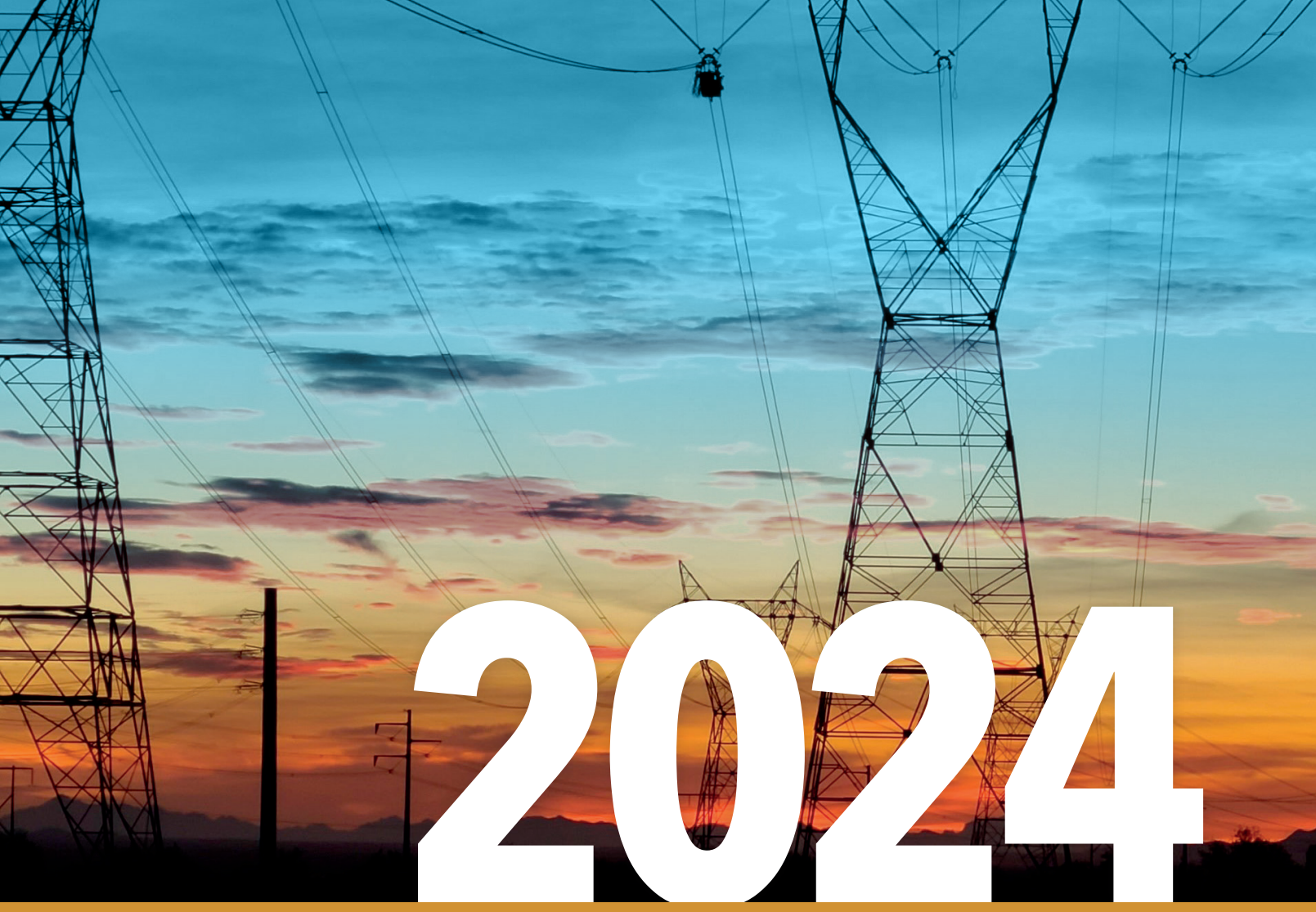

2024

SUMMARY PLAN DESCRIPTION

Health and Welfare Benefits for You and Your Family

LINECO
LINE CONSTRUCTION BENEFIT FUND

NECA
NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION

EN ESPANOL

IMPORTANT CONTACT INFORMATION

Listed below are phone numbers and websites to help you quickly get answers to your questions. Have your Member Identification Number (LINECO/Blue Cross Blue Shield ID Card) available when you call.

LINECO
821 Parkview Boulevard, Lombard, IL 60148 - 3230
www.lineco.org or **1-800-323-7268**

FOR INFORMATION ABOUT	CONTACT	PHONE NUMBER	WEBSITE
Life Insurance / Weekly Income	**Benefit Fund Office**	1-800-323-7268	www.lineco.org
Medical Claims Member Service	**Benefit Fund Office**	1-800-323-7268	www.lineco.org
Dental Claims Member Service	**Benefit Fund Office**	1-800-323-7268	www.lineco.org
Eligibility / Hours Worked	**Benefit Fund Office**	1-800-323-7268	www.lineco.org
Find Medical or Behavioral Health Network Providers	**BlueCross BlueShield**	1-800-810-BLUE (2583)	www.lineco.org
Dental PPO Network Providers	**Dental Network of America (DNoA)**	1-866-522-6758	www.lineco.org
Health Reimbursement Account (HRA)	**Benefit Fund Office**	1-800-323-7268	www.lineco.org
24 / 7 Medical Advice / Behavioral Health	**Teladoc**	1-800-Tel-A-Doc (835-2362)	www.teladoc.com
Expert Medical Opinion / Physician Referral	**Included Health**	1-855-310-6281	www.includedhealth.com/lineco
Precertification – Inpatient Medical / Behavioral / Substance Use Disorder	**LINECO Personal Health Nurse**	1-800-323-7268	www.lineco.org
Healthy Moms = Healthy Babies	**LINECO Personal Health Nurse**	1-800-323-7268 or 1-844-213-5658	www.lineco.org
Diabetic Care Program	**LINECO Personal Health Nurse**	1-844-213-5658	www.lineco.org
Member Assistance Program (MAP)	**Carelon**	1-800-332-2191	www.carelonwellbeing.com/lineco
Prescriptions - Retail / Home Delivery	**Express Scripts (ESI)**	1-877-327-0568	www.express-scripts.com
Prescriptions – Specialty	**Accredo**	1-877-476-2267	www.express-scripts.com
Prescriptions - Medicare Part D	**Express Scripts (ESI)**	1-855-634-0272	www.express-scripts.com
Vision Care	**Vision Service Plan (VSP)**	1-800-877-7195	www.vsp.com
Hearing Care / Ear Care	**Amplifon**	1-877-609-0758	www.amplifonusa.com

ATTENTION NEW PARTICIPANTS

Before any claims can be paid for dependents, you must complete the Family Enrollment online at ***www.lineco.org***. Attach a certified copy of your marriage certificate to enroll your spouse, copy of birth certificates to enroll your children. Attach a copy of your divorce decree/court orders pertaining to medical coverage for a child.

TABLE OF CONTENTS

INTRODUCTION 5
- From the Board of Trustees 5
- Contact the Fund 5
- Trustee Authority 5
- Information About the Summary Plan Description 5

GET THE MOST OUT OF YOUR PLAN 6

SCHEDULE OF BENEFITS 7
- Benefits for Eligible Employees 7
- Benefits for Eligible Employees, Retirees and Dependents 7

ELIGIBILITY FOR ACTIVE EMPLOYEES 11
- Definitions Applicable to Eligibility 11
- Initial Eligibility Requirements 11
- Continuing Eligibility 12
- Continuing Eligibility Through Working 12
- Rollback Eligibility Benefit Chart 13
- Rollback Eligibility Benefit Example (Calculation) 13
- Continuing Eligibility by Making Short-Hours Self-Payments 14
- Continuing Eligibility Through COBRA Self-Payments 14
- Other Eligibility Provisions 15
- Termination of Eligibility 18

LIFE EVENTS THAT AFFECT YOUR COVERAGE 21
- If You Get Married 21
- If You Acquire a Stepchild Through Marriage 21
- If You Have a Baby 21
- If You Adopt a Child 22
- If You Take FMLA Leave 22
- When Your Child Turns 26 22
- If Your Dependent's Eligibility for Benefits Changes for any Other Reason 22
- If You Divorce / Legally Separate 22
- If You Become Disabled 23
- If You Retire 23
- If You Become Eligible for Medicare 23
- If You Die 23

RETIREE COVERAGE 25
- Eligibility for Retiree Benefits 25
- Self-Payment Rules for Retiree Benefits 28
- Continuing Eligibility for Surviving Dependents of Retirees 28

Termination of Retiree Benefits 29
COBRA Coverage for Retirees 29
CONTINUING YOUR COVERAGE UNDER COBRA 31
Qualifying Events/Maximum Coverage Period 31
Benefit Options Under COBRA 32
Notification Responsibilities 32
COBRA Election Procedures and Rules 33
Additional Rules Governing COBRA 33
Termination of COBRA 34
Note About Other Coverage Options 34
For More Information 34
GENERAL RULES GOVERNING MEDICAL BENEFITS 35
BlueCross BlueShield PPO Network 35
Precertification Program 35
Knee and Hip Center of Excellence / Blue Distinction Program 36
Teladoc 36
Healthy Moms = Healthy Babies 36
MEDICAL BENEFITS 39
Medical Benefit Quick Facts 39
Deductibles 39
In Network / Out of Network Plan Payment Percentages 40
Calendar Year Out of Pocket Maximums 40
Benefit Limitations 40
Extension of Medical Benefits 40
COVERED MEDICAL SERVICES 43
Benefits for Preventive Care 43
Department of Transportation (DOT) Physicals – Employee Only 44
Other Covered Medical Expenses 44
Diagnostic X-Ray and Lab Benefit 50
Provisions Governing Hospice Care 50
PRESCRIPTION DRUG PROGRAMS 53
Summary of Prescription Drug Benefits 53
Actives and Non-Medicare Retirees 53
Medicare Prescription Drug Program 56
HEALTH REIMBURSEMENT ACCOUNT (HRA) 57
Your HRA Account 57
HRA Qualified Expenses 57
How to Use Your HRA 58

MEMBER ASSISTANCE PROGRAM (MAP) 61
Free Counseling Services 61
Legal and Financial Services 61
DENTAL BENEFITS 63
Dental Network of America (DNoA) 63
Predetermination of Benefits 63
Payment of Dental Benefits 63
Dental Treatment Other Than in a Dentist's Office 64
Covered Dental Expenses 64
Dental Exclusions and Limitations 66
VISION BENEFITS 67
Covered Vision Care Services and Eyewear 67
Vision Benefit Exclusions and Limitations 67
Extension of Vision Benefits 68
INSURANCE BENEFITS 69
Life Insurance 69
Accidental Death & Dismemberment Insurance 70
WEEKLY INCOME BENEFITS 73
HOW TO FILE CLAIMS 75
WHAT THE PLAN DOES NOT COVER 77
Exclusions and Limitations 77
OTHER LIMITATIONS ON YOUR BENEFITS 81
Subrogation and Repayment Agreement 81
Payment of Benefits for Compensated Injuries 82
Coordination of Benefits (C.O.B.) 83
GENERAL PLAN PROVISIONS AND INFORMATION 87
Definitions 87
Claim and Appeal Procedures 91
Trustee Interpretation, Authority and Right 95
Examinations 95
Workers' Compensation Not Affected 95
Plan Discontinuation or Termination 95
False or Inaccurate Information 96
Fund's Right to Recover Overpayments 96
Release of Information 96
Women's Health and Cancer Rights Act 96
No Surprises Act 96
Notice of Privacy Practices 97

Your Rights Under ERISA 101
Nondiscrimination Statement 102
Information About Your Plan 103
PARTICIPATING NECA CHAPTERS AND LOCAL UNIONS 105
BOARD OF TRUSTEES AND FUND PROFESSIONALS 107
Board of Trustees 107
Fund Professionals 108

INTRODUCTION

From the Board of Trustees

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 ERISA plan managed jointly by IBEW Union and NECA Employer representatives. LINECO provides family coverage for you and your eligible dependents.

We are pleased to provide you with this updated Summary Plan Description, or SPD, which explains your Line Construction Benefit Plan (LINECO) benefits and provides other important information about your Plan. This book includes changes and improvements that have been made to your Plan since the previous book was printed.

The Trustees encourage you to visit our website at ***www.lineco.org*** and consider using the secure myLINECO members portal to view your benefits and elect to receive electronic communications. The LINECO website has recently undergone extensive improvements to offer additional self-service options.

We hope this book is helpful in understanding your Plan. Thank you for your continued support.

Sincerely,
Board of Trustees
Line Construction Benefit Fund

» A COMPLETE LIST OF THE BOARD OF TRUSTEES STARTS ON PAGE 107.

Contact the Fund

To write the Board of Trustees:	**Board of Trustees** Line Construction Benefit Fund 821 Parkview Boulevard Lombard, IL 60148-3230
To write the Fund Office:	**Line Construction Benefit Fund (LINECO)** 821 Parkview Boulevard Lombard, IL 60148-3230
General Inquiries / Member Service:	**Call the Fund Office at 1-800-323-7268**

Trustee Authority

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. For more information, see *Trustee Interpretation, Authority and Right* on page 95.

Information About the Summary Plan Description

This book 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 an agent of the Trustees. If you request 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 Executive Director.

This book 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. Before incurring any non-emergency expense, contact the Fund Office to confirm your current entitlement to coverage.

GET THE MOST OUT OF YOUR PLAN

Visit the LINECO Website: *www.lineco.org*	Use the **secure member portal** for: • New employee family enrollment • Hours reported, claims history and Explanation of Benefits (EOBs) • Download important forms, including electronic ID Cards • View your benefits dashboard and HRA balance
Use Network Providers	• BlueCross BlueShield PPO Network • Dental Network of America (DNoA) dentists • Vision Service Plan (VSP) eye-doctors • Amplifon Hearing Health Care Network
Use the Mail Service Rx	See *Prescription Drug Programs* starting on page 53 for more information.
Call for Precertfication	LINECO's Personal Health Nurse Team handles all inpatient medical, behavioral health, and substance abuse admissions. Please call the Fund Office at 1-800-323-7268 for precertification of all medical/surgical/ behavioral/substance abuse inpatient treatment.
Take Advantage of the Member Assistance Program (MAP)	For free, confidential counseling and referral for a wide range of personal, emotional, work/family problems. The MAP is administered by Carelon. See page 61.
Participate in the Healthy Moms = Healthy Babies Program	Female employees and spouses who participate in LINECO's prenatal program can earn a $250 gift card. See page 36.
Use Teladoc	There is no charge to eligible employees, retirees and dependents who use Teladoc, a telemedicine service for common minor ailments or behavioral health or substance use disorder counseling. See page 36.
Enroll in Diabetes Care Program	If you are a diabetic, contact LINECO's Personal Health Nurse for additional benefits, including 100% coverage for certain diabetic supplies, treatment and medication. See page 37.
File Claims Correctly and on Time	Follow the procedures described in *How to File Claims* on page 75.
Notify Fund of Address Change	It is very important to inform the Fund of your new address. You may change your address online via our member portal at ***www.lineco.org***.
Expert Second Opinion	Consider contacting Included Health for a Expert Second Medical Opinion. This service is FREE. Visit ***www.includedhealth.com/lineco***.

SCHEDULE OF BENEFITS

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

Benefits for Eligible Employees

* Life Insurance Benefits & Weekly Income Not Provided for Utility / REA / Electric Cooperative Members, or Retirees, or Dependents*

INSURANCE BENEFITS (SEE PAGES 69-70)	
Life Insurance	**$20,000**
Accidental Death Insurance	**$20,000**
WEEKLY INCOME BENEFIT FOR NON-OCCUPATIONAL DISABILITIES ONLY (SEE PAGES 73)	
Amount of weekly benefit	**$600**
Maximum weeks payable per period of disability	**26 weeks**
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.	

Benefits for Eligible Employees, Retirees and Dependents

MEDICAL / PRESCRIPTION BENEFIT (SEE PAGES 35-56)		
Deductibles		
Individual (calendar year)	**$400**	
Individual and Dependent (calendar year) – 2 family members	**$800**	
Family (calendar year) – 3 or more family members	**$1,200**	
Hospital Precertification Noncompliance per admission (in addition to the calendar year deductible)	**$250**	
Emergency Room (each occurrence of hospital emergency room treatment – waived if admitted)	**$150**	
Plan Payment Percentages After satisfying your deductible, the Plan will typically pay the following percentages. (Note: See below for exceptions.)		
	Blue Cross Blue Shield In-Network (Plan Pays)	**Out-of-Network (Plan Pays)**
Covered Medical Expenses (unless stated otherwise)	**80%**	**70%**
Emergency Room (services for an emergency as defined on page 89)	**80%**	**80%**
Knee and Hip Replacements at Blue Distinction Centers (see page 36).	**100%**	**70%**
Prescription Drugs (Retail)	**80%**	**n/a**
Chiropractic Care (up to $600/year)	**50%**	**50%**

Out-of-Pocket Maximum

The out-of-pocket maximum is the most you will pay for covered services under the Plan each calendar year. Non-covered services and expenses for hearing, dental and vision do not apply toward your out-of-pocket maximum.

