Group P14479 (GLW)
Effective October 1, 2015

Summary Plan Description

LOCAL NO. 731, I.B. OF T. GARAGE ATTENDANTS, LINEN AND LAUNDRY HEALTH AND WELFARE FUND

INTRODUCTION

To All Plan Participants:

The Trustees of your Welfare Fund are pleased to provide you with this new, updated Plan Document and Summary Plan Description booklet. Be sure to read this booklet carefully (have your Spouse read it too) and keep it with your other important papers for future reference.

Sincerely,
Board of Trustees

About This Book – This book is intended to serve as the Plan Document and Summary Plan Description. The Plan Document and Summary Plan Description were formerly separate documents. The Trustees have determined to combine the Summary Plan Description and Plan Document. This document ("The Plan") describes the rules, regulations, benefits, and limitations of the payment of health benefits by the Fund. Only the full Board of Trustees is authorized to interpret and apply the Plan described in this book, except that individuals or Committees designated by the Trustees may also interpret and apply the Plan. The Trustees' (or their designee's) interpretation and application of the Plan 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. No agent, representative, officer or other person from the Union or an Employer has the authority to speak for the Trustees or to act contrary to the written terms of the governing Plan documents. If you have questions about eligibility or claims, only the Welfare Fund Office is authorized to answer the questions for the Trustees. Matters that are not clear, or which need interpreting, will be referred to the Trustees or their designees.

No Vesting of Benefit Rights – Plan Participants and their Dependents do not have a vested right to benefits provided by the Plan or to coverage under the Plan. The Board of Trustees has full authority to increase, reduce or eliminate benefits and to change the eligibility rules or other provisions of the Plan at any time. The Plan is maintained for the exclusive benefit of the Plan Participants and Beneficiaries.

IMPORTANT NOTICE

In the event there appears to be a conflict between any description of a Plan provision in this Summary Plan Description (SPD) and any other information you may have received, either written or orally, the language contained in this SPD is the official and governing language.

This SPD shall act as the Plan Document. The Trustees have **SOLE AND ABSOLUTE DISCRETION** with regard to the Plan and its interpretation and/or application. As the Plan is amended from time to time, you will be sent information in the form of a Summary of Material Modification (SMM) explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

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PLAN INFORMATION

This Summary Plan Description sets forth the benefits for Teamsters Local 731 Members who are eligible to participate in the benefits of this Welfare Fund.

The Plan provides the following benefits: Hospital, Medical, Death, Accidental Death and Dismemberment, Prescription Drug, Dental, Hearing, and Vision.

COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to a number of Collective Bargaining Agreements (CBA). A copy of any such agreement may be obtained by Participants or their Beneficiaries upon written request to the Welfare Fund Office. The Fund Office will also provide, upon written request, information as to whether a particular employer is sponsoring the Plan and, if so, the name and address of the employer.

PLAN INFORMATION

Plan Name:	Local No. 731, I.B. OF T. Garage Attendants, Linen and Laundry Health and Welfare Fund
Plan Administrator:	Board of Trustees Local No. 731, I.B. OF T. Garage Attendants, Linen and Laundry Health and Welfare Fund
Address of Plan:	Local No. 731, I.B. OF T. Garage Attendants, Linen and Laundry Health and Welfare Fund 1000 Burr Ridge Parkway, Suite 301 Burr Ridge, IL 60527 Telephone (630) 887-4150
Plan Number:	501
Employer Identification Number:	36-6073849
Plan Fiscal Year Ends:	June 30th
Plan Year:	January 1 through December 31
Agent for Service of Legal Process:	Richard J. Clarson, CEBS Local No. 731, I.B. OF T. Garage Attendants, Linen and Laundry Health and Welfare Fund 1000 Burr Ridge Parkway, Suite 301 Burr Ridge, IL 60527 Telephone (630) 887-4150 Note: Service of any legal process may be also made on the Board of Trustees or any individual Trustee at the Fund Office's address.
Plan Type:	Hospital, Medical/Surgical, Life and Accidental Death & Dismemberment, Dental, Major Medical, Hearing, and Vision

PLAN SPONSORSHIP AND ADMINISTRATION

The Plan is sponsored and administered by a joint labor-management Board of Trustees.

The Board of Trustees is divided equally between Trustees appointed by the Union and Trustees appointed by Employers contributing to the Fund. The legal address of the Board of Trustees is set forth above and the names of the individual trustees are listed at the end of this booklet. The Board of Trustees is assisted in its administration by the Administrator and Welfare Fund Office staff who are responsible for maintaining eligibility records, paying claims and initial denial of claims (when necessary).

FINANCING OF THE PLAN

The benefits provided by this Plan are funded through Employer contributions as required by the Collective Bargaining Agreements between the Union and the Contributing Employers. The contributions are received and held in Trust by the Board of Trustees for the payment of benefits and administration of the Plan. The amount of the contributions is determined by the terms of the Collective Bargaining Agreements.

WELFARE FUND PRIVACY OFFICER

If you believe that your HIPAA privacy rights have been violated, please refer to Your Individual Privacy Rights Section of this SPD. You may file a complaint with the Welfare Fund in care of the Privacy Officer at the following address:

Richard J. Clarson, CEBS, Privacy Officer
1000 Burr Ridge Parkway, Suite 301
Burr Ridge, IL 60527
Telephone (630) 887-4150

CONTACT INFORMATION

WELFARE FUND OFFICE

Contact the Welfare Fund Office to discuss all questions regarding the benefits available under the Plan.

Local 731 Welfare Funds
1000 Burr Ridge Parkway, Suite 301
Burr Ridge, IL 60527
Tel: (630) 887-4150

To Find Out About:	Contact:	Telephone Number:	Website:
ELIGIBILITY/BENEFITS	Fund Office	(630) 887-4150	www.ibt731funds.org
CLAIM STATUS	Fund Claims Department	(630) 920-1939	Claim status not available on website
PPO PROVIDER FINDER	Blue Cross / Blue Shield of Illinois	(800) 810-2583	www.bcbsil.com
SLEEP STUDY COORDINATOR	Med-Care Management	(800) 367-1934	None
SLEEP APNEA / EQUIPMENT COORDINATOR	Med-Care Management	(800) 367-1934	None
MEDICAL PRE-CERTIFICATION	Med-Care Management	(800) 367-1934	None
PRESCRIPTION PLAN	OptumRx	(800) 880-1188	www.mycatamaranrx.com
DENTAL PLAN	Delta Dental of Illinois	(800) 323-1743	www.deltadentalil.com
VISION PLAN	Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
HEARING PLAN	Epic Hearing	(866) 956-5400	www.epichearing.com
MEMBER ASSISTANCE PROGRAM (MAP)	Employee Resource Systems	(800) 292-2780	www.ers-eap.com User: ibt731 Password: teamsters
IMAGING PROVIDER (CAT SCAN/MRI/PET SCAN)	Absolute Solutions	(800) 321-5040	www.absolutedx.com
WELLNESS PROGRAM	Interactive Health	(800) 840-6100	www.myinteractivehealth.com

TIP: OptumRx is formerly known as Catamaran. Your Catamaran drug card will still work.

TIP: The Fund provides you access to a network of doctors and hospitals that discount to fees for services they provide to eligible Participants. Your out-of-pocket expenses depend on whether you decide to go in-network or out-of-network for your care. Generally, the Fund pays a higher level of benefits for care received from participating (in-network) providers.

TIP: Links to all service providers to the health plan can be found on the Fund Office website at www.ibt731funds.org.

DEFINITIONS

These are some of the terms used in your booklet. Some other terms are described as they are used. PLEASE READ THEM CAREFULLY. It can help you to better understand what your benefits are.

Allowed Amount is the maximum amount of the billed charge of which the Plan deems payable for Covered Expenses rendered by participating providers and facilities or by non-participating providers and facilities. Plan provisions (Deductible, Co-insurance) are applied to allowable amounts. If your provider charges more than the Allowed Amount, you may have to pay the difference. This is referred to as "Balance Billing." See "Reference Based Pricing" definition for out of network allowed amounts.

Ambulatory Surgical Facility (or Ambulatory Surgical Center) means a health care facility in which surgery is performed on patients on an outpatient basis.

Appeal is a request for the Plan to review a decision. Please refer to the section on Appeal Procedures.

Balance Billing in out-of-network cases, the Plan pays up to the Allowed Amount. In some cases, the provider may charge a higher amount than the Allowed Amount, and will then bill the patient the balance above the Allowed Amount (in addition to your Co-Insurance). This is called "Balance Billing."

Beneficiary means the person entitled to receive benefits under the terms of the Plan following the death of an active Employee Member.

Board of Trustees are the individuals with whom Fund property is legally committed in trust. The Board has the legal obligation of managing Fund assets on behalf of the Participants in the Fund.

Case Managers are professionals hired by the Plan for clinical review, support and assistance in determining medical necessity.

Child - For purposes of this definition, "Child" means:

- Your legitimate child born of a valid marriage of yours;
- Your natural child of yours who is not a legitimate child born of a valid marriage, provided you submit satisfactory proof of your parenthood (birth certificate, voluntary acknowledgement of paternity, etc.);
- Any child legally adopted by you or any child placed in your home for the purpose of adoption;
- A stepchild of yours (meaning any child of your current Spouse who was born to your Spouse or who was legally adopted by your Spouse before your marriage to that Spouse);
- A foster child of yours, meaning a child who is placed with you pursuant to legal guardianship of the child or other court order, provided that no state or private social service agency pays any support or compensation to you or any member of your household for the support or maintenance of the child; and
- Any child determined by the Trustees to be an "alternate recipient" under the terms of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations by calling or writing the Welfare Fund Office.

The Fund Office will require proof of a person's Dependent status. Such proof may be in the form of copies of certified marriage or birth certificates, court orders, or other documents. These documents should be kept readily available to submit to the Fund Office when they are requested.

Class A refers to Active Employees.

Class B refers to Pre-age 65 Retirees and Non-Medicare disabled retirees.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Co-Insurance means the amount that you must pay for services or supplies, as per the Plan provisions. For example, the Plan pays 80%, you pay 20%. 20% is the Co-Insurance amount.

Co-Payment means the amount that must be paid by active Participants for certain services that are not fully paid under the Plan. The Co-Payment is a flat-dollar payment that is the same for a given service provided to Participants regardless of the cost of the service. Co-Payment can also mean the amount of money you may be required to pay on a monthly or weekly basis to maintain health coverage.

Collective Bargaining Agreements (CBA) were established between Employers and the International Brotherhood of Teamsters, Local 731 ("Union") and have been maintained through succeeding agreements under which Employer contributions to the Plan are required.

Contributing Employer is an employer required to contribute to the Fund pursuant to the terms of a Collective Bargaining Agreement or other written agreement.

Covered Employment means work for which your employer must contribute to the Fund on your behalf.

Covered Expenses or Covered Medical Expenses means the Reasonable and Customary expenses incurred by a Participant that are eligible to be considered for payment under the Plan, subject to the provisions, limitations and exclusions of the Plan.

Custodial Care is care that is designed primarily to assist an individual in meeting the activities of daily living, regardless of what the care is called, including any care intended primarily to help a disabled person meet basic personal needs when there is no plan of active medical treatment to reduce the disability or the plan of active medical treatment cannot reasonably be expected to reduce the disability.

Deductible means the amount that a covered Participant must pay under the Plan for each calendar year and/or service before becoming eligible for payment of certain Covered Expenses.

Dependent means:

- Your Spouse, while not legally separated from you.
- Your Child (see "Definition of Child"):
  a. Who is less than 26 years old and is not eligible to enroll in an employer-sponsored health plan where the Child's eligibility is based on his or her own employment or the employment of the Child's Spouse; or

> **NOTE:** Effective January 1, 2014, the requirement for eligible enrollment based on the Child's own employment is eliminated. In other words, Children up to age 26 are eligible.

  b. Who is age 26 or older and who is incapable of self-support due to mental incapacity, mental retardation or physical disability which began before the Child attained age 26 and is dependent upon you for support and maintenance. The coverage of such a Child will be continued for as long as you are eligible and for as long as the incapacity and dependency continue.

At the time the first claim is filed on behalf of the Child, you must furnish proof, at no expense to the Plan that the Child was so disabled before becoming age 26. However, if the required proof includes a physical examination of the Child by a Doctor, the Plan will pay for the exam. If you do not provide the proper proof, the Child will not be covered beyond the date he becomes age 26. You must furnish proof of the Child's continued disability from time to time thereafter if requested by the Trustees (but not more often than once in a 12-month period). If proof is requested but not received on or before the date set by the Trustees, the Child's coverage will terminate on that date.

If a Child works for a Contributing Employer and is eligible for benefits under this Plan as an Employee, or if the Child is a full-time active member of the military service of any country, the Child is not considered a Dependent under this Plan (except as shown under "COBRA Coverage").

Durable Medical Equipment is Medically Necessary equipment and supplies ordered by a health care provider for everyday or extended use.

Eligible Employee - An Employee who has met the eligibility requirements established by the Trustees for being eligible under the Plan and is entitled to receive benefits under the Plan.

Emergency is defined as a medical condition which, if immediate medical attention is not provided, can reasonably be expected to lead to death, serious dysfunction of any bodily organ or part or other serious medical consequences. These conditions must be severe, sudden in onset and involve one or more of the major organ systems of the body, such as the cardiovascular, metabolic, respiratory, nervous, gastrointestinal or urinary system. In no event will a condition be considered an Emergency if the first Treatment by a Doctor is provided more than 24 hours after the onset of the symptoms. If symptoms exist that reasonably may have been interpreted as an Emergency under the definition above, that condition will be considered an Emergency, even if the final diagnosis is of another condition. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an Emergency even if the final diagnosis indicates that it was not actually a heart attack. In addition to medical conditions that are Emergencies as defined above, there are some conditions that result from accidents that appear to be serious and so threatening to a body part that emergency room treatment is recommended. These conditions will be considered Emergencies, even though they do not meet the definition above. Being taken for treatment to the nearest Hospital or trauma center by police, fire department or ambulance, when such transportation is made under circumstances over which the person has no control, will be considered an emergency.

Employee or Employee Member or Member means an individual who is the Employee of an Employer who is covered under the terms of a Collective Bargaining Agreement. The Trustees shall have the sole and absolute discretion to verify whether an individual is an Employee of an Employer.

Employer means an employer required to contribute to the Plan on behalf of Employees pursuant to a Collective Bargaining Agreement or other written agreement.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Excluded Services are health care services that are not covered by this Plan.

Experimental means any treatment procedure, facility, drug, device or supply not yet recognized as acceptable medical practice and any such items requiring Federal or government agency approval for which such approval has not been granted at the time services are provided. The Trustees have the authority to determine whether a treatment, service or supply is Experimental. The fact that a Physician has prescribed, ordered, recommended or approved the treatment, service or supply does not in itself make it an acceptable medical practice.

Fund Office means the office maintained by the Trustees of Local 731 Welfare Funds, where the business of said Fund is conducted. It is located at: 1000 Burr Ridge Parkway, Suite 301, Burr Ridge, IL. 60527. The telephone number is: (630) 887-4150.

HIPAA means the Health Insurance Portability and Accountability Act.

Home Health Agency is a public agency or private organization, or a subdivision that meets all of the following requirements: (1) It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients; (2) It has established policies governing the services that it provides; its services are supervised by a Doctor or a registered nurse (R.N.); (3) It maintains records on all of its patients; (4) It is licensed according to the applicable laws of the state in which the patient receiving the treatment lives and of the locality in which it is located or in which it provides services; and (5) It is eligible to participate in Medicare.

Hospice is a public agency or private organization (or a part of either), primarily engaged in providing a coordinated set of services at home or in outpatient or institutional settings to persons suffering from

a terminal medical condition. The agency or organization (1) must be eligible to participate in Medicare; (2) must be appropriately licensed by the state in which it operates; (3) must have an interdisciplinary group of personnel that includes the services of at least one Doctor and one R.N.; (4) must maintain clerical records on all patients; (5) must meet the standards of the National Hospice Organization; and (6) must provide, either directly or under other arrangements, the services and supplies listed as Covered Expenses under the Hospice Benefit.

Hospital means an institution which:

- Is primarily engaged in providing, by or under the supervision of Physicians, inpatient diagnostic, and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or inpatient rehabilitation of injured, disabled or sick persons;
- Maintains clinical records on all patients;
- Has bylaws in effect with respect to its staff of Physicians;
- Has a requirement that every patient be under the care of a Physician;
- Provides 24-hour nursing service rendered or supervised by a registered graduate nurse;
- Has in effect a hospital utilization review plan;
- Is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and
- Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

Unless specifically provided, the term *"Hospital"* does **not** include any institution, or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility, or facility for the aged or for the care and treatment of substance abuse, or a facility where more than 15% of beds are allocated for the treatment of mental or nervous disorders, nor does it mean any institution that makes a charge that the Member is not required to pay.

Investigational means any service, supply, drug, or other treatment that does not meet all of the following criteria:

- The service, supply, drug, or treatment has received final approval from the appropriate governmental regulatory bodies;
- Scientific evidence permits conclusions concerning the effect of the service, supply, drug, or treatment on health outcomes; and
- The service, supply, drug, or treatment is generally accepted as standard medical treatment of the condition being treated.

Medical Necessary refers to only those services, treatments or supplies provided by a Hospital, Doctor or other qualified provider of medical services and supplies that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an injury or sickness. To be considered Medically Necessary, the service, treatment or supply: (1) must be consistent with the symptoms and diagnosis and treatment of the condition, disease, sickness or injury; (2) must be appropriate according to standards of good medical practice and be the most appropriate service or supply that can safely be provided to the patient under the circumstances; (3) must not be solely for the convenience of the patient, the Doctor or the Hospital; and (4) could not be omitted without adversely affecting the patient's condition or the quality of medical care.

Medicare means the medical benefits provided by Title XVIII of the Federal Social Security Act, as amended from time to time.

Medical Review Organization means the professional medical organization whose staff reviews specified services and supplies to ensure that they are Medically Necessary and appropriate for the treatment of the Participant's condition.

Mental or Nervous Disorder means neurosis, psychopathy, psychoneurosis, psychosis or mental or emotional disease or disorder of any kind, regardless of any physiological or traumatic cause or origin of such condition.

Motor Vehicle means a "motorized vehicle," which is not limited to an automobile, truck or van. It includes motorcycle, moped, all-terrain vehicle, snowmobile and other recreational vehicles.

Network is a group of providers that are under a contract with the Plan to provide health care services to our eligible Participants under pre-determined prices. For example, Blue Cross Blue Shield Preferred Provider is a Network.

Out-of-Pocket Maximum is the most you pay in a calendar year towards Allowed Amounts for Covered Expenses as per the providers of the Plan. For this Plan, the following DO NOT apply to Out-Of-Pocket Maximums: Amount paid for deductibles, copayment, amounts charged above any applicable maximum benefit, amounts charged for chiropractic or infertility treatments, Prescription Drug co-pays and coinsurance, charges above Reasonable & Customary by non-PPO providers, non-compliance deductibles for failure to obtain required pre-certification.

Participant, Eligible Participant, Plan Participant, Covered Person or Covered Individual means an individual satisfying the Eligibility provisions of this Plan for coverage as an Eligible Employee, Retiree or Dependent.

Physician or Doctor refers to a physician, surgeon or other individual licensed under the Illinois Medical Practice Act, or any such individual licensed in other states.

Plan means the Local No. 731, I.B. of T., Garage Attendants, Linen and Laundry Health and Welfare Fund.

Plan Administrator means the Board of Trustees.

Plan Trustees means the Board of Trustees of the Plan.

Preferred Provider Organization (PPO) is a Network of doctors and/or facilities; See Network.

Preventive Service Benefits is care that helps you stay healthy. For a complete list of services considered to be Preventive Services Benefits, go to www.healthcare.gov. These include certain physicals and immunizations.

Reasonable and Customary (R&C) Charge is an amount determined by comparing a particular charge with the charges made for similar services and supplies in the locality concerned to individuals of similar age, sex, circumstances and medical condition. The result of this comparison will determine the amount that is the maximum Allowed Amount to be considered a Covered Expense under the Plan. The Fund used R&C through 12/31/2015. See Reference Based Pricing.

Reference Based Pricing – Effective January 1, 2016, the Fund will use “Reference Based Pricing” as a method to determine the maximum allowed amount to be a Covered Expense for charges not determined under a network arrangement (i.e. non-network services covered by the Fund). The intent is to follow acceptable industry standards.

Allowed Amount for Covered Expenses by a non-network provider can be determined as follows:

1) A negotiated amount of which the non-network provider will accept without “Balance Billing” the patient or
2) For Hospital/Facility Claims: 150% of current Medicare hospital inpatient prospective payment system (IPPS) or hospital outpatient prospective payment system (OPPS) or
3) For Professional Claims: 120% of current Medicare Resource Based Relative Value Scale (RBRVS)

In determining the above, the Fund will utilize resources available from professional firms with resources to assist in payment determinations.

Methodologies may be subject to change based on guidance from the Affordable Care Act or other common industry practices.

Retiree or Retired Employee means a Pre-Age 65 Retiree or Disabled Retiree.

Skilled Nursing Facility is an institution, or a distinct part of an institution, that complies with all licensing and legal requirements and that 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 them 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.
3. It provides 24-a-day nursing services under the supervision of an R.N., and it has an R.N. on duty at least 8 hours a day.
4. 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 general hospital.
5. It maintains daily medical records on all patients, and it provides appropriate methods and procedures for the dispensing and administering of drugs and biological.
6. It has a utilization review plan.
7. It has a transfer agreement with one or more Hospitals.
8. It is eligible to participate under Medicare.
9. It is not, other than incidentally, 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.

Spouse means a person who is legally married to the Eligible Employee.

Substance Abuse or Chemical Dependency means the abuse, addiction to or dependency on the use of drugs, narcotics, alcohol or any other chemical (except for nicotine).

Treatment Facility for Chemical Dependency is a rehabilitation facility for the treatment of persons suffering from alcoholism and/or drug abuse or drug addiction. To be considered an approved treatment facility for the purposes of this Plan, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or meet certain requirements specified by the Trustees.

Trust means all cash, securities and other property that at the time of reference has been deposited in the trust account established pursuant to the Trust Agreement.

Trustee(s) means the individual Union Trustees, the individual Employer Trustees and, when acting as Trustees, their alternates and successors.

Trust Agreement means the Agreement and Declaration of Trust, as amended from time to time, which establishes the funding vehicle for the Plan and sets forth the respective rights, obligations and responsibilities of the Administrator, the Board and the Trustees.

Union means the Excavating, Grading, Asphalt, Private Scavengers and Automobile Salesroom Garage Attendants, Linen and Laundry Union Local No. 731, I.B. of T.

You or Your when used in this document refers to the Employee who is covered by the Plan. **Those terms do not refer to any Dependent except as set forth in the Subrogation section.**

NOTE: Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine unless the context clearly indicates the contrary.

ACRONYMS

The Health Care Industry uses many acronyms, which can be confusing. Listed below are common acronyms used in the industry to assist you.

