospice from which he will receive the hospice care. The patient can revoke his hospice election at any time. In the future, he can re-elect hospice care, but the \$20,000 lifetime maximum benefit will not start over.

Once a person has received \$20,000 in benefits for hospice care, no further benefits for hospice care will be paid. Expenses incurred for any further treatment of his terminal condition will be considered for payment under the regular Medical Benefit provisions, subject to all applicable provisions and limitations governing covered medical expenses.

Hospice Care Program Covered Expenses - Only covered expenses incurred for hospice care of a person's terminal condition apply under this Program. Covered expenses include charges made for the following:

- Nursing care by an R.N. or L.P.N. and services of homemakers and home health aides (such services may be furnished on a 24-hour basis during a period of crisis or if the care is necessary to maintain the patient at home);
- Chaplaincy; and medical social services, counseling services and/or psychological therapy by a social worker or a psychologist;
- Physical and occupational therapy and speech language pathology;
- Non-prescription drugs used for palliative care, medical supplies, bandages and equipment, and drugs and biologicals used for pain and symptom control; and
- Skilled nursing facility short-term inpatient care to provide respite care, palliative care or care in periods of crisis.

Hospice Care Program Exclusions and Limitations - Charges for the following services and supplies are not covered under the Hospice Care Program:

- Services or supplies not provided as core services by the hospice providing the hospice care;
- Bereavement counseling (counseling services provided to a terminal person's family) after his death;
- Administrative services; child care and/or housekeeping services; or transportation, except in emergency situations; or
- Long-term inpatient care; surgical operations or hospital confinements due to medical complications of the terminal condition; or treatment of any injury or sickness other than the person's terminal condition. (Covered expenses incurred for these services and supplies are considered for payment under the regular Medical Benefit provisions and limitations governing covered medical expenses.)

Contact the Fund Office before seeking hospice care for any member of your family.

Extension of Medical Benefits

The term “extension of benefits” means that under certain circumstances some benefits will be paid for a totally disabled person for up to a maximum of twelve (12) months after his coverage terminates. The extension of benefits rules apply separately to you and each of your dependents.

An extension of benefits will not apply to any person who is covered under Medicare or under any other welfare fund, any group plan, or any plan sponsored by any employer at the time his eligibility under this Plan terminates.

Rules Governing an Extension of Benefits

- To qualify for an extension of benefits, a person must be totally and continuously disabled at the time his coverage terminates, the injury or sickness causing the total disability must have happened while the person was covered under the Plan, and the person must remain totally disabled (see page 79 for the definition of “totally disabled”).
- The person will be covered under an extension only as long as he has not received medical benefits totaling his calendar year maximum benefit, and benefits will be payable only to the extent that benefits would have been if the person’s coverage had not terminated.
- The extension will apply only to expenses incurred for treatment of the sickness or injury (and related conditions) that was the primary cause of the person’s total disability.
- An extension of benefits for a person will terminate on the first to occur of the following dates: (1) the date the person is no longer totally disabled; (2) the date the person has received benefits equaling any stated benefit maximum; (3) the date the person becomes covered under Medicare or under any other welfare fund or any group plan or any plan sponsored by an employer; or (4) the end of the 12-month period following the date his coverage terminated.

PRESCRIPTION DRUG PROGRAMS

Retail Program

You can buy your *short-term or acute prescription drugs* at discounted prices through the Retail Program (administered by Express Scripts). You should use this program **ONLY** for short-term (acute) prescription drugs such as antibiotics—your out-of-pocket costs will be lower if you use the Mail Service Program for your long-term prescription drug needs.

Don't send your pharmacy receipts to the Fund Office—these are your responsibility.

The Retail Program (unlike the Mail Service Program) is part of the regular Medical Benefit. In addition to the \$300 calendar year deductible, the 80% Plan payment percentage and the out-of-pocket maximum and the maximum benefit provisions apply. Once your deductible has been satisfied, you will pay your 20% co-pay directly to the pharmacy. There are no claims to file.

The Express Scripts I.D. card is recognized at most pharmacies nationwide. All the major pharmacy chains are in the Express Scripts network. Each time you have your prescription filled, you can get up to a 30-day supply, or, if less, the amount prescribed by your doctor.

Covered Drugs

- Covered drugs and medications under the Retail Program are drugs and medicines which may only be legally dispensed by a registered licensed pharmacist according to a doctor's written prescription which includes the name of the drug, and certain diabetic supplies not requiring a doctor's prescription. (Medications and supplies that can be dispensed without a written doctor's prescription are not covered, even when there is a written doctor's prescription.)
- Covered drugs also include the prescription medications and products covered under the Plan's preventive care provisions, such as certain birth control bills for female participants age 18 and older.
- If you choose a brand name drug even though your doctor has allowed generic substitution, you will pay the difference in cost between the brand and generic, in addition to your co-pay.
- The Plan exclusions (starting on page 64) also apply to the Retail Program. For example, the Plan does not cover over-the-counter (non-prescription) or experimental/investigative drugs, most vitamins or nutritional supplements, or drugs for infertility, obesity or sexual dysfunction, even if you have a doctor's prescription.
- Some prescriptions may require prior authorization which is a verification from the prescribing physician to ensure that the medication is being used for a medically approved indication. Prior authorization promotes clinically appropriate and cost effective therapy.

Specialty Drugs - CuraScript/Accredo Pharmacy, a mail-service pharmacy that provides specialized medications, is Lineco's exclusive provider for specialty pharmacy medications. CuraScript/Accredo, which is a subsidiary of Express Scripts, Inc., is one of the nation's largest specialty pharmacy providers.

Patients **MUST** go through CuraScript/Accredo for all specialty drugs. This applies regardless of where the drug will be administered (including drugs administered in a doctor's office).

Specialty drugs are high-cost injectable, infusion, intravenous (IV) drugs and certain oral medications that are prescribed for diseases such as multiple sclerosis, rheumatoid arthritis, hepatitis C and asthma. These medications are not only very expensive, they require special storage and handling, frequent dosage changes, and

periodic laboratory testing. They are not usually stocked in retail pharmacies. Some common specialty drugs are:

Aranesp	Copegus	Humatrope	Neulasta	Peg-Intron	Remicade
Avonex	Enbrel	Humira	Neupogen	Procrit	Ribavirin
Betaseron	Forteo	Lovenox	Nutropin	Pulmozyme	Synvisc
Copaxone	Gammagard	Lupron Depot	Pegasys	Rebif	Xolair

(This is NOT a complete list of all the specialty drugs available through CuraScript/Accredo.)

CuraScript/Accredo will dispense up to a 30-day supply of your specialty medication at one time for a co-pay amount of 1/3 of the normal mail-service co-pay. The 30-day limit may be extended on a case-by-case basis. For more information, call CuraScript/ Accredo’s toll-free telephone number which is shown on the inside front cover of this booklet. You can also find information about CuraScript/Accredo Pharmacy at www.express-scripts.com.

Allowable Charge Limitation - Any amount that is determined to be in excess of the allowable charge is not covered. For example, the Fund’s arrangement with Express Scripts, including their specialty pharmacy, CuraScript/Accredo, includes discounted prices for expensive medications, and you are required to obtain your specialty drugs through CuraScript/Accredo. In addition, the Fund Office may be able to secure more favorable terms for other pharmaceuticals. If so, the Fund Office will contact you. If you do not purchase your medications through the recommended source, the Plan will not cover any charges in excess of what the recommended provider would have charged.

Specialty Drug Step Therapy Program - “Step therapy” is used to guide a patient with a chronic condition to a less costly medication (called a “step one” drug), if appropriate, before he tries a more expensive drug (called a “step two” drug). The goal is to ensure that the patient receives an appropriate medication for his condition. Since an appropriate drug is not always the most costly, step therapy can also help reduce costs. If you present a new prescription to your pharmacist for a drug included in this program, and you haven’t tried a step one drug first, you may have to pay full price for your prescription. In such case, you can talk to your doctor about prescribing a covered step one drug instead.

This program currently affects four categories of specialty drugs:

Erythroid stimulants:	Epogen, Arenesp
Growth hormones:	Genotropin, Humatrope, Nutropin/AQ, Tev-Tropin, Norditropin/Norfles, Omnitrope, Saizen
Multiple sclerosis:	Extavia, Avonex
Inflammatory conditions:	Simponi, Cimzia, Kineret, Amevive, Stelara, Rituxan, Remicade, Orenzia, Actemra

If this Plan is secondary to any other plan that provides coverage for prescription drugs:

- You should show both prescription I.D. cards to the pharmacist and indicate which is primary. Most of the time the pharmacy can process the claim under the primary and secondary plan at the time of purchase.
- For Mail Service Program, follow the rules of the primary plan and then file a claim with ESI for any balance. See page 63 for more information.

Prescription Drug Program for Medicare-Primary Individuals

Persons for whom Medicare is their primary plan pay a 20% co-pay when they purchase their covered prescription drugs from a participating pharmacy. No deductible applies. When a Medicare-primary individual's 20% retail co-pays and his mail-service co-pays combined total \$1,000 during a calendar year, his retail and mail-service co-pays during the remainder of that year will be \$0. Use of participating pharmacies is mandatory—no benefits will be provided for out-of-network pharmacy purchases. In addition, use of the mail-service pharmacy is mandatory for maintenance drugs after the original supply plus one refill.

Don't send your 20% co-pay receipts to the Fund Office—these are your responsibility.

Step Therapy for Medicare-Primaries - A step therapy program applies to prescription drugs purchased by Medicare-primary individuals at retail pharmacies or through the mail-service pharmacy. The step therapy procedures apply to Nexium Lipitor, Zocor, Prevacid, Diovan and other maintenance medications. You may have to pay full price for a step two drug if you haven't tried a step one drug first.

Medicare Part D Prescription Drug Plans - Covered individuals who are also entitled to Medicare (whether or not they are retired), have the option of dropping their prescription drug coverage through Lineco and switching to a Medicare Part D plan. See *Medicare Part D Prescription Drug Plans* on page 25 for more information.

MAIL SERVICE PRESCRIPTION DRUG PROGRAM

The Mail Service Program is for *long-term or maintenance prescription drugs*, which are prescription drugs needed on an ongoing basis for conditions such as high blood pressure, high cholesterol, arthritis, diabetes, etc. It is not for drugs taken on a short-term basis, such as antibiotics.

Covered Drugs - Covered drugs and medications under the Mail Service Program are the same as those covered under the Medical Benefit and the Retail Program.

Payment Provisions - The Medical Benefit's regular deductible and payment percentage(s) do not apply to prescriptions filled by the mail-service pharmacy. Your co-pays do not apply toward satisfaction of any deductibles under the Medical Benefit or toward meeting any out-of-pocket limits.

Instead, you pay the following co-pays to Express Scripts each time you order up to a 90-day supply of your medication:

- Generic drugs - \$10
- Preferred brand name drugs - \$20
- Non-preferred brand name drugs - \$35

Order Forms? Questions?

Call Express Scripts 1-877-327-0568 (toll free)
Or go to www.express-scripts.com.

If you choose a brand name drug instead of an available doctor-approved generic, you must pay the difference in cost between the brand name drug and its generic equivalent, in addition to the \$10 generic co-payment.

About Preferred Drugs - Preferred prescription drugs are brand name medications that have been evaluated by Express Scripts physicians and pharmacists and determined to be the most effective for treatment of certain conditions for most patients, and are reasonably priced. They are often referred to as "formulary" drugs. The list of preferred drugs is frequently reviewed and updated. For up-to-date information about the formulary/status of a specific drug, con-

Download a copy of the formulary list at www.express-scripts.com and take it with you when you visit your doctor.

tact Express Scripts.

Ordering Prescriptions - You can order authorized refills by mail, telephone, via the internet (www.express-scripts.com), or via a mobile device app. Your first mail-service order takes longer to process.

There's an app for that! Express Scripts has a mobile phone app that, among other things, allows you to order refills, check your order status and set up reminders.

To avoid lost prescriptions, you should inform Express Scripts if you move. You can phone in your change of address to Express Scripts at 1-877-327-0568. (And don't forget to notify the Lineco Fund Office too!)

LINECO MEMBER ASSISTANCE PROGRAM (MAP)

You and your covered dependents can use the MAP if you are eligible for Lineco benefits.

The Lineco Member Assistance Program (MAP) is administered by ValueOptions, a professional mental health care counseling and management organization. ValueOptions has thousands of experienced, professional counselors to help you with any kind of personal problem.

Free Counseling Services

To access the Lineco MAP, call ValueOptions at 1-800-332-2191. You can access the MAP 24 hours per day, 365 days per year.

You can receive up to **6 free face-to-face visits** per problem with a MAP counselor.

You can receive MAP counseling services at no cost to you for up to six (6) face-to-face office visits per problem. There are no deductibles, co-payments or claim forms involved. You must call the MAP in order to get your 6 free visits. Your call, your meeting and any discussions you have will be kept completely confidential.

MAP counselors include a wide variety of licensed professional mental health practitioners. The MAP Care

Manager will select the type of specialist best suited to your particular circumstance. If there are no MAP counselors in your geographic area who can assist you, the MAP will refer you to a counselor who is not affiliated with the MAP. In that case, your first 6 office visits will be treated the same as if your visits were with a MAP counselor. Any other covered care you receive for that counselor will be paid under the Out-of-Network Schedule of Benefits.