Per Individual, includes prescription drug co-pays	**$2,500**
Per Individual and Dependent – 2 family members	**$5,000**
Per Family	**$7,500**
Per Individual, if Medicare-eligible	**$1,625**
Per Individual, if Medicare-eligible – 2 family members	**$5,000**
Per Family, if Medicare-eligible	**$7,500**

SPECIAL BENEFITS AND LIMITATIONS

UNLESS STATED OTHERWISE, THE PLAN PAYMENT % FOR THE FOLLOWING TYPES OF TREATMENT ARE THE % SHOWN ABOVE.

ACUPUNCTURE	**12 visits** per calendar year
Blue Distinction Center (knee or hip replacement, see page 36) *Deductible does not apply. Precertification required.*	**100%**
Chiropractic (see page 46)	**50% to $600** per calendar year
Hearing Care (see page 46) *Deductible does not apply.*	**80% to $2,500** every 5 years (every 2 years for children)
Home Health (see page 47)	**40 visits** per calendar year
Hospice (see page 50)	**180 days**
Behavioral Health and Substance Use Disorders (see page 48) *Precertification required for inpatient, residential, and partial inpatient treatment.*	**Same as medical/surgical** (80% in-network, 70% out-of-network after deductible)
Preventive Care (see pages 43-44)	**Blue Cross Blue Shield In-Network**: **100%** Deductible does not apply. **Out-of-Network**: **70%** Deductible applies.
Routine physical examinations (see footnote (1) on page 44) *Deductible does not apply.*	**100% up to $125** per calendar year
Outpatient diagnostic x-ray and lab (employee and spouse only – see page 50)	**100% up to $150** per calendar year, regular benefits after
Speech Therapy – outpatient (see page 49)	
Maximum allowable number of sessions per person per calendar year	**50 visits** per calendar year
Maximum allowable amount per visit	**$90**
Teladoc (telehealth medical / behavioral health consult – see page 36)	**No charge**
TMJ (see page 49)	
Surgical TMJ treatment that is out-of-network or not precertified	**$3,000 maximum**, per lifetime
Non-surgical TMJ treatment	**$1,000 maximum**, per lifetime
Skilled Nursing Facility (see page 49)	**60 days** per calendar year

PRESCRIPTION DRUG PROGRAMS (SEE PAGES 53-56) *DOES NOT APPLY TO RETIREES AND THEIR DEPENDENTS WHO ARE ELIGIBLE FOR MEDICARE.*	**Participant Pays**
Retail (up to 30-day supply)	
Participant co-pay percentage	**20%** (after deductible)
Mail-Order (up to 90-day supply)	
Generic drugs	**$10**
Preferred (formulary) drugs	**$20**
Non-preferred (non-formulary) drugs	**$35**
For LINECO-primary individuals who are also Medicare-eligible, use of the mail-order for a maintenance medication is mandatory after the original supply plus one refill. 3rd retail fill attempt will reject. *You cannot use the mail-order pharmacy if LINECO is secondary to any other drug plan.*	
Specialty Medications (up to 30-day supply) See page 54 for a complete list of the rules that apply to specialty drugs.	**Specialty Medications must be filled through Accredo Specialty Pharmacy**
Generic specialty drugs	**10% up to $100 maximum co-pay**
Preferred (formulary) drugs	**20% up to $250 maximum co-pay**
Non-preferred (non-formulary) drugs	**20% with no maximum co-pay**
Specialty Drug Assistance Program *Applies to certain specialty medications. SaveOnSP administers this program.*	**Co-pays May Vary** See page 55
Out-of-Pocket Rx Maximum Medicare Eligibles – Only applies to prescriptions for covered persons who are Medicare eligible	**$1,000/person** **$2,000/family** See page 56
Mandatory Generic Rule – If a brand is chosen over an available generic	Difference in cost plus applicable coinsurance/deductible
Express Scripts Medicare Drug Plan (when Medicare is primary) (see page 56)	See Express Scripts PDP Evidence of Coverage
MEMBER ASSISTANCE PROGRAM (SEE PAGE 61)	
Member Assistance Program (MAP) is administered by Carelon 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.	**6 FREE VISITS** per problem (If MAP visits exhausted, normal medical benefits can be used)

DENTAL BENEFIT (SEE PAGES 63-66)	
Deductible (per calendar year per person) *Does not apply to preventive care.*	**$100**
Maximum benefit (per calendar year per person) *Preventive and diagnostic services for ages 0-20 are covered at 100%.*	**$2,000**
Plan payment percentage ** Anesthesia for children ages 6 through 12 is payable at 50%. See page 64 for details*	**80%***
Orthodontia lifetime maximum *For dependent children only. Orthodontia benefits do not apply to $2,000 annual dental maximum.*	**$2,000**

VISION BENEFIT (SEE PAGES 67-68)

	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 $175 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 up to $175/pair**	Up to $100/pair
Safety Glasses – every two years (employees only)	**Covered in full**	Not Covered

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.

HRA (SEE PAGES 57-59)

Health Reimbursement Account (HRA) program is a flexible spending plan that covers a wide range of healthcare expenses NOT payable by LINECO.

Individual HRA accounts are funded by separate employer contributions.

Not all employers participate in this program.

Please only use your HRA account after LINECO's regular plan of benefits are paid first.

For additional services payable under the HRA, refer to IRS Publication 502.

Covers deductibles, co-pays and coinsurance for medical, prescription, dental, vision and hearing expenses.

Also covers self-payments for LINECO coverage.

HRA follows guidelines established by the IRS as to what is allowed for reimbursement as an eligible health related expense.

ELIGIBILITY FOR ACTIVE EMPLOYEES

IN THIS SECTION

- **Initial Eligibility Rules**
- **Continuing Eligibility**
- **Short-Hours Self Pay**
- **Eligibility During Disability**
- **Utility / REA Eligibility**
- **Unique Eligibility Situations**
- **Termination of Eligibility**

» THIS SECTION DESCRIBES THE ELIGIBILITY RULES THAT APPLY TO ACTIVE EMPLOYEES. IF YOU ARE A UTILITY / REA / ELECTRIC COOPERATIVE EMPLOYEE, YOU SHOULD ALSO REVIEW PAGE 16. THE RULES GOVERNING COBRA COVERAGE START ON PAGE 31. THE RETIREE ELIGIBILITY SECTION STARTS ON PAGE 25.

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 participant and his or her dependents are covered under the Plan because the participant 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 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 15); and
- Any hour credited to an employee while the employee is attending a JATC-sponsored school (see page 16).

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 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 employer will report those hours during February to the Fund), and your coverage will begin on March 1st for the entire month of March. Work hours for February (reported to the Fund during March) provide eligibility for April and so forth.

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

Dependents—The Plan provides family coverage. If you have eligible 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 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

125 Credited Work Hours in This Month	Make You Eligible in This Benefit Month
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 Eligibility Benefit—An average of 125 credited hours per month looking back at the previous 12 months' work history beginning with the current month.

The Rollback Eligibility Benefit is **NOT** an hour's bank. Hours do **NOT** accumulate for use at any time in the future. The following calendar and chart show how the Rollback Eligibility Benefit works.

Rollback Eligibility Benefit Chart

Eligibility in the Plan is gained by working at least 125 hours in a given month (For Example: 125 hours worked in January provides benefit coverage for March). The Trustees recognize there may be work months in which members do not achieve the full 125 hours or may be laid off for various reasons. The Rollback Eligibility Benefit is intended to assist members in maintaining their eligibility temporarily into the future until they can requalify via 125 hours worked.

To use the chart below, find the benefit month at the far left that you are most interested in. Then follow that row across to determine if you qualify via any of the work hours requirements.

ELIGIBLE BENEFIT MONTH	125 Worked Hours in	250 Worked Hours in	375 Worked Hours in	500 Worked Hours in	625 Worked Hours in	750 Worked Hours in	875 Worked Hours in	1,000 Worked Hours in	1,125 Worked Hours in	1,250 Worked Hours in	1,375 Worked Hours in	1,500 Worked Hours in
March	January	Dec-Jan	Nov-Jan	Oct-Jan	Sep-Jan	Aug-Jan	Jul-Jan	Jun-Jan	May-Jan	Apr-Jan	Mar-Jan	Feb-Jan
April	February	Jan-Feb	Dec-Feb	Nov-Feb	Oct-Feb	Sep-Feb	Aug-Feb	Jul-Feb	Jun-Feb	May-Feb	Apr-Feb	Mar-Feb
May	March	Feb-Mar	Jan-Mar	Dec-Mar	Nov-Mar	Oct-Mar	Sep-Mar	Aug-Mar	Jul-Mar	Jun-Mar	May-Mar	Apr-Mar
June	April	Mar-Apr	Feb-Apr	Jan-Apr	Dec-Apr	Nov-Apr	Oct-Apr	Sep-Apr	Aug-Apr	Jul- Apr	Jun-Apr	May-Apr
July	May	Apr-May	Mar-May	Feb-May	Jan-May	Dec-May	Nov-May	Oct-May	Sep-May	Aug-May	Jul-May	Jun-May
August	June	May-Jun	Apr-Jun	Mar-Jun	Feb-Jun	Jan-Jun	Dec-Jun	Nov-Jun	Oct-Jun	Sep-Jun	Aug-Jun	Jul-Jun
September	July	Jun-Jul	May-Jul	Apr- Jul	Mar-Jul	Feb-Jul	Jan-Jul	Dec-Jul	Nov-Jul	Oct- Jul	Sep-Jul	Aug-Jul
October	August	Jul-Aug	Jun-Aug	May-Aug	Apr-Aug	Mar-Aug	Feb-Aug	Jan-Aug	Dec-Aug	Nov-Aug	Oct-Aug	Sep-Aug
November	Sept.	Aug-Sep	Jul-Sep	Jun-Sep	May-Sep	Apr-Sep	Mar-Sep	Feb-Sep	Jan-Sep	Dec-Sep	Nov-Sep	Oct-Sep
December	October	Sep-Oct	Aug-Oct	Jul- Oct	Jun-Oct	May-Oct	Apr-Oct	Mar-Oct	Feb-Oct	Jan-Oct	Dec-Oct	Nov-Oct
January	November	Oct-Nov	Sep-Nov	Aug-Nov	Jul-Nov	Jun-Nov	May-Nov	Apr-Nov	Mar-Nov	Feb-Nov	Jan-Nov	Dec-Nov
February	December	Nov-Dec	Oct-Dec	Sep-Dec	Aug-Dec	Jul-Dec	Jun-Dec	May-Dec	Apr-Dec	Mar-Dec	Feb-Dec	Jan-Dec

Rollback Eligibility Benefit Example (Calculation)

For Example, a member works 200 hours / per month from January through November or 2,200 hours.

In December, the member only works 50 hours. Because he did not work at least 125 hours in December (he normally would not be eligible during the benefit month of February). Total hours worked in the 12 months was 2,250 hours.

However, due to the Rollback Eligibility Benefit, LINECO's eligibility system will automatically calculate his 12-month average for January through December. Overall, the member worked, 2,250 hours in the 12 month "look back period". Since the member averaged 187.5 hours over the past 12 months, he will remain eligible for the benefit month of February even though he only worked 50 hours in December.

In January, the member is unable to work due to poor weather and has zero hours. Normally he would not be eligible in March because he did not work at least 125 hours. However, under the LINECO Rollback Rule will automatically calculate his work hours from January back to the previous February (12 months). He worked 200 hours per month in

February through November. He worked 50 hours in December and zero hours in January. He worked a total of 2,050 hours in the past 12 months or an average of 170.83. Since he averaged more than 125 hours in the past 12 months, he will be made eligible for the benefit month of March.

As a reminder your eligibility and hours reported to the Fund can be tracked on-line at ***www.lineco.org***.

Reminder: Your work hours can be tracked on the secure "myLINECO" portal at *www.lineco.org*.

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 Eligibility Benefit, you can make a short-hours self-payment to continue your eligibility in the corresponding benefit month. Making a Short-Hours payment results in losing all previous rollback hours. Rollback hours will begin to be earned again once eligibility through work hours is established.

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.

Additional Rules Governing Short-Hours Self-Payments

- You are only entitled to a self-pay period if you are an active, bargaining unit employee who is already covered under the Plan when your hours shortage occurs. You cannot make self-payment(s) 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).
- Non-bargaining and utility / REA / electric cooperative employees are not eligible to make short-hour self-payments, however you can make COBRA payments.
- 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.
- In the event you do not earn enough hours to stay eligible in the Fund, a self-payment notice will be sent to you at your last known address. 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. Alternatively, self–payments may be made online at ***www.lineco.org*** via the secure myLINECO member portal. To utilize your HRA funds to make a payment for short hours, please call the Fund Office at 1-800-323-7268.
- Self-payments will not be refunded unless the Fund receives valid hours from a participating employer.
- You must maintain continuous eligibility after making your first self-payment. If you fail to make a self-payment on time, a late payment will not be accepted, and your coverage will be terminated.
- 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 and pay for COBRA for continued health care if coverage is lost for certain reasons. See page 31 for COBRA rules.

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 through 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 *Continuing Your Coverage Under COBRA* starting on page 31).
- 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 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)

Upon receipt of a copy of appropriate certification from your employer and a record of the approved leave time, your eligibility will be continued for up to the maximum period required by Federal law (usually twelve weeks).

JATC School Eligibility

If you attend a Joint Apprenticeship Training Committee (JATC) 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 73.

Reciprocity or Electronic Reciprocal Transfer System (ERTS)

LINECO is signatory to the International Brotherhood of Electrical Workers (IBEW) Reciprocal Agreement. The purpose of the reciprocity agreement is to permit you to retain eligibility when contributions are made for you when you are traveling / working in another IBEW Welfare Funds jurisdiction.

If you want LINECO to be your "Home Fund" when you travel outside of LINECO's jurisdiction, you MUST register online with Electronic Reciprocal Transfer System (ERTS) at your "Home" IBEW Local Union.

When you travel, you should advise the Local Union's Fund Office in whose jurisdiction you are working to send your contributions to LINECO. If you have lost your Login and or Password for the ERTS system, please contact your IBEW Union Hall who are authorized to request that your credential information is reissued by the International Office in Washington D.C.

Note: In general, LINECO will not accept reciprocal hours on behalf of an inside wireman.

LINECO is typically the largest outside electrical construction health and welfare fund in the United States and has nearly 100 participating IBEW Local Unions in our jurisdiction. If your "HOME Local" currently participates in LINECO, there is a strong likelihood that your hours will automatically be sent to LINECO even when you travel. However, LINECO does not have a strong presence in eastern Michigan and the Northeast (NY, MA, NH, VT, and ME). If you travel to these areas to work, your hours may be delayed in reaching LINECO. It is important that you check in with the IBEW Local Unions in the areas that you travel in order to ensure your work hours are reciprocated back to LINECO so that your benefits / eligibility is not negatively impacted.

Utility / Rural Electrical Association (REA) / Electric Cooperative Employees

You are considered a "utility employee or rural electrical association (REA) employee or electric cooperative employee" if you are employed under a collective bargaining agreement or participation

agreement by an employer who is designated as a "utility / REA / electric cooperative" by the Trustees. The utility/REA/electric cooperative must contribute to LINECO at the rate of 174 hours per month for each of its bargained employees who are paid for at least 125 hours per month.

Eligibility – Utility / REA / Electric Cooperative employee eligibility is determined on a month-to-month basis. You will be eligible each month that your employer makes a correct and timely contribution to LINECO in advance of the upcoming month (i.e., payment in May provides eligibility for June). The Rollback Benefit 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 retire, your months of eligibility will be counted toward meeting the eligibility requirements for LINECO Retiree Benefits.

Benefits – The benefits provided to eligible Utility / REA / Electric Cooperative employees and their dependents are the same benefits provided to LINECO construction members and dependents that are discussed in this Summary Plan Description. **However, Life insurance benefits (including AD&D insurance) and Weekly Income Benefits are NOT included for Utility / REA / Electric Cooperative participants via LINECO.**

Opt-Out and Reinstatement Rules for Dependents

Some employed dependents (spouses or children) are eligible for a health plan that requires them to have no other health coverage. Because of such situations, LINECO will allow an eligible dependent to voluntarily terminate (opt out of) LINECO coverage and take their employer-sponsored coverage. The dependent must notify the Fund Office of their desire to terminate LINECO coverage and submit written verification of other insurance. Any such opt-outs will take effect at the end of the calendar month upon approval by LINECO. Voluntary terminations of dependent benefits will only be granted because of the availability of other health care coverage.