ACA - Affordable Care Act
CBA - Collective Bargaining Agreement
CM - Case Management
CMS - Centers for Medicare and Medicaid Services
CSW - Clinical Social Worker
DOL - Department of Labor
EPO - Exclusive Provider Organization
HHS - Department of Health and Human Services
HMO - Health Maintained Organization
ICM - Individual Care Management
IP - Inpatient
IRS - Internal Revenue Service
LCPC - Licensed Clinical Professional Counselor
LMHC - Licensed Mental Health Counselor
LPC - Licensed Professional Counselor
LSW - Licensed Social Worker
MAP - Member Assistance Program
MH/SA - Mental Health/Substance Abuse
MRO - Medical Review Organization
OOA - Out of Area
OON - Out of Network
OOP - Out of Pocket
OP - Outpatient
PBM - Prescription Benefit Manager
PPO - Preferred Provider Organization
R&C - Reasonable and Customary
SNF - Skilled Nursing Facility
SPD - Summary Plan Description
STD - Short Term Disability
TDI - Total Disability Insurance
TMJ - Temporomandibular Joint Disorder
TPA - Third Party Administrator
UR - Utilization Review
VSP - Vision Service Plan

TIP: Health Care people use a jargon that they are familiar with. Please ask questions or for clarification whenever necessary. Sometimes the same acronym means different things to different people – so please ask.

ELIGIBILITY RULES

SPECIAL INFORMATION ELIGIBILITY RULES

GENERAL PROVISIONS

Employees become eligible for benefits if they perform work under the jurisdiction of Collective Bargaining Agreements and their Employer makes the required contributions to the Local No. 731, I.B. of T., Garage Attendants, Linen and Laundry Health and Welfare Fund subject to the satisfaction of eligibility requirements as set forth below. Other groups of employees of signatory employers (i.e. non-bargaining unit employees) are eligible, for whom contributions are made on a month-to-month basis under agreements acceptable to the Trustees.

INITIAL ELIGIBILITY

Employees become initially eligible on the first day of the month following completion of two full consecutive calendar months for which his/her Employer has made the required Contributions on his/her behalf, but in no event will such Employee becomes eligible later than 90 days from his/her first date of continuous, full-time employment with the Employer.

CONTINUATION OF ELIGIBILITY

Once eligible for benefits, an Employee will continue to remain eligible until the end of the month his/her employer has ceased to make the required Contributions on his/her behalf.

PLEASE NOTE: A work month is made up of the four (4) or (5) weeks ending on a Saturday.

For example – the month of May, 2015 is from April 26 (Sunday) through May 30 (Saturday) and consists of five (5) weeks. The month of June, 2015 begins on May 31 (Sunday) and ends on June 27 (Saturday). June consists of four (4) weeks.

MAY 2015

S	M	T	W	R	F	S
----------April----------						
26	27	28	29	30	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

5 Weeks

JUNE 2015

S	M	T	W	R	F	S
May						
31	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27

4 Weeks

SPECIAL CONTINUATION RULES

In the event of unemployment due to layoff, work stoppage, leave of absence or dismissal, the Employee may make timely self-contributions to the Welfare Fund (in the weekly amount that the Employer would contribute if the Employee were working) for a period not to exceed nine (9) months and in such event, the Employee and his eligible Dependents shall remain eligible for benefits during such time.

If you are totally unemployed and take work outside the jurisdiction of Local 731 and the new employer is required to contribute to another group health plan, or provide you with benefits such as are provided under this Plan or under a group health plan, you will not be permitted to make self-contributions to this Welfare Fund.

If you become covered under another group health plan, you will not be permitted to make self-contributions to this Welfare Fund. If unemployment is due to retirement and the Retired Employee meets all the conditions hereafter stated for "Pre-Age 65 Retiree" or a "Disabled Retiree," the benefits specified below may be continued for such "Pre-Age 65 Retiree" or "Disabled Retiree" and/or their Spouse until the end of the insurance quarter coinciding with or following the date the "Pre-Age 65 Retiree" or a "Disabled Retiree" or their Spouse become eligible for Medicare Benefits or Medicaid Benefits, or becomes covered under any other group health plan or attains age 65, provided the required self-contributions are made.

If you choose this self-payment coverage, it will run simultaneously with COBRA up to a combined maximum of 18 months (29 if disabled) of self-payment and COBRA coverage.

SPECIAL HEALTH PLAN CONTINUATION RULES – SELF PAYMENTS AND COBRA

When eligibility in the Health Plan terminates, a Member can continue eligibility by either making self-payments or by electing continuation of health coverage under the terms of the Consolidated Omnibus Budget and Reconciliation Act (known as COBRA).

Members can make self-payments to continue coverage for up to nine months (12 months if totally disabled), whereas COBRA typically allows coverage up to 18 months. The cost of continuing coverage is different for self-payments and for COBRA.

Effective May 1, 2013, the Fund will allow a Member to self-pay, then switch to COBRA if it is cost advantageous to the Member to do so (but you will not be allowed to switch from COBRA to self-pay coverage).

The purpose of this change is to allow a Member the same period of continuation of health coverage allowed under COBRA from the point when eligibility is lost while permitting some months of coverage to be more affordable by making self-payments.

The amount of self-payments can vary based on when you terminate and the Plan's eligibility requirements.

An example is as follows:

Member Paul loses eligibility May 1. Self-payment for May is $300 and then $900 per month thereafter for 8 more months. COBRA family coverage is $1100 per month.

COBRA allows coverage for up to eighteen (18) months. Paul makes self-payments of $300 for the first month, then $900 for the next eight (8) months, then $1100 per month (COBRA) for months ten through eighteen.

Please note that self-pay rates and COBRA rates are reviewed every year and are subject to change. All payments must be made timely or coverage will be terminated. (The amounts listed in the above examples are examples only - not actual rates).

In the event of your death or divorce or your Child's losing eligibility due to age while you are making self-payments, your Dependents will be eligible to make self-payments for an additional 36 months of coverage. The amount of those self-payments is determined by the Trustees. This extended coverage will end earlier if the Dependent reaches age 65 or becomes eligible for Medicare, Medicaid or another group health plan.

NOTE: Payment for COBRA or Self Payment is due before health insurance benefits are provided. Payment should be received by the Fund Office no later than the last day of the month in order to be eligible for health insurance benefits the following month. For example, payment must be received by June 30th for insurance coverage in July. There is a 30-day grace period for ongoing COBRA premiums or Self Payments, however no claims will be paid until payment is received.

DEPENDENT ELIGIBILITY

If an Employee has any Dependents on the date he/she becomes eligible for benefit coverage, the Dependents will become eligible on the same date. A definition of who is covered is as follows:

Your Dependents are your legal Spouse, and your Children from birth to age 26. The Plan will cover your Children from age 19 to age 26 unless they are eligible for coverage from a group health plan based on the Dependent's or Dependent's spouse's employment. Effective January 1, 2014, the Plan will cover all Children up to age 26 regardless of whether they are eligible for other coverage.

A Child whose coverage would otherwise terminate solely due to attainment of the limiting age shall continue to be a qualified Dependent for so long as he or she is incapable of self-support due to mental retardation or physical handicap and is dependent upon you for support and maintenance, provided that written proof of such Child's incapacity is furnished no later than 31 days after attainment of such limiting age.

Adopted newborns will not be covered from birth if (1) one of the child's natural parents covers the newborn's initial Hospital stay; or (2) a notice revoking the adoption has been filed; or (3) one of the natural parents revokes their consent to adoption.

Furthermore, federal law requires group health plans to honor Qualified Medical Child Support Orders (QMCSOs) or National Medical Support Orders (NMSO). For further information on QMCSO's, see that section in this SPD.

If both you and your Spouse are each Members covered by this Plan, you can claim each other as Dependents and both of you can claim Children as Dependents. In such a case, the Plan may pay additional benefits for a particular claim up to the Allowed Amount of the incurred charge. However, in no event will the Plan make payments on behalf of any individual that exceed the individual maximum per illness or injury.

Important Notice:

When you acquire Dependents, or when your Dependents' status changes, it is absolutely necessary that you notify the Fund Office so that your Dependents may be properly insured, classified or terminated.

Spousal insurance information must be submitted to the Fund. If your Spouse is not employed, a letter must be submitted stating that he or she is not employed and the letter must be signed by both you and your Spouse.

NOTE: It is important to keep the Fund Office up to date on new Dependent Children and Spouses so they are added to the Plan. **Don't get surprised at the Emergency Room!**

TERMINATION OF ELIGIBILITY

Coverage of benefits for an Employee and his/her eligible Dependents shall terminate on whichever of the following dates occurs first:

- The date that any contribution required on behalf of the Employee is due and unpaid.
- The date the Employee enters the Armed Forces on full-time active duty.
- The last day of the month in which the Employee ceases active work due to layoff, work stoppage, leave of absence, resignation, dismissal, retirement, commencement of a pension or disability, unless the Employee worked sufficient weeks for that month to require his Employer to contribute more than four weeks of contributions, in which case, coverage will terminate the last day of the following month.
- The date the Dependent no longer meets the definitions of Dependent.

TERMINATION OF A TOTALLY DISABLED EMPLOYEE

If an Employee is totally disabled from a non-occupational accidental injury or illness on what would otherwise be his eligibility termination date, then the Employee shall remain eligible for coverage until the earliest of the following:

- The end of a 26-week period following termination; or
- The date the person becomes covered under any other insurance or group health coverage; or
- The date the person ceases to be totally disabled.

TERMINATION OF ELIGIBILITY - DEPENDENT

Eligibility of a Dependent will terminate upon the occurrence of the first of the following:

- When the Dependent no longer meets the definitions of Dependent as set forth above, or
- When the Employee's eligibility terminates.

MILITARY SERVICE

If you are inducted into the armed forces of the United States or if you enlist in military service, your eligibility and the eligibility of your Dependents will terminate. However, coverage for you and your Dependents may be continued. If you are called into active service for up to 31 days, your medical, dental and vision coverage during that leave period will be continued at no cost to you. If you are called into active service for more than 31 days, you can continue your coverage for up to 24 months. See COBRA Continuation Coverage for more information.

Upon discharge from the armed forces, eligibility for you and your eligible Dependents will be reinstated on the date you return to work in Covered Employment, providing such return to work is within 90 days from the date of your discharge, or such shorter or longer period required by law if you serve less than 180 days.

ELIGIBILITY FOR EMPLOYEES RETIRING BEFORE AGE 65 AND THEIR SPOUSES PRIOR TO REACHING AGE 65

An Eligible Employee, who is retired from work as a Local No. 731, I.B. of T., Garage Attendants, Linen and Laundry Member and whose eligibility for benefits is terminated in accordance with the eligibility rules, may apply to continue eligibility for medical benefits by making self-payments in a manner prescribed by the Trustees providing:

1. He/she has retired from active employment on or after October 1, 1979, and
2. He/she is receiving either Normal, Early or Disability Retirement Benefits under the Local 731, I.B. of T., Private Scavengers and Garage Attendants Pension Trust Fund or the Local 731, I.B. of T., Textile Maintenance and Laundry Craft Pension Plan, and
3. At the time of retirement, he/she was eligible to receive the benefits of the Plan, and
4. Has been eligible during the 60 consecutive months immediately preceding the date of retirement. (5 consecutive years)

If a qualified Pre-Age 65 Retiree does not apply and make the necessary payment for this coverage in the first month for which he/she is eligible, he/she will forfeit the opportunity for continued coverage.

If a Pre-Age 65 Retiree returns to work as Local No. 731, I.B. of T., Garage Attendants, Linen and Laundry Member, he/she will only be eligible for active Employee Benefits upon satisfying the Initial Eligibility requirements of the Plan. In no event can an Employee be eligible for both Employee Benefits and Pre-Age 65 Retiree Benefits.

If you choose this Pre-Age 65 Retiree coverage, you and your Dependent Spouse waive your rights to COBRA Coverage. After your retiree self-pay period starts, you will not be allowed to change to COBRA Coverage or receive any extended coverage as a result of a second COBRA qualifying event.

However, in the event of divorce while you are making these self-payments, your Dependent Spouse will be eligible to make self-payments for an additional 36 months of coverage. The amount of those self-payments is determined by the Trustees. This extended coverage will end earlier if the Dependent reaches age 65 or becomes eligible for Medicare, Medicaid or another group health plan.

TERMINATION OF ELIGIBILITY – PRE-AGE 65 RETIREES/DISABLED RETIREES AND THEIR SPOUSE AND DEPENDENT CHILDREN

When your coverage ends, you and/or your covered Dependent Spouse will automatically be provided with a certificate of creditable coverage that indicates the period of time you were covered under the Plan. Such a certificate of creditable coverage will be provided to you after the Fund has been notified that coverage has been terminated. You may also request a certificate of creditable coverage from the Fund Office at any time within the first 24 months after your coverage ends.

A Retired Employee's and his Spouse and Dependent Children's eligibility for Pre-Age 65 Benefits will terminate upon the occurrence of the first of the following:

1. The Retired Employee's return to work or the Employee or Spouse satisfying the Initial Eligibility requirements of the Plan as described above.
2. The Disabled Retiree having recovered and no longer entitled to Total and Permanent Disability Benefits.
3. The failure to make the required self-payments.
4. The Retired Employee or Spouse enters full-time active duty with the Armed Forces of the United States.

A Retired Employee's eligibility only will terminate (and the eligible Spouse's eligibility may continue subject to the requirements of this section) upon the occurrence of the first of the following:

1. The Retired Employee attains age 65
2. The Retired Employee becomes eligible for Medicare, whether or not the Retired Employee shall have applied for the same.
3. The failure to make the required self-payments for the Retired Employee's coverage.
4. The Retired Employee becomes covered under another group health plan either through his or his Spouse's employment.

A Retired Employee's Spouse's eligibility only (and the eligible Retired Employee's eligibility may continue subject to the requirements of this section) will terminate upon the occurrence of the first of the following:

1. The Spouse attains age 65.
2. The Spouse becomes eligible for Medicare, whether or not the Spouse shall have applied for the same.
3. The date the Retired Employee and Spouse divorce.
4. The failure to make the required self-payments for the Retired Employee's Spouse's coverage.
5. The Spouse becomes covered under another group health plan either through her or the Retired Employee's employment.

A Retired Employee's Dependent Children will also lose coverage when they no longer meet the Plan's definition of Dependent.

When your coverage ends, you and/or your covered Dependent Spouse will automatically be provided with a certificate of creditable coverage that indicates the period of time you were covered under the Plan. Such a certificate of creditable coverage will be provided to you after the Fund has been notified that coverage has been terminated. You may also request a certificate of creditable coverage from the Fund Office at any time within the first 24 months after your coverage ends.

CERTIFICATE OF CREDITABLE COVERAGE

When your coverage ends, you and/or your covered Dependents will automatically be provided with a certificate of creditable coverage that indicates the period of time you were covered under the Plan. Such a certificate of creditable coverage will be provided to you after the Fund has been notified that coverage has been terminated. You may also request a certificate of creditable coverage from the Fund Office at any time within the first 24 months after your coverage ends.

Certificates of creditable coverage indicate the period of time you and/or your Dependent(s) were covered under the Plan (including COBRA coverage), and contain certain additional information as required by law. This certificate may be necessary if you and/or your Dependent(s) become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered Dependents a health insurance policy within 63 days after your coverage under this Plan ends (including COBRA coverage). The certificate is necessary because it may reduce any exclusion for pre-existing conditions that may apply to you and/or your covered Dependents under the new group health plan or health insurance policy.

Please address all requests for certificates of creditable coverage to:

Local 731 Welfare Fund
1000 Burr Ridge Parkway, Suite 301
Burr Ridge, IL 60527
Telephone (630) 887-4150

DOCUMENT REQUIREMENTS FOR DEPENDENTS

Certain documents must be submitted to establish that the Dependent is eligible for coverage. Other types of documentation are required when there is or may be other group coverage available.

Be sure to include your (the Employee's) name and Social Security number on any documents you send. The documents will be kept on file and you do not have to resubmit copies with each subsequent claim for that Dependent. The following are examples of the documentation that must be submitted to the Welfare Fund Office:

For your Spouse:

- Original, Certified or Notarized Copy of the State or County Marriage Certificate.
- If this is not your Spouse's first marriage, the divorce or dissolution decree for any prior marriage.
- If your Spouse is NOT employed, you must indicate this on the claim form and send a letter each following year confirming that your Spouse remains unemployed.
- If your Spouse **IS** employed but **DOES NOT** have group coverage; obtain a letter from the employer stating that your Spouse and/or her dependents are not covered by the plan.

NOTE: If your Spouse's employer **DOES** provide group health coverage, fill out all applicable information on the "Other Insurance Information" form (available on the Funds website). Be sure to indicate which family members are covered by the other plan.

For natural and adopted Children of the marriage:

- Original, Certified or Notarized copy of birth certificate issued by the county in which the birth took place. Hospital certificates are **NOT** acceptable.
- If the Child is over age 26 and totally disabled, proper medical documentation.
- If the Child is adopted, the adoption decree.

For all other Children, including stepchildren:

- All of the documentation applicable to natural Children (see above).
- Divorce decrees, support agreements, paternity decrees, and other court orders and a notarized affidavit that indicate the Child's relationship to you and who has the responsibility for providing medical coverage for the Child.
- Legal guardianship documents.

Depending on the circumstances, other types of documents may also be requested.

FINANCING

An important element of your Local 731 Welfare Fund coverage is money. Where it comes from, how it is managed, and to what uses it may be put should be of interest to you.

Contributions are made by Employers who have an obligation to contribute to the Fund pursuant to a Collective Bargaining Agreement or other written agreement. These contributions (along with investment income) are the revenue sources to finance Benefits provided from the Fund. Employers that are required to make contributions to the Fund are called Contributing Employers.

All of the assets are held in trust by the Board of Trustees of the Fund for the Participants and Beneficiaries of the Plan. The Board of Trustees has the ultimate responsibility for the management of monies and may from time to time utilize the services of investment managers to invest Plan assets.

Benefits under the Plan shall not in any manner nor to any extent, be assignable or transferable by the Participant.

The Fund only accepts contributions directly from Participants who have elected the Self-Pay method or COBRA coverage. Check with your Employer or Union to find out if your Employer requires contributions to be made by you for your coverage.

PRE-EXISTING CONDITIONS

NOTE: Effective January 1, 2014, the pre-existing condition limitation is removed.

The Fund does not provide coverage for "Pre-existing Conditions" except as set forth in this section. For the purposes of the Plan, a "Pre-existing Condition" is any health condition (excluding pregnancy) for which medical advice, diagnosis, care or treatment was recommended or received from a Physician, someone acting under the direction of a Physician or other qualified health care professional (including Prescription Drugs) within the 3-month period prior to the Covered Individual's enrollment date (the pre-existing condition clause is waived for eligible children under age 19), regardless of the cause of such condition. (Note: genetic information may not be treated as a preexisting condition in the absence of a diagnosis). The enrollment date for a plan, such as this one, that imposes a waiting period before coverage is effective is the first day of the waiting period. The waiting period is the period that must pass before coverage becomes effective.

Coverage is excluded for any pre-existing condition for the period beginning on the enrollment date until the earliest of the following:

- The end of *3-consecutive months* during which no medical care or service is received for that condition.
- Dependent Spouse only – The end of the *12-consecutive month* period beginning on the enrollment date.
- Eligible Employee only - The end of the *6-consecutive month* period beginning on the enrollment date, provided that the Eligible Employee is engaged in active full-time work during that period.

The pre-existing condition exclusion period described above is reduced by any period of creditable coverage. Creditable coverage means a continuous period of time, before a person becomes eligible under this Plan, during which the person is eligible for benefits under another health plan.

Coverage under another health plan is not creditable coverage if there is a gap of 63 or more days between the date the person's prior coverage ended and the person's enrollment date under this Plan. The Plan requires that all Covered Individuals provide a certificate of creditable coverage at the time of enrollment. If a Covered Individual cannot provide such certificate, the Plan may require the Covered Individual to provide other evidence of prior creditable coverage.

NOTE: The preexisting limitation does not apply to children under age 19 nor does the limitation apply to pregnancy or to a Child who is newborn or adopted while this Plan is in effect provided the Child is enrolled in the Plan. Additionally, the pre-existing condition limitation is not applicable to a condition based solely on genetic information; provided, however, that if an individual is diagnosed with a condition, even if that condition relates to genetic information, the pre-existing condition limitation applies to such condition.

SCHEDULE OF BENEFITS

LIFE/VISION/DENTAL
ACCIDENTAL DEATH & DISMEMBERMENT
LOSS OF TIME BENEFIT
BENEFITS FOR ACTIVE EMPLOYEES ONLY
CLASS A

Please refer to the appropriate sections of this SPD for details of the following summaries. These benefits are subject to all of the applicable limitations and conditions set forth in this SPD.

LIFE

Life Insurance (Active Employee only) $25,000

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

AD&D Full amount (Active Employee) $10,000

AD&D Full amount (Dependent) $2,000

Seat Belt Benefit (Active Employee) $10,000

Air Bag Benefit (Active Employee) $500

Repatriation Benefit (Active Employee) . . . . . Up to $5,000

Education Benefit (Active Employee). $10,000
for each qualified Dependent

Special Child Education Benefit (Active Employee) $1,000
for each qualified Dependent

LOSS OF TIME BENEFIT

Maximum amount of weekly benefit (Starts 1st day of Accident, 8th day of Illness) eff. 10/1/2015 . . . $400

(Loss of Time Benefit increased from $200 per week to $400 per week, effective 10/1/2015)

Maximum period that benefits are payable per period of disability . . . . . 26 weeks

VISION BENEFIT (No deductible applies)

Network Provider:

- One spectacle examination per Calendar Year (this limit does not apply to Dependent children under age 19)
- Eyeglasses or Contact Lenses every two years:
  - For frames (with no limit on lenses) $200
  - For contact lenses $300

Out-of-Network Provider:

- All eyewear and services, including eye examinations, every two Calendar years $300
- Examinations are not counted toward $300 maximum for Dependent Children under age 19.

DENTAL BENEFIT

Annual Family deductible $25

Maximum benefit payable per person per Calendar Year through December 31, 2015 . . . . . $1,000

Maximum benefit payable per person per Calendar Year effective January 1, 2016 . . . . . $2,000

NOTE: Charges for Diagnostic and Preventive Care for Dependent Children under age 19 are not counted toward the Calendar Year limit.

Plan Co-Insurance percentage of covered dental expenses:

- Network Dentist:
  - Diagnostic and Preventive Care. 100%
  - Restorative Care. 80%
  - Prosthodontic Care 80%
- Out-of-Network Dentist:
  - Diagnostic and Preventive Care. 80%
  - Restorative Care. 80%
  - Prosthodontic Care 80%

ORTHODONTIA BENEFIT – CORRECTION OF MALOCCLUSION

Maximum Lifetime benefit payable. $4,000

Plan Co-Insurance percentage of covered orthodontia expenses. 80%

SCHEDULE OF BENEFITS

MEDICAL AND PRESCRIPTION DRUGS
BENEFITS FOR ACTIVE AND PRE-MEDICARE RETIRED EMPLOYEES
CLASS A AND CLASS B

IMPORTANT NOTES

- Benefit payments are based only on the amount of charges considered to be Reasonable and Customary (R&C). If you use a non-Network provider, you may be required to pay the provider the amount in excess of the R&C rate.
- Notify the Fund Office in the event of divorce. If you do not notify the Fund office of your divorce and the Fund pays claims on behalf of a former Spouse, you and/or your former Spouse will be responsible for repaying the Fund the cost of those claims.
- The following benefits are subject to all of the applicable limitations and conditions set forth in this SPD.
- Benefits will be paid for covered non-Network Hospital expenses as if a PPO Hospital had been used in the following circumstances:
  - If a non-Network Hospital is used for an Emergency admission, provided the Review Organization is called about the Hospital admission within 48 hours (or two business days) after the admission; or
  - If a non-Network Hospital is used for a non-Emergency reason, but the Covered Person does not live within 15 miles of a PPO Hospital, and the treating Hospital is more than 15 miles from the nearest Network Hospital.