Any services you receive from the MAP are completely confidential.

Help is available for a wide variety of problems. The MAP can help you and your family with personal, emotional, work and family matters, including marital or family problems, childcare and elder-care, alcohol and/or substance abuse, emotional problems, depression, anxiety and stress, job dissatisfaction, family illness, and financial or legal concerns.

Legal and Financial Services

The MAP also provides access to a national network of independent attorneys who have experience in a variety of legal areas. You can receive legal advice about bankruptcy, estate planning, taxes, family law, consumer and financial matters, and certain criminal offenses, including driving under the influence (DUI/DWI).

For financial concerns, the MAP also provides telephone information and advisory services provided by a team of experts who include Certified Financial Planners, Certified Public Accountants and insurance specialists.

If legal representation is needed, the MAP will provide a referral to a local MAP-affiliated attorney who provides an initial half-hour face-to-face consultation at no charge. The MAP-affiliated attorney will provide additional legal services at a 25% reduction of his usual fees. You are responsible for any fees after the initial half-hour consultation. While MAP-affiliated attorneys and financial experts can assist you with many issues, certain restrictions apply. For example, you can NOT receive advice about: (a) employee-employer disputes; (b) business law; (c) how another attorney is handling a situation; (d) someone else's legal problem; or (e) specific investments.

This page is intentionally blank.

DENTAL BENEFIT

Dental Network of America (DNoA)

Lineco has an agreement with a dental preferred provider (PPO) network called the Dental Network of America (DNoA). DNoA offers a large network of participating dentists who have agreed to charge negotiated fees that are lower than what these dentists normally charge. This means you will save money on your family's dental bills when you use DNoA dentists. This is a voluntary program—you are not required to use a DNoA dentist.

To find a DNoA dentist, go to www.dnoa.com on the internet and follow the links. Or call 1-866-522-6758.

Predetermination of Benefits

If the dentist's charges will be \$500 or more, your claim should be submitted for predetermination of benefits before any major work is started. To obtain a predetermination, ask your dentist to submit the details of the proposed treatment plan and charges to the Fund Office. (Most dentists are familiar with the predetermination procedure.) The Fund Office will review the proposed treatment plan and charges, and will advise you and the dentist of the amount the Plan will pay.

If you don't want to follow the predetermination procedure, you can just submit your claim after the dental work is done. However, you may have a large, unexpected out-of-pocket cost.

When the Predetermination Procedure Is Not Necessary - Your dentist can perform oral examinations, cleanings, fluoride applications, dental x-rays and emergency treatment before submitting the claim for predetermination. In addition, no predetermination is necessary when the charges for a plan of treatment are expected to be less than \$500 or when emergency treatment is performed.

A predetermination of benefits does not guarantee payment for dental benefits.

Predetermination of benefits doesn't apply to orthodontic care.

A predetermination of benefits does not guarantee payment for dental benefits. Coverage is valid only upon determination of eligibility.

Alternate Courses of Treatment

If alternate services can be used to treat a dental or orthodontic condition, covered dental expenses will be limited to the allowable charge for the service which is most commonly used nationwide in the treatment of that condition and which is recognized by the dental profession to be appropriate in accordance with the accepted nationwide standards of dental practice. In cases where you and/or your dentist choose a more expensive level of care, any charges in excess of the allowable charge will be your responsibility.

Payment of Dental Benefits

The Plan will pay 80% of a covered person's covered dental expenses each year up to a maximum benefit of \$2,000. Once a person has received \$2,000 in dental benefits during a year, he will not be entitled to any further dental benefits during the rest of that year.

A \$100 deductible applies to covered restorative care expenses each year. If any part of a person's deductible is applied to covered dental expenses incurred during October, November, or December of a calendar year, that person's deductible for the following year will be reduced by the amount

applied. The dental deductible cannot be used to satisfy any Medical Benefit deductible or out-of-pocket limit.

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

Dental Treatment Other Than in a Dentist's Office

If a dentist recommends that a person have a dental procedure performed in a hospital (on an inpatient basis or in the hospital outpatient department) or in an outpatient surgical center, a doctor who is an M.D. or D.O. must certify the medical necessity of having the procedure performed in that setting. The doctor must submit a letter to the Fund Office prior to the treatment which gives the medical reasons the procedure should be performed in a hospital or ambulatory surgical center instead of the dentist's office. Be sure to contact the Fund Office for advance approval of any such treatment. (If only the dentist certifies the medical necessity, or if the doctor's letter is not received before the treatment is performed, or if the Fund Office does not approve the treatment, the hospital or ambulatory surgical center expenses will not be paid.)

Covered Dental Expenses

The dental services covered under by the Plan are shown below. Note that Dental Benefits are payable only for:

- Amounts that are considered allowable charges (see page 75 for the definition);
- Services rendered in accordance with accepted standards of dental or orthodontic practice;
- Services performed by a licensed dentist (D.D.S.), or, with respect to orthodontic services, a dentist licensed to practice orthodontia; and
- Services received while a person is covered under this Dental Benefit.

Covered Diagnostic & Preventive Expenses - 80% Reimbursement (No Deductible)

1. Routine oral examinations and prophylaxis (scaling and cleaning of teeth, including periodontal maintenance prophylaxis), up to two per calendar year.
2. Topical application of fluoride.
3. Space maintainers that replace prematurely lost teeth for children under 19 years of age.
4. Emergency palliative treatment.
5. Dental x-rays, including full mouth x-rays (once in a period of 36 consecutive months), supplementary bitewing x-rays (up to two sets per calendar year), and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.
6. For eligible dependent children under age 15 only, sealants on the 6-year and 12-year molars only, with at least 5 years in between a repeat sealant procedure on any tooth.

Covered Restorative Care - 80% Reimbursement (Subject to \$100 Deductible)

(If the charges for the following types of restorative care will be more than \$500, you should ask your dentist to obtain a predetermination of benefits from the Fund Office).

1. Extractions.
2. Oral surgery.
3. Resin-based and composite filling restorations to restore diseased or accidentally broken teeth.
4. General anesthetics when medically necessary and administered in connection with implants and boney impacted teeth. With respect to children, general anesthetics are covered when medically necessary and administered in connection with oral surgery, or when medically necessary for non-surgical procedures performed on children through age 12. The Plan payment percentage for non-surgical anesthesia for a child age 6 through age 12 will be 50%. Non-surgical anesthesia for individuals age 13 and older is not covered.
5. Treatment of periodontal and other diseases of the gums and tissues of the mouth.
6. Endodontic treatment, including root canal therapy.
7. Injection of antibiotic drugs by the attending dentist.
8. Dental implants to anchor a full denture, or implantation of a single tooth when approved by the Fund's dental consultant. If the implantation procedure is begun in one calendar year and completed in another, the combined charges will be subject to the maximum benefit for the year in which the procedure was begun. (If a restoration such as a crown is placed on an implant, the charge for the restoration is considered a separate procedure.)
9. Repair or cementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, limited to one relining or rebasing in any period of 36 consecutive months.
10. Inlays, onlays, gold fillings, or crown restorations to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with a resin-based or composite filling restoration.
11. Initial installation of fixed bridgework (including inlays and crowns as retainers).
12. Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation).
13. Replacement of an existing partial or full removable denture, fixed bridgework, an inlay, an onlay or a single crown, or the addition of teeth to an existing partial removable denture, but only if satisfactory evidence is presented that:
 - a. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or
 - b. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve months from the date of initial installation of the immediate temporary denture; or
 - c. The existing denture, bridgework, inlay, onlay veneer or single crown is at least five years old and cannot be made serviceable.

Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, charges for such bridgework will be included as covered dental expenses.

Denture work performed by licensed denturists will be covered in those states which license denturists.

Covered Orthodontia - 80% (No Deductible) - FOR CHILDREN ONLY

The Plan will pay 80% of the allowable charges incurred for orthodontic treatment for each of your covered dependent children up to a lifetime maximum benefit of \$2,000 per child. No deductible applies to orthodontia expenses. You choose your own orthodontist. However, you may get a better value from this benefit if you use an orthodontist in the DNoA network.

Orthodontia benefits are payable for dependent children ONLY, and the benefits paid for orthodontia do not apply to the child's Dental Benefits maximum. The Plan could pay \$2,000 of regular Dental Benefits in a year plus \$2,000 of orthodontia benefits in that same year. However, once the lifetime orthodontia maximum has been paid, the Plan will not pay any additional orthodontia benefits for that child.

A predetermination of benefits is not necessary for orthodontic care. You should, however, contact the Fund Office to check your eligibility for Dental Benefits.

The following rules apply to orthodontia benefits:

- The initial payment usually required will be considered at up to 25% of the total allowable fee for the treatment plan. This includes the preliminary diagnostic work-up and initial banding. The balance of the charges should be billed to be paid on a quarterly basis until the treatment is completed or until the maximum allowable benefits have been received (unless the child's eligibility for Dental Benefits terminates before then). The orthodontist should submit quarterly verification to the Fund Office that a covered person's orthodontic treatment is continuing.
- If a child is undergoing orthodontic treatment when his eligibility starts, the Plan will pay 80% of the allowable charges that are determined to be incurred after he became eligible. The Plan will only provide reimbursement for payments for services rendered on or after the date a child's eligibility starts. No payment will be made for past due payments.
- There is no extension of benefits for orthodontia expenses. All benefits for orthodontia will terminate on the date that the child's eligibility for Dental Benefits terminates. No Plan payments will be made for payments that are due after the child's eligibility for Dental Benefits terminates. Benefits are only payable on the date that a payment is due the orthodontist.
- No payment will be made for a duplicate or for a replacement of a lost, missing or stolen orthodontic device.

Dental Exclusions and Limitations

No Dental Benefits are payable for:

1. Treatment other than a dentist, except scaling/cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if rendered under the supervision and guidance of a dentist.
2. Services/supplies cosmetic in nature, including personalization or characterization of dentures.

3. The replacement lost, missing, or stolen removable prosthetic device unless no benefits were paid under this Plan for that prosthetic device.
4. Services or supplies which are for orthodontic treatment except as outlined under *Covered Orthodontia Expenses* above.
5. Any duplicate prosthetic device or any other duplicate appliance.
6. Sealants, except for dependent children under age 15 as stated in No. 6 under *Covered Diagnostic & Preventive Care Expenses* above.
7. Oral hygiene, dietary instruction, or a plaque control program.
8. Implants except as specifically stated in *Covered Restorative Care Expenses*.
9. Occlusal adjustments.
10. Splints.
11. Appliances (such as night guards) used to control harmful habits.
12. General anesthesia if a local anesthetic would also have been effective, including for removal of teeth that are not bony impacted.
13. Services by a dentist who is not licensed in the state in which the services are performed.
14. Treatment of conditions related to the temporomandibular jaw joint (TMJ).
15. Treatment for opening of vertical dimension.
16. Services or supplies received as a result of dental disease, defect, or injury due to war, declared or undeclared, or any act of war or aggression.
17. Dental care or services paid for or furnished by or at the direction of any governmental agency, but only to the extent paid for or furnished.
18. Dental procedures that are included as covered medical expenses under the Medical Benefit.
19. Prosthetic devices (including bridges and crowns), and the fitting of such devices, which are ordered while the individual is not eligible for Dental Benefits.
20. Prosthetic devices (including bridges and crowns), and the fitting of such devices, which are ordered while the person is eligible for Dental Benefits but which are finally installed or delivered to the person more than 90 days after termination of eligibility.
21. Adjunctive tests for oral cancer screening (for example, Vizilite).
22. Treatment incurred while a person is not eligible for Dental Benefits.
 - For full or partial dentures, treatment is considered incurred when the impression is taken for the appliances.
 - Root canal therapy is considered incurred when the tooth is opened.
 - Fixed bridgework, crowns, and other indirect restorations (e.g., gold) are considered incurred when the tooth is first prepared.

23. Services, supplies or conditions that are excluded in the *What the Plan Does Not Cover* section starting on page 64.

Extension of Dental Benefits

Dental Benefits will be available for a person for 90 days after his eligibility terminates for covered dental expenses incurred for:

- Fillings, bridgework, crowns or gold restorations, provided the tooth was prepared while the person was eligible for Dental Benefits;
- Full or partial dentures, provided the impression for the appliance was taken while the person was eligible for Dental Benefits; or
- Endodontic treatment, provided the tooth was opened for root canal therapy while the person was eligible for Dental Benefits.

VISION BENEFIT

Vision Benefits are provided through a contract with an organization called VSP (Vision Service Plan). VSP gives you a choice of the way you can receive your Vision Benefits.

- **You Can Use the VSP Doctors** - VSP has arranged for a number of doctors in your area (“VSP doctors”) who will provide professional vision care for you and your dependents. VSP guarantees quality and cost control. VSP doctors provide examinations, professional services, lenses, and good quality frames at no out-of-pocket expense to you. VSP pays the doctors for the services and eyewear provided to you. Any additional vision care, services and/or materials not covered by VSP can be arranged between you and the doctor, based on the wholesale cost difference and a modest service fee.
- **You Can Use Your Own Out-of-Network Provider** - You can go to any optometrist, ophthalmologist and/ or dispensing optician for your vision care. You must pay the provider in full and then file a claim with VSP for reimbursement. You will be reimbursed according to the Out-of-Network column on the Schedule of Benefits (page 8).