If a dependent opts out, no benefits of any kind will be payable by LINECO for that dependent's claims, including HRA claims.

Dependent coverage can be reinstated if reinstatement is requested within 30 days after the other health coverage ceases to be available. The request for reinstatement must be accompanied by proof that the other coverage was in effect during the coverage gap, and that it is no longer available. Coverage will only be reinstated if your dependent still meets the Plan's definition of a dependent. A reinstatement of dependent coverage will be effective on the first day of a calendar month following proper notification and approval by LINECO.

The ability to opt out of Plan coverage is also provided to a dependent who becomes eligible for coverage from a State Children's Health Insurance Program (CHIP) or Medicaid. In such case, the dependent has 60 days to request reinstatement when eligibility for the other coverage terminates.

The Opt-Out option is only available for dependents and does not apply to the employee.

Surviving Dependent Eligibility

If you die while you are an eligible employee member who is NOT making COBRA self-payments, coverage under the Plan for your surviving dependents may be continued under certain circumstances:

- 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.

Your spouse can continue coverage for himself/herself and your children either by making COBRA self-payments, or by making surviving dependent self-payments. If your spouse elects to make COBRA, your spouse will not be entitled to make surviving dependent self-payments at any future date. Similarly, if your spouse chooses the surviving dependent self-payment option, he/she will lose the right to elect COBRA at any future date.

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

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 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 he/she is making COBRA self-payments for himself/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 starting below.

COBRA for Surviving Dependents – If your surviving spouse chooses this option, the rules governing COBRA (starting on page 31) will apply.

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

1. Your spouse will have a choice of 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's first self-payment must be received on or before the due date given on the self-pay notice. 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 your spouse 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, his/her eligibility and the eligibility of any of your surviving dependent children will terminate at the end of the benefit month for which your spouse had already paid. Your spouse 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 age 62, remarries, or becomes covered under another group health care plan.
8. When your spouse becomes age 62, coverage under the active employee Plan will terminate and your spouse will be eligible to elect the Plan's Retiree Benefits.
9. If your spouse doesn't elect to make surviving dependent self-payments when first entitled to do so, your spouse 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, he/she will be entitled to elect LINECO's Retiree Benefits. See *Continuing Eligibility for Surviving Dependents of Retirees* on page 28 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 your spouse 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 upon turning age 62.

Termination of Eligibility

Termination of Employee Benefits

You 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;
- You enter the armed forces of any country on a full-time basis;
- You fail to meet either the 125-hour rule or the eligibility rollback benefit 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 19); or
- Your death.

You may be entitled to elect COBRA if your eligibility as an active employee terminates. See the *Continuing Your Coverage Under COBRA* section starting on page 31 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 25.

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;
- Your dependent is approved to "opt-out" of the Plan due to other insurance;
- With respect to your spouse:
  - » You and your spouse divorce or legally separate;
  - » Your spouse voluntarily suspends or terminates Retiree Benefits from this Plan due to other insurance.
- With respect to a child, the child no longer meet's the Plan's definition of a dependent child; or
- 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 himself/herself and your surviving dependent children (see the *Surviving Dependent Eligibility* section starting on page 17 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 your spouse's 62nd birthday and he/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.

IMPORTANT NOTE: If coverage terminates for one of your dependents, that dependent may be entitled to elect COBRA. See the *Continuing Your Coverage Under COBRA* section starting on page 31 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 their 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/her 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-hour 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.

This page intentionally left blank.

LIFE EVENTS THAT AFFECT YOUR COVERAGE

Certain life events may impact your coverage, and failure to notify the Fund Office when they occur could prevent you from getting the most out of your Plan.

NOTIFY THE FUND OFFICE AS SOON AS POSSIBLE IF YOU EXPERIENCE ONE OF THE FOLLOWING LIFE EVENTS:

IN THIS SECTION

- **Move to a new address**
- **A loss of eligibility (dependents)**
- **Your marriage or divorce**
- **You are terminated / laid-off or your hours or employment are reduced**
- **You have a baby / adopt child**
- **You become disabled**
- **You retire**
- **You take Family Medical Leave**
- **You become eligible for Medicare**
- **You or your eligible dependents enter active military service**
- **Your death (your spouse or beneficiary should contact the Fund Office)**

If You Get Married

If you are covered under the Plan and you legally marry, your spouse is eligible for dependent benefits. **Claims cannot be processed until a certified copy of your marriage certificate is on file at the Fund Office.** Your spouse's effective date will be the date of your marriage. **You must notify the Fund within 60 days of your marriage.**

NOTE: The below information may be updated electronically by logging into your *myLINECO* secure member portal located at ***www.lineco.org***.

Provide the Fund Office with:

- Updated Family Enrollment Form; and
- Certified Copy of Marriage Certificate
- Spouse's Social Security Number
- Information about any other insurance your spouse has.

If You Acquire a Stepchild Through Marriage

Your stepchild may be eligible for LINECO benefits.

Provide Fund Office with:

- Updated Family Enrollment Form;
- Copy of divorce decree / custody order for stepchild;
- Stepchild's birth certificate and Social Security Number;
- Certified copy of your marriage certificate; and
- Information about your stepchild's other health plans.

NOTE: The above information may be updated electronically by logging into your *myLINECO* secure member portal located at ***www.lineco.org***.

If You Have a Baby

Please contact the Fund Office within 48 hours.

- Updated Family Enrollment Form;
- Copy of your baby's birth certificate
- Social Security Number (when it becomes available):
- Copy of any other health plan information.

NOTE: The above information may be updated electronically by logging into your myLINECO secure member portal located at ***www.lineco.org***.

If You Adopt a Child

Contact the Fund Office. The Plan will cover the child as of when they are placed in your home.

Provide the Fund Office with:

- Updated Family Enrollment Form;
- Copy of the adoption certificate or documentation of the start of the adoption proceeding (must include dates when the child was placed in your custody); and
- Information about your child's other health plans
- Social Security Number

NOTE: The above information may be updated electronically by logging into your myLINECO secure member portal located at ***www.lineco.org***.

If You Take FMLA Leave

If you have to take Family Medical Leave time from work, you may be entitled to continue your eligibility in the Plan for up to the maximum period required by Federal law (usually 12 weeks). Please contact your employer about FMLA and have your employer send the approved FMLA forms to LINECO.

Provide the Fund Office with:

- Employer-approved FMLA certification form(s).

When Your Child Turns 26

Your dependent children are covered under this Plan until they turn 26. Generally, your child's eligibility under the Plan will stop on the last day of the month in which your child turns 26 (see No. 2 on page 87 for information on continued coverage for a totally disabled child). Your child's loss of eligibility at age 26 is a "qualifying event" (see page 31), and your child may elect COBRA at that time.

If Your Dependent's Eligibility for Benefits Changes for any Other Reason

If for any reason your dependent no longer meets the Plan's dependent eligibility requirements, you must notify the Fund Office immediately. For example, dependents who enter the armed forces on a full-time basis become ineligible for LINECO coverage. Your failure to provide such notice, and the submission of claims while your dependent is no longer eligible for coverage, may be considered an intentional misstatement of material fact and/or fraud.

If you do not notify the Fund Office when your dependent ceases to meet the eligibility requirements, you will be responsible for reimbursing the Plan for all charges that were paid by the Plan while the dependent was not eligible for coverage.

If You Divorce / Legally Separate

Once you divorce or legally separate, your spouse is no longer eligible for benefits under this Plan, however, your ex-spouse may enroll in COBRA (see pages 31-34). **If you do not notify the Fund Office upon divorce, you will be responsible for reimbursing the Plan for all charges that were paid by the Plan on behalf of your former spouse.**

- Updated Family Enrollment Form (update your life insurance beneficiary if you wish)
- Copy of your divorce decree
- Copy of any Qualified Domestic Relations Order (QDRO); and
- If you have children, copy of any Qualified Medical Child Support Order (QMCSO), if applicable.

If your ex-spouse wants to self-pay for COBRA, they must contact the Fund Office. Your ex-spouse may elect COBRA for up to a maximum of 36 months, provided the Fund Office is informed of the divorce within 60 days of the day the divorce/separation is legally finalized. For more information, see *Continuing Your Coverage Under COBRA* starting on page 31.

If You Become Disabled

If you are an employee and become disabled, you may be eligible for certain Weekly Income Benefits and disability hours. It is important that you contact the Fund Office as soon as possible to ensure that you fully understand this benefit options (see the *Weekly Income Benefit* section beginning on page 73).

To qualify for these benefits, you must visit a medical doctor and be disabled by that doctor within 15 days after your last day of work. In order to qualify for Weekly Income Benefits, your disability must be from a non-occupational accidental bodily injury or illness.

The Weekly Income Benefit does not apply to retired members or utility / REA members.

Contact the Fund Office as soon as possible after you suffer a disabling injury or sickness.

If You Retire

Contact the Fund Office at least 3 months prior to your possible retirement from work in the electrical construction industry. ALL requirements must be met in order to qualify for LINECO Retiree Benefits.

For Early or Normal Retirement, you must meet **ALL** of the following requirements:

- At least age 55; **and**
- Must be retired from any and all employment in the electrical construction industry; **and**
- Must be receiving retirement benefits either from a plan negotiated or sponsored by the IBEW, from a qualified retirement plan, or from Social Security; **and**
- Must be eligible for LINECO benefits on the day immediately preceding the effective date of your LINECO retiree benefits; **and**
- 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 disability retirements, you must meet **ALL** of the following requirements:

- Must be receiving disability retirement benefits either from a plan negotiated or sponsored by the IBEW, from a qualified retirement plan, or from Social Security; **and**
- Must be eligible for coverage under LINECO on the day immediately preceding the day your disability plan benefits become effective.

If You Become Eligible for Medicare

If you are Medicare-eligible (typically age 65), you are required to sign up for Medicare **Part A and Part B**. Failing to sign up for both may cause significant out of pocket expense when claims are processed, and you may also be penalized by Medicare for late enrollment.

You should also notify the Fund immediately if you or your dependent (spouse or child) qualifies for Medicare due to End Stage Renal Disease (ESRD) or Social Security Disability (SSA).

- **Provide the Fund Office with a copy of your Medicare card**

NOTE: there are changes to the major medical out of pocket maximum and prescription benefits once you, or your dependent, become eligible for Medicare. Refer to the Schedule of Benefits starting on page 7 and Prescription Drug Programs on Page 56 for more information.

If You Die

If you are married and you die while you're covered by the Plan as an active employee or retiree, your surviving spouse may elect to continue coverage under the Plan if he/she is eligible for surviving spouse coverage. This coverage applies to your other eligible dependents covered by the Plan at the time of your death. Your spouse must contact the Fund Office and make timely payments to continue the insurance.

Additionally, for eligible employees (not utility/REA/retirees), your beneficiary / dependents may be eligible to collect your $20,000 life insurance benefit and an additional $20,000 if your death was due to an accident.

Your surviving family members should do the following upon your death:

- Notify the Fund Office;
- Provide the Fund Office with a copy of your death certificate;
- Apply for your life insurance benefit (and AD&D benefit, if applicable); and
- If your spouse is eligible for survivor benefits under the Plan, enroll in the Plan and make timely payments.

RETIREE COVERAGE

IN THIS SECTION

- **Retiree Eligibility**
- **Surviving Retiree Dependent Coverage**
- **Termination of Retiree Benefits**
- **Retiree Benefit Coverage**

» CONTACT THE FUND OFFICE AT LEAST 3 MONTHS PRIOR TO RETIRING TO VERIFY YOU QUALIFY FOR LINECO RETIREE BENEFITS.

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 able to provide proof of receiving retirement benefits from a plan negotiated or sponsored by the IBEW, from a qualified retirement 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, disability hours credited to you by the Fund, and hours for which you made short-hours self-payment(s). 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 on COBRA, 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.

» IMPORTANT INFORMATION FOR MEDICARE ELIGIBLE MEMBERS / RETIREES

If you and/or your spouse are Medicare-eligible (typically age 65), you are required to sign up for Medicare Part A and Part B. Failing to sign up for both may cause significant out of pocket expense when claims are processed, and you may also be penalized by Medicare for late enrollment. Please be prepared and plan at least 3 months before you and /or your spouse's 65th birthday to sign up for Medicare Part A and Part B

Failure to appropriately gain Medicare coverage can result in significant out of pocket medical claims cost.

Disability Retirements

- You must be able to provide proof of receiving disability retirement benefits either from a plan negotiated or sponsored by the IBEW, from a qualified retirement 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 may 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.

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 the other coverage terminates.

The postponement and suspension rules apply to spouses only. They do not apply to retirees. 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.

Terminating Spousal Coverage

Retirees are also permitted to terminate spousal coverage. Coverage will be terminated only if the spouse signs a written acknowledgment that LINECO coverage will never become available again except in the event of the death of the retired employee with LINECO coverage.

Retirees Eligible for VA Benefits

A retired employee who is eligible for coverage through the Veterans Administration (VA) may suspend LINECO Retiree Benefits while maintaining LINECO Retiree Benefits for his/her spouse and eligible dependents. Proof of VA coverage must be submitted to the Fund Office. One retiree self-payment must be made to establish Retiree status. The retiree may be reinstated one time only on the Retiree Plan.

Retirees Who Return to Work

The Trustees recognize that some Retirees may need to return to work in the electrical construction industry for short calls, storm duty, or simply because life circumstances may require them to un-retire.

LINECO's Fund Office will monitor current retirees who return to active work and gain eligibility by work hour contributions from a participating employer. If work hours and a Retiree payment are received for the same month of eligibility, the retiree payments will be refunded. This may affect coordination of benefits (especially if the retiree is also covered by Medicare).

If LINECO receives (6) six consecutive months of work contributions of at least 125 hours, that retiree will automatically be transitioned back to "Active" status and will no longer be considered retired by LINECO.

Returning to "Active" status will provide the member with additional benefits, including:

- Short Hours Self-Payments Options
- COBRA Payments
- Life Insurance Benefits
- Weekly Income Benefits
- Spousal One–Time Reinstatement Benefit

Members may return to retiree status by notifying the LINECO Fund Office. This will be allowed upon proof of:

- Retirement Pension Reinstatement / Social Security Award Letter(s)
- Continuous LINECO Eligibility Since Previous Retirement (if there is a break in coverage, participant would have to re-qualify via normal existing LINECO guidelines (see page 25–Early and Normal Retirements)

It is recommended to contact the Fund Office at least 3 months prior to retirement or as soon as you may be returning to work in the industry.

Retiree Benefits

Retiree Plan options include medical and prescription drug benefits only, or medical/prescription plus dental and vision benefits.

- Retiree Benefits generally are the same as your active member medical and prescription drug benefits. However, they 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 a special insured Part D plan through Express Scripts. Additionally, the out-of-pocket individual maximum upon becoming enrolled in Medicare and the Express Scripts Part D Plan will be $1,000 annually. See *Medicare Prescription Drug Program (PDP)* to learn more in next column.

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. The change will be permanent. If you drop dental and vision coverage you cannot re-elect it at a later date.

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

When you become eligible for Medicare, you will receive a new ID card. Be sure to use only Medicare approved providers.

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 must enroll in both Medicare Part A and Part B when eligible to do so. Failing to enroll in both Medicare Part A and Part B when allowed can lead to incurring significant out of pocket costs. For more information see *C.O.B. With Medicare* starting on page 85.

Additionally, the BlueCross BlueShield PPO network does not apply to persons for whom Medicare is primary. Medicare-primary individuals may use any providers that accept Medicare reimbursement (often called Medicare assignment).

Medicare Prescription Drug Program (PDP)

Participants for whom Medicare is their primary plan are automatically enrolled in the LINECO-sponsored Express Scripts Medicare® prescription drug plan (PDP) for LINECO, an insured group Part D plan. Express Scripts Medicare® PDP will provide you with information concerning your co-pays, covered and non-covered drugs, and instructions for using the mail-order and specialty pharmacies. They will also handle customer service, prior authorizations and appeals.

The Express Scripts Medicare® PDP has been developed to mirror the LINECO active prescription drug program. However, because this is a Federal sponsored program, there may be some differences. If you are on a drug that requires any type of special approval, you will be notified by Express Scripts.

Upon a qualifying event (obtaining Medicare Part A / Part B), you will automatically be enrolled in the Express Scripts Medicare® PDP plan unless you take steps to opt out. If you opt out, you will not have any prescription coverage through LINECO. In that case, your self-payment for this Fund's retiree coverage will NOT be reduced, and you will need to obtain creditable drug coverage elsewhere. (If you do not enroll in creditable coverage you may be subject to a late enrollment penalty by Medicare.) To disenroll, call the LINECO Fund Office. You can opt out at any time, but terminations must always be effective at the end of a calendar month. You can enroll later if your circumstances change, but you will have to show proof that you were covered under another qualifying prescription drug plan during your break in LINECO drug coverage.