SERVICE	IN-NETWORK	OUT-OF-NETWORK
Medical Review Program non-compliance Deductible (Applies to each inpatient hospital admission where the Medical Review procedure is not followed, whether admission is to an in-network or out-of-network hospital, in addition to any other deductibles.)	$250	
Calendar Year Deductible (Applies to all benefits unless otherwise stated) Per Person Per Family	 $400 $1,200	

EXAMPLE: (Prior to January 1, 2015) In a family of 5, one person reaches $400, one person reaches $325, one person reaches $390, one person reaches $250, and the fifth person reaches $150. Even though this family has accumulated $1,515 in deductibles, only one person has met their $400 deductible, so until two more family members reach their $400 deductible (for a total of $1,200), the family deductible has not yet been met. Please note: Anything in excess of $1,200 is not refundable once the family deductible has been met.

EXAMPLE: (After January 1, 2015) In a family of 5, once deductibles accumulate to $1,200 for 3 or more family members, the family deductible is satisfied. So in the example above, the family deductible is satisfied once the individual deductibles accumulate to a total of $1,200. It will not go to $1,515.

SERVICE	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Maximum Benefits Per Person, Lifetime	For 2013: $2,000,000 For 2014 and later: Unlimited	
Plan Co-Insurance percentages (What the Plan pays) for all Covered Medical Expenses incurred during a year after satisfaction of all applicable Deductibles (unless an exception is noted in the schedule)	80%	70%
Out-Of-Pocket Maximum of your Co-Insurance percentage for Medical Plan	Individual: $3,000 Family: $6,000	
(i.e. 20% or 30% that the Plan Co-Insurance does not pay)		
Amounts applied to Medical Out-of-Pocket Maximum include out-of-pocket payments made for a person's 20% or 30% Co-Insurance share of Covered Medical Expenses. The following do not apply to out-of-pocket limits: amounts paid for deductibles; amounts charged above any applicable maximum benefits; amounts charged for chiropractic or infertility treatments; a person's Prescription Drug Program co-pays; charges above Reasonable and Customary by non- network providers; deductible incurred (or failure to obtain required precertification)		
Out-of-Pocket Maximum of your Co-Insurance percentage for Prescription Drugs	Individual: $3,200 Family: $6,000	

Summary of Annual Out-of-Pocket Maximums for Covered Medical and Prescription Expenses

Out-of-Pocket Expense	Individual	Family
Deductible:	$400	$1,200
Medical Coinsurance:	$3,000	$6,000
Prescription Drug:	$3,200	$6,000
Total:	**$6,600**	**$13,200**

EXAMPLE: An in-network covered expense is $300. Your deductible of $400 has already been satisfied. $240 (80%) is paid by the Plan, and the $60 (20%) left is your responsibility, and is applied to the Out-of-Pocket Maximum)

SERVICE	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
After the applicable annual Out-of-Pocket Maximum is reached, the Plan pays:	100%	100%
For services and supplies related to Outpatient Surgery performed in an Ambulatory Surgical Facility NOT in the Preferred Provider Network:	N/A	0%
Preventive Service Benefits - Deductible Waived: (Includes Physical, related labs and x-rays, child wellness and immunizations)	100%	70% (Adults) 100% (Children)

TIP: For a complete list of all Preventive Service Benefits, go to www.healthcare.gov and search Preventive Service Benefits. The Plan follows the guidelines of the Affordable Care Act in determining the Preventive Service Benefits it will cover. If a Preventive Service reveals symptoms or conditions that require further testing or treatment, benefits for the additional tests and/or treatment are paid the same as treatment for any other injury or sickness and are subject to all applicable deductibles, Co-Insurance, and other Plan limitations.

SERVICE	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Hospital Expenses (You must pre-certify, see Medical Review Program)	80%	70%
Physician Charges - Office Visits, Specialist Visits	80%	70%
Mental Health/Substance Abuse Mental Health and Substance Abuse are treated like any other illness, following the same rules, limitations and allowances as the medical plan. Court ordered rehabilitation is a covered benefit.	80%	70%
Home Health Care (pre-certification is required)	80%	70%
Maternity Care (Professional Global Delivery Fee Only)	100%	70%
Diagnostic Imaging Services (CAT Scan, MRI, PET Scan) Image Network – Absolute Solutions (deductible waived) BC/BS PPO	 100% 80%	 Not Applicable 70%
Surgical Expense, Anesthesia, Ancillary, Hospital Services and Supplies	80%	70%

SERVICE	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Physical Therapy, Speech Therapy, Occupational Therapy	80%	70%
Ambulance	80%	70%
Emergency Room	80%	70%
Chiropractic Care Limited to 25 treatments per Calendar Year	80%	70%
Hearing Aids Maximum benefit payable for covered hearing aid devices is $750 every 36 months (deductible waived).	100%	100%
Hospice Care (deductible waived) Maximum of 30 days covered per lifetime for In-Patient Maximum of 62 days covered per lifetime for Home Hospice	100%	100%
Infertility Treatment Pre-certification is required (for procedures and injectables only) There is a Lifetime maximum benefit payable per person (artificial reproduction procedures and injections/ medications only) of $10,000	80%	70%
Sleep Apnea Studies/Devices: Pre-certification is required (See Medical Review Program) Plan Co-Insurance for a direct contract provider arranged by Med-Care Management or in-network at home study (deductible waived) Plan Co-Insurance for BC/BS (deductible applies) Maximum amount payable per C-Pap Device is $1,500 Maximum amount payable per Bi-Pap Device is $2,000	100% 80%	Not Applicable 70% R&C
TMJ Benefit (surgical & non-surgical) Maximum of 20 therapy visits per Calendar Year	80%	70%

TIP: If a Preventive Service reveals symptoms or conditions that require further testing or treatment, benefits for the additional tests and/or treatment are paid the same as treatment for any other injury or sickness. This means applicable to Deductibles, Co-Insurance, and other Plan limitations.

TIP: For a complete list of all Preventive Service Benefits, go to www.healthcare.gov and search Preventive Service Benefits. The Plan follows the guidelines of the Affordable Care Act.

PRESCRIPTION DRUG PROGRAM

Drug Card Program - Each prescription or refill of a covered prescription drug (up to a 34-day supply) obtained from a participating pharmacy:

Type of Drug	Your Co-Pay
Generic (Tier I)	Generic Greater of $7 or 20% of discounted price (but not more than cost of drug)
Formulary brand (Tier II)	20% of discounted price*
Non-preferred brand (not on formulary) (Tier III)	40% of discounted price*

* If you choose a brand name drug when a medically equivalent generic is available, the Plan will only pay what it would have paid for the generic drug and you will be responsible for the balance of the cost.

Mail Service Program - Each prescription or refill of a covered prescription drug (up to a 100-day supply) obtained through the mail service pharmacy:

Type of Drug	Your Co-Pay
Generic (Tier I)	$15
Formulary brand (Tier II)	$45
Non-preferred brand (not on formulary) (Tier III)	$95

The Prescription Drug Plan contains various managed care techniques to assist Members and their Dependents to obtain quality prescriptions at a fair price. The Plan, through its prescription benefit manager (PBM) utilizes the following programs:

- Formulary – Prescription drugs on a list approved by the PBM's Pharmacy and Therapeutics Committee.
- Step Therapy – Participant must use Step 1 medication (usually a generic drug (Tier I)) before using the Step 2 medication (preferred brands (Tier II) or non-preferred brands (Tier III)).
- Quantity Limits – To prevent overprescribing / abuse.
- Prior Authorization – To make sure the appropriate drugs are being dispensed and to review for abuse.
- Specialty Drug Copay Assistance Program (Effective January 1, 2016) for certain prescriptions that are high cost and that may require special storage, handling and close monitoring and identified by the specialty drug case manager to apply for copay assistance. These specialty drugs are subject to a 30% coinsurance, with a minimum of $25 for each 30-day supply. The specialty drug case manager will reduce the price with the drug manufacturer to cover most, if not all, of the 30% copay. If the copay assistance is not available, the copay defaults to the structure above.

MEDICAL REVIEW PROGRAM

The Trustees have arranged for a professional Medical Review Organization to review and certify the following:

WHO TO CALL

Med-Care Management (800) 367-1934	
Inpatient Hospitalizations	Durable Medical Equipment (over $500 only)
Surgeries – Inpatient and Outpatient	Prosthetics
Skilled Nursing	Orthotics
Sleep Apnea Studies (Effective January 1, 2014)	Cardiac Rehabilitation
Home Health Care	IV Infusion and IV Antibiotics
Infertility (for related injectables and procedures only)	Speech Therapy

TIP: C-Pap machines and supplies are considered Durable Medical Equipment and must be pre-certified.

Member Assistance Program (800) 292-2780	
Substance Abuse – Inpatient and Outpatient	Mental Health – Inpatient and Outpatient

OptumRx (800) 880-1188
Specialty Drugs / Injectables and other Prior Authorizations (See Prescription Drug section for additional information)

The review procedures apply to you and your Dependents.

WHEN TO MAKE THE CALL

You, your Doctor or the Hospital must call the Review Organization at: **(800) 367-1934** for the following services:

- **Hospitalization -** BEFORE a non-Emergency inpatient Hospital admission; or within 48 hours (two business days) after an Emergency Hospital admission.
- **Surgeries** - When your Doctor recommends non-Emergency Inpatient surgery or Outpatient Surgery performed in a facility (Outpatient Surgery performed in a doctor's office does not require pre-certification).
- **Injectable Drugs** - Before purchasing any medication that is administered by injection. Effective January 1, 2014, call OptumRx for Prior Authorization of Injectable Drugs at 1(800) 880-1188. You do not have to call for review of insulin, cortisone, immunizations, vaccinations, allergy shots or bee sting kits.
- **Home Health Care, Speech Therapy, Infertility, Sleep Apnea Studies, Prosthetics, Durable Medical Equipment, Skilled Nursing, Orthotics, Cardiac Rehabilitation, IV Infusion, and IV Antibiotics** - When your Doctor recommends such supplies or services.

- **Substance Abuse and Mental Health Treatments** must be pre-certified and approved. You may also call the Fund's Member Assistance Program at (800) 292-2780 for assistance in finding the right treatment and/or facility for you and your dependents.

IF YOU DON'T FOLLOW THE REVIEW PROCEDURES

Hospitalizations, Inpatient and Outpatient Surgeries – A $250 non-compliance deductible will be imposed if the procedures outlined above are not followed for these services. This deductible will apply to Covered Expenses incurred during that Hospital service and will apply to every Hospital admission for which the proper procedures are not followed.

Specialty/Injectable drugs – OptumRx is often able to negotiate lower prices for injectable medications, but only if they are notified in advance. Therefore, if you do not call OptumRx before purchasing a supply of an injectable medication, and if the medication is Medically Necessary and otherwise meets all the Plan's criteria for coverage, you may be required to pay the difference between the price you paid and the price that would have been charged had OptumRx been able to manage the purchase.

Home Health Care, Speech Therapy, Prosthetics, Cardiac Rehab, Orthotics, IV Infusions, IV Antibiotics, Skilled Nursing or Infertility Services – If the Review Organization is not notified prior to the start of the treatment program, for Home Health Care, Speech Therapy, Prosthetics, Cardiac Rehab, Orthotics, IV Infusions, IV Antibiotics, Skilled Nursing or Infertility Services (for related injectables and procedures only), a $250 non-compliance deductible will be applied to the course of treatment.

Durable Medical Equipment (in excess of $500) - If the Review Organization is not notified prior to the purchase of such supplies, a non-compliance deductible of $250 will be applied to the purchase price.

EXAMPLE: If you or your Physician do not pre-certify a Medically Necessary inpatient stay, and then do not pre-certify a piece of Durable Medical Equipment over $500, then the non-compliance penalty will be $500 ($250 + $250).

NOTE: Any non-compliance Deductibles or Co-Payments required by this section are in addition to any other Deductibles and Co-Insurance that apply to the expenses. You are responsible for paying any expenses used to satisfy Deductibles for yourself and your Dependents.

For health services to be covered by the Fund, they need to be "Medically Necessary" in the "appropriate provider setting". The Medical Review Program reviews the services provided for this purpose. Exceptions are specific services that are noted in the Fund as being covered. An example is preventative services as defined by the Affordable Care Act.

YOUR NETWORK HOSPITAL AND DOCTOR

You and your Dependents are encouraged to use providers (Hospitals and Doctors) that participate in the Plan's preferred provider organization (Network).

You Save Money – Network providers will provide medical services to you and your covered Dependents at reduced charges. Your out-of-pocket costs will be further reduced because, in many cases, higher Plan benefits are payable when you use Network providers. See your Schedule of Benefits for details.

TIP: The Fund provides you access to a network of Doctors and Hospitals that discount their fees for services they provide to eligible Participants. Your out-of-pocket expenses depend on whether you decide to go in-network or out-of-network for your care. Generally, the Fund pays a higher level of benefits for care received from participating (in-network) providers.

Exceptions: Plan benefits will be paid as if a Network Hospital had been used in the following circumstances:

- If a non-Network Hospital is used for an Emergency admission, provided the Review Organization is called within 48 hours (or two business days) after the admission; or
- If a non-Network Hospital is used for a non-Emergency reason, but the Covered Person does not live within 15 miles of a Network Hospital and the treating Hospital is more than 15 miles from the nearest Network Hospital.

I.D. Cards – You will be provided two medical care I.D. cards plus two prescription drug I.D. cards. You should present your medical I.D. cards whenever you or a family member receives medical care. The I.D. card identifies you as a Network Participant so that the proper discounts can be applied to the bill and tells the providers how to submit their bill.

How to Find Network Providers – Information about Network Hospitals and Doctors is available by calling the Network's toll-free number (Blue Cross Blue Shield 800- 810-2583) or visiting their web site at: www.bcbsil.com, shown on your I.D. card.

COMPREHENSIVE MAJOR MEDICAL BENEFIT
GENERAL INFORMATION AND RULES

This section includes an explanation of all of the health care benefits provided by this Plan.

If you or any of your Dependents have an accidental injury or become sick, the Plan will provide benefits for the Reasonable and Customary amount of the expenses you incur for treatment of the injury or sickness. Payment will be made for the charges incurred for the treatment up to the amount shown on your Schedule of Benefits.

DEDUCTIBLES

A deductible is a stated amount that is deducted from a Covered Person's Covered Expenses before the Plan will pay any benefits for any remaining Covered Expenses. Once the amount of a particular deductible has been deducted from the expenses, the person has "satisfied" that deductible.

General Rules Governing All Deductibles

- Only charges that are considered Covered Medical Expenses will count toward satisfying a deductible.
- Each deductible is in addition to all other deductibles that may apply to the Covered Expenses.
- You are responsible for paying out of your own pocket the amount or Covered Expenses used to satisfy deductibles.

The amounts of the various deductibles are shown on your Schedule of Benefits and apply as follows.

Medical Review Program Non-compliance Deductible – Please refer to the Medical Review Program section of this SPD for details on this deductible.

Calendar Year Deductibles – The amount of the Calendar Year deductible shown on the Schedule of Benefits will be deducted from the Covered Medical Expenses you incur during a year before the Plan will pay any benefits for any remaining Covered Medical Expenses incurred during that year. If a Covered Person suffers from a condition for which Covered Medical Expenses are incurred in two or more Calendar Years, the deductible must be met for each Calendar Year.

Family deductible is the amount of the Calendar Year deductible shown in the Schedule of Benefits that will be deducted from the Covered Medical Expenses you and the covered members of your family incur during a year. When three covered members of your family each meet the individual deductible amount, this Plan considers all deductible met for the entire family for the remainder of that Calendar Year. No refunds will be provided for deductibles paid on other family members who did not meet the deductible.

The Calendar Year deductible applies to each Covered Person every Calendar Year except that:

- If you and your Dependent(s) are injured in the same accident, only one deductible is applied each Calendar Year to all Covered Medical Expenses resulting from that accident.
- Any Covered Medical Expenses incurred in October, November or December which are applied to a person's Calendar Year deductible when no benefits are paid will be applied to the person's deductible for the next Calendar Year.

CO-INSURANCE PERCENTAGES

If a "Plan Co-Insurance percentage" is shown on your Schedule of Benefits under a certain benefit or for a certain type of treatment, it means that the percentage shown is the percentage of Covered Medical Expenses the Plan will pay after satisfaction of all deductibles. You are responsible for paying the remaining percentage of the Covered Expenses on behalf of yourself and your Dependents.

Please note that there are differences in the percentage the Plan pays under the various benefits. PPO expenses are generally paid at, a higher Co-Insurance percentage than non-PPO expenses.

OUT-OF-POCKET MAXIMUMS

The Plan keeps track of the amounts you have to pay out-of-pocket for each family member's Covered Expenses during each Calendar Year. See the Schedule of Benefits for the Out-of-Pocket Maximums that apply to you and your covered family members.

- Amounts applied to the PPO out-of-pocket limit also apply to the non-PPO out-of-pocket limit and vice versa.
- Amounts accumulated toward an out-of-pocket limit during a year do not carry over to the next year.
- Amounts paid as deductibles or for charges over Reasonable and Customary do not apply to the out-of-pocket limit.

Amounts That Do Not Apply To Out-of-Pocket Limits – Your out-of-pocket payments for the following will not be applied to any out-of-pocket limit:

- Non-compliance deductibles, such as failure to pre-certify penalties;
- Charges in excess of Reasonable and Customary amounts;
- Charges not considered Covered Medical Expenses;
- Charges incurred in excess of any applicable maximum benefit;
- Charges for non-PPO services and non-PPO supplies related to Outpatient Surgery in a non-PPO Ambulatory Surgical Facility;
- Charges incurred for Infertility treatment.

MAXIMUM BENEFITS

Each person who is covered under this Plan may be entitled to several different types of maximum benefit amounts. These are shown on the Schedule of Benefits. When you refer to your Schedule of Benefits information about a particular benefit or coverage for a particular type of treatment, be sure to note which type of maximum benefit applies to that benefit or type of treatment.

Comprehensive Benefit Annual Maximum Benefit – This maximum includes all Comprehensive Major Medical benefits paid on a person’s behalf in the past Calendar Year under any previous major medical plans of the Fund plus all Comprehensive Benefits paid under the Plan and in the future for treatment of all injuries and sicknesses during each year.

Special Maximum Benefits on Types of Treatment – There are separate maximum benefits listed on your Schedule of Benefits for particular types of care or treatment. Be sure to become familiar with your Schedule of Benefits so that you will know whether the Plan covers a particular type of care or treatment, what the amounts of the maximum benefits are, whether they apply on a lifetime or Calendar Year basis, whether they apply only to certain persons in your family, and whether they apply to each Covered Person or to your family as a whole.

COVERED MEDICAL EXPENSES

The following expenses are considered Covered Medical Expenses under the Comprehensive Benefit. Covered Medical Expenses are the actual Reasonable and Customary Charges incurred by a Covered Person for the following Medically Necessary services and supplies that are required in connection with treatment of the Covered Person for accidental injury or sickness. If a charge is not a Reasonable and Customary Charge the Plan will recognize only the amount that is considered Reasonable and Customary.

Covered Medical Expenses include charges incurred for:

1. **Hospital Room and Board Charges** (up to the semi-private room rate), including any charges that are made by the Hospital as a condition of occupancy or on a regular daily or weekly basis such as general nursing services. Also included is the Hospital's charge for intensive care and coronary care units.

2. **Ancillary Hospital services and supplies** that are rendered by the Hospital to a person and required for the treatment of the person, including drugs and medicines.

3. **Hospital nursery** Room and Board Charges, miscellaneous services and supplies, and Doctors' services for newborn infants during the initial Hospital confinement after birth.

4. **Facility charges for Outpatient Surgery** - Facility services and supplies provided in a Hospital outpatient or emergency department, a Doctor's office, or a clinic.

5. **Diagnosis and treatment, surgery** - Services rendered by a Doctor or surgeon for medical or surgical treatment of a person, rendered either in or out of a Hospital. Services of consulting Doctors and assistant surgeons are also covered. Charges by an assistant surgeon are limited to 25% of the primary Surgeon's fee, or 25% of the Reasonable and Customary Charge for the surgery, whichever is less.

   Medically Necessary services may also be provided by a Clinical Psychologist, a Licensed Clinical Social Worker, a Licensed Certified Professional Counselor, a Licensed Physical and Occupational Therapist, a Certified Registered Nurse Anesthetist, a Certified Surgical Assistant (C.S.A.), a Nurse Practitioner (N.P.) or a Physician Assistant (P.A.). Benefits for expenses incurred for treatment furnished by any such individual shall be payable only within the provisions and limitations of the Plan and only if the individual is acting within the scope of his or her license at the time and place the services are performed.

   The Fund will not pay separately for services billed by a C.S.A., N.P. or P.A. if the services have been previously billed by the provider's employer (Doctor or Hospital) and the amounts billed by the Doctor or Hospital have not been reduced accordingly. Charges for the services of a C.S.A. are limited to 80% of the allowable charge by an in-network assistant surgeon.

6. **Transportation** as follows:

   a. Local professional ambulance service that is deemed Medically Necessary and not for patient convenience.

   b. If a Doctor certifies that a person's illness or injury requires specialized treatment at another facility, transportation for such treatment is a Covered Medical Expense. Transportation to a distant geographic area must be by regularly scheduled airline or railroad or by air ambulance if necessary and must be within the limits of the United States of America. The covered transportation expense is only from the area where the illness or injury occurred to the nearest Hospital qualified to render the special treatment.

7. **Physical therapy** rendered by a licensed Physical Therapist. The treatment may be rendered in or out of a Hospital and must be recommended by your Doctor.

8. **X-Ray and laboratory examinations**, including routine outpatient x-rays and laboratory tests, such as electrocardiograms (EKGs), mammograms, PSAs, blood tests, Pap smears, urinalysis,

etc., when ordered by a Doctor as part of a comprehensive routine physical examination. Covered Medical Expenses include the necessary lab fees and fees for interpretation by a pathologist or radiologist.

9. **Gynecological exam** – The Fund will cover gynecological exams and Pap tests for eligible female Participants. This coverage is in addition to the regular annual physical exam covered by the Plan.

> **TIP:** The Plan covers Preventive Services as defined under the Affordable Care Act (ACA). For further details, refer to www.healthcare.gov and type Preventive Services in the search portal.

10. **Radiation therapy** - X-ray, radon, radium and radioactive isotope treatments.
11. **Chemotherapy** for cancer treatment.
12. **Anesthetics** and their administration.
13. **Immunizations and inoculations** for a covered Dependent Child subject to the maximums and limitations as shown in the Schedule of Benefits.
14. **The following medical supplies:**
    a. **Diabetic materials**, such as syringes, needles, lancets, glucose strips and chem strips (ONLY when obtained through the Prescription Drug Program).
    b. **Whole blood** or blood plasma and its administration.
    c. Initial external **breast prosthesis** and special brassiere following mastectomy. Additional external breast prosthesis once every three years, unless recommended more frequently by the Physician and the first permanent internal breast prosthesis necessary because of a mastectomy.
    d. **Surgical supplies** including the initial appliance or prosthesis to replace a lost physical organ or part of an organ, such as an artificial limb or eye.

       Replacement of an appliance or prosthesis is also a Covered Expense when the need for the new device is certified by the Review Organization to be Medically Necessary because: (1) the previous device has worn out and is no longer serviceable, or (2) for a Child, if the Child has outgrown the previous device. However, under no circumstances will the Plan cover more than one replacement every two years for a Child under age 16, or every five years for all other Covered Individuals.