Covered Vision Care Services and Eyewear

The following are the vision care services and eyewear that you will receive at no cost if you use a VSP doctor. If you use an out-of-network provider, these are the services and eyewear for which VSP will reimburse you according to the Out-of-Network column on the Schedule of Benefits:

- **Vision Examination** - Allowable once every calendar year. This includes a complete analysis of the eyes and related structure to determine the presence of vision problems or other abnormalities.
- **Frame** - Allowable once every two calendar years. You can select from a wide selection of quality frames within the frame allowance.
- **Lenses (eyeglass)** - Allowable every calendar year, if required.
- **Contact Lenses** - If you choose contacts instead of glasses, you can get up to \$100 toward the cost of the contact lenses plus the contact lens exam, evaluation and fitting.

If you use a VSP doctor, all of the covered vision care services listed above are provided at no cost to you (except items listed under the Vision Benefit Exclusions and Limitations section).

Remember - This benefit is designed to cover your visual needs rather than cosmetic materials. If you select any eyewear listed in the Vision Benefit Exclusions and Limitations section, VSP will not reimburse any of the cost incurred from an out-of-network provider, and there will be an extra charge by a VSP doctor if he doesn't receive prior authorization from VSP to provide them.

To Find a VSP Doctor
Call 1-800-877-7195 toll free
or go to www.vsp.com

Using a VSP Doctor

- Choose the VSP doctor you want to use.
- Make an appointment for an examination. Tell the doctor's office that you are covered by VSP through the Line Construction Benefit Fund. You will be asked for your name and date of birth. Before your scheduled examination, the VSP doctor will obtain authorization for services from VSP.

- Keep the appointment and make any necessary payments for the additional materials agreed upon by you and the VSP doctor. The doctor and VSP will take care of the rest.

Using an Out-of-Network Provider

If you use an out-of-network provider, you must pay the bill in full and get an itemized paid receipt. You cannot assign these benefits. Then you must submit a copy of your itemized receipt along with your name and address to VSP for reimbursement (see page 63). VSP will reimburse you for the allowable charges up to but not to exceed the amounts shown in on the Schedule of Benefits. There is no assurance that the reimbursement amounts will be sufficient to reimburse you for the amount you paid the out-of-network provider for the examination and materials.

Vision Benefit Exclusions and Limitations

Covered vision care services and supplies do not include:

- Medical or surgical treatment of the eyes.
- Orthoptics, vision training or subnormal vision aids.
- Two pair of glasses in lieu of bifocals.
- Lenses and frames furnished under this program which are lost or broken. They will not be replaced except at the normal intervals when services are otherwise available.
- Contact lenses (except as stated), aniseikonic lenses, faceted lenses, plano (non-prescription) lenses, oversize lenses, coated lenses, blended and progressive lenses, tinted and photochromatic lenses (except pink No. 1 and No. 2), multifocal plastic lenses, laminated lenses, a frame that costs more than the benefit allowance, or any other cosmetic item.
- Any eye examination required by an employer as a condition of employment.
- Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.
- Vision care services or supplies which may be excluded in the section titled *What the Plan Does Not Cover* starting on page 64.

Extension of Vision Benefits

If a person has an eye exam and a prescription is ordered while he is eligible for Vision Benefits, benefits will be payable even if the eyewear is provided to the person after his eligibility for these benefits terminates.

Do not submit vision claims to the Fund Office. Send out-of-network claims to VPS (see page 63 for the address). There are no claims to file if you use VSP doctors.

LINECO HRA

The Lineco Health Reimbursement Account (HRA) program is a flexible spending plan that covers a wide range of healthcare expenses not payable by Lineco. HRA accounts can also be used to make active and retiree Lineco self-payments when you lose eligibility or retire.

Individual Lineco HRA accounts are funded by separate employer contributions. Not all employers will be participating in this program.

Your Lineco HRA Account

- When you work for a Lineco HRA contributing employer, a Lineco HRA contribution will be made on your behalf and credited to your Lineco HRA account. Contributions to the Lineco HRA will be on an employer-specific basis—not every employer will choose to participate.
- You will become an eligible Lineco HRA participant when your account balance is at least \$100. Your Lineco HRA eligibility is not dependent on your regular Lineco eligibility.
- You determine how and when to use your HRA. You can choose to use it to pay for HRA-qualified expenses or other services not covered by Lineco, or to make short-hour self-payments to continue coverage, or for COBRA or retiree coverage.
- The amount in your Lineco HRA account rolls over from year to year and will remain available to you until you need it, subject to the forfeiture rule described below.
- Your Lineco HRA account can only be forfeited due to inactivity. An account will be considered inactive if it has a balance of less than \$100 and no account activity for the prior two years (24 months). “No account activity” means no employer contributions into the account and no withdrawals out of the account for qualified Lineco HRA expenses.

HRA Qualified Expenses

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

- | | | |
|--|--|---|
| • Medical expenses, including deductibles and coinsurance | • Infertility treatment | • Medigap policies |
| • Prescription drug co-pays | • Vision expenses | • Smoking cessation products and programs |
| • Dental services, including deductibles, coinsurance, and non-covered services such as implants | • Hearing care expenses | • Electronic body scans |
| • Home modifications and equipment to accommodate a disabled person | • Active and retiree self-payments to Lineco | • OTC drugs (doctor’s prescription required) |
| | • Premiums for other healthcare plans | • Weight loss programs |
| | • Medicare Part B or Part D premiums | • Residential homes for care of an intellectually or developmentally disabled dependent |

Your Lineco HRA account can NOT be used for the following:

- | | | |
|--------------------|---|--------------------------------|
| • Cosmetic surgery | • Household help | • Air purifiers or humidifiers |
| • Electrolysis | • Food/dietary supplements | • Health club memberships |
| • Burial expenses | • Premiums for life insurance or loss of income insurance | • Child or elder care |

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

In addition, medical expenses are only covered under this program if the expenses are: (1) not reimbursable by Lineco, another health plan, or any other party; (2) incurred for you or a dependent (a

person you can claim as a dependent under Federal income tax rules); and (3) not claimed as deductions on your or a dependent's Federal income tax return.

Some purchases will require documentation to substantiate that the expense is covered under this program. CompuSys will contact participants directly if additional documentation is required.

How to Use Your HRA

Prepaid Benefits Card ("Benny™ Card") - CompuSys will provide you with two prepaid debit cards, called "Benny Cards," that can be used to access your Lineco HRA funds. You can use the card to make your HRA qualified purchases at many participating healthcare providers, discount stores, eye-glass stores, etc. Your expenses will be automatically deducted from your Lineco HRA.

Call CompuSys (not Lineco) at 1-877-282-8665 if you have any questions about how to use your Benny Card, your account balance, eligible expenses, or how to file claims.

You can only use your Benny Card to cover expenses not covered by Lineco or another healthcare plan. If you are covered under the regular Lineco plan, you should wait until you receive your Explanation of Benefits (EOB) from Lineco before using your Benny Card.

You can request additional or replacement Benny Cards by calling CompuSys. The cost is \$10 for two cards.

Self-Payments to Lineco - You can also use your Lineco HRA account to make self-payments for active or retiree Lineco coverage, or to pay COBRA premiums to Lineco. Contact CompuSys for information on authorizing these types of payment(s) from your Lineco HRA account.

Medical and Pharmacy Out-of-Pocket Amounts - If you receive a balance due statement from a doctor or hospital and want to use your HRA account to pay for it, you can write your Benny Card account number on the statement just like you would if you were paying with a credit or debit card. If the service is incurred while you are eligible for regular Lineco benefits, you must wait until Lineco has processed the claim before you can pay the unpaid balance from your HRA account. (The same applies if you have any other healthcare coverage in addition to or instead of Lineco.) You can also file claims directly with CompuSys. Claim forms are available by following the

Claim forms are available through the HRA link on the Lineco website (www.lineco.org) or by calling CompuSys at 1-877-282-8665.

links on the Lineco website.

More Information About the Lineco HRA Program

Tracking Your Account Balance - You can track your account activity online securely through a link to the HRA program on the Lineco website: www.lineco.org.

Your Share of the Investment Yield - Each calendar year the Fund will determine the aggregate investment yield on the total amount in all Lineco HRA accounts, net of administrative costs, and will credit a proportional amount to your account no later than March 31 of the subsequent year.

In the Event of Your Death or Disability - Death or disability benefits cannot be paid from your Lineco HRA. However, in the event of your death, the balance in your account can be used by your surviving spouse or eligible dependents for qualified expenses, including healthcare premiums and Lineco self-payments (subject to Lineco's eligibility rules).

HRA Accounts Are Not Vested - Although one of the purposes of the Lineco Health Reimbursement Account program is to help participants defray the cost of medical coverage after retirement, this is not a pension plan or bank account. You are not vested in the balance. Because this is a health and welfare benefit, all amounts in individual Lineco HRA accounts remain general assets of the Line Construction Benefit Fund. The Trustees reserve the right to eliminate or modify this program at any time and in their sole discretion.

HOW TO FILE CLAIMS

If you need to file a claim, please follow the directions below. All claims should be itemized and include your name, Social Security number, and the patient’s name. **Note that the claim filing time limit is two years after the date the claim is incurred.** No benefits will be paid for bills submitted more than two years after the date of loss.

Type of Expense	Where to Send Claims
<ul style="list-style-type: none"> Medical (Hospital and Doctor) Claims Most providers will automatically file their claims for you. 	Your local Blue Cross Blue Shield plan.
<ul style="list-style-type: none"> When Lineco is the Secondary Payer to Another Plan Submit a copy of the other plan’s Explanation of Benefits form to the Fund Office. 	Lineco 2000 Springer Drive Lombard, IL 60148
<ul style="list-style-type: none"> Prescription Drug Claims In most cases you will not need to file prescription drug claims because Lineco now has updated technology that will allow the pharmacy to process the claim at the time of purchase. However, if you do need to submit a drug claim, send it to Express Scripts. 	Express Scripts Claims P.O. Box 2872 Clinton, IA 52733-2872 ATTN: Commercial Claims
<ul style="list-style-type: none"> Dental Claims Dentist can use standard dental claim form. Dentists can also file claims electronically. 	Lineco 2000 Springer Drive Lombard, IL 60148 Electronically: Web MD/Emdeon™ ID # LCB01
<ul style="list-style-type: none"> Out-of-Network Vision Claims Out-of-network providers should itemized bills with a completed HCFA-1500 or generic claim form to VSP. 	Vision Service Plan P.O. Box 997105 Sacramento, CA 95899-7105
<ul style="list-style-type: none"> Lineco HRA Claims Claim forms are available through the HRA link on the Lineco website (www.lineco.org) or by calling CompuSys at 1-877-282-8665. 	CompuSys at the address on the HRA claim form.
<ul style="list-style-type: none"> Hearing Claims Weekly Income Benefits Life and AD&D Insurance Claims 	Lineco 2000 Springer Drive Lombard, IL 60148

This page is intentionally blank.

WHAT THE PLAN DOES NOT COVER (Exclusions and Limitations)

No payment will be made under this Benefit Plan for loss sustained as a result of, or for charges incurred for or as a result of, any of the services, supplies and expenses listed in this section. These exclusions do not apply to the Lineco HRA which has its own set of coverage criteria.

1. Accidental bodily injury, sickness or disease sustained while the individual was performing any act of employment or doing anything **pertaining to any occupation or any employment** for remuneration or profit.
2. Any charge or portion of a charge that is determined to be in excess of the amount considered to be the **allowable charge** (as defined on page 75).
3. Treatments, care, services or supplies which are not recommended, ordered or **approved by the attending doctor**.
4. Services or supplies furnished, paid for or otherwise provided due to past or present service of any person in the **armed forces** of a government.
5. **Applied behavior analysis** or similar programs, dietary therapy, pet therapy, family counseling, or inpatient, partial inpatient, residential, in-home or intensive therapies, for autism spectrum disorder or any other disorder or childhood.
6. **Aversion therapy** or any program of treatment for substance abuse that includes aversion treatment.
7. **Biofeedback**.
8. **Chiropractic care** in the balance of a calendar year in which an individual has already received payments in the amount of \$600 for chiropractic care charges incurred in that calendar year.
9. Completing of **claim forms** (or any forms required by the Plan for the processing of claims) by a doctor or other provider of medical services or supplies.
10. **Contraceptives**, except as specified under the preventive care provisions of the Medical Benefit, and when prescribed by a doctor for therapeutic treatment of a specific sickness.
11. **Cosmetic** or elective treatment, devices or surgery, including non-emergency plastic or cosmetic surgery on the body (including but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue), and devices or surgical implantations for simulating natural body contours. This exclusion does not apply to cosmetic surgery for the correction of defects incurred through traumatic injuries sustained as a result of an accident; the correction of congenital defects; corrective surgical procedures on organs of the body which perform or function improperly; breast reconstruction following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance; abortions performed on female employees and retirees and dependent spouses of employees and retirees; and vasectomies and other sterilization procedures for employees, retirees, and dependent spouses.
12. Any care or treatment ordered by a **court, judge** or any court officer unless the care or treatment is determined to be medically necessary and is certified by ValueOptions.
13. Services or supplies provided to a person who is not **covered under the Plan** except as may be provided under the Extension of Benefits provisions of the Plan.
14. Any type of **custodial care**, which is care designed primarily to assist an individual in meeting the activities of daily living. This exclusion applies to all such care regardless of what the care is called (unless the care is provided to a person under an approved Hospice Care Program).
15. Services or supplies received from a doctor or hospital that does not meet this Plan's **definition of a doctor or a hospital**.
16. Inpatient substance abuse treatment in a facility that does not meet this Plan's **definition of a**

substance abuse treatment facility (as defined on page 79).