Prescription benefits for Medicare eligible retirees and their dependents are provided through an enhanced Part D plan that is separate from the benefits described in this booklet.

Spouses enrolled in the Express Scripts Medicare® PDP plan are required to have separate I.D. cards.

Retirees who do not live in the United States / Puerto Rico and incarcerated individuals are not permitted to enroll in Part D plans. LINECO will contact any such participants directly.

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.
- LINECO requires payment for retiree coverage be made via direct debit from your personal bank account or your LINECO HRA. Direct debits are typically taken from your bank account on/about the 10th of each month prior to the month of coverage. For example, your payment for March will be debited around February 10th. Payments from your LINECO HRA are deducted from your account the month prior to the month of coverage.
- 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 himself/herself and any dependent children by making self-payments as explained in the following section.

» RETIREE BENEFITS SELF-PAYMENTS ARE REQUIRED TO BE PAID BY AUTOMATIC WITHDRAWAL FROM YOUR PERSONAL BANK ACCOUNT OR YOUR LINECO HRA (IF APPLICABLE).
CONTACT THE FUND OFFICE FOR MORE INFORMATION ABOUT THIS SERVICE.

Continuing Eligibility 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 himself/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*
- Your surviving spouse can continue to make self-payments until the earlier of the date on which he/she remarries or dies unless coverage terminates earlier according to the *Termination of Dependent Benefits* rules on page 29.
- 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 his/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 their LINECO coverage), your spouse will have the option of electing Retiree Benefits coverage (including coverage for your qualifying dependent children), provided your spouse 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 is age 65;
- The dependent voluntarily postpones / suspends or terminates retiree coverage; or
- 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 coverage by making surviving dependent self-payments to continue coverage for himself/herself and your surviving dependent children (see the *Continuing Eligibility for Surviving Dependents of Retirees* section starting on page 28 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 he/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 the child 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).

COBRA Coverage for Retirees

Instead of electing LINECO's Retiree Benefits, you have the option of electing COBRA when you retire. Retirement is a qualifying event under COBRA that entitles you to an 18-month COBRA period.

If you elect COBRA, you CANNOT elect the Retiree Benefits plan later, regardless of the length of your COBRA period.

If you elect COBRA:

- Medicare entitlement is a terminating event under COBRA. A person who becomes eligible for Medicare while making COBRA payments will lose the right to make any additional payments for COBRA.
- 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 *Continuing Your Coverage Under COBRA* starting on page 31.

This page intentionally left blank.

CONTINUING YOUR COVERAGE UNDER COBRA

IN THIS SECTION

- **COBRA Qualifying Events**
- **Notification Responsibilities**
- **Payment Procedures**

This section summarizes LINECO's COBRA coverage rules. Federal regulations govern continuation coverage under COBRA, and any situations that are not completely addressed in this summary will be subject to those regulations.

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 14 -15) 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

Qualifying Event	Who May Elect COBRA	Maximum Period of Coverage
Employee loses eligibility due to termination or reduction in hours of employment (including retirement)	Employee, spouse and/or dependent children	18 months
Termination or reduction in hours while employee or dependent in same family is disabled	Employee, spouse and/or dependent children	29 months (18 months plus an additional 11)
Employee or retiree dies	Spouse and/or dependent children	36 months
Employee or retiree is divorced from spouse	Spouse and/or dependent children	36 months
Child is no longer considered a dependent under the Plan's definition	Dependent child	36 months

- 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 15.

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

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. **If you fail to notify LINECO of your divorce or dependent child losing eligibility, you may be financially responsible for any misuse of LINECO benefits by your ex-spouse or dependent child due to non-notification of above events.**

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: It is important to notify the Fund Office if you change your address so that the appropriate COBRA notices can be mailed to the correct location.

COBRA Election 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. To elect COBRA, return the completed election form within 60 days of receipt of the notice or 60 days after your coverage would terminate (Whichever is the later). The election date is the date of postmark or the faxed election form is received.
3. 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.
4. Upon receipt of the election form, LINECO will provide payment instructions including payment amount and due dates.
5. COBRA payment must be received within 45 days from the initial election date. You will not be considered eligible until the on-time payment is received.
6. COBRA self-payments must be made monthly. COBRA self-payment is due on the first day of each benefit month. Payment is considered on time if it is postmarked or received prior to the last day of that month.
7. If a self-payment is not made by the due date, COBRA for all affected family members will be terminated.
8. The self-payment rates are determined by the Trustees based on Federal regulations. The amounts are subject to change. Current COBRA rates can be found at ***www.lineco.org***.
9. Once a self-payment has been accepted by the Fund Office, it will not be returned.
10. If you, the employee, make COBRA self-payments because of reduced hours, you will be credited with125 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.

NOTE: LINECO accepts COBRA payments via personal check or online via credit card. Please read your COBRA notice closely for payment options.

Additional Rules Governing COBRA

- COBRA may be elected for a person who is entitled to Medicare on his/her election date, however, if the person *becomes* covered under Medicare *after* they have elected COBRA, 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 begins.)**
- COBRA 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/she has* elected COBRA e, the person's COBRA 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. If you elect COBRA for yourself and your dependents, your election is binding on your dependents. If you don't elect COBRA for your dependents when they are entitled to COBRA, your dependent spouse has the right to elect COBRA 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.
- In considering whether to elect COBRA you should take into account that you have special enrollment rights under Federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after

your LINECO coverage ends because of the qualifying event listed above. You may also have the same special enrollment right at the end of your COBRA continuation coverage if you get COBRA for the maximum time available to you.

Termination of COBRA

COBRA 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 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; or
- The person becomes entitled to Medicare.

Note About Other Coverage Options

There may be other coverage options for you and your family. You are now able to buy coverage through the Health Insurance Marketplace (also called the exchange(s)). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

For More Information

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at ***www.dol.gov/ebsa*** or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit ***www.healthcare.gov***.

GENERAL RULES GOVERNING MEDICAL BENEFITS

IN THIS SECTION

- **PPO Medical Network Information**
- **Precertification Rules**
- **Knee and Hip Blue Distinction Program**
- **Teladoc**
- **Mental Health / Substance Abuse Benefits Information**
- **Healthy Moms = Healthy Babies Program**
- **Diabetes Care Program**

BlueCross BlueShield PPO Network

The BlueCross BlueShield PPO Network is the largest network of hospitals and physicians throughout the United States and Puerto Rico. BlueCross BlueShield PPO providers will provide medical care, behavioral health, and substance use treatment to LINECO participants at negotiated rates. When you use BlueCross BlueShield PPO hospitals and doctors, you help LINECO control healthcare costs and also save yourself money by avoiding higher out of pocket costs from non-participating providers.

- Rates charged by PPO providers are usually lower and the Plan will pay a higher percentage of your covered expenses.
- BlueCross BlueShield 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.
- Show your LINECO/BlueCross BlueShield I.D. card whenever you receive medical treatment, even if the treatment is provided by a non-network provider.

» TO FIND BLUECROSS BLUESHIELD PPO PROVIDERS GO TO ***WWW.LINECO.ORG*** OR CALL 1-800-810-BLUE (2583)

Precertification Program

The Precertification Program is administered by LINECO's Personal Health Nurse Team. LINECO's Personal Health Nurses will work with you and your doctor to help avoid unnecessary facility admissions and ensure services rendered meet coverage guidelines under the terms of the Plan whenever possible. 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 inpatient stay if the admission is not precertified. Facility admissions include hospital inpatient stays, residential treatment admissions, and partial inpatient treatment.

In addition to the inpatient precertification, please notify LINECO of any intensive outpatient treatment or if you require an organ transplant.

The Plan also has separate notification requirements for Bariatric Surgery and Jaw Surgery / TMJ. Please see page 45 / 49 for this information.

How to Have Inpatient Admissions Precertified

To start the precertification process, you, a family member, your doctor or the facility must call the Fund Office's toll-free number and ask for the LINECO Personal Health Nurse (PHN) Team. Call *before* a non-emergency inpatient facility admission. Call within two working days after an emergency admission. (Treatment in a hospital's emergency room does not require precertification unless the person is admitted as an inpatient.)

For precertification of inpatient Facility admissions, call the Fund Office at 1-800-323-7268, 8:00 a.m.-5:00 p.m.,CST and ask for LINECO's Personal Health Nurse Team.

For maternity, call as soon as the pregnancy is confirmed (or during the first trimester) and again within 48 business hours after delivery. Also call within two working days after an admission for any

pregnancy-related conditions such as false labor, miscarriage, etc.

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

After the call has been made to LINECO about a proposed inpatient facility admission, you will be sent a letter explaining LINECO's clinical recommendations regarding the Precertification of the inpatient facility stay under the terms of the Plan. This letter is your proof the Precertification Program was contacted.

Knee and Hip Center of Excellence / Blue Distinction Program

» THERE IS 100% COVERAGE FOR ELIGIBLE LINECO PARTICIPANTS AND DEPENDENTS IF THEY HAVE THEIR HIP OR KNEE REPLACEMENT PERFORMED AT A BLUE DISTINCTION CENTER.

LINECO will pay 100% of the covered facility expenses incurred by qualifying participants who obtain their knee or hip replacements at a Blue Distinction Center.

A Blue Distinction Center (BDC) is a surgical center or hospital identified by BlueCross BlueShield as meeting certain quality and service criteria. Blue Distinction Centers must demonstrate a commitment to quality care, and must have better overall outcomes for patients who undergo knee and hip replacement procedures.

LINECO's Personal Health Nurses, will work with qualifying patients to help them find a BDC near them.

Contact the Fund Office or BlueCross BlueShield to see if your facility is a BDC facility well before you schedule your surgery.

Teladoc

LINECO members and eligible dependents can obtain convenient and timely medical and behavioral health consultations through Teladoc, a leading provider of telehealth services throughout the United States.

Teladoc provides confidential medical advice from a board-certified physician 24 hours a day, 7 days a week (24/7). It is intended to help patients with common and minor ailments (allergy issues, sinus infections, cold / flu symptoms, etc.) You can find more information and a link to Teladoc at ***www.lineco.org***. or contact Teladoc directly by calling 1-800-Teladoc (835-2362).

There is no charge to eligible LINECO members or eligible family members for this service.

Teladoc also provides FREE Behavioral Health and Substance Use Disorder counseling to LINECO members 13 years and older. Please consider contacting Teladoc if you are struggling with a behavioral or substance use disorder. Sessions typically must be scheduled a few days in advance for this type of counseling session.

Healthy Moms = Healthy Babies

Female members/retirees and spouses are encouraged to participate in a special program provided by LINECO designed to help reduce complications and premature births. Women will receive a $250 gift card if they participate.

The goals of the Healthy Moms = Healthy Babies Prenatal Care Program are a healthy pregnancy and delivery. Early education and adequate prenatal care throughout pregnancy can help achieve these goals. LINECO's Personal Health Nurses are specially trained staff who 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 and call again by the first business day after delivery. LINECO's Personal Health Nurses (PHN) may 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 the nurses in order to qualify for the $250 gift card.

For more information, call 1-800-323-7268 and ask for a Personal Health Nurse.

Better Health with Diabetes

Living with diabetes doesn't have to be challenging, but medications and supplies can be expensive. LINECO has a Diabetes Management Program to improve care and reduce costs for members with Diabetes.

When you join this program, you will have a team that will assist and support you in your health and wellbeing goals. All information is kept private and confidential and never shared with your employer. We hope you will consider joining the program. To enroll, please outreach you're a LINECO Personal Health Nurse at 844-213-5658.

All covered active members and their dependents (except those who are Medicare-eligible) living with diabetes or at high risk for developing diabetes are eligible to participate in this free program that will help them enjoy better health.

Program participants will be eligible for the following benefit enhancements. Items must be medically necessary and certain devices/ supplies must be obtained through LINECO's preferred partners.

To enroll call 1-844-213-5658 or go to *www.lineco.org*. Click on Enroll Today link under "Get a Personal Health Nurse Coach Today!"

- Free test strips;
- Oral medications covered in full;
- Insulin pumps and supplies covered in full (ordered through Express Scripts or Livongo);
- Free eye exam via your VSP benefit
- In-Network Endocrinologist visits covered in full (primary diagnosis must be diabetes); and
- $50 gift card every six months you participate with your personal health nurse or "health coach."
- Access to Teladoc's Livongo Diabetes Care Management Tools.

LINECO will provide each participant with a "personal health nurse." The nurse will act as your "health coach" and is your patient advocate and will help you better manage your diabetes. Your personal health nurse:

- Will be your one-on-one resource for health information you can trust; and
- Will provide support and education to help you reach your goals for a healthier lifestyle.

This page intentionally left blank.

MEDICAL BENEFITS

IN THIS SECTION

- **Medical Benefits Quick Facts**
- **Deductibles**
- **Plan Payment %**
- **Out of Pocket Maximums**
- **Preventive Care**
- **Covered Medical Expenses**

Medical Benefit Quick Facts

DEDUCTIBLES (PARTICIPANT PAYS)	
Individual (calendar year)	**$400**
Individual and Dependent (calendar year)—2 family members	**$800**
Family (calendar year)—3 or more family members	**$1,200**
Hospital Precertification noncompliance per admission (in addition to the calendar year deductible)	**$250**
Emergency Room (each occurrence of hospital emergency room treatment—waived if admitted)	**$150**

PLAN PAYMENT PERCENTAGES (LINECO PAYS)	Blue Cross Blue Shield In-Network	Out-of-Network
Covered Medical Expenses (unless stated otherwise)	**80%**	**70%**
(Plan payment percentages are payable after satisfaction of deductible(s) and before satisfaction of the person's or family's out- of-pocket maximum.)		

Deductibles

PRECERTIFICATION NONCOMPLIANCE DEDUCTIBLE: $250

If the Precertification Program procedures explained on page 35 are not followed when a person is hospitalized or receiving inpatient facility care, a $250 deductible will apply to the covered medical expenses incurred for each such admission in addition to the calendar year deductible. The noncompliance deductible will not apply to inpatient facility 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 LINECO is not contacted as described above.

CALENDAR YEAR DEDUCTIBLES: $400 INDIVIDUAL OR $1,200 FAMILY

You are responsible for the first $400 of covered medical expenses you and your dependents each incur during a year. After three or more persons in your family have incurred a total of $1,200 in covered medical expenses applied toward the calendar year deductibles, 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 there are only two people in your family, your family's deductible limit will be $800 (2 times the individual deductible).

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: $150 PER OCCURRENCE

A $150 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.

In Network / Out of Network Plan Payment Percentages: 80% / 70%

After you satisfy any applicable deductibles, the Plan usually pays 80% for covered in-network expenses and 70% for covered out-of-network expenses. Coinsurance is determined based on whether the treating provider, including but not limited to radiologist, anesthesiologist, pathologist, facilities etc., is in or out of network. 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.

Calendar Year Out of Pocket Maximums: $2,500 Individual or $7,500 Family

Once the amounts of your individual out-of-pocket payments for your deductible and coinsurance for a calendar year total $2,500, the Plan will pay 100% of the covered medical and prescription drug expenses you incur during the remainder of that year. These maximums apply to the combined medical (hospital / doctor) and prescription drug (Rx) expenses.

If the amounts applied to you and your family's individual out-of-pocket maximum total $7,500 for a calendar year ($5,000 for a family of 2), the Plan will pay 100% of the covered medical and prescription drug expenses incurred by you and all your covered family members during the remainder of that year.

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 began.

Any out-of-pocket payments you make for non-covered charges do not count toward any individual or family maximum out-of-pocket maximum. In addition, expenses for hearing, dental, and vision care do not apply to out- of-pocket maximums and will not be paid at 100% even if your out-of-pocket maximum has been met.

NOTE: For Medicare eligible members that continue in LINECO's Medicare Part D prescription program, your medical out-of-pocket maximum will be $1,625 per individual instead of the normal $2,500. LINECO members (including dependents) will automatically be enrolled in the LINECO Medicare Part D prescription program when they become eligible for Medicare.

Benefit Limitations

A benefit limitation is the maximum amount of benefits the Plan will pay for a person for a particular type of treatment. Limitations apply even if the person's eligibility is interrupted or status changes. For example, a member goes from active employee to retiree status. The amounts of the Plan's benefit limitations are stated on the Schedule of Benefits.

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 or her 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, marketplace or any plan sponsored by any employer at the time his or her 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 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 91 for the definition of "totally disabled").
- 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 and any Plan maximums/limitations will apply.
- 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 becomes covered under Medicare or under any other welfare fund or any group plan, marketplace, or any plan sponsored by an employer; or (3) the end of the 12-month period following the date his or her coverage terminated.
- Upon election of extension of benefits, COBRA, active, retiree and self-pay continuation coverage will not be offered.
- Please contact the Fund Office if you feel you may qualify for the Extension of Benefits.

This page intentionally left blank.