       Charges for Medically Necessary repairs, adjustments, or servicing of the device due to changes in the Covered Individual's physical condition are covered.

       The Plan also covers the first pair of eyeglasses or contact lenses required after cataract surgery.
    e. **Oxygen** and the rental of equipment for its administration, subject to pre-approval by the Review Organization.
    f. **Casts, splints, braces, crutches and trusses**.
    g. **Durable Medical Equipment Rental**, including rental of a wheelchair, scooter, a hospital-type bed, or therapeutic mechanical equipment necessary for treatment of the patient's medical condition. If the projected rental cost is greater than the purchase price of a covered item, the Plan will cover the lowest estimated purchase price of the standard model of such covered item that is appropriate for the medical condition of the Covered Individual, subject to pre-approval by the Review Organization. Equipment obtained for improvement of lifestyle or environment rather than treatment of a medical condition or necessary compensation for a disability condition is not covered.
    h. **Speech Generating Device** for Dependent Children with a diagnosis of autism, [a speech generating device] that enables such Children to communicate, provided that the device is

prescribed to treat autism and not primarily for the improvement of lifestyle or environment. Precertification by the Fund's Review Organization of the selected device shall be required as well as a determination of whether rental or purchase would be appropriate.

i. **Breast pump and supplies** are covered at 100% in-network under guidelines established by the Affordable Care Act (ACA). To qualify for 100% reimbursement, the breast pump and supplies require a prescription from a Physician, must be obtained from an in-network durable medical equipment provider, up to one (1) pump per childbirth, and up to six (6) storage bottles. The Plan allows up to $250 (rent to purchase) anything over $250 must be pre-authorized by the Medical Review Organization (Med-Care Management, 1-800-367-1934). Purchases of breast pumps from a retail store are not eligible for reimbursement from the Plan.

15. **Drugs and medicines** that are identified by a prescription number and dispensed by a licensed pharmacist and that may only be purchased on the written prescription of a Doctor.

    Special Rules for Certain Types of Prescription Drugs

    - OptumRx (Prescription Drug Vendor) must be contacted before purchasing any medication that is administered by injection. (You do not have to call for review of insulin, cortisone, immunizations, vaccinations, allergy shots or bee sting kits.)

16. **Treatment of injury to sound natural teeth** - Treatment by a Doctor or dentist of an accidental injury to the jaw or to sound natural teeth provided the first treatment is rendered within six months of the injury. This includes initial replacement of the natural teeth (excluding implants) and any necessary dental x-rays.

17. **Speech therapy** rendered by a qualified speech therapist that is Medically Necessary and pre-certified with the Medical Review Organization.

18. **Breast reconstruction** following a mastectomy, including reconstruction of the non-affected breast to achieve a symmetrical appearance.

19. **Chiropractic care** - Chiropractic care is defined as services and supplies provided or ordered by a chiropractor. Coverage is subject to the maximums and limitations specified on your Schedule of Benefits.

20. Treatment of **Mental or Nervous Disorders** as follows:
    a. Treatment can be rendered in or out of a Hospital or approved treatment facility.
    b. Outpatient treatment of a Mental or Nervous Disorder must be rendered by a psychiatrist, a duly licensed psychologist, a Licensed Social Worker (LSW), Clinical Social Worker (CSW), Licensed Clinical Professional Counselor (LCPC) or a Licensed Professional Counselor (LPC) or other, as approved by the Medical Review Organization.
    c. All benefits are subject to the Co-Insurance percentages, limitations and maximums specified on the applicable Schedule of Benefits.

21. **Chemical Dependency** treatment, subject to the following provisions:
    a. Any inpatient treatment must be received in a Hospital or an approved Treatment Facility for Chemical Dependency. Participation in post-treatment maintenance programs is not covered.
    b. Admission for a course of treatment must be upon the recommendation or approval of a Doctor (with the exception of court-ordered treatment), and treatment may only be terminated upon the recommendation of a Doctor. If a course of treatment is terminated without a Doctor's recommendation, no benefits are payable for any part of that course of treatment.
    c. All benefits are subject to the Co-Insurance percentages, limitations and maximums specified on the applicable Schedule of Benefits.

22. **Home nursing care** after a Hospital confinement as follows:

a. The program of home nursing care must be established and approved in writing by the patient's Doctor and must be pre-certified and managed by the Medical Review Organization.

b. The Doctor must certify that the care is for the same or related conditions for which the patient was hospitalized and that proper treatment of the patient's condition would require hospitalization if the services and supplies provided as part of the program of home care were not provided.

c. The home care must be provided by or through an organization that meets the definition of a "Home Health Agency."

d. Covered Expenses for home nursing care are the Reasonable and Customary expenses incurred for:

1) Part-time or intermittent home health aide services provided under the supervision of a registered nurse (R.N,) for four hours per day;

2) Part-time or intermittent nursing care provided by or under the supervision of a registered nurse (R.N.);

Services of a licensed practical nurse (L.P.N.) are covered if the patient's condition requires such services;

3) Medical services of interns and residents in training under an approved teaching program of a Hospital with which the Home Health Agency is affiliated;

4) Physical therapy provided under the supervision of a Doctor; medical supplies (other than drugs and biologicals); and the use of medical appliances; and

5) Social Workers;

6) Any of the above items and services which, through arrangements made by the Home Health Agency, are provided on an outpatient basis at a Hospital or Skilled Nursing Facility because they involve the use of equipment or services that cannot readily be provided to the patient in his home.

23. Infertility treatment is as follows:

a. Diagnosis and treatment of infertility shall include, but are not limited to, the following procedures:

1) In vitro fertilization;

2) Uterine embryo lavage;

3) Embryo transfer;

4) Artificial insemination;

5) Gamete intrafallopian tube transfer;

6) Zygote intrafallopian tube transfer; and

7) Low tubal ovum transfer.

b. Charges for drugs and medicines used for the treatment of infertility are covered, provided they are properly identified and ordered in writing by a Physician and dispensed by a licensed pharmacist or Physician. These claims are payable through your medical benefit, not through your prescription drug program.

c. In addition, benefits for procedures for in vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer shall be payable only if:

1) The Covered Individual has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under the Plan.

2) The Covered Individual has not undergone four (4) completed oocyte retrievals, except that is a live birth follows a completed oocyte retrieval, then two (2) more completed oocyte retrievals shall be covered.

24. **Hearing aid devices** prescribed by a licensed Otologist or Audiologist, subject to the maximum benefit specified on the Schedule of Benefits.

25. **Voluntary sterilization** for Eligible Employees, Retirees and Dependent Spouses.

26. **Maternity healthcare expenses are covered** for the Member, Eligible Spouse, and Eligible Dependent Children.

27. **Bariatric surgery** for eligible participants over age 18, once per lifetime, provided that all of the following criteria have been satisfied:

    a. The participant is diagnosed with morbid obesity and satisfies at least one of the following criteria:

        a. BMI (body mass index) greater than or equal to 45 kg/meter squared.

        b. BMI greater than or equal to 40 kg/meter squared with at least one of the following co-morbid conditions: (1) hypertension, (2) dyslipidemia, (3) diabetes, or (4) coronary heart disease.

    b. The participant participates in a weight loss program (monitored and documented by a health care provider) for at least six consecutive months prior to the surgery and satisfies one of the two criteria listed above after participation in the weight loss program.

    c. The Plan's Medical Review Organization has determined that the surgery is medically necessary.

    d. The bariatric surgery is performed by a PPO provider at a PPO facility. Claims from non-PPO providers for bariatric surgery will not be paid under any circumstances.

    Provided that the bariatric surgery is approved in accordance with the guidelines above, any pre-operative testing and any medically necessary treatment for complications of the approved bariatric surgery will also be considered Covered Medical Expenses.

CASE MANAGEMENT PROVISION FOR ALTERNATE TREATMENT PLAN UNDER CASE MANAGEMENT

In cases where the patient's condition is or is expected to be of a serious nature, the Plan may arrange for review and/or case management services from a professional qualified to perform such services. The Case Manager may recommend altering or waiving the normal provisions of this Plan when it is reasonable to expect a cost effective result without sacrifice to the quality of patient care.

Benefits provided under this section are subject to all other Plan provisions. Whether the Plan will provide alternative coverage arrangements will be determined on the merits of each individual case, subject to the discretion of the Trustees or Fund Administrator. Any approved alternative coverage arrangements will not be considered as setting any precedent and the Plan will not be required to provide future coverage for such arrangements with respect to you, your Dependents or any other Participants.

HOSPICE CARE

Hospice Care is a system of care for the terminally ill. It differs from traditional therapies in that it provides services for the family as well as the patient. Hospice teams help the patient and family cope with the physical, psychological, spiritual, economic and social stress of a terminal illness, death and bereavement. When possible, Hospice Care is administered at home. The team of professionals may include Physicians, nurses, psychiatrists, psychologists and social workers.

To receive benefits, the attending Physician must certify **in writing** that the patient has a life expectancy of six (6) months or less.

The Plan reimburses up to a maximum of 30 days for care as an in-patient in a Hospice facility or up to 62 days for home care. Once a person has received the maximum benefits for Hospice Care,

benefits for any further care and treatment of the person's terminal condition will be payable under the provisions of other health care benefits provided under the Plan.

NOTE: NURSING HOMES ARE NOT COVERED.

Hospice Care Definitions

- **Palliative Care –** Care provided to a terminally ill person for the purpose of relieving or alleviating symptoms without curing.
- **Period of Crisis –** A period during which a terminally ill person requires continuous care which is primarily provided by a nurse. This care must be necessary to achieve palliation or management of acute medical services.
- **Respite Care –** Short-term (5 days or less) inpatient care provided to a terminally ill person only when necessary to relieve family members caring for him.

Eligibility for Hospice Benefits – No later than 2 days after a person begins receiving Hospice Care, a Doctor must certify that the person's medical condition is terminal. The certification may be provided by a Hospice Doctor if the Hospice Doctor is his personal Doctor, or by the person's personal Doctor and a Hospice Doctor.

Election of the Hospice Benefit – After a person's condition has been certified as terminal, he must elect to receive his benefits under the Hospice Benefit for most of the care of his terminal condition instead of receiving benefits for that care under the other health care benefits provided by the Plan.

- Surgical operations or Hospital confinements due to medical complications of the terminal condition are not covered under the Hospice Benefit - they are considered for payment under the regular provisions and limitations of the other health care benefits.
- If a person with a terminal condition incurs expenses for treatment of an injury or sickness totally unrelated to his terminal condition, those expenses are considered for payment under the regular provisions and limitations of the other health care benefits.

Before any Hospice Care is provided, an election form must be submitted through the Hospice facility from which he is to receive the Hospice Care. A person can revoke his election to receive benefits under the Hospice Benefit at any time. Charges for any further treatment of his terminal condition will be considered for payment under the regular provisions and limitation of the other health care benefits.

Covered Expenses – Covered expenses for Hospice Care are the expenses incurred for the following Hospice Care services and supplies:

- Nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) and services of home health aides.
- Medical social services under the direction of a Doctor; counseling services and/or psychological therapy rendered by a social worker or a psychologist; and chaplaincy.
- Non-prescription drugs used for Palliative Care, medical supplies, bandages and equipment and drugs and biologicals used for pain and symptom control.
- Skilled Nursing Facility short-term inpatient care to provide Respite Care, Palliative Care or care in Periods of Crisis.

Exclusions and Limitations – No benefits will be payable under the Hospice Benefit in excess of any limitation stated on your Schedule of Benefits or stated in this benefit explanation or for any of the following:

- Bereavement counseling provided to a terminal person's family after his death.
- Administrative services; child care and/or housekeeping services; services or supplies that are rendered, provided or supplied by family members; or transportation (except in Emergency situations).

- Services or supplies not provided as "core services" by the Hospice providing the Hospice Care; or services or supplies for which charges would not be made in the absence of this Hospice Benefit.
- Services or supplies that are not reasonable and necessary for the palliation or management of the terminal condition.
- Long-term inpatient care, surgery or Hospital confinements due to medical complications of the terminal condition, or any services or supplies provided for treatment of any injury or sickness other than the terminal condition.
- Services, supplies or types of treatment which are stated as excluded in the benefit explanation or which are stated as excluded in "What the Plan Doesn't Cover."

SLEEP APNEA BENEFITS

Sleep studies performed in your home are covered at 100%, not subject to deductible or coinsurance if administered by a network provider. The sleep study will be performed in your home and will be paid in full by the Plan. The Plan will also cover the cost of your apnea machine and all necessary supplies such as masks, tubing, filters and humidifiers coordinated through Med-Care Management.

For your convenience, the Trustees have contracted with certain providers to provide a sleep apnea benefit for Participants in the Welfare Fund at 100%. Contact Med-Care Management to coordinate a provider for you.

This benefit is available for all Participants (Eligible Employees and Dependents), including existing apnea patients. An existing patient can obtain his or her apnea machine supplies through this program and if a replacement machine is necessary, the program will also cover the replacement machine. The 100% benefit is only available for sleep studies performed at home by a Blue Cross Blue Shield PPO network provider and equipment coordinated through Med-Care Management.

HOW TO OBTAIN THE SLEEP APNEA BENEFIT WITH NO DEDUCTIBLE/ COINSURANCE

SLEEP STUDIES – If your doctor recommends that you or an eligible Dependent obtain a sleep study; call Med-Care Management at (800) 367-1934 to arrange for your testing.

APNEA MACHINES – If you are prescribed a sleep apnea machine:

- First call the Plan's Medical Review Program at (800) 367-1934 for pre-certification. Your doctor can make the call on your behalf.
- After pre-certification has been obtained, make arrangements with the Medical Review Program (Med-Care Management) by calling (800) 367-1934 to obtain your equipment. You can only receive the 100% benefit for sleep apnea machines when the machine is obtained through recommendation from Med-Care Management. Med-Care Management has arranged for preferred pricing.

For more information about the services and supplies available through this program, call Med-Care Management at (800) 367-1934.

HEARING AID BENEFIT

Eligible Participants are provided with benefits for hearing examinations and hearing aids once every 36 months if the test is performed by an Otologist or Audiologist. A necessary repair to hearing aids is also covered, if prescribed. For eligible Members who now have a hearing aid, replacement will be reimbursed only if an Otologist or Audiologist certifies that the replacement is necessary.

An Otologist is an ear, nose and throat Physician. An Audiologist is not usually a Physician. Anyone with a Master's degree in speech and hearing may call himself an Audiologist.

The Benefit Fund Office has entered into an agreement with EPIC Hearing, effective December 1, 2015. Epic Hearing is a network of quality providers that affords available discounted prices and assistance to help you acquire the upmost coverage that the Funds can provide. You can utilize EPIC by following these easy steps:

1) Call the EPIC network at 1 (866) 956-5400
2) An EPIC Hearing Counselor will walk you through the referral regarding a participating provider.

NOTE: To acquire additional information, please go to the Fund website at www.ibt731funds.org.

The hearing test should consist of:

- An audiogram for air and bone conduction;
- A discrimination test score; and
- A speech reception score

Plan pays as per Schedule of Benefits up to $750 every 36 months.

NOTE: This benefit is paid at 100% and is available once in each 36-month period.

DIABETES PROGRAM BENEFIT

The Welfare Fund is pleased to present a wellness program to assist diabetics to improve their quality of life.

Those with diabetes face numerous challenges throughout the course of everyday life. Although not easy, managing diabetes will allow a diabetic to live a long and productive life. The Diabetes Program is a support curriculum that provides important educational materials that will allow you to face and address everyday challenges, and, more importantly, reach your long-term goals.

Please remember this program has been developed to assist you and your family members. Any active Plan Participant or eligible Dependent of an active Employee who has diabetes, or has been informed by their Physician that they are at risk of diabetes, or has a family history of diabetes is eligible to enroll in this new program.

If you or an eligible Dependent have been diagnosed with diabetes or are at risk of diabetes, please call the Wellness Program (See contact information) and an assigned nurse will enroll you in the program. There is no cost to you to enroll or participate in this program.

TIP: Until further notice, the Trustees have elected to cover all medical services related to the diagnosis and treatment of diabetes including necessary prescription medications at 100% without applying the deductible, coinsurance or copay.

PLAN PAYMENT

Payment from the Plan is intended for reimbursement to you, the Eligible Employee. However, if you want plan benefits paid directly to the Doctor or Hospital, you must authorize the Plan to do so by signing the claim assignment statement on the Plan's claim form. This feature of the Plan is only to facilitate payment of benefits and the legal liability shall in no way be assumed by the Fund. If you paid for the services and are claiming reimbursement, you must also submit a bill or receipt showing the amount you paid along with the claim form.

NOTE: In-Network providers typically file claims directly to the network administrator (i.e. BCBS of IL) who coordinates payment.

TIP: Some provider charges may be more than the allowances under our Plan. In that case you or the patient will be responsible for the additional amount over the maximum Plan allowance. Whenever possible, discuss the situation with the doctor in advance so that you will have an idea of what you might have to pay.

FACILITY OF PAYMENT

If you or your Dependents are not legally capable of giving valid receipt for a benefit payment, the Plan has the right (if there is no legal guardian) to pay the party the Plan believes is entitled to such payment. Once such payment is made, the Plan has no further obligation with respect to the amount so paid.

It is your responsibility to keep the Fund Office informed of any life change, including marriage, divorce, birth of children, death of Spouse, etc.

RIGHT TO RECOVER EXCESS OR ERRONEOUS PAYMENTS/OFFSETTING PLAN BENEFITS

The Fund will pay claims only when covered under the terms of the Plan. If the Fund pays a claim that it is not required to pay (such as payments on behalf of a former Spouse) or pays in excess of the maximum amount permitted under the Plan, it may recover and collect payments from the Participant, the Participant's covered family members and/or any other individual, entity or organization that received the overpayment. If the Fund pays claims on behalf of a former Spouse, it may recover and collect payments directly from the former his dependents. Spouse or from the Covered Member and Recovery of such payments may be made through, but is not limited to, offset or reduction of future benefits payable to the Participant or the Participant's covered family members or through a lawsuit. When offsetting benefits for claims from PPO providers, the Fund will pay only 5% of the Allowed Amount rather than 80% until the amount owed to the Fund is recouped. You will be responsible for the remaining 95% of the Allowed Amount. The Fund's payment of claims from non-PPO providers will not count toward the Participant's reimbursement responsibility.

EXAMPLE: John Divorces his Spouse and fails to notify the Fund. The Fund pays $10,000 in claims on behalf of John's former Spouse. Because John is unable to repay the Fund $10,000, the Fund notifies John that the Fund will offset all of the future claims of John and his Dependent Children until the $10,000 is repaid. After notifying John of his repayment obligation, John's son Allen goes to the emergency room and the amount of the bill is $10,000. If the Hospital is part of the PPO Network, the Fund will confirm that his son is eligible, but will pay only 5% of claims until the $10,000 is recouped. The bill for the Hospital is discounted and the Covered Medical Expense is $2,000. The Fund pays 5% of the Covered Medical Expense, which is $100. John is responsible for the remaining 95% of the Covered Medical Expense, which is $1,900. Under normal circumstances, the Fund would have paid 80% of the Covered Medical Expense, which would have been $1,600. The Fund thus paid $1,500 less than it normally would have ($1,600 - $100). Therefore, John's repayment obligation is reduced by $1,500 and he now owes the Fund $8.500 ($10,000 - $1,500). The Fund will process the claims of John and his Dependent Children in this manner until the remaining $8,500 is recouped and will continue to advise providers of his limited eligibility.

For out-of-Network claims, the Fund will not pay any amount until the amount owed is recouped and the denied out-of-Network claims will not count toward the repayment obligation. However, in the event of an emergency, the Fund will pay any out-of-Network claims as if they were Network claims (5% of the Allowed Amount) and will reduce the Participant's repayment obligation accordingly.

PRESCRIPTION DRUG BENEFITS

The Fund's program covers all *"Legend Drugs." "Legend Drugs"* are defined as all medications which require a prescription by Federal Law and are prescribed by a licensed practitioner. Our program also covers medications which require a prescription under applicable State Law. Additionally, the use of the prescription must be Medically Necessary.

Over-the-counter medications are **not** covered regardless of whether a Physician prescribes them (except certain preventive medications as specified by the Affordable Care Act). The prescription drug benefits are handled by an outside administrative service (OptumRx).

NOTE: Catamaran is now known as OptumRx. Your Catamaran cards will still work.

When your coverage starts, you will be issued a prescription drug identification card which may be used at participating pharmacies. How your prescription expenses are covered by the Drug Card **Program or the Mail Service Program depends on how and where you get them filled.**

TIP: To save even more money, ask your doctor for drug samples during your next visit.

PRESCRIPTION CARD PROGRAM

To use the Drug Card Program, simply take each prescription or refill of a covered prescription drug (up to a 34-day supply) to a participating pharmacy and your co-pays will be as follows:

Type of Drug	Your Co-Pay
Generic (Tier I)	Greater of $7 or 20% of discounted price (but not more than cost of drug)
Formulary brand (Tier II)	20% of discounted price*****
Non-preferred brand (not on formulary) (Tier III)	40% of discounted price*****

***** If you choose a brand name drug when a medically equivalent generic is available, the Plan will only pay what it would have paid for the generic drug and you will be responsible for the balance of the cost.

NOTE: Effective January 1, 2014, the mandatory provision of the mail order program has been removed. If you prefer the retail pharmacy, you may do so. The retail pharmacy is subject to up to a 34-day supply limit and the co-pay structure listed above. **Effective November 1, 2015** the retail pharmacy limit was increased to a 100-day supply.

MAIL SERVICE PROGRAM

To use the Mail Service Program, simply contact OptumRx and they will provide you with a full explanation of the home delivery program, including instructions on how to order refills and new prescriptions (up to a 100-day supply). Your co-pay will be as follows:

Type of Drug	Your Co-Pay
Generic (Tier I)	$15
Formulary brand (Tier II)	$45
Non-preferred brand (not on formulary) (Tier III)	$95

GENERIC DRUGS

Generic drugs are drugs which are identified by their "official" (or chemical) name rather than a brand name. All drugs (whether generic or not) **must** meet the same governmental standards for safety and effectiveness.

Many companies market the same drugs under a more expensive brand name, so you end up paying more for the same quality. Therefore, it makes sense to ask your doctor to prescribe a generic drug whenever possible. This is to afford Participants the most coverage possible.

MAINTENANCE DRUGS

A maintenance medication is a drug that you will be taking on a regular basis over a period of time. The Fund has made provisions for those Participants on maintenance prescription drugs to receive a 100-day supply of these drugs through a Central Fill Pharmacy. Please contact OptumRx at: www.mycatamaranrx.com or at: (800) 880-1188 for information and instructions on how to become part of their maintenance drug program.

SPECIALTY PRESCRIPTION DRUGS

A specialty drug is a prescription drug that is high cost and requires special storage, handling and close monitoring of the patient's drug therapy. These drugs, also known as biologicals, can be injectable, infused, oral or inhaled. Our plan currently requires you to utilize the Briova Specialty Pharmacy should you require one of these drugs.

These drugs are extremely costly and can run thousands of dollars for each prescription.

Effective January 1, 2016, the Trustees have formalized a "Specialty Prescription Co-Pay Assistance" Program. This Program was instituted to assist both you and the Funds regarding cost savings relative to obtaining specialty drugs. The program is administered by a firm called IPC Evergreen. IPC Evergreen will identify high cost specialty drugs that are eligible for co-pay assistance. Co-pay assistance comes from the manufacturer of the drug. The Fund will apply 30% co-pay, with a minimum of $25.00 for each 30-day supply. IPC Evergreen will reduce the price with the manufacturer to cover most, if not all of the 30%. You will not pay more out of pocket than you would under the current copay structure.