17. **Dental services and supplies** rendered for treatment of the teeth, the gums (other than for tumors) or other associated structures primarily in connection with the treatment or replacement of teeth, including treatment rendered in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, unless the charges are for services rendered for the repair of accidental injury to sound natural teeth or are specified as payable under the Dental Benefit.
18. **Education**, training or room and board while a person is confined in an institution which is primarily a school or institution of learning or training.
19. Services which are primarily **educational in nature**; or special education, regardless of the type or purpose of the education, the recommendation of the attending doctor or the qualifications of the individual providing the education.
20. **Eye refractions, eyeglasses** (except for the first pair of glasses following cataract surgery, which are covered subject to a maximum benefit payment of \$200), contact lenses (except for the first pair of contact lenses following cataract surgery), dental prosthetic appliances, including any charges made for the fitting or repair of any of these appliances, unless the service or supply is specified as payable under the Dental Benefit or the Vision Benefit. (Note: If eyeglasses, contacts or dental prosthetic appliances are damaged or broken as the result of an injury, the Plan does NOT cover any charges for their replacement.)
21. Any treatment, care, services, supplies, procedures or facilities that are **experimental or investigative** (as defined on page 77).
22. Hormone therapy, artificial insemination, or any other direct attempt to induce or **facilitate fertility** or conception.
23. **Genetic testing**, including testing to screen or confirm a diagnosis, except as specified under the preventive care provisions of the Medical Benefit and when performed in connection with an actual treatment plan for a diagnosed illness.
24. **Health club memberships** or exercise equipment.
25. **Home, workplace or vehicle improvements** to accommodate a person's physical limitations or needs, including but not limited to elevators, stair lifts or swimming pools.
26. **Household items** and general health and comfort items, including by not limited to any of the following list, regardless of intended use: air conditioners, air purifiers, whirlpools, humidifiers, dehumidifiers, allergy-free pillows, blankets or mattress covers, commodes, electric heating units, orthopedic mattresses, vibratory equipment, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, orthopedic shoes (except as described in No. 18-f on page 43), wigs, , or communication devices.
27. **Hospice care** except as provided in the *Provisions Governing Hospice Care* section starting on page 45.
28. Physical therapy or any other type of therapy if either the prognosis or history of the person receiving the treatment or therapy does not indicate to the Trustees that there is a reasonable chance of **improvement**.
29. Elective or non-emergency **jaw surgery**, including but not limited to surgery on the maxilla, mandible, and the temporomandibular jaw joint, except as provided in *Other Covered Medical Expenses*, No. 16 on page 42.
30. Surgical or **laser procedures to correct nearsightedness**, farsightedness or astigmatism, including Laser Assisted In-Situ Keratomileusis (LASIK) surgery.
31. Charges incurred by an eligible family member which you or the family member are not **legally required to pay**.
32. Any charges incurred for a particular type of treatment once a covered person has received benefits for that type of treatment totaling any **maximum benefit** stated on the Schedule of Bene-

fits.

33. Treatments, care, services or supplies that are not **medically necessary** (as defined on page 78).
34. Prescription drugs for a Medicare-eligible individual who has elected a **Medicare Part D** prescription drug plan.
35. Any **military service**-connected injury or sickness.
36. **Newborn nursery charges** care if the mother's maternity confinement is not covered, or for care beyond the joint confinement of the mother and child, or after the end of the period that either the mother or newborn child is no longer medically required to remain in the hospital.
37. Confinement, services or supplies incurred while in a **nursing facility** except as provided in *Other Covered Medical Expenses*, No. 24 on page 43.
38. Except as specified under the preventive care provisions of the Medical Benefit, **nutritional supplements, food supplements, vitamins** or any other items of a like nature, whether or not prescribed by a physician, except as may be expressly stated as covered in *Other Covered Medical Expenses*, No. 18-e on page 42.
39. Services, treatment, or surgical procedures rendered in connection with any overweight condition or condition of **obesity** except as stated in *Other Covered Medical Expenses* No. 5 page 39.
40. Except as specified under the preventive care provisions of the Medical Benefit, **over-the-counter drugs** or medications, or medications that can be legally dispensed by a registered pharmacist without the written prescription of a doctor (except for certain non-prescription diabetic supplies), or more than a 90-day supply of a drug or medicine obtained at one time.
41. In-hospital items such as telephones, TV's, cosmetics, newspapers, magazines, laundry, guest trays, or beds or cots for guests or other family members, or any other **personal comfort items** or items that are not medically necessary.
42. Unless specifically stated otherwise, any type of **physical examination** (employment, premarital, school, etc.) or any other medical examination or test for check-up purposes where not necessary for diagnosis or treatment of a sickness, disease or injury.
43. **Pregnancy or pregnancy-related condition of a female child**. Ultrasounds, high risk pregnancy care, abortions or other pregnancy-related care for female children are not covered except for routine prenatal visits which are covered under the preventive care provisions of the Medical Benefit.
44. Treatments, care, services or supplies that do not meet the **prevailing standards** of medical practice.
45. Additional treatments which a person may receive **as a result of being exposed** to a particular disease or to prevent the contraction of any disease.
46. Routine **circumcision** of a male child after 30 days of age.
47. Individual or **private nursing care** except as provided in *Other Covered Medical Expenses*, No. 11 on page 41.
48. Hospital charges for a **private room** which are in excess of the hospital's most common charge for a semi-private room.
49. Care or treatment rendered to you or a dependent which is provided by a person who is a **relative** in any way to you or to the dependent receiving the care or who ordinarily lives in your home or in the home of the dependent receiving the care.
50. **Reversal** of, or attempts to reverse, a previous elective sterilization.
51. Any operation or treatment in connection with sex transformations or any type of **sexual dysfunction**, including any complications arising from such conditions. This exclusion also applies to erectile dysfunction drugs (except for up to ten tablets a month for the twelve-month period immediately following a radical nerve-sparing prostatectomy).
52. Rental or purchase of any durable medical equipment or other equipment that is not used solely

for therapeutic treatment of a **single individual's injury or sickness**.

53. Except as specified under the preventive care provisions of the Medical Benefit, any type of service or supply provided in connection with **smoking cessation**, including but not limited to medications (prescription or non-prescription) and therapy or counseling of any type.
54. As a result of treatment or consultation with a **social worker or marriage counselor**. This exclusion does not apply to services provided under the Hospice Care Program or the Lineco Member Assistance Program.
55. Unless specifically stated otherwise, any service, supply, treatment or procedure which is not rendered for the treatment or correction of, or in connection with, a **specific sickness, illness or accidental bodily injury**.
56. Any type of **speech therapy** except as stated in *Other Covered Medical Expenses* No. 25, page 44.
57. Maternity and delivery charges incurred by a covered person acting as a **surrogate** mother, meaning a female who has become pregnant with a child that is not her own with the intent or understanding that she is to relinquish the child following its birth. In addition, any child born of a covered person acting as a surrogate mother will not be considered a dependent of the surrogate mother or her spouse.
58. Accidental bodily injury or sickness for which you or an eligible dependent, whether or not a minor, have a right to recover payment from a **third party**, except to the extent provided in Payment of Benefits for Compensated Injuries (starting on page 70).
59. Non-surgical treatment of **TMJ** except as provided in *Other Covered Medical Expenses*, No. 26 on page 44.
60. **Travel or transportation**, whether or not recommended by a doctor, except as stated in *Other Covered Medical Expenses*, No. 2, page 39.
61. Bodily injury, disease or sickness caused by any act of **war**, whether war is declared or undeclared, any act of international armed conflict or any conflict involving the armed forces of any international body, or insurrection.
62. Charges which **would not have been made** if this Plan did not exist.
63. Treatment, care, services, supplies or procedures provided while a person is confined in a hospital operated by the **U.S. Government** or its agency, provided, however, that if charges are made by a Veterans Administration (V.A.) hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service-related disability, to the extent required by law such charges will be considered covered medical expenses to the extent that they would have been considered covered medical expenses had the V.A. not been involved.
64. Accidental bodily injury, sickness or disease for which benefits are or may be payable in whole or in part under any **Workers' Compensation** Act or any Occupational Diseases Act or any similar law.

The above is not an all-inclusive listing of excluded services and supplies. It is only representative of the types of services and supplies for which no Plan payment is made and of the types of situations in which loss may be sustained or in which expenses may be incurred for which no payment is made.

OTHER LIMITATIONS ON YOUR BENEFITS

Subrogation and Repayment Agreement

The purpose of the Plan is to pay covered expenses if they are not paid or payable by anyone else, whether or not such payments are the legal responsibility of the eligible employee or another eligible individual. It is the intent of the Trustees that no person shall receive any profit from the payment of insurance or other benefits, or from the payment of any compensation for injuries.

In some cases, a third party is or may be responsible or liable for paying all or part of the expenses for which a claim is filed with the Plan; such a situation is called a “third party incident.” A third party is any person or entity other than the person receiving the services. A third party could be, but is not limited to: a third party tortfeasor (an individual or other entity of any kind who caused harm, such as the driver of another car in an automobile accident); an employee welfare plan or arrangement; a medical or hospital benefit plan; a no-fault or other car insurance policy; an uninsured or underinsured motorist provision or medical pay provision of your car insurance policy; a homeowners’ insurance policy; or a liability insurance policy of any kind or nature.

“Subrogation” is a legal term for a rule that gives the Plan the right to be repaid for benefits it pays on a claim if a third party is responsible for paying the expenses for which the claim is made.

“Compensation” includes any judgment, award or any settlement, whether or not the terms of the judgment, award or settlement specifically includes or excludes medical expenses and disability recovery.

If a claim is submitted for expenses for which a third party is or may be legally responsible:

- The eligible employee (and any adult eligible individual for whom reimbursement of covered expenses is claimed under the Plan), must agree to and execute a “repayment and subrogation agreement” in a form acceptable to the Trustees or legal counsel for the Trustees before benefits will be payable under the Plan; and
- Such eligible employee or other adult eligible individual must agree: (a) that the Plan will have a lien on the proceeds of any recovery arising out of the third party incident to the full extent of its subrogation rights and to the full extent of its rights to repayment under the repayment and subrogation agreement that may be independent of its subrogation rights; (b) that, to the full extent of benefits paid pursuant to the Plan, such recovery will be held in trust for the sole use and benefit of the Plan, and that the Plan shall have the right to obtain payment of such recovery being thus held in trust; and (c) that the Plan may sue in any court of competent jurisdiction to enjoin the use of such proceeds for any purpose other than their payment to the Plan; and
- The attorneys for all such persons must sign an agreement that they will honor and enforce the terms of the repayment and subrogation agreements before disbursing the proceeds of any recovery arising out of the third party incident; and
- If the injured individual is a minor or is otherwise legally incompetent, the eligible employee and the legally incompetent person’s parent, legal guardian or “next friend” must sign a legally binding repayment and subrogation agreement on behalf of the injured incompetent person as a condition precedent to the Plan’s obligation to pay any benefits arising out the third party incident.

The repayment and subrogation agreement specifies, among other things, that the eligible employee, and the injured individual, agree:

- That the eligible employee and/or the injured individual will repay to the Plan the amount of such assets held in trust for the Plan, whether or not the claimant is made whole by any subsequent recovery; and

- That the Trustees may participate in any legal action filed against a third party by or on behalf of the eligible employee and/or the injured individual to recover the expenses; and
- That the Trustees may file suit in the name of the eligible employee and/or the injured individual to recover the expenses the Plan pays on the claim if the responsible party does not pay for the expenses voluntarily and if the eligible employee and/or the injured individual does not sue the responsible party for recovery of the expenses; and
- The eligible employee and/or the injured individual will notify the Trustees before accepting any payment prior to the initiation of a lawsuit. If the Plan is not notified, and less than the full amount of the benefits advanced by the Plan have been accepted, the eligible employee and/or individual will still be required to repay the Plan, in full, for any benefits paid. The Plan may withhold benefits if the eligible employee and the injured individual waive any of the Plan's rights to recover or fail to cooperate with the Plan in any respect regarding the Plan's reimbursement or subrogation rights. If the eligible employee and eligible individual refuse to reimburse the Plan from any recovery or refuse to cooperate with the Plan regarding its subrogation or reimbursement rights, the Plan has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against future benefit payments under the Plan. Non-cooperation includes the failure of any party to execute a repayment and subrogation agreement and the failure of any party to respond to the Plan's inquiry concerning the status of any claim, request for any information or any other inquiry relating to the Plan's rights.

The Plan shall not be liable for, nor shall it have any obligation to pay, any benefit arising out of a third party incident unless and until a repayment and subrogation agreement in a form satisfactory to the Trustees executed by all persons to the full satisfaction of the Trustees, has been received by the Plan.

