MICHIANA AREA ELECTRICAL WORKERS' FRINGE BENEFIT FUNDS

Michiana Area Electrical Workers' Health and Welfare Fund
Michiana Area Electrical Workers' Pension Fund
Michiana Area Electrical Workers' Money Purchase Plan

Managed for the Trustees by:
TIC INTERNATIONAL CORPORATION

September 2011

TO: ALL PARTICIPANTS IN THE MICHIANA AREA ELECTRICAL WORKERS' HEALTH & WELFARE FUND

RE: SUMMARY OF MATERIAL MODIFICATIONS – WORKING SPOUSE RULE

Dear Plan Participant:

Effective January 1, 2012 the Michiana Area Electrical Workers Health and Welfare Fund ("Fund") will include a Working Spouse Rule requiring that working spouses of participants enroll in their employers' health plans. Spouses that do not enroll in their employers' health plans will have **no coverage** through the Fund unless they qualify for the HARDSHIP EXEMPTION as explained below.

You must provide information regarding your marital status and your spouse's employment status (if you are married) on an annual basis. Please complete the enclosed Spouse Employment Information Form and return it to the Fund Office by no later than **October 19, 2011**.

YOU ARE REQUIRED TO COMPLETE AND RETURN THIS FORM REGARDLESS OF YOUR MARITAL STATUS OR YOUR SPOUSE'S EMPLOYMENT STATUS

THE BASIC "WORKING SPOUSE RULE"

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

Additional details regarding the "working spouse rule" and the hardship exemption may be found on the back of this letter. If you have any questions, please contact the Fund office.

Sincerely,

Board of Trustees,
Michiana Area Electrical Workers' Health and Welfare Fund

6525 Centurion Drive • Lansing, MI 48917-9275
(517) 321-7502 • (877) 244-9473 Toll Free
FAX (517) 321-7508
www.ibew153benefits.org

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

1. **Has gross annual wages of less than $20,000, or**

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

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

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

Additional provisions and exceptions to the Working Spouse Rule:

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

2. It applies to retirees as well as active employees, but only if the retiree's spouse is still actively employed.

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

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

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

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

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

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

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

2011 SPOUSE EMPLOYMENT INFORMATION FORM

Complete and return to Fund Office. You are required to keep the Fund Office advised if any of the following information changes. BE SURE THAT YOU AND YOUR SPOUSE SIGN THE FORM ON THE BACK.

Participant's Name____

Member ID or Social Security Number ______________________________

Are you currently married? Yes No If you are not married, no further information is required. Please sign and date this Form below and return the Form to the Fund Office.

If married, please answer the following questions about your spouse's employment

1. Name of Spouse ____
2. Spouse's employment status not employed full-time part-time self-employed retired
3. Name and address of spouse's employer: ______________________________

   ______________________________ Hire Date:______________
4. Telephone number of spouse's employer:______________________________
5. Does your spouse's employer offer a health plan? yes no

Answer the remaining questions only if you answered "yes" to No. 4

6. Is your spouse eligible to enroll in the employer's health plan? yes no
7. Is your spouse enrolled in the employer's plan? no yes, single coverage yes, family coverage

If your spouse's employer offers health coverage but your spouse is not eligible to participate, you must submit a letter from the employer on company letterhead. The letter should be addressed to the Michiana Area Electrical Workers Health & Welfare Fund and should state that your spouse is not eligible for the employer's health plan and the reason for his or her ineligibility (for example, because your spouse works part-time).

8. Give name and address of insurance company: ______________________________

   ____

   Group No.__________ Individual ID No.______________ Effective Date ____________________

   Type of coverage (check all that apply): medical Rx dental vision

   Please include a copy of the front and back of your spouse's insurance identification card.

9. If spouse is NOT enrolled, when will your spouse be eligible to enroll in that plan? ________________

If your spouse declines to elect available coverage, the Michiana Area Electrical Workers Health and Welfare Fund will NOT pay any benefits for your spouse. This rule may be waived for a newly eligible participant whose spouse was offered but declined the employer's plan. You must submit a letter from the employer on company letterhead verifying this information The letter should be addressed to the Michiana Area Electrical Workers Health and Welfare Fund and should state when and under what circumstances your spouse will have another opportunity to enroll. The Michiana Area Electrical Workers Health and Welfare Fund will waive non-payment rule only until the other plan's next available enrollment date.

HARDSHIP EXEMPTION

The Fund's non-payment rule will not apply if your spouse (1) has annual gross earnings less than $20,000, **OR** (2) has annual gross wages greater than or equal to $20,000 but less than $30,000; AND must pay more than $150 per month toward the cost of the least expensive health plan offered by his or her employer. You are responsible for demonstrating your spouse's entitlement to a hardship exemption by submitting a letter from the employer on company letterhead attesting to wages and cost of coverage. The Fund Office will determine whether a spouse with variable wages qualifies for the hardship exemption by looking at the spouse's average wages over the past twelve (12) months.

IMPORTANT

YOU MUST SIGN THE FORM WHERE INDICATED BELOW

I affirm that the information given above is true and correct to the best of my ability and I understand that if I have given false information or made any material misrepresentations in response to the questions in this Form, it could result in a loss of coverage to my spouse and myself and could also result in penalties and fines and possibly prosecution. ***I also understand that it is my responsibility to notify the Fund Office if any of the above information changes.***

Signature of PARTICIPANT/RETIREE	**Member ID or Social Security #**	**Date**

IMPORTANT

YOUR SPOUSE MUST SIGN THE AUTHORIZATION BELOW

THIS ENTIRE FORM AND THE SIGNED AUTHORIZATION MUST BE RETURNED TO THE MICHIANA AREA ELECTRICAL WORKERS HEALTH & WELFARE FUND OFFICE

I hereby authorize my employer to release information regarding my employer's health plan, and my eligibility for coverage under that plan to the Michiana Area Electrical Workers Health & Welfare Fund. I understand that this authorization shall remain in effect as long as I am eligible for benefits under the Michiana Area Electrical Workers Health and Welfare Fund. I understand that the purpose and scope of this authorization is to allow the Michiana Area Electrical Workers Health and Welfare Fund to verify with my employer whether I am eligible to obtain coverage under my employer's plan. I further affirm that the information given above is true and correct to the best of my ability and I understand that if I have given false information or made any material misrepresentations in response to the questions in this form, it could result in a loss of coverage to my spouse and myself, and could also result in penalties and fines and possibly prosecution. ***I also understand that it is my spouse's responsibility to notify the Fund Office if any of the information on this Form changes.***

Signature of Spouse	**Social Security #**	**Date**