If a drug does not qualify for copay assistance, the copay defaults to the normal Tier I, Tier II or Tier III plan design as described above.

PRIOR AUTHORIZATIONS

For certain drugs, OptumRx will require what is known as a *prior authorization*. A prior authorization is a "medical review" to determine the necessity or quantity of specific drugs. The Fund relies on the

prescription benefit manager (OptumRx) and other medical professionals to determine what drugs require prior authorization.

For Example, a prior authorization will be required for drugs that are categorized as a specialty drug (described above). Another example would be when a drug is prescribed outside of clinical dosing guidelines. For instance, a drug's normal clinical dose is once per day, but your doctor prescribed the drug for 3 times per day. That drug would be rejected pending a prior authorization.

STEP THERAPY PROGRAM

The Welfare Fund and OptumRx are working to make prescription drugs more affordable. As a result, your Plan uses a program called Step Therapy.

Step Therapy Pharmacy Program Description

Often when there are many different medications available to treat a medical condition, it is useful to follow a stepwise approach (called "Step Therapy") to find the best treatment for you. The Step Therapy Program can help you save money by ensuring that you get the most cost effective medication that is appropriate for your condition. Under the Program, the pharmacist will work with you and/or your Physician to find an equally effective, yet less expensive, alternative medication known to be safe and effective for most people rather than the more expensive named brand drug (your "Affected Medication"). These are the steps:

Step 1: Try a generic medication first. If a generic medication is appropriate, it will be covered by the Fund at the generic medication Co-Payment. In this instance, you will just need to purchase the medication at the pharmacy and show your ID card.

Step 2: If you present necessary evidence that the generic or preferred alternative medication does not adequately treat your condition, then the original prescription medication will be dispensed and covered by the Plan.

If you choose not to try the Step 1 medication before filling your prescription, your Affected Medication will not be covered by the Fund and you will need to pay the entire cost of the medication.

Should you have any questions, please feel free to contact the OptumRx's Customer Care Center at (800) 626-0072.

Birth Control

The Plan covers birth control under the guidelines established by the Affordable Care Act and are available for women less than age 55. All reimbursable birth control requires a prescription from a Physician. Coverage of birth control includes the following:

- OTC female contraceptive products* (with prescription):
  - Female Condoms - Quantity limit of 12 units per month
  - Spermicides (e.g. vaginal gel/foam/film/suppositories) – Quantity limit of 12 units (or days supply for gel/foam) per month
  - Sponges – Quantity limit of 12 units per month

- Prescription contraceptive drugs:
  - Emergency contraceptives* - generics only, excludes branded products; Quantity limit of 2 courses per year
  - Oral contraceptives – Quantity limit of 1 tab per day applies to all products
    - Monophasic, Biphasic, Triphasic, Extended Cycle – generics only; excludes branded products
  - Four-phasic – only brand product available within drug class (Ortho-Evra), Quantity limit of 3 patches per month

  - Contraceptive Ring – only brand product available within drug class (Nuvaring); quantity limit of 1 ring per month
  - Injectable Contraceptives – generics only, excludes branded products; Quantity limit of 1 injection per 90 days
- Prescription contraceptive devices
  - Diaphragms – Quantity limit of 1 unit per year
  - Cervical caps – Quantity limit of 1 unit per year
  - Contraceptive Implants
  - IUD

*OTC female contraceptive products and prescription emergency contraceptive products are not considered maintenance medications; therefore, these products are not eligible for 90-day supplies.

EXCLUSIONS

The prescription drug benefit does not cover the following:

- Medications purchased while a person was not covered under the Plan.
- Vitamins, whether prescribed or not. (Exception: Pre-Natal Vitamins and items covered as Preventive under the Affordable Care Act)
- Non-prescription items such as over-the-counter drugs, bandages, heating pads, aspirins, etc., even though a doctor may order them on a prescription blank.
- Infertility and impotency drugs.
- Anti-smoking medications or preparations, unless identified as a Preventive Service Benefit under the Affordable Care Act.
- Drugs for cosmetic purposes, such as Retin A and including but not limited to treatment for baldness.
- Drugs or medications that are considered "Step 2" medications except as allowed under the Step Therapy Program as set forth above.
- Food substitutes and supplements.
- Drugs that are excluded under this Section or which are stated as excluded in "What the Plan Doesn't Cover."
- Abortifacient Drugs or male contraceptives (e.g. condoms)
- Rogaine or similar drugs and preparations, even with a doctor's prescription.
- Any medications available over the counter, unless specified by the Plan.
- Drugs specifically taken for weight loss

IMPORTANT: If you are not personally presenting a prescription for dispensing, please make sure that the individual picking up the medication is able to state the age of the patient and his/her relationship to the cardholder.

PRESCRIPTION DRUG BENEFITS FOR ACTIVES AND DEPENDENTS WHO ARE MEDICARE ELIGIBLE

If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D (Medicare's Prescription Drug Plan).

Medicare covers prescription drug benefits under Part D. For Active Participants and/or their Dependents who are Medicare-eligible, this Plan offers "Creditable Coverage." This means that the

Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard Medicare prescription drug benefit will pay. Since this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have this Plan's prescription drug coverage. When you lose this coverage, you may enroll in a Medicare Prescription Drug Plan either during a special enrollment period or during Medicare's annual enrollment period (November 15th - December 31st of each year) by calling 1-800-MEDICARE. If you would rather elect Medicare's coverage, you can enroll in the Medicare Part D plan no sooner than 3 months prior to, through 3 months after, your 65th birthday; otherwise, you may incur a premium penalty. For more information about creditable coverage see Plan's Notice of Creditable Coverage that will be mailed to you from the Plan once a year. You may request another copy of this Notice by calling the Fund Office and asking for one.

VISION BENEFIT PROGRAM

The Trustees of the Local No. 731 Welfare Funds have contracted with Vision Service Plan (VSP) to provide the Funds' vision care network and to administer vision benefits on behalf of the Fund. Under the Vision Benefit Program, payments are made for covered vision expenses incurred by you and your Eligible Dependents at a licensed optometrist or ophthalmologist up to the Plan maximum.

If you use a VSP doctor:

The VSP doctor will provide personalized care that focuses on keeping you and your eyes healthy year after year. When you utilize a VSP doctor, you will get the most out of your vision benefit, have lower out-of-pocket costs and the doctor will bill VSP for the benefit amount, and you will only pay the doctor the amount, if any, over the Plan maximum. You will be eligible to receive one spectacle examination per Calendar Year (except Dependent Children who are not subject to the limit as specified by the ACA), plus one of the following every two Calendar Years:

- $200 toward the retail cost of eyeglass frames and full coverage of eyeglass lenses; or
- $300 toward contact lenses and contact lens fitting and evaluation fees. (Note: Only Dependent Children are entitled to polycarbonate eyeglass lenses under the in-network benefit)

TIP: Vision coverage is based on Calendar Year (January through December), not service date to service date. For example, if you used your benefit to purchase eyeglass lenses on May 12, 2014, then you will be eligible again on January 1, 2016 for the full benefit.

Prescription Glasses

Lenses are covered every other calendar year and include:

- Single vision, lined bifocal, lined trifocal and progressive lenses.
- Polycarbonate lenses covered for Dependent Children.
- Refer to the below "Extra Discounts and Savings" section for additional non-covered lens option savings.
- You will receive an average of 20-25% savings on all non-covered lens options.
- You will receive 20% off additional prescription glasses, including lens options, from any VSP doctor within 12 months of your last Well Vision Exam.

Frames are covered every other calendar year and include:

- $200 allowance toward a wide selection of frames.
- 20% off the amount over your allowance.

Contact Lens Care (in lieu of lenses and frame) is available every other calendar year and includes:

- A total of $300 allowance that can be used for contact lenses, contact lens fitting and evaluation fees.
- Current soft contact lens wearers may qualify for a special program that includes a contact lens exam and initial supply of replacement lenses.
- 15% off cost of contact lens fitting and evaluation.
- If you use disposable contact lenses, benefits will be paid for multiple sets of disposable contact lenses obtained under a vision prescription during a two Calendar Year period up to the $300 maximum.

TIP: Call VSP at (800) 877-7195 to find a participating eye doctor. A card is not required for services, but **be sure you tell your eye doctor you have VSP when you make your appointment.**

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Out-of-Network Reimbursement Amount:

- A total allowance up to $300 is available every other calendar year. This allowance can be used for exam, lenses, lens options, frame, contact lenses and contact lens fitting and evaluation fees.
- Members cannot utilize both in-network and out-of-network services during the same benefit period.
- When you use an out-of-network provider, you must pay the bill in full and submit your itemized receipt along with a signed claim form to VSP for reimbursement. Out-of-network coverage is $300 for all eyewear and services (including spectacle examinations) every two Calendar Years.

You cannot combine in-network and out-of-network claims during the same benefit period.

TIP: Ask in advance about costs so that you know how much, if anything, you may have to pay in addition to the Plan allowance for services.

VISION BENEFIT EXCLUSIONS AND LIMITATIONS

Charges made for the following are not considered covered vision expenses under the Vision Benefit Program:

1. Vision treatment that is incurred while a person was not covered under the Plan.
2. Services or supplies which are covered in whole or in part under any other benefit provided by this Plan.
3. Services or supplies resulting from any occupational injury or sickness, whether or not covered by a Workers' Compensation Law or similar law.
4. Special procedures, such as orthoptics or vision training; anti-reflective coatings; subnormal vision aids; or special supplies such as safety glasses, non-prescription glasses or non-prescription sunglasses.
5. Contact lenses or eyeglasses which are required after cataract surgery. (One pair is covered under the Comprehensive Major Medical Benefit after cataract surgery.)
6. Services or supplies rendered in connection with any medical or surgical treatment.
7. Services or supplies not listed as covered vision expenses under the Vision Benefit Program.
8. Eye examinations (or lenses or frames required as a result of such examination) which are required by an employer as a condition of employment and for which the employer is required to pay according to the provisions of any labor agreement or statute.
9. Services, supplies or types of treatment which are stated as excluded in this benefit explanation or which are stated as excluded in "What the Plan Doesn't Cover."

In order to locate a VSP doctor, request out-of-network claim forms or check the status of a claim, please contact VSP at (800) 877-7195.

You may also visit their website at www.vsp.com.

DENTAL BENEFITS

You and your Eligible Dependents are entitled to benefits for dental care each Calendar Year up to $2,000 per person. The Plan will pay the Co-Insurance percentage for covered dental expenses as shown on the Schedule of Benefits. All benefits paid on your behalf are applied to your Calendar Year maximum benefit. Once the maximum benefit has been paid on your behalf by the Plan during a Calendar Year, no further benefits will be payable on your behalf until the following calendar Year. The same applies to each of your Dependents. You will be responsible for paying any amount of incurred dental expenses which are not reimbursed by the Plan.

You and your Dependents may go to any dentist you choose for dental treatment.

Delta Dental Plan of Illinois administers your Dental Benefit on behalf of the Fund.

Eligible Participants will receive a Delta Dental I.D. card and additional information about this program. Alert your dentist to send his bill to Delta Dental, and identify yourself as a Participant in this program, by presenting your Delta I.D. card when you receive dental services. Non-contracted dentists may require you to pay the entire bill up front. For information on filing a claim, contact Delta Dental's customer service at: (800) 323-1743 to receive a claim form.

DELTA PPO NETWORK

Delta provides a dental PPO network which can save you money. If you use a Delta PPO dentist:

- A higher percentage will be paid for covered preventive and diagnostic services.
- Delta PPO dentists' fees are discounted according to contract. Therefore, the amount you pay out-of-pocket as your percentage share of the charges will be lower.

You do not have to enroll or sign up with a Delta PPO dentist to get the better benefits. Just call the Delta PPO dentist of your choice to make an appointment. You can use a Delta PPO dentist for part of your dental care and an out-of-network dentist for another part of your care. Family members can use Delta PPO dentists and others can use out-of-network dentists. You can switch from one Delta PPO dentist to another Delta PPO dentist any time.

OUT-OF-NETWORK DENTISTS

If you use a dentist who is not a Delta PPO dentist, your benefits are paid under the out-of-network section on the Schedule of Benefits. You must pay your dentist the difference between the dentist's fee and the Reasonable and Customary charges for such service in addition to your Co-Insurance percentage.

PREMIER DENTISTS

In addition to their Delta PPO network, Delta has contracted with a large number of dentists who have agreed to certain fee limitations. Delta calls this group their Premier network. You will save money because Premier dentists will not bill you for any balances in excess of reasonable and customary fees. This network is not the same as the Delta PPO network, and claims for covered services by Premier dentists will be paid under the out-of-network schedule.

COVERED DENTAL EXPENSES

Covered dental expenses are the charges incurred by you or a Dependent for necessary services and supplies which are rendered in a course of treatment for a dental condition in accordance with accepted standards of dental practice, are performed by a licensed dentist, and are received while the individual receiving the treatment is covered under the Plan. The applicable Plan co-insurance percentage for each type of covered dental expenses is shown in the Schedule of Benefits.

DIAGNOSTIC AND PREVENTIVE CARE COVERED EXPENSES (DEDUCTIBLE WAIVED)

- Routine oral examination and prophylaxis (cleaning of teeth) twice per Calendar Year.
- Fluoride – Topical application of sodium fluoride and stannous fluoride.
- Space maintainers.
- Emergency palliative treatment.
- Dental x-rays, including full-mouth x-rays, supplementary bitewing x-rays and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.
- Sealants.

RESTORATIVE CARE COVERED EXPENSES

- Extractions, other than impacted teeth (impacted teeth are covered under your comprehensive major medical benefit).
- Oral surgery, limited to minor oral surgery not covered under the Comprehensive Major Medical Benefit.
- Fillings – Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or broken teeth.
- Endodontic treatment, including root canal therapy.
- Treatment of periodontal disease and other diseases of the gums and tissues of the mouth.
- Dental anesthetics, such as Novocain and nitrous oxide, when Medically Necessary and administered in connection with oral or dental surgery.
- Injection of antibiotic drugs by the attending dentist.

PROSTHODONTIC CARE COVERED EXPENSES

- Crowns and Inlays – Inlays, onlays, gold fillings or crown restorations to restore diseased or broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling restoration.
- Bridges – Initial installation of fixed bridgework (including inlays and crowns as abutments).
- Dentures – Initial installation of partial or full removable dentures (including precision attachments and any adjustments following installation).
- Repair or cementing of crowns, inlays, onlays, bridgework or dentures and replacing broken teeth; relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months.
- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework.

NOTE: 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. No benefits will be paid for any replacement of a previous denture which is not separated from such previous treatment by five years.

Delta Dental Summary of your Dentist Choices		
Preferred Provider (PPO) Dentist	**Premier Dentist**	**Out-Of-Network**
• Preventive benefits paid at 100% of contracted rate	• Preventive benefits paid at 80% of contracted rate	• Preventive benefits paid at 80% of the Reasonable and Customary Charge
• No balance billing for charges over what the Plan pays	• No Balance Billing for charges over what the Plan pays	• Will Balance Bill for charges over what the Plan pays
		• May require payment up front

TIP: To find a Preferred Provider dentist, contact Delta Dental of Illinois at 800-323-1743 or visit www.deltadentalil.com.

TIP: Delta Dental determines the fee that will be paid for a particular service. PPO and Premier Dentists accept that fee and will not bill you for any difference if their bill is higher than the fee allowed by Delta Dental. Call Delta Dental at 800-323-1743 if you have any questions.

DENTAL BENEFIT EXCLUSIONS AND LIMITATIONS

No benefits will be payable under the Dental Benefit in excess of any limitation stated on your Schedule of Benefits or stated in this benefit explanation, or for any of the following:

1. Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a dentist.
2. Services or supplies which are covered in whole or in part under any other portion of this Plan.
3. Services or supplies resulting from any occupational injury or sickness, whether or not covered by a Workers' Compensation Law or similar law.
4. Services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
5. Any duplicate prosthetic device or any other duplicate appliance.
6. Prosthetic devices (including bridges and crowns), and the fitting of such devices, which are ordered while the person is not eligible for Dental Benefits.
7. Dental charges incurred prior to the date the person was eligible for Dental Benefits. See "Determination of Date of Incurred Charges" for more information.
8. Dental services or supplies provided for the repair of congenital oral defects or repair which is primarily for the restoration of the vertical dimension of the face.
9. Treatment of TMJ (see Medical Benefits).
10. Charges incurred during a Calendar Year after benefits totaling the maximum benefit have been received.
11. Services, supplies or types of treatment which are stated as excluded in this benefit explanation or which are stated as excluded in "What the Plan Doesn't Cover."
12. Implants, veneers, and bleaching.
13. Night guards and bruxers for treatment of bruxism (teeth grinding).

14. Oral surgery and related treatment performed in a Hospital or otherwise covered as a Covered Medical Expense.

Alternate Courses of Dental Treatment - Situations frequently arise where there are two or more alternate methods of treating a particular dental condition. In these situations, the amount included as covered dental expenses will be determined as follows:

- If alternate services may be used to treat a dental condition, covered dental expenses will be limited to the Reasonable and Customary expense for that service which is most commonly used nationwide in the treatment of that condition, and is recognized by the dental profession to be appropriate in accordance with the accepted nationwide standards of dental practice.

Determination of Date of Incurred Charges - Some dental conditions require a number of visits to the dentist, depending on nature of the treatment and the appliances involved.

- If a person is in the process of being treated for one of these dental conditions before he becomes eligible for Dental Benefits, no benefits will be paid for treatment which is considered to have begun before the person became eligible.
- If a person is in the process of receiving any of the dental services listed in the following paragraph when his eligibility for Dental Benefits is terminated, subject to the Calendar Year family maximum benefit, the Plan will pay benefits for that treatment for 90 days after termination of his eligibility for Dental Benefits if the treatment began while the person was eligible for Dental Benefits.

Treatment is considered to begin and the charges are considered incurred as follows:(1) For fixed bridgework, crowns or gold restorations, when the tooth is first prepared; (2) For full or partial dentures, when the impression for the appliance is taken; (3) For endodontic treatment, when the tooth is opened for root canal therapy; and (4) For necessary follow-up treatment on oral surgery or periodontal surgery, when the surgery is performed.

ORTHODONTIA BENEFIT

Payment of Benefits - There is no Deductible. The Plan will reimburse you 80% of the Allowed Amount incurred for covered orthodontia expenses including surgery to correct malocclusion up to the Plan's lifetime maximum of $4,000.

Orthodontists usually bill the entire fee for a course of orthodontic treatment before treatment starts and require a percentage of the total to be paid up front. The Plan will pay the lesser of twenty-five percent (25%) of the total case fee or the dentist's initial placement fee as the down payment at 80%. The balance will be prorated monthly over the treatment period not to exceed the orthodontia maximum benefit. If for any reason the treatment plan is terminated before completion of the treatment, no further benefits are payable.

Once benefits totaling the maximum benefit have been paid by the Plan, no further Orthodontia Benefits will be payable. You will be responsible for paying any amount of incurred orthodontia expenses which are not reimbursed by the Plan.

Treatment in Process When Coverage Starts - The Plan will pay 80% of the charges that are billed to you after you become covered (unless another plan has already assumed the responsibility for the orthodontic treatment). The Plan will only reimburse you for the payments which have a due date on or after the date you or your Dependent become eligible. Any past due payments are not eligible for expenses.

No Extension of Benefits Upon Termination of Eligibility - There is no extension of benefits for orthodontia expenses. All benefits for orthodontia will terminate on the date that your eligibility for Orthodontia Benefits terminates or, in the case of a Child who becomes age 26, whichever date occurs first. Any payments that are due for orthodontic services after your eligibility for Orthodontia Benefits terminates, or after the Child's eligibility for Orthodontia Benefits terminates, are your responsibility.

WHAT THE PLAN DOESN'T COVER
(GENERAL EXCLUSIONS)

No payment will be made under this Benefit Plan for loss sustained or for charges incurred for any of the following:

1. Care, treatment, services, supplies, procedures or confinements that are not recommended and approved by the attending Doctor, Dentist or other applicable health care professional.
2. Care, treatment, services, supplies, procedures or confinements that are not rendered for the treatment or correction of, or in connection with, a specific accidental bodily injury or sickness, unless specifically identified as being covered under the Plan.
3. Services or supplies received from a doctor or a hospital that do not meet this Plan's definition of "Doctor" or "Hospital."
4. Care, treatment, services, supplies, procedures or confinements that are not considered "Medically Necessary."
5. Any medical charge or portion of a medical charge that is in excess of the Reasonable and Customary Charge.
6. Care, treatment, services, supplies, procedures or confinements that are "Experimental or Investigational."
7. Medical or dental services or supplies 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, except as provided under "Covered Medical Expenses" section, or as provided under the Dental Benefit, or as specifically stated as covered under one or more benefits under this Plan.
8. Services or treatments that are preventive in nature, except for services covered under the Preventive Services Benefit.
9. Patent drugs or medicines or other drugs that can be obtained without a Doctor's prescription, or any other drugs or medicines not legally dispensed by a licensed pharmacist according to the written prescription of a Doctor, unless specifically stated otherwise in this Plan.
10. Any type of Wellness exam outside of the guidelines of the Preventive Services Benefit as established by the Affordable Care Act (ACA).
11. Transportation or travel or any room or board expenses incurred in connection with such transportation or travel, whether or not recommended by a Doctor, except as covered under "Covered Medical Expenses."
12. Treatments, services, or surgical procedures that are of an elective nature (including all non-Emergency plastic or cosmetic surgery on the body, including but not limited to such areas as the eyelids, nose, face, breasts, or abdominal tissue). This exclusion also applies to services or supplies provided in connection with treatment of complications resulting from a prior treatment or procedure for which Plan benefits are or would have been excluded under this exclusion if a claim had been submitted for such treatment or procedure.

    Exceptions: This exclusion does not apply to:

    a. Breast reconstruction following a mastectomy, including reconstruction of the non-affected breast to achieve a symmetrical appearance.
    b. Vasectomies and other sterilization procedures for Employees, Retirees and Dependent Spouses
    c. Correction of congenital defects - surgery which provides functional repair or restoration of any defective body part when repair is necessary to achieve normal bodily functioning. The defect must have existed at birth.
    d. Cosmetic surgery for the correction of defects incurred through traumatic injuries sustained by a person as a result of an accident.

13. Abortions.
14. Vasectomies or other sterilization procedures for Dependent Children.
15. Reversal or attempted reversal of any vasectomy or other sterilization procedure.
16. Any operation or treatment in connection with sex transformations or any type of sexual dysfunction, including any complications arising from such conditions or situations.
17. Eye refractions, eyeglasses or contact lenses (except the first pair of eyeglasses or contact lenses required following cataract surgery) except as payable under the Vision Benefit.