No individual will be required to repay to the Plan more than the benefits the Plan pays on the claim, nor more than the gross amount the injured individual receives in recovery, whichever is less, without regard to attorneys' fees and expenses incurred in obtaining any such recovery; however, the Plan may agree to share in the payment of the injured individual's attorney's fees if the Trustees determine it is in the Plan's interest to do so.

The repayment and subrogation agreement, the Plan's right of Subrogation, and the Plan's right to recover assets held in trust for its benefit are separate and distinct rights and obligations, and the failure or invalidity, in whole or in part, of one such right or obligation shall not impair or otherwise adversely affect any other such right or obligation.

If a judgment or settlement is received by or on behalf of the injured individual, the individual on whose behalf the Plan paid benefits shall repay to the Plan the lesser of the full amount of benefits the Plan paid, or the amount of any recovery, whether or not that individual was legally responsible for the payment of those expenses. If such repayment is not made to the Plan, the Plan shall have the right, in addition to any other legal rights it may have, to reduce future benefits on claims made by the eligible employee and any eligible dependent, until the full amount of the agreed upon repayment has been paid to the Plan.

Notwithstanding the foregoing, no benefits will be paid under the Plan if the law or public policy of the state in which the person lives, or in which the claim against the third person has been or may be filed, prohibits the Plan from being reimbursed in the event the person, whether or not a minor, recovers from the third person, unless such prohibition is unenforceable because it is preempted by the Employee Retirement Income Security Act of 1974, as amended.

Payment of Benefits for Compensated Injuries

For the purposes of this provision, "compensated incident" shall mean any occurrence taking place at any time or over a period of time from which any settlement, award or recovery is or was granted to an eligible individual. It includes a single act, or a number of acts occurring over a period of time

which result in injury to the eligible individual (such as, but not limited to, continued exposure to a harmful agent, prolonged misdiagnosis of a condition, etc.).

Notwithstanding any provision of the Plan to the contrary, no benefit shall be payable under the Plan for any covered expense which arises out of or is attributable to a compensated incident, either directly or indirectly, unless and until the total of benefits payable under the Plan's terms for all claims related to that incident equals or exceeds the total amount of compensation paid from another source. In determining the total amount paid by another source, the Plan will include amounts paid for medical services provided or rendered as a result of or in connection with any injury, sickness, accident, or condition arising out of or related to the compensated incident, whether the compensation is in the form of a judgment, settlement, or otherwise, and however such compensation is described or designated.

This provision shall apply irrespective of the designation or description of such compensation or recovery (i.e., loss, punitive damages, pain and suffering, medical expenses, attorneys' fees, costs, etc.). For the purpose of this provision, any and all compensation and recovery shall first be applied to compensation for medical expenses.

This provision shall apply regardless of who institutes the action against another source and regardless of who pays the compensation or recovery to the eligible individual, and whether recovery is in the form of a judgment, settlement or otherwise, and whether the eligible individual is an eligible employee or an eligible dependent, or a legally competent or incompetent person, or a representative of any such person.

The determination of whether a covered expense is within the purview of treatment and/or service attributable to a compensated incident is a question of fact which shall be determined by the Trustees in their sole discretion.

The eligible individual (or, in the case of an incompetent eligible individual, his or her representative), shall assist and cooperate with representatives designated by the Trustees in making a determination as to whether the treatment and/or service can be attributable to the compensated incident. The eligible individual (or, in the case of an incompetent eligible individual, his or her representative) shall sign any and all necessary documents, releases and waivers reasonably requested by the Trustees or their representatives in making their determinations of whether the treatment and/or service can be attributable to the compensated incident. No benefit shall be payable for any covered expense incurred in the treatment of a condition or injury which may be attributable to a compensated incident, whenever incurred, to or on behalf of an eligible individual during any period of time during which the eligible individual or, if applicable, the representative, fails or refuses to render reasonable aid, or sign any document, waiver or release reasonably related to furthering the intent of this provision.

This provision shall in no way affect or otherwise diminish the Plan's right to subrogation or recovery under a repayment agreement for medical expenses incurred prior to, or if applicable, subsequent to, the eligible individual's recovery.

This provision shall not be deemed waived by reason of satisfaction or release of the Plan's claim or lien under the Plan's subrogation rights without the express written agreement by the Trustees of such waiver. Any purported waiver of this provision by an eligible individual (or, in the case of an incompetent eligible individual, his or her representative) shall be null and void insofar as it applies to the Plan or Trustees or to any benefits claimed to be due and owing under the Plan.

Coordination of Benefits (C.O.B.)

Benefits are coordinated when you or any of your dependents are covered by this Plan as well as by another group health plan (usually your spouse's plan). Coordination allows benefits to be paid by two or more plans up to but not to exceed 100% of the allowable expenses on the claim.

General C.O.B. Rules

- Benefits are coordinated on all employee, retiree and dependent claims. C.O.B. doesn't apply to life insurance, AD&D insurance, Weekly Income Benefits, the Lineco Member Assistance Program (MAP) or the Lineco HRA.
- The Fund Office may release or receive necessary information about your claim to or from other sources. You must furnish the Fund Office with any information they need to process your claim.
- You must file a claim for any benefits you are entitled to from any other source. Whether or not you file a claim with these other sources, your Plan payments will be calculated as though you have received any benefits you are entitled to from the other source(s).
- Benefits are coordinated with other group plans, Medicare, and with individual plans paid for by the individual if that plan has a C.O.B. provision. You can contact the Fund Office to find out whether that plan fits the definition of a group plan.
- If you and your spouse are both covered as employees under this Plan and one of you has a claim, the Plan will coordinate benefits on the claim (two claims must be submitted—one by you and one by your spouse).
- Benefits are paid under C.O.B. for allowable expenses, which are expenses that are eligible to be considered for reimbursement.
- When Lineco is the secondary plan, the following types of expenses will NOT be considered to be allowable expenses and no payment will be made for:
 - ~ Any amount the primary plan didn't cover because you did not follow its rules and procedures. For example, if the primary plan reduced its benefits because you did not obtain pre-certification, get a required second opinion, or use a PPO provider, etc., the reduced amount is not an allowable expense. This means that Lineco will not pay for the amount of any penalty reductions assessed by the primary plan because of your (or your family member's) failure to comply with the other plan's rules or procedures.
 - ~ If there is a difference between the amount the primary plan allows and the amount allowable by Lineco, Lineco will coordinate its benefits using the higher amount. However, if the primary plan has a contract with the provider (HMOs and PPOs usually have such contracts), the combined payments of both plans will not be more than the primary plan's contract calls for. Exception: If both Lineco and the other plan have a contract with the same provider, the allowable expense will be the higher of the two contracted or negotiated fees.

Order of Benefit Payments

A plan that is required to pay its normal benefits on a claim before another plan pays its benefits is the *primary plan*, or *pays first*. The plan that makes payments based on the amount that is not paid by the primary plan is the *secondary plan*, or *pays second*. When a person who has a claim is covered under one or more other plans, this Plan will determine and pay its benefits in accordance with the first of the following rules that applies. Some of these rules depend on which person in a family a specific plan is for. Note that Lineco is for the covered employee, and dependent coverage is provided as a supplement to the employee's coverage.

1. If a person is covered under another group plan that doesn't have C.O.B. rules, that other plan will pay its benefits first and this Plan will pay second.
2. The plan covering the person for whom the claim is filed as an employee or retiree will pay first, and the plan covering the person as a dependent will pay second.
3. The benefits of a plan which covers a person as an employee who is not retired will be paid before the benefits of a plan which covers that person as a retired employee. The same is true if a

person is a dependent of a person who is covered under one plan as a retiree and the other plan as an employee.

4. If a person who has COBRA coverage is also covered under another plan as an employee, retiree or dependent, the COBRA coverage is secondary. Note: If you are covered under Lineco's COBRA coverage and are also eligible for Medicare, you must enroll in Medicare Part B.
5. On claims for children, the following order of benefit payment will be as follows:
 - a. The primary plan is the plan of the parent whose birthday is earlier in the year (called the "birthday rule") if: (1) the parents are married; or (2) the parents are not separated (whether or not they were married to each other); or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health coverage. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
 - b. If the non-custodial parent is given responsibility for the child's medical expenses in a divorce or separation decree, and if the non-custodial parent does provide health care coverage for the child, the plans will determine their benefits using the following order: (1) the plan of the non-custodial parent, (2) the plan of the custodial parent, (3) the plan of the spouse of custodial parent, and 4) the plan of the spouse of non-custodial parent.
 - c. If the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, then the responsible parent's plan is primary. If the legally responsible parent does not have health coverage for the child, but his or her spouse does, the spouse's plan becomes primary.
 - d. If the parents are not married and not living together, or are separated or divorced and no court decree allocates responsibility for the child's health care expenses, or if a court decree states that the custodial parent is responsible for the child's health care expenses, the order of benefits for all possible plans is: 1) the plan of the custodial parent; 2) the plan of the spouse (if any) of the custodial parent; 3) the plan of the non-custodial parent; and then 4) the plan of the spouse (if any) of the non-custodial parent.
 - e. If an eligible child is employed and/or married, the plan covering the child as an employee will pay first, the plan covering the child as a spouse will pay second, and the plan covering the child as a dependent child will pay third.

If the above rules still don't clearly show which plan should pay first, the plan that has covered the person (for whom the claim is filed) for the longest period of time will pay first. The plan which has covered the person for the next longest period of time will pay second, and so on.

C.O.B. With Sub-Plans - If Lineco is secondary but the primary plan has a rule allowing it to pay less than its normal benefits when there is secondary coverage, then the maximum payable by Lineco for all claims incurred by that is \$1,000 per calendar year.

C.O.B. With Medicare (For Retirees and Their Dependents Who Are Eligible for Medicare)

If you are a Medicare-eligible retiree, this Plan will coordinate benefits with Medicare on your claims. This means that Medicare will pay first, and this Plan will pay after Medicare pays based on amounts not paid by Medicare. (Individuals who are entitled to Medicare can decline coverage under this Plan so that Medicare will be their only health care coverage. To decline Lineco coverage and have Medicare as your only health care coverage, contact the Fund Office.)

Enrollment in Medicare Required - Both you and your spouse are each responsible for enrolling in Medicare Part A and Part B when eligible to do so. You can normally apply for Medicare during the period that begins three months before and ends three months after your 65th birthday. Contact your local Social Security office for more information.

Medicare-eligible retirees and their dependents are required to enroll in Medicare Parts A and B. If you fail to enroll in Parts A and B of Medicare, you will have to pay the amount normally paid by Medicare out of your own pocket.

This Plan will only pay benefits equal to the benefits it would have paid if you were enrolled in Parts A and B of Medicare. If you fail to enroll, you will have to pay the amount normally paid by Medicare. To avoid being confronted with large out-of-pocket expenses, be sure that both you and your spouse enroll in both Medicare Part A AND B when you are eligible to do so.

If Your Doctor Opts Out of Medicare - A physician who opts out of Medicare is only permitted to see Medicare patients if the patient signs an agreement saying he will be responsible for paying the provider's bills.

When Lineco is secondary to Medicare, and the physician providing the service has opted out of the Medicare system, Lineco will coordinate its benefits the same *as if* the provider had *not* opted out, and you will be responsible for the 80% that Medicare would have paid. You will also be responsible for any amounts over and above the Medicare allowable amount. Your total out-of-pocket costs could be substantial. This rule will not apply to pathologists, anesthesiologists, radiologists or, emergency medicine physicians.

C.O.B. With Medicare in Other Situations

Medicare-Eligible Employees and Dependents of Employees Under 65 - If you (or any of your dependents) are entitled to Medicare for reasons other than age (for example, because of disability or end stage renal disease), this Plan will usually be the primary plan unless it is legally permitted to pay second. This provision doesn't apply to retirees or their dependents.

Employees Continuing to Work After Age 65 (and Their Medicare-Eligible Dependents) - If you continue to work for a contributing employer who has 20 or more employees after you become age 65 and eligible for Medicare, this Plan will be your primary plan unless it is legally permitted to pay second. The same rule applies if your dependent is eligible for Medicare while you are still working and eligible (regardless of your age). If your dependent is covered under her own plan, her plan will pay first, this Plan will usually pay second, and Medicare will pay last.

If you continue to work for a contributing employer who has fewer than 20 total employees after you are age 65, this Plan will usually be secondary to Medicare.

Medicare and COBRA - If you or a family member elect COBRA through Lineco and then become eligible for Medicare, Lineco's COBRA coverage will terminate. If, however, you already have Medicare when COBRA starts, you can keep your COBRA coverage. If your Medicare entitlement is due to age or disability, then Medicare will be your primary plan. If your Medicare entitlement is due to end stage renal disease, then your Lineco COBRA coverage will be the primary payer for a 30-month period starting with your Medicare start date and Medicare will be secondary.

Excess Coverage Limitation

Regardless of any other rule stating otherwise, all benefits payable under this Plan will be limited to being in excess of the benefits which are payable by any other group plan, group insurance policy or blanket insurance policy which is or purports to be an excess policy or an excess plan paying benefits only in excess of benefits provided by any other plan or policy.

If an entity or insurer of such other group excess plan, group excess policy or blanket insurance policy agrees to pay benefits as if it were not an excess plan or policy, this Plan's benefits will be payable without regard to the provisions of the previous paragraph, subject to the C.O.B. provisions above.