COVERED MEDICAL SERVICES

Benefits for Preventive Care

LINECO covers a wide range of preventive and wellness services designed to keep eligible members and eligible dependents healthy.

Benefits for the preventive services will be paid as follows:

- Typically, the Plan will pay 100% with no deductible when you use a BlueCross BlueShield (BCBS) PPO provider. Out-of-network (non-PPO) services will be paid at 70% of reasonable and customary subject to the calendar year deductible.
- Childhood immunizations (under age 21) 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 may change from time to time:

- 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 (ACIP) 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 (HRSA).

» **PARTIAL LISTS OF THE PREVENTIVE SERVICES COVERED UNDER THIS BENEFIT ARE LISTED BELOW.**
GO TO ***WWW.LINECO.ORG*** FOR MORE INFORMATION ABOUT COVERED PREVENTIVE SERVICES.

CHILDREN		
AGES 0-2	**AGES 2-18**	**IMMUNIZATIONS** *(Ages 0-20)*
Newborn screenings	Physician's exams	Covid-19
Well-baby check-ups	Measurements	Diphtheria, tetanus & pertussis
Measurements	Developmental screenings	Hepatitis A
Developmental screenings	Metabolic screening	Hepatitis B
Metabolic screening	Hemoglobin test	Human papillomavirus
Hemoglobin test	Autism screening	Influenza
TB test	Behavioral assessment	Influenza type B
Lead testing	TB test	Measles, mumps & rubella
	Lead testing	Meningococcal
		Pneumonia
		Polio
		Rotavirus
		RSV
		Varicella

ADULTS		
ANNUALLY	**ONE PER LIFETIME IF NEEDED**	**IMMUNIZATIONS**
Starting at Age 18	Depression screening	Covid-19
Well-woman visit	Diet counseling	Hepatitis A
Other routine exams[1]	Bone density scan	Hepatitis B
Pap test		Human papillomavirus
Pelvic exam	**OTHER, AS NEEDED**	Influenza
Blood pressure check	Tobacco use intervention[4]	Measles, mumps & rubella
Cholesterol testing	Breastfeeding support[5]	Meningococcal
STD screening	FDA-approved female contraceptives[6]	Pneumonia
Routine tests incl. EKGs & blood & urine tests[2]	Folic acid supplements[6]	RSV
HIV screening	Prenatal visits[7]	Tetanus, diphtheria & pertussis
Starting at Age 40	Prenatal – Low Dose Aspirin	Varicella
Mammogram	Obesity counseling[8]	Zoster
Starting at Age 45		
Occult blood test		
Colorectal cancer screening[3]		
Starting at Age 65		
Occult blood test		
Abdominal aneurysm screening		

(1) *Up to $125 for a routine exam per year for employees, retirees and spouses is paid if the provider is out-of- network. Also see Department of Transportation (DOT) Physicals – Employee Only on page 44.*

(2) *Up to $150 for active members, retirees and spouses 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, six lactation counseling sessions 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. This benefit is NOT for dependent children of any age.*

(8) *Up to 26 face-to-face behavioral counseling sessions per year with a doctor or covered mental health provider, plus one dietary assessment by a nutritionist. Exercise and diet programs are excluded unless directly supervised by an M.D. or D.O. Patient must have a BMI ≥ 30.*

Department of Transportation (DOT) Physicals – Employee Only

LINECO covers required Department of Transportation (DOT) physical exams for eligible employees under the routine exam benefit. Exams are paid at 100% in-network. Otherwise the plan covers up to $125 for out-of-network providers.

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.

1. **Acupuncture** provided by a covered provider. Services 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.

   The Plan does NOT cover acupuncture for smoking cessation or weight loss.

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 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: It is (1) emergent AND determined medically necessary AND standard of care (as defined on page 90) (2) the transportation must be by regularly scheduled commercial airline or railroad or by professional air ambulance; (3) the transportation may only be from the location 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); (4) only the first trip to the hospital for any one sickness and for all injuries resulting from any one accident are covered; and (5) the transportation is limited to the United States, Canada, Mexico, or the Caribbean Islands.

   NOTE: If you have no control over which ambulance service is used, the Plan will pay the related covered charges at 80% subject to reasonable and customary guidelines, even if the ambulance service is not in the PPO network.

   Please also be aware that air ambulance services and costs are protected by the No Surprises Act (NSA). Please refer to page 96 to understand your rights and protections provided under the No Surprises Act.

3. **Anesthetics** or anesthesia and its administration.

4. **Autism assistance** – early detection and medically necessary and appropriate treatment of autism spectrum disorder, (as defined on page 87) for children, benefits including but not limited to as follows:

   a. Applied Behavior Analysis (ABA) therapy by a licensed behavioral therapist, when ordered by an M.D., D.O, or psychologist;
   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 when ordered by an M.D., D.O. or psychologist.

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 their medically desirable weight and have a Body Mass Index (BMI) of at least 40;
   b. The obesity must be a 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 seven (7) office visits: the initial visit, plus one monthly visit of physician assisted attempts to reduce weight by more conservative measures for 6 consecutive months. These visits must be done during the 12-month period prior to the proposed surgery. BlueCross BlueShield in-network office visits will be covered at normal benefit levels upon completion of a successful bariatric surgical procedure that was pre-approved by the Fund.
   d. The surgery must be performed in a Blue Cross Blue Shield PPO facility by PPO physician(s)/surgeon(s); 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. **Biofeedback**—Biofeedback is covered if it is considered medically necessary and standard of care.
7. **Chiropractic care**, includes any covered provider that performs spinal manipulations, spinal adjustments, and related services.
8. **Clinical trials**—The patient costs for a covered person enrolled in an approved clinical trial. An "approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition. A "life-threatening condition" is any disease from which the likelihood of death is probable unless the course of the disease is interrupted. "Routine patient costs" include all services and supplies that are typically covered by the Plan for persons not enrolled in clinical trials. Routine patient costs do NOT include: (a) the investigational item, device or service itself; (b) services that are provided solely to satisfy data collection and analysis needs, or (c) services that are clearly inconsistent with the widely accepted and established standards of care.
9. **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 when performed to diagnose or determine a treatment plan in the presence of signs and symptoms of disease.

   Dental services—see *Dental Benefit* starting on page 63.
10. **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.
11. **Durable medical equipment** as follows:
    a. *Appliances, and prostheses* (such as artificial limbs and eyes) to replace physical organs/limbs or parts of organs/limbs. LINECO will cover the initial prosthesis or appliance and replacement prostheses or appliances during the individual's lifetime. Replacement prostheses will be covered only if the need for replacement is certified as medically necessary by LINECO's Personal Health Nurse / Clinical Team. Covered medical expenses also include breast prostheses following a mastectomy. Typically, durable medical equipment will be reimbursed at the rental amount up and until the normal purchase price is reached.
    b. *Oxygen* and rental of 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.
    e. *Communication devices*—Plan will cover a medically necessary speech generating device not to exceed $5,000 lifetime. Prior authorization is strongly recommended. Please contact the Fund Office.
12. **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.
13. **Genetic Testing**—Except as provided under the Plan's preventive care benefits, genetic testing is covered only when performed to diagnose and determine a treatment plan in the presence of signs and symptoms of disease.
14. **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. The $2,500 covers bilateral hearing aids; if only one is purchased, the benefit maximum is $1,250. 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 Amplifon network. Use of Amplifon is voluntary under the Plan. **Contact Amplifon at 1-877-609-0758 for more in formation about the discounts**

available to LINECO participants for hearing aids and batteries.

15. **Home Health** – 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 40 visits 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;
    c. The doctor must certify that the home nursing care is proper and medically necessary treatment of the patient's condition: and
    d. Each four hours of continuous hours of care is considered one visit.

    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.

16. **Hospice care**, subject to the rules in *Provisions Governing Hospice Care* starting on page 50.

17. **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.

18. **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 89.)
    » 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 letter is not received before the treatment is performed, or if the Fund Office does not approve the treatment as medically necessary (see page 90), the hospital or ambulatory surgical center expenses will not be paid.)

19. **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, including children.

    NOTE: *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, retiree 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.

20. **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.) (Refer to *Prescription Drug Programs* starting on page 53 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 LINECO's Personal Health Nurse Team; (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).

21. **Mental / Behavioral disorders and substance use disorder**, follow normal medical coverage guidelines and reminders are listed below:
    a. The BlueCross BlueShield provider network(s) 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 residential treatment facility, an M.D., a licensed clinical psychologist, or a licensed clinical therapist/ counselor. Please refer to the definition of "residential treatment facility" on page 90.
    c. Precertification is required for inpatient, residential and partial inpatient.
    d. Partial Hospitalization (PHP)—The Plan will cover medically necessary partial hospitalization programs for treatment of a substance use disorder or mental nervous disorder.
    e. Inpatient treatment must be provided by a covered facility and pre- approved by LINECO's Personal Health Nurse Team.
    f. Outpatient / Office Treatment—The Plan will only cover outpatient / office visits for treatment of a substance use or behavioral disorder when the treatment is rendered by a licensed mental health practitioner. This rule applies to in-network and out-of-network services. Treatment must also be medically necessary and standard of care.

Call LINECO at 1- 800-323-7268 to find network providers and to certify your inpatient behavioral health or substance use disorder treatments.

NOTE: If the 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. The MAP program is voluntary and regular medical benefits can be utilized for Mental / Behavioral disorders and substance abuse treatment at any time.

22. **Occupational Therapy** rendered by certified occupational therapist as long as it rehabilitative, medically necessary and standard of care. Occupational Therapy must meet the same conditions as outlined in the Physical Therapy section directly below.

23. **Physical therapy** rendered by a registered physical therapist, and **occupational therapy** rendered by a licensed occupational therapist,

on an inpatient or outpatient basis, provided all the following conditions are met:

a. The therapy is performed based on a written plan of care prescribed by a medical doctor (M.D., D.O.).
b. The therapy is aimed at significantly improving or restoring functions which have been impaired or permanently lost as a result of an illness or injury.
c. The therapy requires the unique knowledge, skills, and judgment of a physical or occupational therapist due to the severity and/or complexity of the patient's medical condition; and the patient's function could not reasonably be expected to improve without the therapy.
d. There is a reasonable expectation that the therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time.
e. The therapy documentation objectively verifies progressive functional improvement over specific time frames.

24. **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 88.

25. **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.

    Charges by a physician (MD, DO, or DPM) who is providing surgical assistance, the maximum allowable covered medical expense is 25% of the allowable surgeon's fee. With respect to charges by a non- physician (PA, CRNA, licensed midwife, etc.) who is providing surgical assistance, the maximum allowable covered medical expense is 15% of the allowable surgeon's fee.

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

27. **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 60 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 90).

28. **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, 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.

29. **TMJ**

    a. *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 90.)
    b. *TMJ surgery*, including hospital and doctors' / surgeons' services, and other medically necessary services and supplies provided for or in connection with the surgery. TMJ

surgery must be precertified by the Fund Office if the surgery would otherwise have been covered but is not precertified by the Fund, or is not performed by a BlueCross BlueShield PPO provider at a BlueCross BlueShield PPO facility, the maximum benefit payable for all covered expenses will be $3,000 per person, per lifetime.

30. **Transplants**—Benefits are payable for certain medically necessary organ transplants. It is strongly encouraged that you utilize a BlueCross BlueShield *Blue Distinction Center For Transplant* facility. Covered expenses related to a transplant include: donor acquisition, transplant evaluation tests and laboratory, transplant surgical fees and related facility fees, and post-transplant follow-up care. Patients are encouraged to notify the Fund Office as soon as they are added to a transplant list by their medical care team so the LINECO Personal Health Nurse (PHN) can offer assistance.
31. **Vision Services**—See the Vision Benefit section of starting on page 67.

Diagnostic X-Ray and Lab Benefit

The Plan pays the first $150 of covered diagnostic x-ray and lab expenses for member, retiree or spouse 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 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.

For eligible members, retirees and their spouses, covered medical expenses also include diagnostic tests ordered, provided the tests are appropriate for the patient's age, sex and medical history and are consistent with prevailing medical standards.

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 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 77).

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. Please contact the Fund Office / LINECO's Personal Health Nurse Team at 1-800-323-7268 to notify and coordinate hospice care. The patient can revoke his/her hospice election at any time. In the future, the patient can re-elect hospice care, but the 180 days maximum will not start over.

Once a person has received benefits for 180 days of hospice care, no further benefits for hospice care will be paid. Expenses incurred for any further treatment of the 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 provider;
- Bereavement counseling (counseling services provided to a terminal person's family) after the patient's 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.

This page intentionally left blank.

PRESCRIPTION DRUG PROGRAMS

IN THIS SECTION

- **Prescription Benefit Overview**
- **Specialty Drug Coverage**

LINECO provides a robust prescription drug program for our active members and our retirees. In most cases the prescription drug program is part of the major medical program. This means that prescription drug claims and costs are applied toward your overall annual deductible and out of pocket maximum.

Summary of Prescription Drug Benefits

Retail Drug Supply (up to 30-day supply)	**Participant Pays**
Participant co-pay percentage	**20%** (after medical deductible)
Mail Order Drug Supply (up to 90-day supply)	**Participant Pays**
Generic drugs	**$10**
Preferred (formulary) drugs	**$20**
Non-preferred (non-formulary) drugs	**$35**

For LINECO Primary individuals who are Medicare-eligible, use of the mail-order for a maintenance medication is mandatory after the original supply plus one refill. You cannot use the mail-order pharmacy if LINECO is secondary to any other drug plan.

Specialty Medications (up to 30-day supply) Note: Specialty drugs must be filled via Accredo Specialty Pharmacy	**Participant Pays**
Generic specialty drugs	**10% up to $100 maximum co-pay**
Preferred (formulary) drugs	**20% up to $250 maximum co-pay**
Non-preferred (non-formulary) drugs	**20% with no maximum co-pay**
SpecialtyAssistanceProgram – Is mandatory and applies to certain specialty medications	**Co-pays will vary** (see page 54)

Actives and Non-Medicare Retirees

» IF MEDICARE IS YOUR PRIMARY HEALTH CARE PLAN, SEE "MEDICARE PRESCRIPTION DRUG PROGRAM" ON PAGE 56.

LINECO's prescription drug program is administered by Express Scripts, Inc. (ESI). You can purchase your short- term or acute prescription drugs at discounted prices through retail pharmacy that participates in the ESI network. The ESI I.D. card is recognized at most pharmacies nationwide, including all the major pharmacy chains. Each time you have your prescription filled, you can get up to a 30-day supply. If you need long-term or maintenance drugs, you should use the Express Scripts mail-order pharmacy.

Benefit Provisions

Your co-pay amounts are shown on the Schedule of Benefits (page 7). As shown on the Schedule, your out-of- pocket costs will be lower if you use the

mail-order program for your long-term prescription drug needs.

For most participants, prescription drug co-pays apply to their deductible and out-of-pocket maximum under the regular Medical Benefit. Medicare-secondary participants (when LINECO is the primary plan), however, have separate medical and prescription out-of-pocket maximums, and no prescription drug deductible.

Mandatory Generic Substitution – 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.

Preferred Drugs – Preferred prescription drugs are brand / generic name medications that are FDA approved and have been evaluated by Express Scripts physicians and pharmacists and have been determined to be the most effective for treatment of certain conditions for most patients. They are also the most reasonably priced when considering clinical effectiveness as well as cost. These drugs are often referred to as "formulary" drugs.

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

The list of preferred drugs is frequently reviewed and updated. LINECO's Prescription Drug Plan follows the Express Scripts National Preferred Formulary. Drugs not included on the National Preferred Formulary will not be covered by the Plan and you will be required to pay for the complete cost of the drug. For up-to-date information about the formulary or status of a specific drug, contact Express Scripts.

The rules and provisions described above will NOT apply to you if Medicare is your primary health plan. Medicare is primary for retirees and their dependents, and in a few special cases for actives and their dependents. See Medicare Prescription Drug Program (PDP) on page 56 for more information.

Order Forms? Questions?
Call Express Scripts 1-877-327-0568 (toll free) or go to *www.express-scripts.com*.

Specialty Drugs

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 very expensive, and they require special storage and handling, frequent dosage changes, and periodic laboratory testing. Some common specialty drugs are:

SOME COMMON SPECIALTY DRUGS

Enbrel	Neulasta	Neupogen	Soliris
Harvoni	Sovaldi	Cimzia	Humira
Remicade	Stelara	Copaxone	Euflexxa
Orencia	Viekira Pak	Procrit	Synvisc

(NOT a complete list.)

Due to the complexity and high cost involved in these drugs, the LINECO Board of Trustees has partnered with the Accredo Specialty Pharmacy. **You must use the Accredo Specialty Pharmacy, a mail-order pharmacy that provides specialized medications. Accredo is LINECO's exclusive provider for specialty pharmacy medications and is Express Scripts specialty pharmacy.**

Accredo will dispense up to a 30-day supply of your specialty medication at one time. For more information, call Accredo at 1-877-476-2267. (Important contact information is also located on the front cover of this book.)