    Exceptions: If any of these services or supplies are rendered as a result of accidental bodily injury, charges for such services and supplies will be considered Covered Expenses.
18. Dental prosthetic appliances, including any charges made for their fitting, except as covered under the Dental Benefit, unless the appliances are required as a result of accidental bodily injury.
19. Treatment or consultation for the purpose of marriage counseling.
20. Care of a healthy Child (well-baby care) other than as provided to a newborn during the initial Hospital confinement after birth or for routine immunizations and inoculations and exams as stated in the Schedule of Benefits.
21. Care, treatment, services or supplies provided in a nursing home, rest home, home for the aged, convalescent home or similar establishment or facility, with the exception of an approved confinement in a Skilled Nursing Facility.
22. Services, treatment, or surgical procedures rendered in connection with an **overweight condition** or condition of **obesity** and/or **morbid obesity**, including charges attributable to complication arising from such services, treatment or surgical procedures, **except those related to approved bariatric surgery** as described in the Covered Medical Expenses section.
23. Special education, regardless of the type or purpose of the education, the recommendation of the attending Doctor, or the qualifications of the person rendering the special education (except for one course of diabetes self-management training, including medical nutrition education, upon the initial diagnosis of diabetes by the Participant's Physician).
24. Education, training, or room and board while the person is confined in an institution that is primarily a school or other institution of learning or training.
25. Any type of Custodial Care (care that is designed primarily to assist a person in meeting the activities of daily living), regardless of what the care is called.
26. Any care or treatment of a person once the person has already received Plan benefits totaling the maximum benefit for that type of care and treatment as specified on the Schedule of Benefits.
27. With respect to treatment for a Mental or Nervous Disorder or Chemical Dependency:
    a. Treatment in a residential facility or any treatment facility that does not meet the definition of an approved treatment facility;
    b. Outpatient treatment of a Mental or Nervous Disorder that is not rendered by a psychiatrist, a duly licensed psychologist, a Licensed Social Worker (LSW), Clinical Social Worker (CSW), Licensed Clinical Professional Counselor (LCPC), Licensed Mental Health Counselor (LMHC), Licensed Professional Counselor (LPC) or other, as approved by the Medical Review Organization, rendering treatment.
    c. Treatment of a Mental or Nervous Disorder if either the prognosis or history of the person receiving the treatment does not indicate that there is a reasonable chance of improvement;
    d. Any course of treatment for Chemical Dependency that is terminated without the recommendation of a Doctor; or
    e. Any psychiatric or psychological consultation or session with or treatment of any family member that is primarily in connection with the treatment of a Mental or Nervous Disorder of another family member (i.e. marriage counseling and family therapy).
28. Home nursing care except as specified in the "Covered Medical Expenses" section.

29. Treatment of injuries sustained in the course of the commission of a crime, if the offense could be punished as a felony, except injuries related to domestic violence.
30. Services rendered by an individual who ordinarily resides in the Covered Person's home or who is a member of the Covered Person's immediate family.
31. Rogaine or similar drugs and preparations, whether or not obtained with a Doctor's prescription.
32. Drugs or medicines which are not prescribed to treat a mental or physical condition for which the U.S. Food and Drug Administration (FDA) has approved usage of such product, or that are not prescribed or used in a manner consistent with the FDA's intended and approved usage.
33. Services rendered as the result of any occupational injury or illness sustained in the course of, or arising out of, any activity for wage or profit, whether or not covered by a Workers' Compensation Law or Occupational Diseases Law or similar law; except that, if the employer (or the employer's worker's compensation insurer) denies liability for an injury or illness alleged to be work related, the Trustees may agree to pay for Medically Necessary services provided that (1) the Covered Individual, and any attorney representing the Covered Individual in the matter, signs a Reimbursement Agreement in accordance with the "Subrogation" section of this Plan, (2) they receive confirmation in writing that the employer, or the employer's worker's compensation liability insurer, has denied responsibility for the injury or illness and (3) the Covered Individual demonstrates that he or she is pursuing a claim against the employer and/or the employer's worker's compensation insurer, unless the Trustees determine, in their discretion, that such a claim is not viable based on the facts and circumstances surrounding the injury or illness.
34. A confinement in a Hospital owned or operated by the U.S. government or any agency of the U.S. government, except that, to the extent required by law, the Plan will reimburse a Veteran's Administration (VA.) Hospital for the reasonable cost of care of a non-service-related disability if the Plan would normally cover such care if the VA was not involved.
35. Services or supplies that are furnished, paid for, or otherwise provided for, due to past or present service of any person in the armed forces of a government, unless required by law.
36. As a result of any bodily injury or sickness caused by: war or any act of war, whether declared or undeclared; any act of international armed conflict; any conflict involving the armed forces of any international body; or riot or insurrection.
37. Any type of treatment that is incurred outside the limits of the United States of America and Canada if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, dental services, drugs or supplies.
38. Charges by a Doctor or other provider of medical services or supplies for the completing of claim forms (or forms required by the Plan for the processing of claims), or interest charges.
39. Services, supplies or Hospital confinements for which the Covered Person is not required to pay.
40. Charges that would not have been made if this Plan did not exist.
41. Charges for services or supplies provided to a person after the person's eligibility for benefits has terminated.

    Exceptions: This exclusion does not apply to:

    a. If a Covered Person is hospitalized as an inpatient on the date that eligibility would otherwise terminate, the Covered Expenses incurred during that continuous period of hospitalization; or
    b. Certain dental services that began before termination of eligibility, but only as specified in the Dental Benefits section.
42. Rental or purchase of any Durable Medical Equipment or other equipment that is not used solely for therapeutic treatment of a single individual's injury or sickness.

43. Any of the following list of items or items of a similar nature, regardless of intended use, including but not limited to:

air conditioners	exercising equipment
air purifiers	health club memberships
whirlpools	vibratory equipment
swimming pools	hot tubs
humidifiers/dehumidifiers	shoe inserts
pillows (including allergy-free pillows)	scales
mattresses (including orthopedic mattresses)	chiropractic braces
blankets or mattress covers	diabetic shoes
commodes	stethoscopes
electric heating units	clinical thermometers
communication devices (except for autism)	blood pressure instruments
elevators or stair lifts	shower chairs
devices or surgical implantations for simulating natural body contours (except for breast prostheses following mastectomy)	

44. Special home construction to accommodate a disabled person.
45. Surgery to correct malocclusion, except as provided under Orthodontia Benefits.
46. Non-PPO Services and supplies related to Outpatient Surgery performed in an ambulatory surgical center NOT included in the PPO network.
47. Charges incurred for the services of a mid-wife.
48. Food substitutes and supplements.
49. Genetic testing (Exception: test for breast cancer – BRCA1/BRCA2)

The preceding list is not an all-inclusive listing of the Benefit Plan's conditions, limitations, and excluded procedures, services or supplies. It is only representative of the types of situations for which no payment, or limited payment, is made. Basically, benefits are only payable under this Plan for the direct treatment of non-occupational accidental injuries and sicknesses.

TIP: See the Prescription Drug Section for additional exclusions.

MEMBER ASSISTANCE PROGRAM

The Member Assistance Program (MAP) is provided to you and your eligible Dependents. These CONFIDENTIAL SERVICES were developed to help you and your Dependents cope with personal difficulties that can affect your lives both at home, and at work.

1 (800) 292-2780
Call 24/7 - 365 Days
Substance Abuse / Chemical Dependency / Stressful Issues

MAP Services - Members and dependents who are eligible to use the MAP have access to up to three counseling sessions per problem, situation or issue, at no cost. Services may include a comprehensive evaluation, brief counseling and a referral, if necessary. Some services not covered under the Plan may be provided by the MAP, at no cost to you.

Contact information - MAP services are available 24 hours a day seven days a week by calling **(800) 292-2780.** Calls are always answered directly by clinical professionals who provide immediate service, even after standard business hours. The 800 hotline number can be used anywhere in the United States.

TIP: Call the MAP to assist in selecting the appropriate facility for substance abuse.

How the MAP works - When you or your Dependent contacts the MAP, the immediate task of the MAP counselor is to rule out any threat to the life and safety of the caller or the risk caused by the caller. Once safety has been established, the MAP offers an in-person session or provides services over the phone. A thorough assessment of your current situation is conducted. A variety of issues presented to the MAP can be assessed within the scope of up to three in-person counseling session model currently in place for the Plan. Short-term counseling through the MAP is appropriate for individuals who are experiencing a variety of stressors including a difficult transition, stress, depression, and relationship and family conflicts. If, during the assessment, it becomes apparent that brief counseling is either inappropriate or insufficient to address your concern, the MAP counselor will guide you to the appropriate in-network provider and the correct level of care. There are also cases in which individuals may contact the MAP in order to secure the higher benefit level but have no interest in using the MAP benefit. In these situations, the MAP will act as an educator, explaining the benefits that are available and reminding the individual about the importance of selecting in-versus out-of-network providers.

The Member Assistance Program (MAP) is administered by Employee Resource Systems (ERS).

The MAP also offers Work-Life Services. To access, please go to the ERS website at

www.ers-eap.com
Username: ibt731
Password: teamsters

The Work-Life website provides a library of information about childcare, pet-care, education, adoption, family matter, elder care, wellness and other everyday life issues.

Confidentiality. All contact with the MAP is confidential. The MAP counselor will not speak with any supervisor, coworker, union official, or family member without permission from the Member (or the Dependent using the MAP), subject to the privacy rules of HIPAA (see Statement of Privacy Practices section). Confidentiality is compromised only when a threat exists (e.g., risk of suicide or homicide, stalking or child abuse). Contacting the MAP can be a first step toward resolution of personal difficulties.

Issues not covered - The MAP does not address difficulties related to salaries, or job assignments. Should you or your Dependent require care beyond the MAP, you will be directed to the best and most appropriate in-network provider available.

WELLNESS PROGRAM

The Board of Trustees initiated a Wellness Program in fall of 2012. Effective in October, 2015, the Trustees have selected Interactive Health to administer the Wellness Program. Interactive Health also performs the blood work at the annual Health Fairs.

The objective of the Wellness Program is as follows:

- Provide an educational resource for all members and their families so they may obtain information on becoming and remaining healthy.
- Identify those members and spouses that may be at risk for a serious unhealthy episode.
- Provide support to those identified to be at risk with a Nurse Educator or Wellness Coach.

Educational Resources available through the Wellness Program include information on:

- Weight Management
- Activity and Exercise Tips
- Healthy Eating Guidance
- Stress Management Assistance
- Various health videos and other interactive tools
- Heart Health & Disease Prevention
- Body Mass Index Calculating
- Self-Assessment
- Diabetes Awareness
- Smoking Cessation

TIP: These resources are available to you through the portal at www.myinteractivehealth.com or by contacting them at 1(800) 840-6100.

IDENTIFYING PLAN PARTICIPANTS THAT MAY BE AT HIGH RISK

The Wellness Program evaluates utilization data to identify those with high risk health conditions.

The purpose is to reach out to these individuals to ensure they are getting the support and education they need to provide them with the highest quality of life possible.

Health risk conditions can include, but are not limited to Diabetes, high cholesterol, high blood pressure and metabolic syndrome.

TIP: The Wellness Program is voluntary at no cost to the member and family.

If you or your spouse is identified with a high risk health condition or any conditions or circumstances that may lead to an unhealthy episode, a Health Coach or Nurse Educator will reach out to you, either by phone or by mail.

TIP: The Wellness Program may reach out to you to discuss your health conditions. All information is kept strictly confidential.

NOTE: The Wellness Program is a "work-in-progress" to promote healthy lifestyles and identify those that may have or are heading for serious health conditions.

Each year, the Trustees review the Wellness Program plan design and may adjust it at periodic intervals. Please check the Fund website and be sure to read any materials sent to you in the mail.

WELLNESS INCENTIVE

The Trustees, from time to time, may provide an incentive to encourage you to participate in getting information to the Wellness Program.

Any incentive you receive will be tax-free, in the form of a reimbursement for eligible health care expenses. As a tax-free benefit by the Plan, the Fund must adhere to all applicable IRS guidelines and regulations.

TIP: The incentives and other plan design concepts are reviewed by the Trustees each year and are expected to be reviewed whenever appropriate. You will be informed of any changes.

Please check the website, www.ibt731funds.org or contact the Fund Office at 630-887-4150 for the current incentive arrangement.

OBTAINING REIMBURSEMENT FROM THE HEALTH SPENDING ACCOUNT INCENTIVE:

Health care expenses must be incurred on or after January 1, 2013. You must be an eligible Participant at the time the expense is incurred. The expense must be for you, or on behalf of your eligible Dependents. This means if you qualify for the incentive and one of your eligible Children incurs an out-of-pocket health care expense, said expense on behalf of your Child is eligible for reimbursement. The Fund office will forward you the reimbursement automatically. You will need to file a claim form for other Covered Expenses, as explained below.

- **Reimbursement for medical expenses that the Benefit Fund Office administers:**
  The Benefit Fund Office operates as a self-administered Fund that processes and provides payment of covered health claims in-house utilizing the extensive discount network of Blue Cross Blue Shield of Illinois. The Fund utilizes the preferred providers that are contracted with Blue Cross Blue Shield of Illinois to receive the discounted medical rates, but understand; the claims are actually processed and paid by our own staff at the Local 731 Benefit Fund Office.

  The types of medical expenses that the Local 731 Benefit Fund Department processes in-house include Doctor's visits, hospitalizations, diagnostic tests, out-patient facility expenses, emergency room expenses, home health care, Durable Medical Equipment, hearing aids, and physical therapy expenses.

  Since we process and pay these claims, the Benefit Fund Office has a complete record of the medical claim expense, the date the service was rendered, who the claim is for and a full verification of the eligible out-of-pocket expenses. The Fund automatically processes your reimbursement from your Health Spending Account regarding any eligible out-of-pocket expenses. This includes amounts applicable to your Deductible, Co-Insurance, Co-Payment and amounts you may owe that are greater than a Plan limitation. For example, if you incur an expense of $75.00 that is applicable to your Deductible, then your reimbursement shall be $75.00.

  The timing regarding automatic reimbursement is that any expense incurred in a month will be paid to the Participant the following month. For example, any expense incurred in January will be reimbursed in February.

- **Reimbursement for other covered expenses:**
  You will have to file for other expenses the Fund does not administer on premises. These expenses would include dental claims (which are administered by Delta Dental), vision care expenses (which are administered by Vision Service Plan), and prescription drug expenses (administered by OptumRx - formerly known as Catamaran). For expenses administered by these other vendors, kindly obtain and complete the necessary claim form available on our website or by contacting the Benefit Fund Office directly.

  Other expenses include mileage to and from a doctor's office or to and from a pharmacy. The mileage rate for 2014 is $0.235 per mile and $0.23 per mile in 2015. Please note, the IRS dictates the allowable amount concerning mileage expenses.

THE CLAIM FORM IS SELF-EXPLANATORY, LISTED BELOW ARE ADDITIONAL INSTRUCTIONS:

- Identify the date the expense is incurred (i.e. the date of your Doctor's visit or the date your prescription was filled).
- The full name of the person who incurred said expense (you, your Spouse, your Dependent Child).
- The miles driven to and from the Doctor's visit, medical facility or pharmacy.

Only expenses that are not covered by the Local 731 Teamsters Health and Welfare Plan or by any other health plan (such as your Spouse's health insurance) will be considered. You cannot obtain reimbursement from another Plan in addition to the Health Spending Account reimbursement from the Local 731 sponsored Plans.

TIMING OF FILINGS FOR REIMBURSEMENT FROM THE HEALTH SPENDING ACCOUNT INCENTIVE:

You have sixty (60) days following the end of the year to file. For example, expenses incurred on or after January 1, 2015 through December 31, 2015 must be filed no later than February, 2016.

EXAMPLES OF EXPENSES THAT ARE ELIGIBLE FOR REIMBURSEMENT FROM THE HEALTH SPENDING ACCOUNT:

Items listed as an eligible expense directly from IRS Publication 502 such as:

- Deductible from your health plan
- Co-Insurance from your health plan
- Dental expenses covered in part by your health plan
- Vision expenses covered in part by your health plan
- Prescription Sunglasses
- Acupuncture
- Artificial Teeth
- Contact Lenses
- Hearing Aids
- Orthopedic Shoes
- Therapy (must be prescribed to treat a diagnosed condition)
- Vaccines
- Vasectomy

EXAMPLES OF EXPENSES THAT ARE NOT REIMBURSABLE FROM THE HEALTH SPENDING ACCOUNT:

- Babysitting Expenses

- Bandages
- Cosmetic Supplies or Surgery
- Dance Lessons, even if prescribed by a Doctor
- Diapers
- Diet foods and Related Supplies
- Funeral Expenses
- Health Club Membership Dues or Fees
- Maternity Clothing

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Life Insurance $25,000

Accidental Death & Dismemberment $10,000

EMPLOYEE LIFE INSURANCE

These benefits apply only to **you**, the **Member**.

The general rules and regulations of eligibility for benefits coverage and termination of coverage which are described in this SPD apply to Life Insurance and Accidental Death and Dismemberment Benefits.

The Life Insurance and Accidental Death & Dismemberment Benefits are insured benefits.

Life Insurance Benefits are for Eligible Employees (Primary Participants) only. The benefits payable are as follows:

Life Insurance Benefit $25,000

The Basic Life insurance benefit (a non-negotiated benefit) is provided through the coverage of the Fund. Some employers may provide additional coverage, (a negotiated benefit) through their Collective Bargaining Agreement. Check with your employer to see if this applies to you.

BENEFICIARY

You may name anyone you wish as your Beneficiary and you may change your Beneficiary at any time without the consent of your Spouse or Beneficiary, by completing a change of Beneficiary form with the Fund office. The change will be effective when the Fund receives your completed form. Please keep the Fund informed of changes in your family status.

If you have not named a Beneficiary (or if your Beneficiary dies before you do), the Beneficiary of your life insurance benefit will be the first survivor in the following classes: (1) your Spouse, (2) your children, (3) your parents, (4) your brothers and sisters, or (5) your estate. If there is more than one survivor in the class in which payment is being made, the payment will be distributed in equal shares to all survivors in that class. If a Beneficiary is a minor, benefits will be paid to the minor's guardian for the benefit of the minor.

TIP: Be sure the Fund Office has your Beneficiary information on file in writing to ensure your benefit goes to who you want.

Continuation of Life Insurance During Permanent and Total Disability (Waiver of Premium) - If you become permanently and totally disabled and unable to work, your life insurance may be continued for the benefits then applicable at no cost to you. The conditions for continuing your life insurance under this provision are as follows: (1) The disability must begin before your 65th birthday; (2) You must be totally disabled; (3) Your total disability must have existed for a period of at least 180 days; and (4) You must submit acceptable medical evidence that your total disability is permanent, and the first notice of proof of your total disability must be received within 12 months of the date you become totally disabled. Afterwards, proof of total and permanent disability must be furnished each year, within 90 days of a request of additional proof of loss is mailed. The Plan will continue your life insurance (but not AD&D insurance coverage) for as long as you are totally disabled. When your total and permanent disability ends, your life insurance will no longer be continued under this provision.

Accelerated Benefit – If you qualify for Waiver of Premium and give satisfactory proof of having a Qualified Medical Condition while you are insured under the Group Policy, you may have the right to

receive during your lifetime a portion of your Insurance as an Accelerated Benefit. A Qualified Medical Condition means that you are terminally ill as a result of an illness or physical condition which is reasonably expected to result in death within 12 months.

Conversion Privilege – If a Participant's life insurance ends because his employment or membership in a class ends, the Participant may elect to buy an individual life insurance policy.

No evidence of good health will be required for the converted policy. The converted policy may be in forms other than that of your current policy.

Please contact the Fund Office.

Portability of Insurance – If your life insurance and AD&D insurance ends because your employment ends, you may be eligible to buy portable group insurance coverage for yourself without submitting evidence of insurability. To be eligible, you must satisfy the following requirements:

- On the date your employment terminates, you must be able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience.
- On the date your employment terminates, you are under age 65.
- On the date your employment terminates, you have been continuously insured under the Group Policy for at least 12 consecutive months.
- You must apply in writing and pay the first premium within 31 days after the date your employment terminates.

The minimum combined amount of Life and AD&D insurance you are eligible to buy is $10,000. However, the combined amounts of insurance purchased under this Portability of Insurance provision and the Right to Convert provision cannot exceed the amount in effect under the Policy on the day before your employment terminates.

Coverage will become effective the day after your employment ends, if you apply within 31 days after the date your employment terminates. If death occurs within 31 days after the date insurance ends under the Group Policy, life insurance benefits, if any, will be paid according to the terms of the Group Policy in effect on the date your employment terminates and not the terms of the Group Life Portability Insurance Policy. AD&D benefits, if any, will be paid according to the terms of the Group Policy or the Group Life Portability Insurance Policy, but not both. In no event will the benefits paid exceed the amount in effect under the Group Policy on the day before your employment terminates.

ACCIDENTAL DEATH AND DISMEMBERMENT

Accidental Death and Dismemberment Insurance (AD&D) is provided for active Eligible Employees and his or her Dependents as shown in the Schedule of Benefits. Payments will be made under this benefit if you suffer any of the losses listed below. The loss must occur within 180 days of an accidental injury which occurs while you are covered under the Plan and must result solely from that injury.

The full amount of your AD&D Insurance is shown in the Table of Losses below; the amount payable for all losses resulting from anyone accident cannot be more than the amount shown. The amount paid for accidental death (loss of life) is in addition to the amount of your life insurance benefit. If you suffer any combination of the losses shown below as the result of one accident, only one amount (the largest) is payable for all losses. For each of the following losses, the Plan will pay the amount shown.

Table of Losses		
Type of Loss	**Active Employee**	**Dependent**
Loss of life	$10,000	$2,000
Two hands, two feet, or sight of two eyes	$10,000	$2,000
One foot and sight of one eye, or one hand & sight of one eye, or one hand & one foot	$10,000	$2,000
One hand, one foot or sight of one eye	$5,000	$1,000

In the event of your loss of life, the full amount set forth in the Table of Losses is payable to your Beneficiary. In the event of the loss of life of any of your Dependents, the full amount set forth in the Table of Losses is payable to you. In the event that you or your Dependents suffer from a loss described in the Table of Losses other than loss of life, the full amount or one-half the full amount (depending on the injuries) will be payable to you.

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

Losses Not Covered – No payments will be made for any loss which is not the direct and sole result of an accident. Additionally, no payments will be made under this benefit for any loss which occurs more than 365 days after the accident; or which results directly or indirectly from or is contributed by any of the following:

- Disease or infirmity of mind or body, and any medical or surgical treatment thereof;
- Infection, except a pus-forming infection of an accidental cut or wound;
- Suicide or attempted suicide, while sane or insane;
- Intentionally self-inflicted injury;
- Travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft;
- Commission of, or participation in, or an attempt to commit a felony or being engaged in an illegal occupation;
- Being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison, or any other controlled substance, unless as prescribed by a licensed Physician and used in the manner prescribed;
- Intoxication as defined by the laws of the jurisdiction in which the accident occurred.
- Active participation in a riot; or
- War or act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

Seat Belt Benefit – The amount of the Seat Belt Benefit, shown on your Schedule of Benefits, will be paid if all of the following requirements are met:

- You (member) die as the result of an automobile accident for which an AD&D Insurance Benefit is payable for loss of life; and
- The deceased individual was wearing and properly utilizing a Seat Belt at the time of the accident, as evidenced by a police accident report; and
- The deceased individual was driving or riding in an automobile driven by a licensed driver who was neither driving while intoxicated or impaired nor under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance.

Seat Belt means those belts that form an occupant restraint system.

Air Bag Benefit – The amount of the Air Bag Benefit, shown on your Schedule of Benefits, will be paid if all of the following requirements are met:

- You (member) die as the result of an automobile accident for which an AD&D Insurance Benefit is payable for loss of life; and
- The deceased individual was positioned in a seat that was equipped with a factory-installed Air Bag; and
- The deceased individual was properly strapped in the Seat Belt when the Air Bag inflated, as evidenced by a police accident report.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the automobile or proper replacement parts as required by the automobile manufacturer's specifications that inflates upon collision to protect an individual from injury and death.