No benefits are payable by this Plan for any injury or sickness for which there is other non-group coverage through an automobile insurance policy or plan providing medical, sickness, or similar payments or medical expense coverage, regardless of whether the other coverage is primary, excess or contingent to this Plan.

GENERAL PLAN PROVISIONS AND INFORMATION

Definitions

This is not a complete list of the definitions applicable to this Plan—additional definitions are included in the Plan Document. If you have a question about the meaning of a word, term or phrase used in this Summary Plan Description, please contact the Fund Office.

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

- For **in-network providers**, the allowable charge is the contracted fee.
- For **out-of-network providers**, the allowable charge is the reasonable and customary amount. This amount is determined by comparing a particular charge with the charges made for similar services and supplies in the locality concerned to individuals of similar age, sex, circumstances and medical condition.

The result of any such comparison determines the amount that is the maximum allowable charge to be considered a covered medical expense, a covered dental expense, or a covered orthodontia expense under this Plan.

You will be responsible for amounts charged by out-of-network providers for any amount in excess of the allowable charge.

AMBULATORY SURGICAL CENTER - A licensed free-standing facility that is wholly owned and operated by a hospital on the same basis as the outpatient department of its main facility, or a legally constituted institution that is established, equipped and operated primarily for the purpose of performing surgical procedures.

AUTISM; AUTISM SPECTRUM DISORDER - Autistic disorder, Asperger's syndrome and pervasive developmental disorders not otherwise specified, but excluding childhood disintegrative disorder and Rett's syndrome.

CHIROPRACTIC CARE - Any services or supplies that are provided or ordered by a chiropractor.

DEPENDENT - A dependent is any one of the following:

1. A person who is your (employee's or retiree's) spouse, provided she is not legally separated from you. A certified copy of your marriage certificate must be on file at the Fund Office before claims for your spouse can be processed. If your spouse is a full-time active member of the military or armed forces of any country, she won't be considered a dependent under this Plan.
2. A person who is your (employee's or retiree's) child (see *Definition of Child* below):
 - a. Who is less than 26 years old; or
 - b. Who is 26 or older, unmarried, and totally disabled because of mental retardation, mental incapacity or physical handicap. The child must have become disabled before becoming age 26; must remain disabled and be incapable of self-sustaining employment; and must be dependent on you for the major portion of his support. When the first claim is filed for the child, you must furnish proof that he became disabled before he became 26. You must furnish the proof at your own expense except that, if the Trustees require a physical examination, the Plan will pay for it. If the Trustees request proof of the child's disability in the future, you must furnish the proof or the child's coverage will terminate.

Definition of Child - For purposes of this definition, a child means any of the following:

1. A natural child of yours;
2. Any child legally adopted by you or placed in your home for adoption;
3. A stepchild of yours, meaning any child of your spouse who was born to your spouse or who was legally adopted by your spouse before your marriage to your spouse;
4. A child who is determined to be an alternate recipient under the terms of a court order which the Trustees determine to be a Qualified Medical Child Support Order. A copy of the court order will be required by the Fund Office before claims for the child will be considered for payment. You can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations by calling or writing the Fund Office; or
5. A foster child who was placed in your home by a state or private social service agency.

The Plan will also cover your or your spouse's grandchild, sibling, nephew or niece under age 19, provided you have an order of guardianship or custody, and provided the child lives in a parent-child relationship with you, and is dependent on you for the major portion of his support. Coverage can be continued after age 19 if he is and remains unmarried and a registered full-time student in an accredited secondary school, college, university, vocational or technical school, and remains dependent upon you for the major portion of his financial support. Proof of full-time student status for each school term must be submitted to the Fund Office before the child will be covered. Coverage will terminate when your grandchild, sibling, nephew or niece reaches age 25 or ceases to be a full-time student, whichever occurs first.

If a child is a full-time active member of the military or armed forces of any country, the child is not considered a dependent under this Plan.

Any child born of a covered person acting as a surrogate mother, that is, a female who became pregnant with the intent or understanding of relinquishing the child following the child's birth, will not be considered a dependent of the surrogate mother or her spouse.

Note About Other Coverage - If a dependent is also covered by another plan, see *Order of Benefit Payments* starting on page 72 to determine which plan is primary and which is secondary.

DOCTOR; PHYSICIAN - A legally qualified doctor or surgeon who is a Doctor of Medicine (M.D.) a Doctor of Osteopathy (D.O.), a Doctor of Chiropractic (D.C.), a Doctor of Dentistry (D.D.S.), a Podiatrist (D.P.M.), or a Doctor of Optometry (O.D.), provided that any such individual renders treatment only within the scope of his license and specialty.

Note that with respect to mental/nervous and substance abuse disorders, all ValueOptions network providers are covered, including Masters-level mental health providers such as social workers and counselors. Masters-level non-PPO providers, including but not limited to social workers, are not covered.

Additional Covered Providers - Subject to all Plan limitations, other covered providers include the following practitioners who render such services within the scope of each such individual's license and specialty:

- A licensed clinical psychologist (PhD);
- A licensed nurse practitioner (LNP);
- A physician's assistant (PA);
- A certified registered nurse anesthetist (CRNA);
- A surgical assistant;
- A licensed midwife (for pregnancy-related services only); and

- A state-licensed acupuncturist (for covered acupuncture services only).

ELIGIBLE EMPLOYEE - Any employee who has met the eligibility requirements established by the Trustees for being covered under the Plan.

ELIGIBLE RETIREE - A retired employee who has met the eligibility requirements established by the Trustees for being covered under the Plan and who is entitled to receive the Plan benefits provided for retirees.

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

EMPLOYEE

- Any individual on whose behalf an employer makes contributions to the Fund under the terms of a collective bargaining agreement or participation agreement; and
- Any individual who is a full-time employee of the Fund.

EMPLOYER; CONTRIBUTING EMPLOYER

- Any person, firm, association, partnership or corporation which is required, under the terms of a collective bargaining agreement with a union, to make contributions to the Fund on behalf of its employees covered by the agreement; and
- Any union, association or other employer which is required, under the terms of a participation agreement with the Trustees, to make contributions to the Fund on behalf of its employees who are not covered by a collective bargaining agreement; and
- The Fund, on behalf of its full-time employees.

EXPERIMENTAL OR INVESTIGATIVE - A treatment, procedure, facility, equipment, drug, device or supply will be considered to be “experimental or investigative” if it falls within any one of the following categories:

- It is not yet generally accepted among experts as accepted medical practice for the patient’s medical condition; or
- It cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other Federal agency, and such approval had not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply was rendered, provided or utilized; or
- It is the subject of ongoing Phase I or Phase II clinical trials, or is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses, or if the prevailing opinion among experts regarding any such treatment, procedure, facility, equipment, drug, device or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses.

Determination of whether a treatment, procedure, facility, equipment, drug, device or supply is experimental or investigative shall be determined solely by the Trustees, in their sole discretion and judgment, in consultation with medical experts of their choosing.

FUND; TRUST FUND - The Line Construction Benefit Fund.

HOSPITAL - An institution which is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patients' expense and which fully meets all of the requirements set forth in No. 1 or No. 2 or No. 3 below:

- It is a hospital that is qualified to participate in Medicare and to receive Medicare payments; or
- It is a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
- It is an institution which: (a) provides diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and sick persons under the supervision of a staff of doctors licensed to practice medicine; (b) provides on the premises 24-hour-a-day nursing services by or under the supervision of R.N.s; and (c) is operated continuously with organized facilities for operative surgery on the premises.

A hospital is not an institution which is primarily a clinic or, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics or a nursing or convalescent home or similar establishment.

JAW SURGERY - Any surgical procedure involving the maxilla and/or mandible, or any surgical procedure to treat TMJ (as defined on page 79).

MEDICALLY NECESSARY - Only those services, treatments or supplies provided by a hospital, a doctor, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an eligible individual's injury or sickness and which are: (1) consistent with the symptoms or diagnosis and treatment of the individual's condition, disease, ailment or injury; (2) appropriate according to standards of good medical practice, meaning that it is in conformance with the recognized standard of care; (3) not solely for the convenience of the individual, doctor or hospital; (4) if more than one alternative is available, the most cost-effective alternative that can meet the individual's essential health needs; and (5) not experimental or investigative. The fact that the treating doctor finds that the treatment is medically necessary is not binding on the Trustees.

MENTAL OR NERVOUS DISORDER - A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, regardless of any physiological or traumatic cause or origin of such condition.

PLAN; BENEFIT PLAN; PLAN OF BENEFITS - The self-funded program of health and welfare benefits provided by the Line Construction Benefit Fund as described in this booklet.

RETIREE; RETIRED EMPLOYEE - A person who was an eligible employee under this Plan on the day preceding the date of his retirement and who is now retired either under the retirement provisions of a pension plan negotiated or sponsored by the IBEW, a qualified pension plan provided by a contributing employer, or under the provisions of the Social Security program.

SKILLED NURSING FACILITY - An institution, or a distinct part of an institution, which complies with all licensing and other legal requirements and which, to be approved for the purposes of this Plan, meets all of the following criteria: (1) it is primarily engaged in providing inpatient skilled nursing care, physical restoration services and related services for patients who are convalescing from injury or sickness and who require medical or nursing care to assist the patients to reach a degree of body functioning to permit self-care in essential daily living activities; (2) it provides 24-hour-a-day supervision by one or more doctors or one or more R.N.'s responsible for the care of its inpatients, it provides 24-hour-a-day nursing services by licensed nurses under the supervision of an R.N., and it has an R.N. on duty at least eight hours a day; (3) every patient is under the supervision of a doctor, and it has available at all times the services of a doctor who is a staff member of a general hospital; (4) it maintains daily medical records on all patients, and it provides appropriate methods and procedures

for the dispensing and administering of drugs and biologicals; (5) it has a utilization review plan; (6) it has a transfer agreement with one or more hospitals; (7) it is eligible to participate under Medicare; and (8) it is not, other than incidentally, an institution which is a place for rest, for custodial care, for the aged, for drug addicts, for alcoholics, a hotel, a place for the care and treatment of mental diseases or tuberculosis, or a similar institution.

SUBSTANCE ABUSE - Alcoholism, alcohol abuse, drug addiction, drug abuse, or any other type of addiction to, abuse of, or dependency on any type of drug or chemical (excluding nicotine).

SUBSTANCE ABUSE TREATMENT FACILITY - A rehabilitation facility for the treatment of individuals suffering from substance abuse. The facility must either be accredited by the Joint Commission on Accreditation of Healthcare Organizations, be part of the ValueOptions provider network, or be approved by ValueOptions.

TMJ - Temporomandibular joint syndrome, maxillary or craniomandibular disorders, and other conditions of the joint linking the jaw bone and the skull, along with the complex of muscles, nerves, and other tissues related to that joint. For the purposes of the Plan, the term “TMJ” includes all of these conditions.

TOTALLY DISABLED; TOTAL DISABILITY - An eligible employee is totally disabled if he is completely unable to perform any and every duty of his occupation or employment because of an accidental bodily injury or sickness. A dependent or a retiree is totally disabled if he is completely unable to perform the normal activities of a person of like age and sex because of a non-occupational accidental bodily injury or sickness. A doctor must submit written certification of a person’s total disability before the person will be considered totally disabled under the terms of the Plan.

TRUSTEES - The individuals responsible for the operation of the Line Construction Benefit Fund in accordance with the terms of the Trust Agreement, together with such Trustees’ successors. Trustees appointed by the association are Employer Trustees; Trustees appointed by the union are Union Trustees.

UNION - Any local union affiliated with the International Brotherhood of Electrical Workers which has entered into a collective bargaining agreement requiring contributions to the Fund.

Claim and Appeal Procedures

Claim Processing Procedures

When used in the following explanation, the term “Plan office” means the office or organization designated by the Trustees for handling claims.

When you file a claim for benefits, be sure to follow the proper claim filing procedures. The Fund Office receives claims during regular business hours Monday through Friday. If you or your medical provider is requesting pre-certification of a claim that requires you to get approval from one of the Plan’s review organizations, you must follow the rules and time frames for pre-certifying the proposed treatment. The Plan’s claim filing procedures are described on page 63. Claims must be submitted within two years after the date the claim is incurred.

Claim Processing Time Limits - The amount of time the Plan office can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

- A claim is “post-service” if you have already received the treatment or supply for which payment is now being requested. Most claims are post-service claims.
- A “disability claim” is a claim for Weekly Income Benefits.

- A “pre-service claim” is a request for preauthorization of a type of treatment or supply that requires approval in advance of obtaining medical care in order for benefits to be paid.
- An “urgent care claim” is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, health, or ability to regain maximum function, or that could subject you to severe pain that cannot be adequately managed without the proposed treatment.
- A “concurrent care claim” is a request to extend a course of treatment beyond the period of time or number of treatments previously approved.

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

- Post-service claims—within 30 days.
- Disability claims—within 45 days.
- Pre-service claims—within 15 days.
- Urgent care claims—within 72 hours.
- Concurrent care claims—within 24 hours if the concurrent care is urgent and if the request for the extension is made within 24 hours prior to the end of the already authorized treatment. If the concurrent care is not urgent, then the pre-service time limits apply.