You can also find information about Accredo Pharmacy at ***www.express-scripts.com***.

All prescriptions and refills of a specialty medication must go through Accredo. Accredo will permit an initial supply of a new prescription to be filled at a retail pharmacy only in certain special situations. Any additional specialty fills at retail will not be covered.

In some instances, specialty medications are administered at a physician or facility office. If you are aware that you will need a specialty injection, please contact Accredo at least two week(s) in advance of your appointment to ensure the medication is approved and can be sent directly to the physician/facility.

Patients MUST go through Accredo for all specialty drugs, even when the drug will be administered in a doctor's office.

Specialty Drug Program Assistance / Co-Pay Assistance Program – Due to the continued rising cost of medications, some drug manufacturers provide patient co-pay assistance programs for expensive specialty medications used for oncology

patients and diseases like Hepatitis C. If an assistance program is available for your medication, the following special provisions will apply:

- You must use Accredo for all fills. Accredo will enroll you in the assistance program for your first and all subsequent fills.
- The amount of your co-pay will vary. It will be set so that you and LINECO can both benefit from the financial assistance. You will not pay more than you would have paid in absence of this program.
- Only the amount you actually pay will apply to your out-of-pocket limit. The amount offset by the assistance will not count toward the limit since it is not a true out-of-pocket cost.
- If you qualify for co-pay assistance, you will be contacted by representatives of Accredo who will enroll you in the program. Additionally, you may contact Accredo directly if you need assistance and/or want to know if there is an assistance program for your medication.
- You may also be required to enroll in the SaveonSP Program. **When you participate in this program, select specialty medications will be free of charge ($0).** The specialty medications will still be filled through Accredo, our existing specialty pharmacy. You will be contacted directly by SaveonSP or Accredo with instructions on how to enroll in this program. Enrollment will only take a single phone call. If you do not enroll, your out-of-pocket expense may exceed the normal $250 specialty copayment significantly and will not apply toward your deductible / out of pocket. Visit ***www.saveonsp.com/lineco*** for a listing of medications covered by this program.

Specialty Step Therapy Program – Step therapy is used to guide a patient with a chronic condition. In general, a patient is required to utilize an equivalent drug to treat a condition (the preferred step), if appropriate, before the patient tries a non-preferred drug that may be more expensive. The goal is to ensure that the patient receives an appropriate medication for the condition. If you present a new prescription to your pharmacist for a drug included in this program, and you haven't tried a preferred drug first, you may have to pay full price for your prescription. In such case, you can talk to your doctor about prescribing a preferred drug instead.

In addition to step therapy, specific clinical guidelines established by both Accredo and Express Scripts must be met and adhered to by the prescribing physician in order for most specialty medications to be approved.

Covered Drugs

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

- **You must 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-order purchases, follow the rules of the primary plan and then file a claim with ESI for any balance. See page 75 for more information.**

Covered drugs are medications that are FDA-approved and may only be legally dispensed by a registered licensed pharmacist according to a doctor's written prescription. Certain diabetic supplies are also covered.

Covered drugs also include the prescription medications and products covered under the Plan's preventive care provisions, such as certain birth control pills for female participants.

The Plan exclusions (starting on page 77) also apply to prescription drugs. For example, the Plan does not cover 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.

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, Accredo, includes discounted prices for expensive medications. You are required to obtain your specialty drugs through Accredo. If you do not purchase your medications through the recommended source, the Plan will not cover any charges.

Over-the-Counter and Compound Medications

Unless required by the Affordable Care Act, over-the-counter medications are not covered under the Plan, even with a written prescription. Additionally, prescriptions that contain an over-the-counter equivalent will not be covered. Allegra and Prilosec

OTC are examples of non-covered drugs that are equivalent to over-the-counter products.

Compound medications are not covered by the Plan unless they are approved by Express Scripts and covered under the Express Scripts compound management program.

Medicare Prescription Drug Program

» IF MEDICARE BECOMES YOUR PRIMARY PLAN, THE EXPRESS SCRIPTS MEDICARE® PDP PLAN WILL PROVIDE YOU WITH A BENEFIT SCHEDULE, I.D. CARDS, AND OTHER INFORMATION ABOUT THAT PROGRAM. YOU WILL BE AUTOMATICALLY ENROLLED IN THIS PROGRAM. THERE IS NO COST TO ENROLL.

Participants for whom Medicare is their primary plan are automatically enrolled in the LINECO-sponsored Express Scripts Medicare® Prescription Drug Plan (PDP), an insured group Part D plan. Express Scripts will provide you with information concerning your co-pays, covered and non-covered drugs, and instructions for using the mail-order and specialty pharmacies. They will also handle customer service, prior authorizations and appeals. Upon a qualifying event (obtaining Medicare Part A / Part B), you will automatically be enrolled in the Express Scripts Medicare® PDP plan.

The Express Scripts Medicare® PDP has been developed to mirror the LINECO active prescription drug program. However, because this is a Federal sponsored program, there may be some differences.

If you are an end-stage renal patient, please contact the LINECO Fund Office as soon as possible as specific coordination efforts are required with Medicare.

Reminder: For LINECO Medicare eligible members who are enrolled in the Express Scripts Medicare PDP program, your annual prescription drug out of pocket maximum will not exceed $1,000 per individual.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

IN THIS SECTION

- **About Your HRA Account**
- **Qualified HRA Expenses**
- **How to Use Your "Benny Card"**

The Health Reimbursement Account (HRA) program is a spending plan that covers a wide range of healthcare expenses not payable by LINECO. HRA accounts can also be used to make short-hour and retiree self- payments for continued LINECO coverage. This benefit is commonly referred to as the LINECO HRA.

The LINECO HRA is considered integrated within the Line Construction Benefit Fund and any other group health plan that a member who retains a balance may be a participant. It was created in 2012 by the Board of Trustees to provide greater access to health funds for services not covered by LINECO (or another group health plan) and for retirement health care premiums.

The LINECO HRA is intended to be a tax-exempt employer-provided medical care reimbursement plan with the intention to qualify as a medical reimbursement plan within the meanings of Sections 105 and 106 of the Internal Revenue Code of 1986 (Code). Only Employer contributions may fund the LINECO HRA.

Individual LINECO HRA accounts are funded by separate employer contribution. Not all employers participate in this program.

Your HRA Account

- Contributions can only be made by an employer on your behalf … not all employers participate in the HRA.
- Generally, you determine how and when to use your LINECO HRA, subject to IRS reimbursable medical expense guidelines.
- 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 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.
- You may permanently opt out of the LINECO HRA plan (so you can seek subsidized coverage through a health insurance exchange). See *Opting Out of the HRA Program* on page 59 for more information.

» IT IS VERY IMPORTANT TO ONLY USE YOUR LINECO HRA AFTER YOUR REGULAR LINECO BENEFITS HAVE BEEN EXHAUSTED FOR MEDICAL, PRESCRIPTION DRUGS, OR DENTAL. USING YOUR LINECO HRA DEBIT CARD PRIOR TO LINECO RECEIVING YOUR CLAIM FROM YOUR PROVIDER MAY RESULT IN AN OVERPAYMENT BY YOUR LINECO HRA ACCOUNT.

HRA Qualified Expenses

Qualified expenses are costs incurred for medical care as defined under Section 213(d) of the Internal Revenue Code or Publication 502 Qualified expenses include, but are not limited to:

- Medical expenses, including deductibles and coinsurance
- Prescription drug co-pays
- Dental services, including deductibles, coinsurance, and non-covered services
- Home modifications and equipment to accommodate a disabled person
- Infertility treatment
- Vision expenses
- Hearing care expenses

- Active and retiree self-payments to LINECO
- Medicare Part B or Part D premiums
- Medigap policies
- Smoking cessation products and programs
- Electronic body scans
- OTC drugs (doctor's prescription required)
- Weight loss programs
- Residential homes for care of an intellectually or developmentally disabled dependent

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

- Cosmetic surgery
- Electrolysis
- Burial expenses
- Household help
- Food/dietary supplements
- Premiums for health insurance on the state or marketplace exchanges
- Premiums for life insurance or loss of income insurance
- Air purifiers or humidifiers
- Health club memberships
- Child or elder care

For a complete list of qualified HRA medical and dental 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. LINECO will contact participants directly if additional documentation is required.

Reminder: LINECO's regular plan of benefits provides comprehensive health and welfare coverage. Members are reminded not to swipe/use their LINECO HRA card until a claim has first been sent and processed by the LINECO regular plan of benefits.

How to Use Your HRA

Prepaid Benefits Card ("LINECO HRA Card")—LINECO will provide you with two prepaid debit cards, called "LINECO HRA Cards," that can be used to access your LINECO HRA funds at retail or provider point of sale locations. You can use the card to make your HRA qualified purchases at many participating healthcare providers, discount stores, eyeglass stores, etc. Your expenses will be automatically deducted from your LINECO HRA.

You can only use your LINECO HRA 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 LINECO HRA Card or Account.

You can request additional or replacement cards by calling LINECO at 1-800-323-7268. The cost is $10 for two cards.

Self-Payments to LINECO—You can also use your LINECO HRA account to make short—hours, retiree, or COBRA self- payments to LINECO. Contact LINECO for information on authorizing these types of payment(s) from your HRA account. Please call LINECO at 1-800-323-7268 to discuss this option.

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 LINECO HRA 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 LINECO HRA. Claim forms are available by following the links on the LINECO website.

Additional HRA Program Information and Claim forms are available through the HRA link at *www.lineco.org*.

» CALL LINECO AT 1-800-323-7268 IF YOU HAVE ANY QUESTIONS ABOUT HOW TO USE YOUR LINECO HRA CARD, YOUR ACCOUNT BALANCE, ELIGIBLE EXPENSES, OR HOW TO FILE CLAIMS.

Ultimately, you and your qualified dependents are responsible for following the LINECO HRA program rules and complying with IRS guidelines as it relates to qualified medical and dental allowable expenses. LINECO may require receipts, proof of payment, and/or medical records to substantiate the HRA payments were made in accordance with LINECO HRA and IRS program rules.

If a non-qualified expense (i.e., cosmetic surgery) was used with LINECO HRA funds, you will be required to reimburse the LINECO HRA and your card may be suspended until the non-qualified expense is resolved. Additionally, non-qualified expense reimbursement activities may result in taxable income earnings distributed by the Fund for the participant.

Tracking Your Account Balance and Claims Activity—You can track your account activity online securely through a link to the HRA program at ***www.lineco.org***. Additionally, you may download the LINECO HRA mobile application by searching for "lineco hra" on your mobile device. Your LINECO HRA balance may also be obtained by calling the Fund Office at 1-800-323-7268 and following the prompts on our phone system

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, and will credit or debit a proportional amount. The investment yield will typically be posted in March / April each year.

Your Share of the Administrative Cost—Each calendar year the Fund will determine the administrative cost to run the LINECO HRA program and will debit a one-time annual administrative fee to run the program. The Administrative fee will typically be posted in March / April each year.

Reimbursements After Termination of LINECO Eligibility—When participation under the HRA terminates, a former Participant will not be able to receive reimbursements for qualified medical expenses unless there is an account balance, in which case claims can be reimbursed from the HRA after the date of termination if the former Participant is enrolled in another group health plan.

For eligible retirees, as defined by the Plan's Eligibility rules, contributions to the HRA will stop, but the HRA account will continue to be available for LINECO retiree premiums or to be used under another group health plan.

Claim Denials—The denial of any HRA claim will be subject to the Fund's claims and appeals procedures applicable to post-service claims as explained on page 91.

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

If you are not married on the date of your death or your spouse dies, any remaining balance in the LINECO HRA account may be used by your eligible dependent children survivors for qualified expenses. If there is more than one eligible dependent child survivor, the remaining balance in the LINECO HRA account will be divided equally based on the number of eligible dependent children survivors.

If the participant dies, or his surviving spouse dies, and there are not eligible dependent children survivors, the remaining balance in the LINECO HRA account will be forfeited, and the forfeited amount will be used to assist in lowering the HRA's operating expenses.

Opting Out of the HRA Program—The Affordable Care Act allows Plan participants an opportunity to permanently opt out of the HRA plan (so they can seek subsidized coverage through a health insurance exchange). If you opt out, the balance in your account is forfeited and you waive the right to future reimbursements. You are allowed to opt out effective each January 1st. It is anticipated that opting out will be an extremely rare occurrence. Please send written correspondence indicating your intent to opt out of the HRA to the Fund Office.

Timely Filing of HRA Claims—The timely filing limit to file claims or information to perfect a claim is 2 years from the date of service or the date the information was requested by the Plan.

Trustee Rights—The Trustees reserve the right to eliminate or modify this program at any time and at their sole discretion.

This page intentionally left blank.

MEMBER ASSISTANCE PROGRAM (MAP)

IN THIS SECTION

- **Free Member Assistance Program**
- **Legal and Financial Services**

You and your covered dependents can use the Member Assistance Program (MAP) if you are eligible for LINECO benefits.

The Member Assistance Plan is administered by Carelon, a professional mental health care counseling and management organization. Carelon has thousands of experienced, professional counselors to help you with any kind of personal problem.

» HELP IS AVAILABLE FOR A WIDE VARIETY OF PROBLEMS.

THE MEMBER ASSISTANCE PLAN 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 USE DISORDER, EMOTIONAL PROBLEMS, DEPRESSION, ANXIETY AND STRESS, JOB DISSATISFACTION, FAMILY ILLNESS, AND FINANCIAL OR LEGAL CONCERNS.

CALL CARELON AT 1-800-332-2191

Free Counseling Services

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

Any services you receive from the Member Assistance Plan are completely confidential.

MAP counselors include a wide variety of licensed professional mental health practitioners. The Care Manager will select the type of specialist best suited to your particular circumstance. If there are no counselors in your geographic area who can assist you, you will be referred 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 as out-of-network (70% after the deductible).

You can access the Member Assistance Program 24 hours per day, 365 days per year at 1-800-332-2191 or by logging into *www.carelonwellbeing.com/lineco*.

Legal and Financial Services

The Member Assistance Program 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).

This page intentionally left blank.

DENTAL BENEFITS

IN THIS SECTION

- **Dental Benefit Overview**
- **Predetermination of Benefits**
- **Covered Dental Expenses**
- **Orthodontia**
- **Dental Exclusions and Limitations**

Dental Network of America (DNoA)

To find a DNoA dentist, go to *www.dnoa.com* or call 1-866-522-6758.

The Plan's dental preferred provider (PPO) network is 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.

Predetermination of Benefits

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

If dental care will be $1,000 or more, the Fund Office recommends your dentist request a predetermination of benefits before any major work is started to ensure that you are aware what the Plan will cover. To obtain a predetermination, ask your dentist to submit the details of the proposed treatment plan and charges to the Fund Office.

The predetermination procedure is not necessary for oral examinations, cleanings, fluoride applications, dental x-rays and emergency treatment. Predetermination is recommended when the charges for a plan of treatment are expected to be more than $1,000.

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

Payment of Dental Benefits

The Plan will pay 80% of covered dental expenses each year up to a maximum benefit of $2,000. The maximum does not apply to preventive and diagnostic services for children under age 21. Once a participant or dependent has received $2,000 in dental benefits during a year, he or she 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 participant's or dependent'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.

Incurred Date—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 incurred 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, implants and other gold restorations, when the tooth is first prepared. LINECO will cover expenses incurred while the person is eligible but completed within 90 days after eligible termination.

Dental Treatment Other Than in a Dentist's Office

If a dentist recommends a dental procedure be 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

Dental services covered under by the Plan include:

- Amounts that are considered allowable charges (see page 87 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.
- Services received while a person is covered under this Dental Benefit.
- Preventive services for children under 21 years old, which are covered at 100%.

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, two times per year, for children under age 18 only.
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 (once 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 five (5) years in between a repeat sealant procedure on any tooth.

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

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 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 0 through 5 will be 80% and 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.) The medically necessary replacement of a dental implant is covered subject to the same criteria. A replacement will only be covered if five years have passed since the initial placement.

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 decay 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 – FOR CHILDREN ONLY 80% (No Deductible)

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.

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 monthly/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).
- If a child is undergoing orthodontic treatment when their eligibility starts, the Plan will pay 80% of the allowable charges that are determined to be incurred after the child 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 of 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 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 denturist 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.
    a. For full or partial dentures, treatment is considered incurred when the impression is taken for the appliances.
    b. Root canal therapy is considered incurred when the tooth is opened.
    c. Fixed bridgework, crowns, implants, and other indirect restorations (e.g., gold) are considered incurred when the tooth is first prepared.
23. Dental restorations, appliances, procedures or prosthetic devices, necessitated by abrasion or attrition are not covered.
24. Services, supplies or conditions that are excluded in the What the Plan Does Not Cover section starting on page 77.
25. Sedation for convenience.