Repatriation Benefit – An amount up to the amount of the amount of Repatriation Benefit, shown on your Schedule of Benefits, will be paid for the cost of the preparation and transportation of the deceased individual's body to a mortuary if all of the following requirements are met:

- You (member) die as the result of an accident for which an AD&D Insurance Benefit is payable for loss of life; and
- The deceased individual's death occurs at least 75 miles away from his or her principal residence.

Education Benefit – The amount of the Education Benefit, shown on your Schedule of Benefits, will be payable in the event of your death for which an AD&D Insurance Benefit is payable. The Education Benefit will be paid to your Dependent Child who, on the date of your death, is:

- A full-time post-high school student in a school of higher education; or
- A student in the 12th grade but who becomes a full-time post high school student in a school of higher education within 365 days after your death.

To be eligible for the Education Benefit, your Dependent Child must not be employed full time. This benefit is payable to children up to the age of 26.

Special Child Education Benefit – In the event that the Education Benefit is payable but your Dependent Child does not qualify for such benefit and is enrolled in an elementary or high school, the Fund will pay a Special Child Education Benefit in an amount set forth in the Schedule of Benefits to such Dependent Child.

LOSS OF TIME BENEFIT

Who Is Covered – Loss of Time Benefits are provided for active Eligible Employees who are not maintaining eligibility through COBRA or regular Self-Payments.

Definition of Total Disability – The definition of total disability, as it applied to this benefit, means a period of disability during which you are physically or mentally unable to perform any and every duty of your occupation in your employment by a Contributing Employer. The disability must be due to a non-occupational accidental injury or sickness.

Period of Payment/When Benefits Start – If you become totally disabled and unable to work as a result of non-occupational accidental injury or sickness while you are covered under this Plan, Loss of Time benefits are payable for as long as 26 weeks, provided you are under the continuing care of a Doctor during that time.

- **Accidents –** Benefits will begin on the first day of disability due to an accident if you are under the care of a Doctor on that day. Benefits will not start until you are under the care of a Doctor.
- **Sicknesses –** Benefits will begin on the eighth day of disability due to sickness if you are under the care of a Doctor on that day. Benefits will not start until the eighth day or until you are under the care of a Doctor, whichever occurs later.

TIP: There is a 29 month waiting period before Medicare will cover your health expenses in case of Total & Permanent Disability. Therefore, do not wait to file!

Amount of Benefit – The amount of your weekly benefit is shown on your Schedule of Benefits. If weekly benefits are due for a fractional part of a week, you will receive one-fifth of the weekly benefit for each day of disability. (Withholding tax will be deducted from the weekly benefit to the extent required by law.)

Successive Periods of Disability – Successive periods of disability resulting from or contributed to by the same or related causes will be considered one continuous period of disability unless the second period of disability starts after you have returned to active fulltime employment for at least two months, unrestricted by injury or illness in your activities at work. The lifetime Loss of Time benefits for a disability resulting from or contributed to by the same or related causes is 52 weeks.

If the second period of disability is due to an accidental injury or sickness entirely unrelated to the cause of the first disability and begins after you have returned to work for a Contributing Employer for one full day of active full-time employment, then the second disability will begin a new period of disability if you are eligible for benefits on the day on which you return to work.

If you have two or more disabilities at the same time while receiving disability benefits, the benefits payable for all of the disabilities will be limited to a maximum of 26 weeks. Successive periods of disability due to injuries received in one accident will be considered one period of disability.

Exclusions and Limitations – No payment will be made for any period of total disability:

- Caused by occupational injury or sickness sustained in the course of, or arising out of, any activity for wage or profit, whether or not covered by a Workers' Compensation Law or Occupational Diseases Law or similar law;
- Resulting from any accidental injury or sickness for which you are not under the regular care of a Doctor (this means an M.D. or a D.O. - a chiropractor is not considered a "Doctor" for the purposes of certifying disability for Weekly Disability Benefits); or
- Caused by or related to any medical or dental procedure or procedures not covered under the terms of this Plan, including any complications resulting from such procedures.

Health Coverage – Effective July 1, 2013, if you qualify for the Loss of Time Benefit (non-occupational short term disability income benefit) you will be credited with full active healthcare coverage for you and your eligible Dependents while you are disabled (up to a maximum of 26 weeks).

The purpose of this change is to allow you and your Dependents to continue health coverage for up to 26 weeks while you are out of work due to a non-occupational disability.

CLAIM FILING AND APPEAL PROCEDURE

This section describes the procedures for filing claims for Benefits from the Plan. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

TIP: If you disagree with the way your claim was paid or with an eligibility ruling, you can inquire informally by calling or writing the Fund Office. If you still disagree, there is a formal process to follow to have your claim reconsidered.

WHEN CLAIMS MUST BE FILED

Claims must be filed within 15 months following the date the charges were incurred. Claims filed later than 15 months after treatment begins or Hospital confinement started will be denied.

NOTE: No plan benefits will be paid for any claim not submitted within 15 months. If you or a Dependent incurs expenses for treatment of a sickness or injury**,** you must notify the Fund within 90 days of the date that the sickness started or the injury occurred. Your written proof of loss, claim form, and any other necessary documentation must be submitted within 15 months after the charges are incurred. If the Fund requires additional information from you to process your claim, you have 60 days from the date of the letter requesting the information. If you do not abide by this timetable, the Fund will deny the claim.

TIP: How to file a medical claim is described on the back of your Blue Cross/Blue Shield ID Card.

WHERE TO FILE CLAIMS

Your claim will be considered to have been filed as soon as it is received by the appropriate organization that is responsible for determining the initial determination of the claim. These are as follows:

1. Hospital and Medical Claims

You are generally not required to file a claim form in order to be reimbursed for Hospital or Medical/Surgical benefits because most claims are submitted directly by the Hospital or provider. You are not required to file a claim in order to be reimbursed for these benefits if you use a Participating Provider.

If you use an out-of-network provider or if you have a Hospital or medical claim to submit, you must submit a completed claim form to the Fund Office.

2. Dental Claims

If you use a Participating provider, there are no claim forms to file. This Plan provides both in-network and out-of-network benefits. To file out-of-network claims regarding Dental Benefits contact:

Delta Dental of Illinois
Tel: (800) 323-1743

3. Optical Claims

Vision care is provided by the Vision Service Plan network of providers. If you use a participating provider, there are no claims to file. To request an out-of-network claim form, or a listing of participating providers, please contact

Vision Service Plan (VSP)

1 (800) 887-7195
www.vsp.com.

If you use an out-of-network provider, in order to obtain reimbursement, please submit your paid in full, itemized receipt and completed and signed claim form directly to VSP.

4. Retail Prescription Claims

You do not need claim forms when visiting a OptumRx participating pharmacy. Simply present your card and your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim and appeal under these procedures. If you need to file a claim, contact OptumRx directly at: (800) 880-1188.

5. Mail Order Prescription Claims

The health organization to contact is:

Catamaran Home Delivery
(800) 881-1966
www.mycatamaranRx.com

TIP: All claim forms can be found on the Fund's website. Just go to www.ibt731funds.org and click on the "Forms & Notices" tab at the top. See directions on each claim form to find out where to submit your claim. Mailing claims to the Fund Office if they should be directed elsewhere will slow down processing.

TIP: Whenever you interact with insurance coverage, keep a copy of anything you send in the mail. Keep track of dates you call and the names of employees you speak with.

In order for the Plan to pay benefits, a claim must be filed with the Plan, under the procedures described below. A claim can be filed by you, your eligible Dependent, or by someone authorized to act on behalf of you or your Dependent. The person who has incurred the claim is called the "Claimant" except that, if the claim is incurred by a Dependent Child, then the adult who files the claim or is legally authorized to act on behalf of the Child is the Claimant. In these Procedures, "you" means the Claimant.

1. A claim for a benefit is considered to have been filed on the date it is received at the Fund Office. Even if a claim is incomplete – for example, the Fund Office has received a medical bill but has not received a claim form – the claim is considered to have been filed on the date the Fund Office first receives notice of the claim.

    a. When you file a claim for benefits, be sure to follow the proper claim filing procedures (see How to File a Claim section).

    b. If you incur a medical expense and ask the Plan to pay benefits, that is considered a claim. A claim includes the failure of the Plan to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on a determination of an individual's eligibility for coverage, the imposition of a preexisting condition exclusion, a denial of part of the claim due to the terms of

the Plan regarding Co-Payments, Deductibles or other cost sharing requirements. A claim also includes a termination of coverage regardless of whether there has been an incurred medical expense. This paragraph does not apply to "pre-service" claims (defined below).

c. Claims must be submitted within 15 months after the date the loss occurred.

d. If the Welfare Fund Office requires additional information from you to process your claim, you have 60 days from the date on which you receive the written request for information to respond to the Fund.

2. You may designate another person as your authorized representative for purposes of filing a claim. Except in the case of an "urgent care" claim (defined below), such designations must be in writing.

   a. Unless your (the Claimant's) authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you. Where such authorization is received from a provider, it shall not be considered valid until you have filed a written authorization form confirming your understanding of the consequences of the authorization.

   b. A routine assignment of benefits to a medical provider, so that the Plan will make payment directly to the provider, is not considered to be a designation of the provider as your authorized representative.

3. You (the Claimant) may not assign your rights as a Plan Participant to a provider or other third party or in any way alienate your claim for benefits. Any attempt to assign those rights or in any way alienate a claim for benefits will be void and will not be recognized by the Fund for that purpose. The Fund will treat any document attempting to assign your rights as a Plan Participant or to alienate a claim for benefits to a provider, to be only an authorization for direct payment by the Fund to the provider. For example, the Fund will NOT allow Claimants to assign to their provider any rights as a Participant in the Plan, including, but not limited to, the right to appeal a claim denial or the right to receive documentation concerning claims. In the event that the Fund does receive a document claiming to be an assignment of benefits, the Fund will send payments for the claims to the provider, but will send all claim documentation, such as an Explanation of Benefits, and appeal procedures directly to the Claimant. If the Fund should deny any claim, only the Claimant will have the right to appeal. (However, Claimants may, in accordance with the applicable Plan rules, designate their provider as their authorized representatives to file a claim or appeal on their behalf and/or receive notices on their behalf.)

4. The Fund will pay claims only when covered under the terms of the Plan. If the Fund pays a claim that it is not required to pay, it may recover and collect payments from the Claimant or any other entity or organization that was required to make the payment. Recovery of such payments may be made through, but is not limited to, offset or reduction of future benefits from the Claimant or the Claimant's covered family members.

5. The Claimant will be provided, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the claim review, as well as any new or additional rationale for a denial at the appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

6. Conflicts of interest: The Fund's decisions with respect to hiring, compensation termination, promotion or other similar matter with respect to an employee or contractor, such as a claims adjudicator or medical expert, will not be based upon the likelihood that the individual will support the denial of benefits.

TIME PERIODS FOR PROCESSING CLAIMS

The amount of time that the Plan can take to process a claim depends on the type of claim. There are three categories:

1. **Post-Service Claims**

   a. Most medical claims are of this type. A claim is "post-service" if

      - The Claimant has already received the treatment or service and the claim consists of asking the Plan for payment;
      - The treatment or service has not yet been provided but the Plan does not require the Claimant to obtain approval before receiving the treatment or service; or
      - Any other claim that is not a 'pre-service" claim or a disability claim (defined below)

   b. Approval or denial of a post-service claim will normally be made within 30 days of the date the claim is received by the Plan. If additional time is required, there are two types of extensions that may apply: a "Plan extension" or a "Claimant extension."

      - A "Claimant extension" occurs when you have not provided the Plan with all information or documents needed to process your claim.
      - A "Plan extension" occurs when there are circumstances beyond the control of the Plan that cause the Plan to need an extension of time, other than where the Claimant has not provided the Plan with all information or documents needed to process the claim. If the Plan needs information or materials from your Physician or medical provider, that is considered a "Claimant extension," even though the materials will come from your medical provider and not from you. As a convenience to you, the Plan may request necessary materials or information directly from your medical provider but you are responsible for providing the Plan with that material.

   c. In the case of a "Plan extension," the Plan can extend the 30-day claim processing period by 15 days. Before the end of the original 30-day period, you will be notified in writing of the circumstances requiring an extension of time and of the circumstances requiring an extension of time and of the date by which the Plan expects to make a final decision on the claim.

   d. When there is a "Claimant extension," the Plan will request the necessary information or material in writing. If the request goes to your medical provider, you will receive a copy of the request. You will then have 45 days to submit, or have your medical provider submit, the information the Plan needs to process your claim. When a "Claimant extension" is in effect, the time for the Plan to decide your claim is extended by the time it takes you or your medical provider to supply the requested information. Once the Plan has received a response to its request, the ordinary time limits (the 30-day period or the 15-day extension) will again start to run. If the Plan does not receive a response to its request within 60 days, the Plan will decide your claim without that information, which may result in the denial of your claim.

2. **Pre-Service Claims**

   a. A claim is "pre-service" only if the Plan specifies that benefits will not be paid unless the claim is approved before care is provided. In addition to normal pre-service claims, there are two special types of pre-service claims, that is, "urgent care" claims and "concurrent care" claims.

      - "Urgent care" claims. If applying the time limits for a non-urgent pre-service claim (see below) could jeopardize the life or health of the patient or subject the patient to severe pain that could be managed with care or treatment, the claim is considered to be an "urgent care" claim.
      - "Concurrent care" claims. If the Plan requires pre-approval for an ongoing course of treatment, then the claim is not only "pre-service," it is also a "concurrent care" claim.

b. Approval or denial of a normal pre-service claim (that is, a pre-service claim that is not an "urgent care" or a "concurrent care" claim) will ordinarily be made within 15 days of the date the claim is received by the Plan.

- If a "Plan extension" is necessary, the Plan can extend the 15-day time period by another 15 days. (The same "Plan extension" and "Claimant extension" rules that apply to "post-service claims," above, explained above, also apply to "pre-service claims.") Before the end of the original 15-day period, you will be notified in writing of the circumstances requiring a "Plan extension" and the date by which the Plan expects to make a final decision on the claim.
- When the Plan needs additional material or information from you or your medical provider, that is a "Claimant extension." (The same "Plan extension" and "Claimant extension" rules that apply to "post-service claims," explained above, also apply to "pre-service claims.") Once the Plan has received a response to its request, the original time limit (the 15-day period or, with the extension, 30 days) will again start to run. If the Plan does not receive a response to its request within 60 days, the Plan will decide your claim without that information, which may result in the denial of your claim.

c. The following time limits apply to "urgent care" claims:

- Within 24 hours of the Plan's receipt of an "urgent care" claim, the Plan (or its representative) will advise you whether or not the treatment or service is approved. This notice may be given by telephone or in writing but, if the notice is by telephone, a written confirmation will follow within 3 days. If the Plan cannot process the claim without additional material or information from you or your medical provider, that will cause a "Claimant extension" and the Plan will request the necessary material within 24 hours of receipt of the claim. You will be given no less than 48 hours to provide the needed information. Once the Plan has received a response to its request, the Plan will make a determination on your claim within 48 hours of the time the additional information is received or, if no information is provided, within 48 hours of the expiration of the time period within which a response was to be made.
- For "urgent care" claims, a medical professional with knowledge of your medical condition can act as your authorized representative. The Plan will not require the medical professional to show that you have designated him/her as your authorized representative.

d. "Concurrent care" claims are processed within the same time limits that apply to normal pre-service claims unless the "concurrent care" claim is also an "urgent care" claim. The following additional rules apply to "concurrent care" claims.

- If the Plan has approved coverage for a specified period of treatment and you request an extension of that period, the request for an extension is treated as a new "pre-service" claim. However, if the extension request is an "urgent care" claim, the Plan will notify you of its decision within 24 hours of the Plan's receipt of the request, provided that the request for an extension is received more than 24 hours before the end of the originally approved period of treatment. Otherwise, the time periods for processing an "urgent care" claim will apply.
- If you have a "concurrent care" claim and the Plan terminates or reduces a previously approved period of treatment, you will have the right to appeal that termination or reduction. (The rules governing appeals are explained below.) The Plan will give you 10 days' advance notice of such a termination or reduction. If you appeal the termination or reduction with the 10-day period, the Plan will not implement the termination or reduction before you are given notice of the outcome of the appeal. This rule, allowing the course of 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 of benefits is the result of a Plan amendment.

3. **Disability Claims**

"Disability claims" are claims for Loss of Time Benefits and any other Plan benefit that is conditioned on a finding of disability.

Approval or denial of a disability claim will normally be made within 45 days of the date the claim is received by the Plan.

- If a "Plan extension" is necessary, the Plan can extend the 45-day time period by 30 days. (The same "Plan extension" and "Claimant extension" rules that apply to "post-service claims," explained above, also apply to "disability claims.") If the 30-day extension is not sufficient, the Plan can apply a second 30-day extension. Before the end of the original 45-day period (or, for a second extension, before the end of the first 30-day extension), you will be notified in writing of the circumstances requiring an extension of time and of the date by which the Plan expects to make a final decision on the claim.
- When the Plan needs additional material or information from you or your medical provider that is a "Claimant extension." (The rules that apply to "Claimant extension" for a post-service claim, described above, also apply "Claimant extension" for a disability claim, and you are given the same 45-day period to respond. Once the Plan has received a response to its request, the ordinary time limits (the 45-day period or the 30-day extension) will again start to run. If the Plan does not receive a response to its request within 45 days, the Plan will decide your claim without that information, which may result in the denial of your claim.

DENIAL OF CLAIMS

If your claim is denied in whole or in part, the Plan will send you a written notice stating the specific reason or reasons for the denial, making reference to pertinent Plan provisions and standards on which the denial was based. Specifically, the denial will include sufficient information to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), and any denial codes and their meanings. The notice will be provided in a culturally and linguistically appropriate manner consistent with the requirements of PPACA. The notice of claim denial will also include:

1. If applicable, a description of any additional material or information necessary to process your claim along with an explanation of why such material or information is necessary;
2. If applicable, a statement that, upon written request, you will be furnished with a copy of any internal rule, guideline or policy that the Plan relied on in processing your claim;
3. If applicable, a statement that, upon written request, you will be furnished with an explanation of any scientific or clinical judgment used by the Plan in denying your claim if the Plan found that the treatment was Experimental or not Medically necessary;
4. A statement that Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), provides that a participant or beneficiary of an employee benefit plan may file suit to recover benefits due under the terms of the Plan, to enforce the terms of the Plan or to clarify the person’s right to future benefits under the Plan;
5. The deadline for filing an appeal of the denied claim;
6. A statement describing the appeal process and the external review process, including information on how to initiate the appeal;
7. A statement that, upon request to the Fund Office, you have the right to receive the diagnosis and/or treatment codes and their meanings for the treatment at issue; and
8. A statement disclosing the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PPACA.

TIP: If you disagree with the way your claim was paid or with an eligibility ruling, you can inquire informally by calling or writing the Fund Office. If you still disagree, there is a formal process to follow to have your claim reconsidered.

APPEALING THE DENIAL OF A CLAIM

If your claim has been denied in whole or in part, you may request a full and fair review (referred to in these Procedures as an "appeal") by filing a written notice of appeal with the Plan.

1. A notice of appeal must be received at the offices of the Plan not more than 180 days after receipt by the Claimant of the written notice of denial of the claim. Your appeal is considered to have been filed on the date the written notice of appeal is received at the offices of the Plan.
2. If you wish, another person may represent you in connection with an appeal. If another person claims to be representing you in your appeal, the Trustees have the right to require that you give the Plan a signed statement, advising the Trustees that you have authorized that person to act on your behalf regarding your appeal. Any representation by another person will be at your own expense.
3. Prohibition Against Assignment to Providers – A Claimant may not assign any right under the Plan or statutory right under applicable law to a provider of services or supplies. The prohibition against assignment of such rights includes, but not limited to, the right:
    a. to receive benefits;
    b. to claim benefits in accordance with Plan procedures and/or Federal law;
    c. to commence legal action against the Trustees, Plan/Fund, its agents or employees;
    d. to request Plan documents or other instruments under which the Plan is established or operated;
    e. to request any other information that a Participant or Dependent as defined by Section 102 of ERISA may be entitled to receive upon written request to a plan administrator; and
    f. any and all other rights afforded a person covered under the Plan, Restated Trust Agreement federal law and state law.

This subsection shall not have the effect of prohibiting the Administrator or Trustees from paying benefits under the Plan directly to a provider of services or supplies in an amount determined by the claims adjuster, the Administrator, the Trustees, or the Trustees' Appeals Committee.

4. In connection with your appeal, you or your authorized representative may review pertinent documents and may submit issues and comments in writing.
    a. Upon written request, the Plan will provide reasonable access to, and copies of, all documents, records or other information relevant to your claim.
    b. If the Plan obtained an opinion from a medical or vocational expert in connection with your claim, the Plan will, on written request, provide you with the name of that expert.
    c. The Plan will not charge you for copies of documents you request in connection with an appeal.
5. Appeals of post-service claims and disability claims will be decided by the Board of Trustees or representatives of the Board of Trustees authorized to act on their behalf. Appeals of pre-service claims may be decided by a Plan fiduciary selected by the Board of Trustees. The person or persons who decide the appeal will not be the same person, or a subordinate of the person, who made the original claim denial. **You (and your authorized representative, if any) are not entitled to appear before the persons deciding your appeal and no hearing will be held on the appeal.** However, in its sole discretion, the persons deciding the appeal may invite you (and your authorized representative, if any) to appear before them for an informal hearing on your

appeal, for example, if they determine they need information you may be able to provide in order to decide your appeal.

6. In deciding your appeal, the persons deciding the appeal will consider all written comments and documents that you submit, regardless of whether that information was available at the time of the original claim denial.
   a. In deciding your appeal, the persons deciding the appeal will not presume that the original denial was correct and will consider the issues with no deference to the original decision.
   b. If an appeal involves a medical judgment, such as whether treatment is Medically Necessary, the persons deciding the appeal will consult with a medical professional who is qualified to offer an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the persons deciding the appeal will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.

TIP: Before bringing legal action against the Plan, you must follow the Claim and Appeal procedures completely.

CLAIMS AND APPEALS WHERE THE BOARD DOES NOT MEET QUARTERLY

Post-Service Claims

1. An appeal will be decided no later than 60 days after it was filed, unless special circumstances require an extension of time for processing, in which case the Participant will be advised in writing before the end of the 60-day period of why the extension of time was needed and when the appeal will be decided. In no case will such an extension exceed a period of 60 days from the end of the initial 60-day period.
2. When the Trustees deciding the appeal determine, in their sole discretion, that they can decide an appeal sooner than the time limits stated above, they will do so.
3. The Plan will mail the Participant a written notice of a review decision within five days after the decision has been made.

Disability Claims

1. An appeal will be decided no later than 45 days after it was filed, unless special circumstances require an extension of time for processing, in which case the Participant will be advised in writing before the end of the 45-day period of why the extension of time was needed and when the appeal will be decided. In no case will such an extension exceed a period of 45 days from the end of the initial 45-day period.
2. When the Trustees deciding the appeal determine, in their sole discretion, that they can decide an appeal sooner than the time limits stated above, they will do so.
3. The Plan will mail the Participant a written notice of a review decision within five days after the decision has been made.