You may have an authorized representative act on your behalf, although the Plan office may verify that the person has been so authorized. However, in connection with an urgent care claim, the Plan will recognize a health care professional with knowledge of your medical condition as your representative.

When Additional Information Is Needed - If additional information is needed from you, your doctor or the medical provider, the necessary information or material will be requested in writing. The request for additional information will be sent within the normal time limits shown above. When the additional information needed to decide an urgent care claim is requested orally, it will be requested within 24 hours.

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

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

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

Claim Denials

If all or a part of your claim is denied, you will be sent a written notice giving you the reasons for the denial. The notice will include reference to the Plan provisions on which the denial was based and a description of the claim appeal procedure. If applicable, it will give a description of any additional

material or information necessary for you to perfect the claim, and the reason such information is necessary. The notice will provide the applicable time limits for following the procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following the denial of an appeal. If the Plan relied upon an internal rule, guideline, protocol or similar criterion to make its decision, the denial notice will state that the Plan will provide you with the specific internal rule, guideline, protocol or criterion used upon request free of charge. If the decision was based on medical necessity or if the treatment was deemed experimental, the notification will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. For urgent claims, a description of the Plan's expedited review process will be provided.

Claim Appeal Procedures

Requesting a Review - If you have an urgent care claim you may orally request that the Claim Review Committee review the decision by calling the Lineco Fund Office at 1-800-323-7268. You may also submit your request in writing to the Claim Review Committee at the address shown below.

If you have a concurrent care claim and the Plan office terminates or reduces a previously approved period of treatment, you will have the right to appeal that termination or reduction. You will be given advance notice of the termination or reduction and allowed to appeal the determination before the termination or reduction. The rule allowing the treatment to continue pending an appeal does not apply if your benefits terminate because you have lost eligibility under the Plan or if the termination or reduction is the result of a Plan amendment.

For all other claims, if you want the Claim Review Committee of the Board of Trustees to review your claim after a denial of benefits, request a claim review form from the Fund Office. When you receive the form, fill it in completely. Attach any additional information that you think will help a favorable decision to be made on your claim. Return the completed form within 180 days after the date the denial was mailed to you to:

Claim Review Committee
Line Construction Benefit Fund
2000 Springer Drive
Lombard, IL 60148

If you submit an appeal and the Plan requests and receives additional information concerning your claim, such as a second written medical judgment, the Plan will provide you with that new evidence if the Plan relied upon it or considered it in connection with the appeal.

You can authorize someone else to file your request for review and otherwise act for you. You and/or your representative can review materials in the Plan's files that are related to your claim. You and/or your representative can submit written issues and comments to support your request for review. You can also make a written request for a personal appearance (by you and/or your representative) before the Claim Review Committee. If you and/or your representative do so, it must be done at your own expense.

Full and Fair Review - The Claim Review Committee will conduct a full and fair review of all the material submitted with your claim, the action taken by the Plan office, the additional information you have provided, and the reasons you believe the claim should be paid. The review will be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination, nor the subordinate of such party. It will not afford deference to the initial adverse benefit determination, and will take into account all comments, documents, records and other information submitted by you, without regard to whether such information was previously submitted or relied upon in the initial determination.

You have the right, upon request and free of charge, to have copies of all documents, records and other information relevant to your claim for benefits.

With respect to a review of any determination based on a medical judgement, the Claim Review Committee will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgement. Such health care provider will be “independent,” which means the person consulted will be an individual different from, and not subordinate to, any individual who was consulted in connection with the initial decision.

Notification Following Review - If your appeal is for an urgent care claim, you will be notified of the Claim Review Committee’s decision about your appeal as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of your request for review. In the case of pre-service claims, you will be notified no later than 30 days after receipt of your request for review.

A review and determination for disability and post-service claims will be made no later than the date of the meeting of the Claim Review Committee that immediately follows the Plan’s receipt of a request for review. The Committee generally meets on a quarterly basis in the months of March, June, September and December. If your request for review has been received by the Committee at least 30 days before its next scheduled meeting, a decision on your request for review will normally be made at the next quarterly meeting. If your request for review is not received by the Committee at least 30 days before the next scheduled meeting date, the decision may be delayed one additional quarter. In addition, in unusual circumstances, the decision may be delayed until the third meeting of the Committee after it has received your request for review. If such circumstances require such a delay, you will be informed.

If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a determination will be rendered not later than the third meeting of the Claim Review Committee. Before the start of the extension, you will be notified in writing of the extension, and that notice will include a description of the special circumstances and the date as of which the determination will be made.

After a decision has been made on a disability or post-service claim, you will be informed in writing of the Claim Review Committee’s decision, normally within five calendar days of the review. When you receive the decision on your appeal, it will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to you claim; a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; and a statement of your right to bring an action under section 502(a) of ERISA. If one was used, you will also be informed of the specific internal rule, guideline, protocol or similar criterion relied on to make the decision free of charge upon request. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request.

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

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

Your Right to a Timely Decision - If the Plan fails to make timely decisions or otherwise fail to comply with the applicable Federal regulations, you may go to court to enforce your rights.

Examinations

The Trustees have the right to have a doctor examine a person for whom benefits are being claimed, to ask for an autopsy in the case of a death, and to examine any and all hospital or medical records relating to a claim.

Workers' Compensation Not Affected

This Plan is not in place of and does not affect any requirement for coverage under any Workers' Compensation Law, Occupational Diseases Law or similar law. Benefits that would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws.

Plan Discontinuation or Termination

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

If there are any assets remaining after payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees according to the Trust Agreement or they may be turned over to another employee benefit trust fund providing similar benefits. However, any use of such assets will be made only for the benefit of Plan participants who were covered under the Plan at the time of the Plan termination.

False or Inaccurate Information

All claims, enrollment forms and other information submitted or provided to the Plan, directly or indirectly, must be accurate and complete. If the Trustees find at any time that false or inaccurate information has been submitted or provided to the Plan, directly or indirectly, in support of a claim, such claim will be denied and the Trustees can offset the amount improperly paid and/or terminate future eligibility for the affected individual and his Eligible Family Members.

Fund's Right to Recover Overpayments

Any employee, retiree or dependent who receives money from the Plan to which he or she is not entitled will be required to fully reimburse the Plan. Future benefits to the participant or a family member of the participant may be reduced or temporarily suspended in order to recover an overpayment of benefits previously made on a participant's behalf.

Release of Information

You must provide the Fund Office with any required authorization for release of necessary information relating to any claim you have filed.

Certificates of Coverage

When you or a dependent are no longer eligible for Plan benefits, you will receive a certificate of coverage from the Fund Office. This certificate provides evidence of your prior health care coverage. You may need to furnish this certificate if you become eligible under another group health plan that excludes coverage for preexisting conditions. You may also need this certificate in order to buy an individual insurance policy with a preexisting condition exclusion or limitation.

If your (or your dependent's) coverage terminates, the Fund Office will automatically send a certificate of coverage to your (or your dependent's) last known address. If you do not receive a certificate because of a change of address, or because the Fund Office was not notified that a dependent's coverage has terminated, or if you would like a certificate for any other reason, you have the right to request one—just call or write the Fund Office at the address and telephone number shown on the inside front cover of this booklet. You may request a certificate of coverage any time within 24 months of when you were last covered under the Plan.

Women's Health and Cancer Rights Act

Lineco covers services provided to a covered person for a medically necessary mastectomy and for the post-surgical reconstruction of the affected breast. Lineco also considers charges for the following services and supplies to be covered medical expenses when the charges are incurred by a covered person who is receiving Plan benefits for a mastectomy, and when the person elects (in consultation with their physician) breast reconstruction in connection with the mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications relating to all stages of the mastectomy, including lymphedemas.

Plan benefits payable for these services and supplies are subject to all applicable deductibles, payment percentages and maximum benefit limitations.

Notice of Privacy Practices

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

The Line Construction Benefit Fund ("Fund") exists for one purpose: to provide health and welfare benefits to participants in the Fund and to their eligible dependents. In the course of providing welfare benefits, the Fund receives and maintains information that constitutes "protected health information" (PHI) as defined in Federal privacy rules. This notice describes the Fund's policies that protect you from the unnecessary disclosure of your health information and give you certain rights regarding your health information.

In this Notice, "you" means any person whose health information is received by the Fund. This Notice applies to you whether you are the Plan participant or an eligible dependent. Privacy rights can be exercised either by you or your Personal Representative (defined on page 87). For a minor child, the parent is the Personal Representative.

Circumstances in Which the Fund Uses or Discloses Health Information

To Process and Pay Your Claims - The Fund may use or disclose your health information to process and pay your benefit claims. Claim processing includes all aspects of the process including, for example:

- Determining benefit eligibility or Plan coverage.
- Reviewing health care services for medical necessity and reasonableness of charges and duration of hospital stays.
- Providing information regarding your coverage or health care treatment to another health plan to coordinate payment of benefits.
- Processing claim appeals.
- Telephoning you (or in your absence, an adult member of your household) to obtain information needed to process your claim.
- Answering questions regarding claim payments and benefits from you, your family members or other relatives or close personal friends, if such a person is involved with your health care or the payment of your claim.
- Answering questions from Local Unions or employers who have entered into Business Associate Agreements with the Fund.

To Collect Contributions for Coverage - The Fund may use or disclose your health information in the process of collecting any payments, such as the cost of COBRA coverage.

For Administrative Purposes - The Fund may use or disclose health information for its own operations. Some examples are:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Underwriting, premium rating or related functions to create, renew or replace Plan benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses.
- General administrative activities of the Fund, including customer service and resolution of internal grievances.

To Provide You With Health-Related Information - The Fund may use and disclose your health information to tell you about or recommend possible treatment options or alternatives, or to advise you of health-related benefits and services that may be of interest to you.

When Legally Required - The Fund will disclose your health information when it is required to do so by any Federal, state or local law. Examples include:

- When the Fund receives an order, issued by a court or a state agency, to disclose your health information.
- When the Fund receives a subpoena or a discovery request in a lawsuit or a workers' compensation case. In the case of a subpoena or discovery request that has not been issued under a court order, the party requesting the information should notify you of the request so that you will have an opportunity to obtain a court order protecting your health information.

To Conduct Health Oversight Activities - The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensing or disciplinary action.

For Law Enforcement Purposes - As permitted or required by state law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, reporting a crime in an emergency or if the Fund has reason to believe that your death was the result of criminal conduct.

For Specified Government Functions - In certain circumstances, Federal regulations require the Fund to use or disclose your health information to facilitate specified government functions, for example those related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

In the Event of a Serious Threat to Health or Safety - The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

Persons Who Will Use Your Health Information

Claims adjusters and other employees in the Fund Office will use your health information to process your benefit claims. The Fund Administrator and other supervisory personnel may use your health information for claim payment, training and administrative purposes, among others. The Board of Trustees, in its capacity as administrator of the Fund, may have access to your health information for appeals or other administrative or supervisory purposes.

Releasing Health Information With Your Authorization

The categories above (“Circumstances in Which the Fund Uses or Discloses Health Information”) describe when the Fund will use or disclose your health information without your authorization. Other than as stated above, the Fund will not disclose your health information, except with your written authorization. The following rules apply to authorizations to release health information:

- Authorizations will be in writing, signed by you or your Personal Representative.
- You or your Personal Representative will receive a copy of the authorization form.
- Authorizations have an expiration date that is stated on the authorization form.
- You or your Personal Representative can revoke the authorization at any time. The revocation must be in writing, delivered to the Fund Office at 2000 Springer Drive, Lombard, Illinois 60148.

Lineco will not release psychotherapy notes unless required by law.

Your Rights With Respect to Your Health Information

You have the following rights regarding your health information that the Fund maintains:

Right to Request Restrictions - You may request restrictions on certain uses and disclosures of your health information. The Fund is not required to agree to your request but the Fund will ordinarily honor any request that the Fund communicate only with you (that is, refrain from disclosing your claim or benefit information to your relatives, friends members of your household, your Local Union or Employer). If you wish to make a request for restrictions, please contact the Fund’s Privacy Officer.

Right to Receive Confidential Communications - You have the right to request that the Fund communicate with you in a certain way. The Fund is not required to honor such requests but the Fund will do so if it can be done without interfering with the Fund’s normal operations, or if you believe that the disclosure of your health information could endanger you. If you wish to receive confidential communications, please make your request in writing to the Fund’s Privacy Officer. Here are some examples of requests for confidential communications:

- A request that the Fund communicate only with you (that is, refrain from disclosing your claim or benefit information to your relatives, friends or members of your household). The Fund will routinely grant this request.
- A request that the Fund only communicate with you at a certain telephone number or send written communications to a P.O. Box instead of your home.
- A request from a child who is of legal age that the Fund not communicate with the participant or his spouse.

Right to Inspect and Copy Your Health Information - You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Fund's Privacy Officer. If you request a copy of your health information, the Fund will charge you \$0.25 per page for copying, plus actual mailing costs.

Right to Amend Your Health Information - If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing to the Fund's Privacy Officer. The Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

Right to an Accounting - You have the right to request a list of certain disclosures of your health information that the Fund is required to keep a record of under the Federal privacy rules, such as disclosures for public purposes, disclosures authorized by law or disclosures that are not in accordance with the Fund's privacy policies or applicable law. The request must be made in writing to the Fund's Privacy Officer. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests will be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

Right to a Copy of this Notice - You have a right to request and receive a copy of this Notice at any time, even if you have received this Notice previously. To obtain a copy, please contact the Fund's Privacy Officer or any employee at the Fund Office. This Notice is also available on the Fund's website at www.Lineco.org.