VISION BENEFITS

IN THIS SECTION

- **Vision Service Plan Overview**
- **Covered Vision Services**
- **Vision Exclusions and Limitations**

Vision Benefits are provided through a trusted partner VSP (Vision Service Plan). VSP gives you a choice of the way you can receive your Vision Benefits.

- **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 doctors provide examinations, professional services, lenses, and quality frames at reduced 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.

To find a VSP Doctor call 1-800-877-7195 or go to *www.vsp.com*

- **Out-of-Network Provider**—You may 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 10).

Do not submit vision claims to the Fund Office. Send out-of-network claims to VSP (see page 75 for the address). Out of Network claims forms can be obtained by contacting VSP.

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 $175 toward the cost of the contact lenses plus the contact lens exam, evaluation and fitting.
- **Safety Glasses**—Allowable once every two calendar years, for active employees only. Safety glasses must be obtained through a VSP provider, and the lenses must be prescription (not plain). Only certain VSP providers participate in this program, members are strongly encouraged to contact VSP directly to obtain a listing of providers participating in the Pro-Tec Safety Glass program.

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.

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 pairs 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 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 photo chromatic 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.

Extension of Vision Benefits

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

- 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 77.

INSURANCE BENEFITS

IN THIS SECTION

- **Life Insurance Benefit**
- **Accidental Death & Dismemberment Benefit**
- **Claim Filing Process**

Life Insurance

The Line Construction Benefit Fund, through its insurance policy with Trustmark Insurance Company, provides life insurance benefit of $20,000 payable to your beneficiary, in the event of your death.

Life insurance is available only for eligible employees. Life insurance is not provided for retirees or dependents or for Utility / REA / Electric Cooperative employees. 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.

If you die while you are eligible for this benefit, your life insurance is payable to your beneficiary regardless of the cause of death. The life insurance and accidental death and dismemberment benefits are determined by Trustmark Insurance Company.

Your Beneficiary – is the person(s) you designate with LINECO to receive your life insurance benefit.

If you name more than one beneficiary, your beneficiary's will share equally unless you indicate otherwise on your beneficiary form.

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. Simply visit ***www.lineco.org*** and access the "Forms" section to print out a Family Enrollment Form or complete an electronic version on the SECURE member portal. (To be valid, the change of beneficiary must be received by the Fund Office while you are still living.)

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

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:

1. You must have been actively employed by a contributing employer within the 90-day period immediately preceding the date your total disability started; **and**
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); **and**
3. Your disability must occur prior to your retirement; **and**
4. Your total disability must last for at least nine months; **and**
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; **and**
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.

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 (up to the amount covered by the Plan) to an individual policy issued by Trustmark Insurance Company. Important conversion rules include:

- Submission of written application and first premium payment to Trustmark must be made within 31 days after termination of your eligibility for life insurance or termination of the group insurance policy;
- You must continue to make on-time insurance premium payments;
- 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; and
- You may convert to any type of individual life insurance policy customarily issued by the insurance company except term insurance, and no medical examination/proof of good health is required.

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.

Contact the Fund Office if you are interested in your conversion privilege.

Accidental Death & Dismemberment Insurance

Accidental Death and Dismemberment (AD&D) insurance is available only for eligible employees who are not utility / REA 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 loss 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 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:

LOSS OF	BENEFIT AMOUNT	
Life	$20,000	Paid to your beneficiary
Two hands or two feet or sight of two eyes	$20,000	Paid to you
One foot and sight of one eye	$20,000	Paid to you
One hand and sight of one eye	$20,000	Paid to you
One hand and one foot	$20,000	Paid to you
One hand, or, one foot, or sight of one eye	$10,000	Paid to you

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. You may change your beneficiary at any time by logging into your *myLINECO* secure member portal at ***www.lineco.org***.

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).

» **WHAT YOUR BENEFICIARY NEEDS TO DO**

YOUR BENEFICIARY SHOULD CONTACT THE FUND OFFICE AT 1-800-323-7268 TO NOTIFY THE FUND OF YOUR DEATH OR QUALIFICATION FOR ACCIDENTAL DEATH / DISMEMBERMENT BENEFITS.

THE FUND OFFICE WILL THEN SEND THE APPROPRIATE INSTRUCTIONS TO YOUR BENEFICIARY SO THAT HE OR SHE CAN COMPLETE THE CLAIM FILING PROCESS.

This page intentionally left blank.

WEEKLY INCOME BENEFITS

IN THIS SECTION

- **Eligibility Rules for Weekly Income**
- **Benefit Amount**
- **Successive Periods of Disability**

Exclusions and Limitations Weekly Income Benefits are available only for eligible employees who are not Utility/REA / Electric Cooperative 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. Weekly Income Benefits are NOT payable for any period of time during which you are able to work. It is your responsibility to notify the Fund Office when you return to work or retire. Failure to do so is considered insurance fraud and may lead to legal action.

Eligibility for Weekly Income Benefits

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

1. You must be eligible for Plan benefits from worked hours on the date your disability begins. 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; **and**
2. You must have been actively employed by a contributing employer within 15 days prior to the date your disability began. "Actively employed" means working at a jobsite, not on vacation and not laid off; **and**
3. 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. LINECO will not consider you to be disabled unless and until you are examined in-person by the doctor; **and**
4. You must see a doctor and be disabled within 15 days AFTER your last day worked to qualify for benefits.
5. LINECO Will NOT accept disability certifications from Doctors of Chiropratic (D.C).

Amount of Benefit

The weekly benefit is **$600 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.

If approved for this benefit, your first weekly income check will be mailed to your home mailing address on file with the Fund Office. Included in your initial payment will be information on the steps needed to receive electronic payment on subsequent weekly income payments.

Please consider utilizing the electronic payment option as it fast, safe, and easy to sign up.

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. The Plan

allows up to 6 weeks for a normal delivery and up to 8 weeks for a Cesarean section.

Your disability will not be considered to have begun until you are treated by a doctor for your disabling medical condition.

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 Use Disorder Treatment

Weekly Income Benefits are payable for eligible employees who are receiving precertified 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 residential 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 and continuing care of a doctor.
- 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 (including side jobs);
- Caused by substance use disorder:
  - » If you are not undergoing covered inpatient treatment in a hospital or a covered residential 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 for which a claim was submitted to LINECO more than two years beyond the start of the disability

» **WHAT YOU NEED TO DO**

CONTACT THE FUND OFFICE AT 1-800-323-7268 TO NOTIFY THE FUND OF YOUR TOTALLY DISABLING ILLNESS OR INJURY. THE FUND OFFICE WILL DIRECT YOU TO ***WWW.LINECO.ORG*** TO DOWNLOAD THE APPROPRIATE WEEKLY INCOME FORMS. IT IS YOUR RESPONSIBILITY TO OBTAIN YOUR EMPLOYER'S AND MEDICAL DOCTOR'S CERTIFICATION, AND RETURN THE COMPLETED FORM TO THE FUND OFFICE.

HOW TO FILE CLAIMS

IMPORTANT NOTE: In a majority of cases, if you utilize a network provider, the provider will file your claim electronically directly to LINECO or to the applicable preferred provider networks. LINECO participates in the Medicare "cross-over" electronic platform and receives claims electronically from Medicare.

All claims should include your name, unique identification number (UID #) (found on your LINECO/BlueCross BlueShield card), and the patient's name.

The claim filing time limit is two years after the date you receive services.
No benefits will be paid for bills submitted more than two years after the date of service or loss.

TYPE OF EXPENSE	WHERE TO SEND CLAIMS
Medical, Behavioral, and Substance Use (All Providers) Most providers will automatically file their claims for you.	Local BlueCross BlueShield Plan
Medical, Behavioral, and Substance Use *(When LINECO is the Secondary Payer)*	Local BlueCross BlueShield Plan
Prescription Drug (Rx) In most cases, you will not need to file prescription drug claims. However, if you do need to submit a drug claim, send it to Express Scripts. Claim forms can be found at ***www.lineco.org***.	Express Scripts Claims P.O. Box 14711 Lexington, KY 40512-4711 ATTN: Commercial Claims
Dental Dentists should file claims electronically. If not, they should use a standard ADA form and submit it to the Fund Office.	**Electronically:** WebMD/Emdeon/Change Healthcare™ ID # LCB01 **OR** LINECO Dental Claims 821 Parkview Blvd Lombard, IL 60148
Vision VSP network providers will handle without filing a claim. Out-of- network providers should send itemized bills with a completed HCFA-1500 or generic claim form to VSP.	Vision Service Plan P.O. Box 385018 Birmingham, AL 35238-0518
HRA Claim forms are available through the HRA link at ***www.lineco.org***	LINECO 821 Parkview Blvd Lombard, IL 60148
Hearing Care **Weekly Income Benefits** **Life and AD&D Insurance Claims**	LINECO 821 Parkview Boulevard Lombard, IL 60148-3230

This page intentionally left 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:**
    a. Sustained while the individual is performing any act of employment or doing anything pertaining to any occupation or any employment for remuneration or profit, whether employed, self-employed (e.g., side jobs) or otherwise; OR
    b. 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.
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 87).
3. **Alternative therapies**, including but not limited to holistic, functional medicine, integrated medicine, naprapathies or naturopathic treatment and any related diagnostic testing or labs that are not medically necessary or standard of care.
4. Treatments, care, services or supplies which are not recommended, ordered or **approved by the attending doctor.**
5. 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.
6. **Aversion therapy** or any program of treatment for substance use disorder that includes aversion treatment.
7. **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.
8. 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 including medical record requests.
9. **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.
10. **Cosmetic** treatment or surgery. This exclusion applies to such things as plastic surgery on the nose, face, breasts or abdominal tissue, and to devices or surgical implantations for simulating natural body contours. As stated in the Plan's definition of "cosmetic" (page 87), the fact that the person may suffer psychological harm or distress without the treatment does not make it non-cosmetic or covered by the Plan.

    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 that significantly impair physiologic function; corrective surgical procedures on organs of the body which perform or function improperly; or breast reconstruction following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance.
11. 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 LINECO.
12. 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.
13. 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).
14. Services or supplies received from a doctor or hospital that does not meet this Plan's **definition of a doctor or a hospital** (as defined on page 88 and page 89 respectively).
15. Inpatient treatment in a facility that does not meet this Plan's **definition of a hospital or residential treatment facility** (as defined on page 90).

16. **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.
17. **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. The only exception is diabetic education will be considered for up to 6 visits per lifetime for a diagnosed diabetic patient.
18. 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. The only exception is diabetic education will be considered for up to 6 visits per lifetime for a diagnosed diabetic patient.
19. **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.).
20. Any treatment, care, services, supplies, procedures or facilities that are **experimental or investigative** (as defined on page 89).
21. Hormone therapy, artificial insemination, or any other direct attempt to induce or **facilitate fertility** or conception. LINECO covers only the initial consultation and tests to determine the underlying cause of a person's infertility provided that neither the covered employee nor their spouse has undergone a prior sterilization procedure, and provided that the infertility is not the result of a normal physiological condition, such as menopause. Only reasonable and standard tests are covered, until the source of the infertility is determined and repeat testing is excluded.
22. **Gender reassignment surgery**, including any complications arising from such surgery; however, nothing in this exclusion shall operate to discriminate against any participant on the basis of race, color, national origin, sex, age, disability, or transgender status.
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. **Habilitative therapy** unless an exception is specifically stated.
25. **Health club memberships** or exercise equipment.
26. **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.
27. **Household items** and general health and comfort items, including but 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 on page 48), or wigs.
28. **Hospice care** except as provided in the *Provisions Governing Hospice Care* section starting on page 50.
29. 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**.
30. Testing to determine the cause of a **child's infertility**.
31. Surgical or **laser procedures to correct nearsightedness**, farsightedness or astigmatism, including Laser Assisted In-Situ Keratomileusis (LASIK) surgery.

32. Charges incurred by an eligible family member which you or the family member are not **legally required to pay**.
33. 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** or frequency limitation stated on the *Schedule of Benefits*.
34. **Marijuana / Cannabis** whether or not legally prescribed.
35. Treatments, care, services or supplies that are not **medically necessary** (as defined on page 90).
36. Prescription drugs for a Medicare-eligible individual who has elected another (not LINECO's) **Medicare Part D** prescription drug plan.
37. **Massage therapy**.
38. Any **military service**-connected injury or sickness.
39. **Maternity related care** if the mother is not eligible under the plan. Additional exclusions include maternity confinement that is not covered, 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. Maternity care for a dependent child is NOT covered as well.
40. Confinement, services or supplies incurred while in a **nursing facility** except as provided in *Other Covered Medical Expenses*, No. 25 on page 49.
41. 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*, on page 48.
42. 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 45. (The Preventive Benefit also covers obesity screening and, if the person is obese, up to 26 face-to-face counseling sessions per year for a person with a medical doctor or behavior therapist (Masters' level or higher) specializing in weight loss.)
43. Except as specified under the preventive care provisions of the Medical Benefit, **over-the-counter drugs, or test kits / labs**, 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.
44. 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.
45. Unless specifically stated otherwise, any type of **physical examination** (employment, pre-marital, 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.
46. **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.
47. Treatments, care, services or supplies that do not meet the **prevailing standards** of medical practice.
48. 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.
49. Routine **circumcision** of a male child after 30 days of age.
50. Individual or **private nursing** care except as provided in *Other Covered Medical Expenses*, on page 49.
51. Hospital charges for a **private room** which are in excess of the hospital's most common charge for a semi- private room.
52. 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.
53. **Reversal** of, or attempts to reverse, a previous elective sterilization.

54. Any operation or treatment of **sexual dysfunction**, including any complications arising from such conditions, including erectile dysfunction drugs (except for up to ten tablets a month for the twelve-month period immediately following a radical nerve-sparing prostatectomy.
55. Rental or purchase of any durable medical equipment or other equipment that is not used solely for therapeutic treatment of a s**ingle individual's injury or sickness**.
56. 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.
57. Treatment or consultation with a **marriage counselor or other licensed practitioner** for marriage, couples, or family counseling. This exclusion does not apply to services provided under the Hospice Care Program or the LINECO Member Assistance Program.
58. 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**.
59. Any type of **speech therapy** except as stated in *Other Covered Medical Expenses*, page 49.
60. 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.
61. Charges filed after the claim filing **time limit**—Claims submitted more than two years after the date the claim is incurred. This rule applies to all benefits the Plan may disburse to or on behalf of a claimant.
62. 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 82).
63. Non-surgical treatment of **TMJ** except as provided in Other Covered Medical Expenses, on page 49.
64. **Travel or transportation**, whether or not recommended by a doctor, except as stated in Other Covered Medical Expenses, page 45.
65. 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.
66. Charges which **would not have been made** if this Plan did not exist.
67. 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.

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 home- owners' 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 member (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 member 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 member 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 member, and the injured individual, agree:

- That the eligible member 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 member and/or the injured individual does not sue the responsible party for recovery of the expenses; and
- The eligible member 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 member 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 member 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 member 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 member 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 member 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 eligible member, retiree and dependent claims. C.O.B. doesn't apply to life insurance, AD&D insurance, Weekly Income Benefits, Teladoc claims, the Member Assistance Program (MAP) or the 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 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 precertification, 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 amounts 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 lesser of the two contracted or negotiated fees, unless the provider's contractual arrangement with the PPO requires LINECO to use the higher of the two 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 entitled to Medicare, you must enroll in Medicare Part B. **Note: if you do not enroll in Part B, LINECO will estimate claims payments as if you have Part B.**
5. On claims for dependent children (regardless of age), the following rules regarding 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. Please see 5. f. below to determine how to handle dependent children when this provision does not resolve the order of benefits.

f. If an eligible dependent child is not employed and/or not married, and the eligible dependent child's natural parents are still married, the plan reverts to 5.a listed on previous page. If an eligible dependent child is not employed and / or not married, and the natural parents were never married, are not married, or divorced, any plan covering the dependent child for the longest period of time will pay first.

If the above rules still do not 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.)

Medicare-eligible persons and their Medicare-eligible 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.

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.

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 Part 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 the patient 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 eligible for Medicare for reasons other than age (for example, because of disability or end stage renal disease), LINECO will usually be the primary plan unless it is legally permitted to pay second. This provision doesn't apply to over age 65 retirees.

Even though LINECO may be primary, you are still required to enroll in Medicare Part A and B as soon as you are eligible. Medicare rules for eligible members under 65 allow LINECO to eventually become the secondary payor.

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 his or her own plan, his/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.

LINECO has an obligation under Medicare Secondary Payor rules to verify with your employer how many are employed.

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 including your own auto 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 supplies 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 (commonly referred to as the R & C). 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 reasonable and customary (R & C) amount may be based on a percentage of Medicare (CMS) reimbursement rates. Additionally, R & C may be calculated according to an independent organization contracted by the Plan which maintains a national database of R & C rates. Secondary networks or negotiated rates may be utilized if they result in lower costs to the Plan or covered individual.