Your Personal Representative

If you are of legal age, you can exercise the privacy rights explained in this Notice. Your rights can also be exercised by your Personal Representative. A Personal Representative is:

- The parent of a minor child.
- The person designated in Health Care Power of Attorney (limited to the rights stated in the Power of Attorney).
- The legal guardian of a mentally incompetent adult.
- The administrator or executor of your estate, or your next of kin.

Obligations of the Fund

The Fund is required by law to maintain the privacy of your health information as described in this Notice and to provide to you this Notice of the Fund's duties and privacy practices. The Fund is required to conform to the terms of this Notice. The Fund reserves the right to change the terms of this Notice at any time. Any change will apply to all health information. If that happens, the Fund will revise the Notice and will provide you with a copy of the revised Notice within 60 days of the change. Any changes in the Fund's privacy practices will apply to all health information that the Fund has, regardless of whether the information was obtained before or after the change in privacy practices. You have the right to submit any complaints regarding privacy issues to the Fund's Privacy Officer. If you believe that your privacy rights have been violated, you have the right to report any violations to the Secretary of the Department of Health and Human Services. The Fund encourages you to express any concerns you may have regarding the privacy of your information. Neither the Fund, your employer or your Union

are permitted to retaliate against you in any way for filing a complaint. The Fund is required to notify you of any breaches of your unsecured protected health information.

Contact Person

The Fund has designated a Privacy Officer. The Privacy Officer is the contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at: Privacy Officer, 2000 Springer Drive, Lombard, Illinois 60148, 1-800-323-7268.

This Notice was effective as of April 14, 2003.

Your Rights Under ERISA

As a participant in the Line Construction Benefit Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. There is a charge 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 the Plan 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. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve (12) months (18 months for late enrollees) after your enrollment date if you should become covered under another plan.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you believe that Plan fiduciaries misuse the Plan's money, or if you believe you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. If you have any questions about your Plan, you should contact the Fund Administrator.

Assistance With Your Questions

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund 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, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also find answers to your questions and list of EBSA field offices at the website of the EBSA at www.dol.gov/ebsa.

How to Read or Get Plan Material

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

Information About Your Plan

Name of Plan/Fund - The name of your Plan is the Line Construction Benefit Fund Plan of Benefits. It is commonly called the Lineco Benefit Plan, or Lineco. The name of the Trust Fund through which your Plan is provided is the Line Construction Benefit Fund.

Plan Sponsorship and Administration - Your Plan is sponsored and administered by a joint labor-management Board of Trustees. The Board is divided equally between Trustees appointed by the unions and by Trustees appointed by contributing employers.

Each vice-presidential district of the International Brotherhood of Electrical Workers (IBEW) has a union Trustee representing it, provided that at least one local union in the district has a collective bargaining agreement requiring contributions to Lineco. Union Trustees are appointed by the Dis-

trict Vice President of the IBEW. Employer Trustees are appointed by the corresponding Chapter of the National Electrical Contractors' Association. The names and addresses of the individual Trustees start on page 92.

The Trustees are assisted in the administration of the Fund by a salaried administrator. The salaried administrator and other personnel of the administration office are employees of the Fund. The address of the Fund Administrator is:

Line Construction Benefit Fund
2000 Springer Drive
Lombard, IL 60148
Telephone: 1-800-323-7268

Service of Legal Process - The name and address of the agent whom the Trustees have appointed for service of legal process is shown on page 94. Service of legal process may also be made on any Trustee.

Source of Contributions/Plan Participation - The Fund receives contributions from employers who have entered into collective bargaining agreements with any local union affiliated with the IBEW and which have a clause requiring contributions to Lineco, and from employers who have participation agreements with the Trustees to provide coverage for their employees who are not bargaining unit employees. Contributions are made monthly to the Fund and enable employees working under such agreements to participate in the Fund.

Employees are entitled to participate in this Plan if they work under one of the collective bargaining agreements or participation agreements and if their employers make the required contributions to the Fund on their behalf. Administrative employees of the Fund are also entitled to participate in the Plan.

The Fund also receives self-payments from employees, retirees and dependents for the purpose of continuing coverage under the Plan.

Accumulation of Assets/Payment of Benefits - Employer contributions and employee, retiree and dependent self-payments are received and held in trust by the Trustees pending the payment of benefits, insurance premiums and administrative expenses. The Fund's financial custodian is Comerica Bank, 411 West Lafayette, Detroit, MI 48226.

The Fund provides medical, surgical, hospital, disability, dental and vision benefits on a self-insured basis. When benefits are self-insured, the benefits are paid directly from the Fund to you. The self-insured benefits payable by the Fund are limited to the Fund assets available for such purposes.

The Fund provides life insurance and accidental death and dismemberment (AD&D) insurance benefits through Trustmark Insurance Company. This Plan is not an insurance policy and no benefits other than the life insurance and AD&D insurance are provided by or through an insurance company. The insurance company's name and address is: Trustmark Insurance Company, 400 Field Drive, Lake Forest, IL 60045. The description of benefits provided in this Summary Plan Description is subject to all the provisions, conditions, limitations and exclusions of the insurance contract between the Fund and Trustmark Insurance Company.

Plan/Fund Year - The Fund's financial records are maintained on a 12-month fiscal year basis, beginning January 1 and ending December 31 of each year.

Plan/Fund Identification Numbers - The Employer Identification Number (EIN) assigned to this Fund by the I.R.S. is 36-6066988. The Plan Number (PN) assigned to the Plan of Benefits is 501.

PARTICIPATING NECA CHAPTERS AND LOCAL UNIONS

These are the various IBEW trade classifications covered under **Lineco**:

C	Communications	LCTT	Line Clearance Tree Trimming	T	Telephone
CATV	Cable Television	MT	Maintenance	U	Utility
CS	Cable Splicers	O	Outside Construction		

Missouri Valley Line Constructors Chapter

2	St. Louis, MO	O, LCTT, CS, CATV, T	714	Minot, ND	O, LCTT, CS
53	Kansas City, MO	O, LCTT, CS, CATV, T	953	Eau Claire, WI	O, LCTT, CS, C, MT, CATV, T
55	Des Moines, IA	O, LCTT, CS, MT, CATV, T	1250	Rapid City, SD	O, CS
95	Joplin, MO	LCTT	1426	Fargo, ND	O, LCTT, CS
160	Minneapolis, MN	O, LCTT, CS, CATV, T	1525	Omaha, NE	O, LCTT
426	Sioux Falls, SD	O, LCTT	2150	Milwaukee, WI	O, LCTT, CS, C, MT, CATV, T

American Line Builders Chapter

17	Detroit, MI	CS, C, CATV, T	307	Cumberland, MD	T
51	Springfield, IL	O, LCTT, CATV, T	309	Collinsville, IL	LCTT, T
70	Washington, D.C.	O, LCTT, T	369	Louisville, KY	O, T
71	Columbus, OH	O, LCTT, T	466	Charleston, WV	T
145	Rock Island, IL	O, CS, T	649	Alton, IL	T
193	Springfield, IL	O, LCTT	702	West Frankfort, IL	O, LCTT, CS, C, MT, CATV, T
196	Batavia, IL	O, MT, T	876	Grand Rapids, MI	O, LCTT, C, MT, T
245	Toledo, OH	O, T			

Northwest Line Constructors Chapter

77	Seattle, WA	O, LCTT, CS	483	Tacoma, WA	O, LCTT
89	Everett, WA	O, CS, C, MT, CATV, T	659	Medford, OR	O, LCTT
125	Portland, OR	O, LCTT, CS			

Southeastern Line Constructors Chapter

84	Atlanta, GA	O, T	553	Raleigh, NC	O
108	Tampa, FL	O	558	Sheffield, AL	O, CS, CATV
130	New Orleans, TN	O	605	Jackson, MS	O
136	Birmingham, AL	O	676	Pensacola, FL	O
175	Chattanooga, TN	O, C, LCTT, MT	700	Fort Smith, AR	O
222	Gainesville, FL	O	760	Knoxville, TN	O, LCTT
238	Asheville, NC	O	776	Charleston, SC	O
270	Oak Ridge, TN	O	779	Columbus, GA	O
295	Little Rock, AR	O	852	Corinth, MS	O
329	Shreveport, LA	O	903	Gulfport, MS	O
342	Winston Salem, NC	O	917	Meridian, MS	O
379	Charlotte, NC	O	934	Blountville, TN	O, CATV
429	Nashville, TN	O, LCTT	995	Baton Rouge, LA	O
436	El Dorado, AR	O	1077	Bogalusa, LA	O
443	Montgomery, AL	O	1516	Jonesboro, AR	O
474	Memphis, TN	O, LCTT	1925	Martin, TN	O
495	Wilmington, NC	O	2113	Tullahoma, TN	O

Southwestern Line Constructors Chapter

20	Dallas, TX	O	611	Albuquerque, NM	O
66	Houston, TX	O	681	Wichita Falls, TX	O
220	Dallas, TX	O	738	Longview, TX	O
278	Corpus Christi, TX	O	769	Phoenix, AZ	O, CS, CATV, T
301	Texarkana, TX	O	898	San Angelo, TX	O
304	Topeka, KS	O, CS, C, MT, CATV, T	1002	Tulsa, OK	O, CS
386	Texarkana, AR	O	1523	Wichita, KS	LCTT
387	Phoenix, AZ	LCTT	2286	Port Arthur, TX	O
602	Amarillo, TX	O			

Northeastern Line Constructors Chapter

126	Philadelphia, PA	LCTT	1319	Wilkes Barre, PA	O, T
-----	------------------	------	------	------------------	------

This page is intentionally blank.

BOARD OF TRUSTEES AND FUND PROFESSIONALS

Board of Trustees

UNION TRUSTEES

Mr. James Bates
Business Manager
Local Union No. 51, I.B.E.W.
301 East Spruce Street
Springfield, IL 62703

Mr. James M. Bell
Business Manager
Local Union No. 222, I.B.E.W.
17850 U.S. Highway 441 North
Reddick, FL 32686-2726

Mr. Joel Bell
Business Manager
Local Union No. 769, I.B.E.W.
1919 West Fairmont, Suite 1
Tempe, AZ 85282

Mr. Mike Byrd
Business Manager
Local Union No. 111, I.B.E.W.
5965 East 39th Avenue
Denver, CO 80207

Mr. Travis Eri
Business Manager
Local Union No. 125, I.B.E.W.
17200 Northeast Sacramento Street
Portland, OR 97230

Mr. Bryan Stage
Business Manager
Local Union No. 71, I.B.E.W.
3403 Farm Bank Way, Building 2
Grove City, OH 43123

Mr. Henry Stanski, Jr.
Business Manager
Local Union No. 1319, I.B.E.W.
69 Public Square, Room 1217
Wilkes-Barre, PA 18701

EMPLOYER TRUSTEES

Mr. Darran Ayres
J.F. Electric, Inc.
P.O. Box 570
100 Lakefront Parkway
Edwardsville, IL 62025

Ms. Christina Ernst
President
Miller Construction Company
518 South 15th Street
Vincennes, IN 47591

Mr. Michael Troutman
Regional Vice President
M.J. Electric, LLC
1047 Shoemaker Ave
Shoemakersville, PA 19555

Mr. Ernie A. Pastor
4 Oceans West Boulevard
#805C
Daytona Beach, FL 32118

Mr. Mark Pellerito
Hydaker-Wheatlake Company
420 Roth Street
Reed City, MI 49677

Mr. Jody Shea
President
Service Electric Company
P. O. Box 3656
1631 East 25th Street
Chattanooga, TN 37404

Mr. Joseph Tucci
12418-136th Avenue East
Puyallup, WA 98374

Mr. Robert Stuart
Business Manager
Local Union No. 53, I.B.E.W.
1100 East Admiral Boulevard
KS City, MO 64106

Mr. Randy Williams
Rocky Mountain Contractors
3268 Ocean View Drive
Helena, MT 59602

Mr. James W. White
Assistant Business Manager
Local Union No. 175, I.B.E.W.
3922 Volunteer Drive, Suite 9
Chattanooga, TN 37416

Mr. Rhett E. Jackson
President
Dacon Corporation
1300 Underwood Road
Deer Park, TX 77536

Fund Professionals

Fund Administrator

Mr. Kevin Chesniak
Line Construction Benefit Fund
2000 Springer Drive
Lombard, IL 60148

Fund Consultant

Foster & Foster, Inc.
One Oakbrook Terrace, Suite 812
Oakbrook Terrace, IL 60181

Fund Auditor

Legacy Professionals LLP
Certified Public Accountants
311 South Wacker Drive, Suite 4000
Chicago, IL 60606

Fund Attorney

Asher, Gittler & D'Alba, Ltd.
Attorneys at Law
200 West Jackson Boulevard, Suite 1900
Chicago, IL 60606

Agent for Service of Legal Process

Mr. Kevin Chesniak
Fund Administrator
Line Construction Benefit Fund
2000 Springer Drive
Lombard, IL 60148

Service of legal process may also be made on any Trustee.