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. The Trustees may amend the reasonable and customary amount methodology from time to time.

You will be responsible for amounts charged by out-of-network providers for any amount more than the allowable charge. It is strongly recommended to use in-network providers whenever possible.

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 syndrome.

CHIROPRACTIC CARE—Any services or supplies that are provided or ordered by a licensed chiropractor that are: (1) permitted by law to be provided by such provider; (2) essential and appropriate for the diagnosis and treatment of an illness or injury to the neuromusculoskeletal system; (3) broadly accepted by the standards of the chiropractic industry; (4) therapeutically safe; (5) clinically effective; (6) appropriate for the patient's age and presenting condition; and (7) not considered to be investigative or experimental.

COSMETIC—A treatment or procedure for the primary purpose of changing the person's appearance. The fact that the patient may suffer psychological or behavioral consequences absent the treatment or procedure does not make it non-cosmetic or covered by the Plan.

DEPENDENT—A dependent is any one of the following:

1. A person who is your (employee's or retiree's) spouse, who is not legally separated from you. This includes a person of the same sex to whom you are legally married. 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, they 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):
   - » Your child who is less than 26 years old; or
   - » Your unmarried child who is age 26 or older and permanently and totally disabled. The child's coverage will be continued as long as you are eligible, provided that the following requirements are met:
     - The child must be incapable of engaging in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or which has lasted or

can be expected to last for a continuous period of not less than twelve months and continue to be so incapable;
- The child must meet the definition of "child" as stated below except for age;
- The child must have become disabled before becoming age 26;
- The child must be dependent on you for the major portion of support; and
- If the Trustees request proof of the child's disability, you must provide the proof, at your expense, within 31 days or the child's coverage under the Plan will be terminated.

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 support. Coverage can be continued after age 19 if the child remains unmarried and is 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 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 84 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/her license and specialty.

With respect to mental/nervous and substance use disorders, covered providers include licensed clinical mental health providers such as social workers and counselors. All Blue Cross Blue Shield network providers are covered providers.

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 "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;
- 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 diagnosis.

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; FUND OFFICE—The Line Construction Benefit Fund.

HEALTH REIMBURSEMENT ACCOUNT—The 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 short-hour and retiree self- payments for continued LINECO coverage. This benefit is commonly referred to as the LINECO HRA and follows guidelines established by the IRS for qualified medical expense accounts.

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 below:

- It is a hospital that is qualified to participate in Medicare and to receive Medicare payments;
- 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.

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.

MEDICARE ELIGIBLE—Generally, Medicare is Federal program for people age 65 or older. You may be able to get Medicare earlier if you have a disability, End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant), or ALS (also called Lou Gehrig's disease). LINECO requires any person eligible or entitled to Medicare to sign up for Medicare Part A (Hospital) and Part B (Medical) as soon as they are eligible for Medicare.

MEMBER—any person who meets the eligibility requirements under the Plan.

MENTAL, BEHAVIORAL HEALTH 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.

RESIDENTIAL TREATMENT FACILITY—A rehabilitation facility for the treatment of individuals suffering from substance use disorder or a mental/nervous disorder. The facility must: (1) provide 24-hour-a-day nursing services by or under the supervision of doctors or R.N.s, with an R.N. on the premises and on duty at least eight hours per day; and (2) either be eligible to participate under Medicare, be accredited by the Joint Commission, or be part of the BlueCross BlueShield BlueCard network.

RETIREE; RETIRED EMPLOYEE—A person who was an eligible employee under this Plan on the day preceding the date of his or her 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 is eligible to participate under Medicare; and (5) 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 USE DISORDER—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).

TIMELY FILING—The claim filing time limit is two years after the date you receive services.

No benefits will be paid for claims submitted more than two years after the date of service or loss. Additionally, if your claim for services is denied for additional information, the Plan will not accept additional information if it is not returned to the Fund within two years of the date requested by the Fund Office.

TMJ—Temporomandibular joint syndrome, maxillary or craniomandibular disorders, and other conditions of the joint linking the jawbone 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 these conditions.

TOTALLY DISABLED; TOTAL DISABILITY—An eligible employee is totally disabled if he or she is completely unable to perform any and every duty of his/her occupation or employment because of an accidental bodily injury or sickness. A dependent or a retiree is totally disabled if he or she 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 precertification 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 precertifying the proposed treatment. The Plan's claim filing procedures are described on page 75. Claims for benefits must be submitted within two years from the incurred date (date of service, procedure date, accident, injury date, date of loss, etc.).

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 if 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.

1. For a denial of a disability claim, the notice, which will be provided in a culturally and linguistically appropriate manner to the extent required by law will include:
   A statement regarding the rights of the claimant and an authorized representative.
2. A discussion of the decision including an explanation of the basis for disagreeing or not disagreeing, including:
   - The views presented by the claimant to the Plan of healthcare professionals treating the claimant and vocation professionals who evaluated the claimant;
   - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and a disability determination regarding the claim presented by the claimant to the Plan made by the Social Security Administration;
   - If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the decision will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
   - The decision will include either specific internal rules, guidelines, protocols, standards or other similar criteria that the Plan relied upon in making an adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

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 821
Parkview Boulevard
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 judgment, 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 judgment. 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.

After a decision has been made on a disability claim, you will be informed in writing of the claim review committee's decision, which will be provided in a culturally and linguistically appropriate manner to the extent required under applicable law and should include:

1. The views presented by the claimant to the Plan of healthcare professionals treating the claimant and vocation professionals who evaluated the claimant;
2. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and a disability determination regarding the claim presented by the claimant to the Plan made by the Social Security Administration;
3. If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the decision will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
4. The decision will include either specific internal rules, guidelines, protocols, standards or other similar criteria that the Plan relied upon in making an adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

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, which will be refunded if the appeal is granted.

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.

Any action by a Member or Beneficiary relating to or arising under the Plan shall be brought and resolved only in the U.S. District Court for the Northern District of Illinois, Eastern Division, and in any courts in which appeals from such court are heard, and such courts shall have personal jurisdiction over the Member or Beneficiary named in such action. A Member or Beneficiary shall include an assignee of the Participant's or Beneficiary's benefits under the Plan

Claim and Appeal Procedures for Life / AD&D Claims

Life / AD&D insurance claims must be filed with the LINECO Fund Office which will forward them to Trustmark Life Insurance Company, the insurer of these benefits.

The insurer will normally issue an approval or denial of a life / AD&D claim within 90 days of the date it receives the claim. An extension of 90 days will be allowed if special circumstances are involved. Trustmark will send a written notification of any extension it requires to review your claim, and the notice will state the special circumstances involved and the date by which it expects to reach a decision.

If Trustmark denies your claim, they will issue a notice written in an understandable manner

explaining the reasons for the denial. The notice will also include an explanation of their claim appeal procedures. Review of claim denials and final decisions on appeal are Trustmark's responsibility.

Since LINECO is the group policyholder, the notices referenced above will be sent to the Fund Office, who will in turn inform you, also in writing, of the reason for the delay, denial or decision on appeal.

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.

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 eligible family members.

Fund's Right to Recover Overpayments

Employees, retirees or dependents who receive money from the Plan to which they are 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.

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.

No Surprises Act

» **IMPORTANT—YOUR CLAIM MAY QUALIFY FOR PROTECTION**
YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency

or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - » Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - » Cover emergency services by out-of-network providers.
  - » Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - » Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Labor at 1-866-444-EBSA (3272).

Visit ***www.dol.gov/ebsa*** for more information about your rights under federal law.

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 100). 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, including health research.
- 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.
- When an individual dies and has elected to be an organ donor, to respond to organ donation requests, medical examiners, funeral directors and organ procurement organizations.

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.

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.

We are required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. When we do so, we must meet many conditions. For additional information on these activities see: ***www.hhs.gov/ocr/hipaa/understanding/consumers/index.html***.

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 may request a copy of the signed 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 821 Parkview Boulevard, Lombard, IL 60148-3230.

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). You have a right to restrict information provided to friends and family members in the event of a natural or other disaster, but such restrictions must be requested in writing. In the absence of such direction, the Fund will disclose information in such circumstances when the Fund determines it to be in your best interests. Please note that we never share or sell your health information for marketing purposes unless we have your written permission. 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 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***.

Right to a Notice of a Breach—We will notify you promptly if a breach occurs that may have compromised the privacy and security of your information.

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 (see ***www.hhs.gov/ocr/privacy/hipaa/complaints/***). The Fund encourages you to express any concerns you may have regarding the privacy of your information. Neither the Fund, your employer nor your Union are permitted to retaliate against you in any way for filing a complaint. 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 not allowed to use genetic information to decide whether or not to provide coverage and the price of that coverage.

Contact Person

The Fund has designated Jeff Marshall as its HIPAA Privacy Officer. This is the contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at 821 Parkview Blvd., Lombard, Illinois 60148, 1 (800) 323-7268.

This Notice was effective as of November 23, 2013.

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.

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.

Nondiscrimination Statement

The Line Construction Benefit Fund (the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The Plan provides language assistant services to persons whose primary language is not English, and free aids and services where necessary to people with disabilities to communicate effectively with us. If you need these services, contact the Fund Office.

If you believe that the Line Construction Benefit Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Fund Office by mail, fax or in person to: Civil Rights Coordinator, LINECO, 821 Parkview Blvd., Lombard, IL 60148, telephone 1-800-323-7268. If you need help filing a grievance, Fund Office personnel are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://***www.hhs.gov/ocr/office/file/index.html***.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800- 323-7268.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1- 800-323-7268.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-323-7268（TTY：1-800-323-7268）。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-323-7268 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-323-7268.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية المجانية تتوافر لك بالمجان. اتصل برقم 1-800-323-7268) رقم هاتف الصم والبكم: -1.)7268-323-800

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-323-7268(телетайп: 1-800-323-7268).

સૂચના: જો તમે ગજરાતી બોલતા હો, તો નન:શલ્ક ભાષા સહાય સવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-323-7268.

. 1-800-323-7268خبردار: اگر آپ اردو بولتے ہیں، تو آپ کے لئے مفت میں دستیاب خدمات کی مدد کی زبان کی خدمات موجود ہیں۔ کال کریں -

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-323-7268.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-323-7268

ध्यान दें: यदद आप ह दी बोलते हैं तो आपके दलए मफ्त में भाषा सहायता सेवाएं उपलब्ध ह। 1-800-323-7268 पर कॉल करें।

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-323-7268(ATS : 1-800-323-7268).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-323-7268.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-323-7268.

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 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 District Vice President of the IBEW. Employer Trustees are appointed by the corresponding District 10 Chapter of the National Electrical Contractors' Association. The names and addresses of the individual Trustees start on page 107.

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 Administrator is:

Line Construction Benefit Fund
821 Parkview Boulevard
Lombard, IL 60148

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 108. 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 a local union affiliated with the IBEW and which have a clause requiring contributions to LINECO and have petitioned and been approved by the LINECO Board of Trustees, 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.

This page intentionally left blank.

PARTICIPATING NECA CHAPTERS AND LOCAL UNIONS

These are the various IBEW trade classifications covered under LINECO:

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

MISSOURI VALLEY LINE CONSTRUCTORS CHAPTER

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

AMERICAN LINE BUILDERS CHAPTER

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

NORTHWEST LINE CONSTRUCTORS CHAPTER

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

SOUTHEASTERN LINE CONSTRUCTORS CHAPTER

84	Atlanta, GA	O, T
108	Tampa, FL	O
130	New Orleans, LA	O
136	Birmingham, AL	O
175	Chattanooga, TN	O, C, LCTT, MT
222	Gainesville, FL	O
238	Asheville, NC	O
270	Oak Ridge, TN	O
295	Little Rock, AR	O
329	Shreveport, LA	O
342	Winston Salem, NC	O
379	Charlotte, NC	O
429	Nashville, TN	O, LCTT
436	El Dorado, AR	O
443	Montgomery, AL	O
474	Memphis, TN	O, LCTT
495	Wilmington, NC	O
553	Raleigh, NC	O
558	Sheffield, AL	O, CS, CATV
605	Jackson, MS	O
676	Pensacola, FL	O
700	Fort Smith, AR	O
760	Knoxville, TN	O, LCTT 7
76	Charleston, SC	O
779	Columbus, GA	O
852	Corinth, MS	O
903	Gulfport, MS	O
917	Meridian, MS	O
934	Blountville, TN	O, CATV
995	Baton Rouge, LA	O
1077	Bogalusa, LA	O
1516	Jonesboro, AR	O
1925	Martin, TN	O
2113	Tullahoma, TN	O

SOUTHWESTERN LINE CONSTRUCTORS CHAPTER

20	Dallas, TX	O
66	Houston, TX	O
220	Dallas, TX	O
278	Corpus Christi, TX	O
301	Texarkana, TX	O
304	Topeka, KS	O, CS, C, MT, CATV, T
386	Texarkana, AR	O
387	Phoenix, AZ	LCTT
602	Amarillo, TX	O
611	Albuquerque, NM	O 6
81	Wichita Falls, TX	O
738	Longview, TX	O
769	Phoenix, AZ	O, CS, CATV, T
898	San Angelo, TX	O
1002	Tulsa, OK	O, CS
1523	Wichita, KS	LCTT
2286	Port Arthur, TX	O

WESTERN LINE CONSTRUCTORS CHAPTER

12	Pueblo, CO	O, C CATV, CS
44	Butte, MT	O, C CATV, CS
47	Diamond Bar, CA	LCCT, O
57	Salt Lake City, UT	O, C CATV, CS
111	Denver, CO	O, C CATV, CS
113	Colorado Spgs. CO	O, C CATV, CS
206	Helena, MT	O, C CATV, CS
291	Boise, ID	O, C CATV, CS
322	Casper, WY	O, C CATV, CS
396	Las Vegas, NV	O, C CATV
449	Pocatello, ID	O, C CATV, CS
969	Grand Jct., CO	O, C CATV, CS
1245	Walnut Creek, CA	O, C CATV, CS

NORTHEASTERN LINE CONSTRUCTORS CHAPTER

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

BOARD OF TRUSTEES AND FUND PROFESSIONALS

Board of Trustees

Union Trustees

Mr. William Hitt
Local Union #222, IBEW
17850 US Highway 441 North
Reddick, FL 32686

Mr. Mark Cunningham
Local Union #769, IBEW
220 N. William Dillard Drive
Gilbert, AZ 85233

Mr. Travis Eri
Local Union #125, IBEW
17200 N. E. Sacramento Street
Portland, OR 97230

Mr. Robert Fox
Local Union #1393, IBEW
3645 S East Street
Indianapolis, IN 46227

Mr. Kevin Owen
Local Union #57, IBEW
3400 W. 2100 Street, Ste. B
Salt Lake City, UT 84119

Mr. Bryan Stage
Local Union #71, IBEW
3403 Farm Bank Way, Building 2
Grove City, OH 43123

Mr. Robert Reilly
Local Union #1319, IBEW
225 Division Street
Kingston, PA 18704

Mr. Grant Rains
Local Union #175, IBEW
3922 Volunteer Drive, Suite 9
Chattanooga, TN 37416

Mr. Glen Petznick
Local Union #1525, IBEW
13336 C Street
Omaha, NE 68144

Employer Trustees

Mr. Darran Ayres
J.F. Electric, Inc.
100 Lakefront Parkway,
P.O. Box 570
Edwardsville, IL 65025

Mr. Andy Carmean
Intren
18202 West Union Road
Union, IL 60180

Mr. Jesse Colley
C and C Powerline
12035 Palmlake Drive
Jacksonville, FL 32218

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

Mr. Mark Pellerito
Newkirk Electric Associates, Inc.
1875 Roberts Street
Muskegon, MI 49442

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

Mr. Michael Troutman
O'Connell Electric
830 Phillips Road
Victor, NY 14564

Ms. Stacy Wilson
Wilson Construction Company
P.O. Box 1190
Canby, OR 97013

Ms. Mindie McIff
Sturgeon Electric
1510 S 4450 West
Salt Lake City, UT 84104

Fund Professionals

Fund Administrator / Agent for Legal Service of Process

Mr. Kevin Chesniak
Executive Director
Line Construction Benefit Fund
821 Parkview Boulevard
Lombard, IL 60148

Fund Auditor

Legacy Professionals LLP
Certified Public Accountants
4 Westbrook Corporate Center, Suite 700
Westchester, IL 60154

Fund Consultant / Actuary

Foster & Foster, Inc.
One Oakbrook Terrace, Suite 720
Oakbrook Terrace, IL 60181

Fund Attorney

Asher, Gittler & D'Alba, Ltd.
Attorneys at Law
200 West Jackson Boulevard, Suite 720
Chicago, IL 60606