Pre-Service Claims

1. For a pre-service claim that is not an “urgent care” claim, the Plan will notify you of the decision on appeal within 30 days of the Plan’s receipt of the appeal.
2. For an “urgent care” claim, the Plan will notify you of the decision on appeal within 72 hours of the Plan’s receipt of the appeal. Also, for appeals of “urgent care” claims, the notice of appeal can be oral instead of in writing, and the Plan may notify you of its decision by telephone or facsimile (fax).
3. If a Claimant whose pre-service claim was denied obtains the service or treatment that had been denied, the claim is no longer a pre-service claim and any appeal of the denial of the pre-service claim will be handled under the rules that apply to post-service claims.

DECISIONS ON APPEAL

1. The notice explaining the decision on your appeal will state the specific reason or reasons for the decision, making reference to pertinent Plan provisions or standards on which the decision was based. The notice will also include sufficient information to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), and any denial codes and their meanings. The notice will be provided in a culturally and linguistically appropriate manner consistent with the requirements of PPACA. If applicable, the notice will also include:

   a. A statement that, upon written request, you will be furnished with a copy of any internal rule, guideline or policy that the Plan relied on in processing your claim; and

   b. A statement that, upon written request, you will be furnished with an explanation of any scientific or clinical judgment used by the Plan in denying your claim if the Plan found that the treatment was Experimental or not Medically Necessary.

   c. A statement that, upon request to the Fund Office, you have the right to receive the diagnosis and/or treatment codes and their meanings for the treatment at issue.

   d. If the appeal is denied, a statement that you will have the right to file suit, under the authority of Employee Retirement Income Security Act of 1974, as amended ("ERISA") and that you are entitled to receive, upon written request and at no cost, copies of documents and information that the Plan relied on in denying your claim.

   e. A statement describing the external review process.

2. If your appeal is approved in full, the Plan will not be required to send you a letter meeting the requirements of this section unless otherwise required by law.

3. A Claimant may not file suit against the Plan until the Claimant has exhausted all of the procedures described in these Claim and Appeal Procedures. However, this rule is subject to the following:

   a. If the Plan does not issue a decision on a claim within the time limits stated in these Procedures, the Claimant shall have the immediate right to file an appeal under these Procedures.

   b. If a decision on an appeal is not furnished within the time limits stated in these Procedures, this requirement to exhaust Plan remedies will not apply.

   c. Under no circumstances can the Claimant file suit against the Plan more than three years after the date on which the Participant received notice from the Plan that the claim was denied or, if the Participant appealed the claim denial, the date on which the Participant received notice from the Plan that the appeal was denied.

TIP: The Trustees or their designated representatives have sole, discretionary authority to make final determination regarding benefits, interpretation and application of the Plan, or any administrative rules adopted by the Trustees.

Appeals need to be submitted in writing to the appropriate organization within *180 days* after you receive notice of denial.

Note: Appeals involving **Urgent Care Claims** may be made orally to the health organization that administers the particular Benefit you are requesting.

Effective as required by federal law, the Plan's claims and appeals procedures have changed to comply with PPACA. If your claim involves an issue dealing with medical judgment or termination of coverage and your claim for benefits is denied after you exhaust the Plan's internal appeal procedures, you may request an external review by an independent review organization (IRO) within four months of the receipt of notice of the final internal denial decision. Your Explanation of Benefits and internal appeal decisions will inform you of your right to request an external review appeal, your external review

rights and your right to file suit in federal court under the Employee Retirement Income Security Act of 1974.

EXTERNAL REVIEW PROCEDURE

This section sets forth procedures for an external review for health claims and coverage terminations.

1. Request for external review. A Claimant may file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of a final internal adverse benefit determination (i.e., an appeal denial). The request for external review must be for a claim involving medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) or termination of coverage. (Please note that external review is only available for an adverse benefit determination (i.e., a claim denial) without first exhausting the internal appeal process when the adverse benefit determination meets the requirements for expedited review as described below).
2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
    a. The Claimant was eligible at the time services were provided;
    b. The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the group health plan;
    c. The Claimant exhausted the Plan's internal appeal process;
    d. The Claimant has provided all the information and forms required to process an external review.

    Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow you to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
3. Referral to Independent Review Organization. The Plan or its agent will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. The Plan will utilize at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IRO's, such as random selection). The IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the final internal adverse benefit determination. Failure by the plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the final internal

adverse benefit determination. Within one business day after making the decision, the IRO will notify the Claimant and the Plan.

Upon receipt of any information submitted by the Claimant, the assigned IRO will within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the assigned IRO and the assigned IRO will terminate the external review

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. The Claimant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;
4. The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
6. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
7. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO will provide written notice of the final external review decision with 45 days after the IRO receives the request for the external review. The IRO will deliver the notice of final external review decision to the Claimant and the Plan.

The assigned IRO's decision notice will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason;
2. The date the IRO received the assignment to conduct the external review and the date;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant; and
6. A statement that judicial review may be available to the Claimant; and

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

Expedited Review: The Claimant will be entitled to make a request for an expedited review if the Claimant receives:

1. An adverse benefit determination (i.e., a claim denial) involving a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal (e.g., appeals for urgent care claims) would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
2. A final adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review 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 concerns an admission, availability of care, continue stay or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements for standard external review to the Claimant of its eligibility determination. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO to review the matter. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process. The assigned IRO must provide notice of the final external review decision, in accordance with the requirements set forth in above for standard reviews, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and the Plan.

After a final external review decision, the IRO must maintain records of a claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

MEDICARE BENEFITS

COORDINATION OF BENEFITS PROVIDED FOR ELIGIBLE PARTICIPANTS WHO QUALIFY FOR MEDICARE

For Employees who continue to work after age 65 for a Contributing Employer *who has 20 or more employees after* you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules.

This Plan will be your primary provider of health care benefits. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

If your Dependent Spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will pay its normal benefits for her before Medicare pays. If she is covered under her own plan, her plan will pay first, this Plan will pay second, and Medicare will pay last.

You (and/or your Spouse) can decline coverage under this Plan. If you do, Medicare will be your only health care coverage. If you and/or your Spouse prefer Medicare as your only health care cover age when you are age 65, contact the Administrator (or your Spouse should notify her own plan). Unless you make such a choice, this Plan will continue to pay primary benefits for you (and its normal benefits for your Spouse) as long as you remain eligible.

For Participants who are under 65 and entitled to Medicare because of End Stage Renal Disease, this Plan will be primary for the person's first 30 months of Medicare coverage and Medicare will be secondary. After the first 30 months, this Plan's coverage will be secondary for as long as the person remains eligible. In all other cases, this Plan will pay secondary to Medicare when it is allowed to do so by law.

You and your Spouse are each responsible for enrolling in Medicare Part A and Part B when eligible to do so. Part A provides Hospital benefits, while Part B covers such items as Doctors' services.

If a Participant is eligible to enroll in Medicare; benefits will be paid as though the Participant is enrolled in Parts A and B, whether or not you are actually enrolled. If a Participant fails to enroll in Medicare Part B when eligible to do so, you will be responsible for paying the benefits Medicare would have paid if that Participant had enrolled in Part B. In order to be entitled to receive Medicare Part B benefits on the first day of the month in which a person becomes eligible for Part B, it is necessary to enroll in Part B in the three-month period prior to their 65th birthday.

TIP: Coordination rules between health insurance (like this Plan) and Medicare is confusing. Many changes have happened over the past several years. Please confirm with the Fund office to ensure you are all set.

TIP: Medicare will contact you three (3) months before you turn age 65.

TIP: If the Plan's eligibility rules provide you with coverage after you reach age 65 (even if you retire and receive a pension) this Plan will be primary, and Medicare will be secondary. For example, you retire April 1, but you worked enough hours to have coverage through May 31, this Plan will be primary until May 31. Medicare will be primary June 1.

COORDINATION OF BENEFITS

Benefits are coordinated when both, you and your Spouse and/or your Dependent Children are covered by this Plan as well as by another group health 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. INFORMATION

- Benefits are coordinated on all Covered Individuals' claims for payment or reimbursement. C.O.B. applies to medical, prescription, vision and dental claims.
- Benefits are coordinated with other group plans, including group Blue Cross and Blue Shield and blanket insurance plans. Benefits are also coordinated with Medicare. If you are covered under a personal individual plan for which you pay the full premiums, this Plan will not coordinate with that plan but will pay its normal benefits.
- You must file a claim for any benefits to which you are entitled 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 to which you are entitled.
- Benefits are paid in C.O.B. for "Allowable Expenses," which are expenses that are eligible to be considered for reimbursement.
- A plan that pays "primary" benefits is the plan that is required to pay its benefits first. The plan that pays "secondary" benefits is the plan that pays its benefits after the other plan has paid its benefits.
- If an eligible Dependent elects membership in a Health Maintenance Organization (HMO) as an employee of another employer, benefits under this Plan are limited to Co-Payment and/or Deductibles not covered under the HMO and Covered Expenses that are specifically excluded under the HMO. There will be no coverage under this Plan for any item not covered by the HMO because the Dependent chose not to avail himself or herself of the HMO participating provider. This provision also applies to any type of exclusive network arrangement where no benefits are payable if that exclusive network is not used. This would include, but is not limited to “Exclusive Provider Organizations”, exclusive “Centers of Excellence” carve out networks, transplant networks, etc.

ORDER OF BENEFIT PAYMENTS WHEN TWO OR MORE PLANS ARE INVOLVED

When both you and your Spouse are covered under group health plans as employees and someone in your family has a claim, you should each file the claim with your own plan. The plans will pay as follows:

- If the other plan does not have C.O.B. rules, that plan will pay its benefits first and this Plan will pay second.
- When the other plan does have C.O.B. rules, the plan covering the person for whom the claim is filed as an employee will pay first and the plan covering the person other than as an employee will pay second.
- The benefits of the plan covering a person as a laid-off or retired employee, or dependent of such person, will be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or a dependent of such person.
- If you elect to make self-payments for COBRA Coverage under this Plan while you are also covered by another plan, the other plan will pay first and this Plan's COBRA Coverage will pay second.

- If you and your Spouse are both covered as Employees under this Plan and one of you has a claim, the Plan will pay primary benefits on the claim as the claim of an Employee and then pay secondary benefits on the claim as the claim of a Dependent.
- On claims for Dependent Children:
    - If one of your Dependent Children is covered under another plan as an employee, the Plan that has insured the child the longest is primary.
    - When the natural parents are married (and not separated or divorced), or when they are not married but living together, the plan covering the parent whose birthday comes first in the year will pay first and the plan covering the parent whose birthday comes later in the year will pay second (the "birthday rule").
    - When the natural parents are legally separated or divorced, or are not married and not living together, benefits are payable according to any existing court decree (i.e., the plan of the parent who is identified as financially responsible for the health care of the Child is primary). If there is not a court decree stating who is financially responsible for a Child's health care (or the decree provides that both parents have financial responsibility for the Child's health care), the plan covering the parent with custody pays first and the plan covering the parent without custody pays second. If the parent with custody has remarried, that parent's plan pays first, the stepparent's plan pays second and the plan covering the parent without custody pays third.
    - If you and your Spouse are both covered as Employees under this Plan, benefits for claims for your Dependent Children will be coordinated, subject to the above rules, up to 100% of the Allowable Expense.

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) the longest period of time will pay first, the plan that has covered the person for the next longest period of time will pay second, and so on.

No benefits will be payable under this Plan to, or on behalf of, a Dependent who has health coverage of any kind under another group health plan unless that plan provides the same maximum benefits to that Dependent as it does to other participants in that plan (without regard to any benefits the Dependent may have under this Plan).

SUBROGATION
(Claims involving Third-Party Liability)

This provision applies to all Participants with respect to all of the benefits provided under this Plan. For the purpose of this provision, the terms "*you*" and "*your*" refer to all Members, covered Spouses and covered Dependents.

GENERAL

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your Illness or Injury or is otherwise responsible for your medical bills. The rules in this section govern how this Fund pays all benefits in such situations.

These rules have two (2) purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there are questions of third party liability, many months pass before the third party actually pays. These rules permit this Fund to pay your covered expenses and provide any other benefits to which you are entitled until your dispute with the third party is resolved.

Second, the rules protect this Fund from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable, in any way, for the injuries giving rise to these expenses, or that third party settles the claim which gave rise to the injuries without an admission of guilt, this Plan must be reimbursed for the relevant benefits it has advanced to you out of any recovery, whatsoever, that you receive that is, in any way, related to the event which caused you to incur the medical expenses. This is true whether or not the settlement is itemized.

RIGHTS OF SUBROGATION AND REIMBURSEMENT

If you incur covered expenses for which a third party may be liable, or if you become entitled to other benefits as a result of the same events which caused you to incur the covered expenses, you are required to advise the Plan of the fact. By law, the Plan automatically acquires any and all rights which you may have against the third party.

In addition to its subrogation rights, the Fund has the right to be reimbursed for payments made to you or on your behalf, under these circumstances. The Plan must be reimbursed in full from any settlement, judgment, or other payment that you obtain from the liable third party. Other expenses, including attorneys' fees, cannot be taken out of the payment.

ASSIGNMENT OF CLAIM

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Fund. If this Fund recovers from the third party any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

FAILURE TO DISCLOSE AND/OR COOPERATE

If you fail to tell this Fund that you have a claim against a third party; if you fail to assign your claim against the third party to this Fund when required to do so (**and** to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's Reimbursement Agreement and forms; if you and/or your attorneys fail to reimburse this Fund out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if the Fund reduces the amount of its lien or otherwise limits its rights); then you are personally liable to this Fund for the reimbursement owed to this Fund by the third party. The Fund may offset the amount you owe from any future benefit claims, or if necessary, take legal action against you.

If any Participant files a claim for medical expenses or Loss of Time Benefits and a third party is legally responsible for paying those expenses, the Fund will not pay benefits on the claim unless the

requirements of the Subrogation Rules stated below are met. A "third party" is any person or corporation (or any insurance company obligated to pay claims resulting from the acts of such a person or corporation) or any other entity which is or may be found legally responsible to pay your medical expenses. The Plan's subrogation rules will not apply to any amount paid under the Participant's own insurance policy, except that the rules WILL apply to payments made under the Uninsured Motorist and Underinsured Motorist provisions of the Participant's automobile insurance coverage. Also, these Subrogation Rules do not apply to benefits you recover under another employer-sponsored group health plan if that coverage is subject to Coordination of Benefits (C.O.B.).

SUBROGATION RULES

If a third party is responsible for paying expenses for which the Participant files a claim, the Fund will only pay benefits on the claim under the following conditions:

- The Participant must repay the Fund the amount of benefits which the Fund pays on the claim out of any recovery of expenses you receive, regardless of whether the recovery is sufficient to fully reimburse the loss.
- The Fund is entitled to a first priority lien on the proceeds of any recovery, to the extent of the full amount of benefits paid, regardless of whether the Participant is made whole by the recovery;
- If the third party does not voluntarily pay the Participant for the incurred expenses and the Participant does not sue the third party for recovery of the expenses, the Fund has the right to sue the third party in the Participant's name to recover the amount it paid. In such a case, if there is a recovery or settlement, the Participant agrees that the Fund's expenses, costs and incurred attorney's fees will also be paid out of the recovery or settlement.
- The Participant cannot assign to another person the Participant's right to recover money from another source, and the Participant must obtain the Fund's consent before releasing another person or entity from liability for any injury.
- The Participant must sign the Fund's Reimbursement Agreement that includes, but is not limited to, the above provisions. The Participant's attorney also must sign the Reimbursement Agreement.
- If the Participant who is injured by a third party is an adult Dependent, the injured adult Dependent must sign the Reimbursement Agreement along with the Eligible Employee or Retiree. If the Participant who is injured by a third party is a minor Dependent Child, the Eligible Employee or Retiree, or any other adult authorized to act on behalf of the Child, must sign the Reimbursement Agreement on behalf of the Child.
- The Fund will be entitled to reimbursement out of any recovery. A recovery shall include all payments from another source (including, but limited to, an employer or its worker’s compensation insurer) the Participant receives or to which the Participant is entitled (including, but not limited to, any amounts allocated to a trust set up for the Participant or on the Participant’s behalf). In the case of a minor Dependent Child, the minor Dependent Child, such Child’s legal representative, and the Eligible Employee are obligated to reimburse the Fund out of any recovery received by or on behalf of the Dependent Child, Child’s legal representative or the Eligible Employee.
- If the Participant obtains a recovery of incurred expenses and does not repay the Fund as the Participant agreed to do when the Participant signed the Reimbursement Agreement, the Fund may file suit against the Participant to recover expenses it paid on the Participant's claim and the attorney's fees and expenses incurred in filing such a suit. The Fund also has the right to reduce any future benefits to which the Participant may be entitled on claims for the Participant and the other eligible Members of the Participant's family until the proper amount has been recovered by the Fund.
- The Fund will not expect repayment of more than the benefits it pays on the claim or more than the amount of the Participant's gross recovery.

- The Fund will not be responsible for legal fees and expenses incurred by the Participant in obtaining a recovery except that, at the discretion of the Trustees, the Fund may agree to pay for a reasonable share of those fees and expenses actually incurred by the Participant in connection with the proof of and recoupment of the payments made by the Fund.
- Once a Participant has obtained a recovery, no further benefits are payable from the Fund for any claims related to the injury at issue, until the total of Covered Expenses arising out of the injury equals the gross amount of the recovery paid to or on behalf of the Participant. The Fund will then consider only the amount of claims that exceeds the amount of the gross recovery, except that in the event of a recovery insufficient to repay in full the benefits the Fund has paid on the claim, the Fund will continue to pay benefits for future claims related to the injury at issue until additional recovery sufficient to reimburse the Fund in full is obtained.
- The Participant must inform the Fund of the progress of any claim, settlement or legal action against the third party responsible for the Participant's injury and must respond to any inquiries made by the Fund as to such progress. The Participant must also inform the Fund of any attempts to settle, release, dismiss or discharge any claim, settlement or legal action against the third party.
- The Participant must furnish the Fund upon demand with all papers, documents or other information in his or her possession necessary for the proper recovery upon any claim, settlement or legal action against the third party.
- In the event that the Participant does not sign a Reimbursement Agreement and the Fund pays benefits on claims for which a third party is legally responsible, the Fund is entitled to a first priority lien on any recovery obtained by the Participant in the same manner as if the Participant had signed the Reimbursement Agreement.
- If the Participant suffers a work-related injury, the Fund will not pay benefits until (1) it receives a Reimbursement Agreement signed by the Participant and the Participant's attorney, (2) it receives confirmation in writing that the employer, or the employer's worker's compensation liability insurer, has denied responsibility for the injury and (3) the Participant demonstrates that he or she is pursuing a claim against the employer and/or the employer's worker's compensation insurer, unless the Trustees determine, in their discretion, that such a claim is not viable based on the facts and circumstances surrounding the injury.
- In the event that the Fund agrees to accept less than the full amount of the lien, the Participant and his or her attorney must sign a release consistent with this section. If the Participant and/or attorney fail to submit a signed release to the Fund when requested to do so, the Fund may demand payment of the balance owed to the Fund and/or deny future claims until the balance owed is recouped.

RESTORATION OF RECOVERED BENEFITS

If a person has a claim which is subject to subrogation and the Plan pays benefits on the claim, the benefits paid by the Plan apply toward all applicable maximum benefit limitations, the same as benefits which are paid for non-subrogation claims. If the Plan pays benefits under the subrogation rules and recovers some or all of the benefits it paid through subrogation, the amount of benefits recovered may be restored to certain maximum benefits. The following rules apply to restoration of recovered benefits:

- Recovered benefits will not be restored to benefit maximums that pertain to a specific accident or injury.
- Recovered benefits will be restored only to Major Medical lifetime maximum.
- A restoration will be effective on the date the recovery is received by the Plan.
- Any increase in a maximum benefit due to a restoration will apply only to claims incurred on and after the date the subrogation recovery is received by the Plan.

TIP: If the Fund receives a claim that may have been caused by an accident or another party (such as an auto accident), the Fund Office will send you a "subrogation form." The Fund will not pay for a claim until this form is returned. You have 60 days to respond.

TRUSTEE AUTHORIZED
DENIAL OR LOSS OF BENEFITS

The Trustees or their representatives are authorized to deny benefits. The following list outlines some circumstances or reasons that all or part of a person's claim may be denied by the Fund that would cause a person to lose benefits or to receive reduced benefits.

1. The person on whose behalf you filed the claim was not eligible for benefits on the date the expenses were incurred (see the "Eligibility" section), or, in the case of a Dependent, the person does not meet the Plan's definition of a "Dependent."
2. You did not file the claim within the Plan time limits (15 months from the date the claim was incurred) or you failed to furnish, when requested, information or documents available to you that were necessary to complete the claim within 60 days of such request.
3. The expenses that were denied are not considered Covered Expenses under the Plan, or the expenses for which you filed the claim were not actually incurred.
4. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense.
5. Some other plan was primarily responsible for paying benefits on the expenses.
6. No payment, or a reduced payment, was made because some or all of the expenses were applied against a Deductible.
7. A third party, such as the driver of a car that caused an accident for which medical expenses were incurred, was responsible for paying the expenses and you and/or your attorney did not sign the required Reimbursement Agreement which would permit the Plan to pay your claim and recover payment from the third party or his insurance company.
8. The Plan of Benefits was terminated.
9. The Trustees amended the Plan's eligibility rules or decreased Plan benefits.
10. The Trustees reduced or temporarily suspended future benefit payments to a Covered Person in order to recover an overpayment of benefits previously made on that person's behalf.
11. Benefits were reduced due to the fact that a noncompliance Deductible was applied because the procedures of the Medical Review Program were not followed.
12. A non-PPO Hospital was used and reduced benefits were paid.

The list specified above is not an all-inclusive listing of the circumstances that may result in a claim denial or loss of benefits. It is truly representative of the types of circumstances, in addition to failure to meet the eligibility requirements for coverage under the Plan, that may result in denial of claims or loss of benefits.

PLAN CHANGE OR TERMINATION

It is anticipated that the Plan will remain in effect indefinitely. However, the Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under the Plan and (2) the eligibility rules.

This booklet includes information concerning the benefits provided by the Trustees to Participants and their Dependents and the circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits that a participant or dependent might otherwise reasonably expect a Plan to provide. The benefits and eligibility rules applicable to Participants and their Dependents have been established by the Trustees. The right to terminate, amend or modify the eligibility rules and plan of benefits for Participants and Dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of benefits for Participants and their Dependents and the eligibility rules relating to qualification therefore are subject to modification and revision by the Trustees in accordance with their authority contained in the Agreement and Declaration of Trust.

No Employee, Retiree, Dependent or Beneficiary has a vested right to future coverage under the Plan or to the continuation of any given benefits provided for Participants and their Dependents. In addition to the right to terminate any benefits of Participants and/or their Dependents at any time, the Trustees also reserve the right in their sole and absolute discretion to terminate the Plan and Trust at any time, and there shall not be any vested right by any Participant or Dependent or Beneficiary nor any contractual rights thereafter. If the Trust is terminated, the Agreement and Declaration of Trust provides that any remaining assets of the Fund, after payment of the Fund's obligations, will be used to provide benefits for Employees who are covered at the time of termination. In their discretion, the Trustees may also transfer remaining funds to another trust fund that covered Employees who were covered under this Fund prior to its termination. Under no circumstances will any surplus assets revert to the Employers.

Plan benefits and eligibility rules for active, retired or disabled Participants are provided under the Plan and:

- Are not guaranteed;
- May be changed, amended or discontinued by the Board of Trustees at any time or eliminated entirely;
- Are subject to the Trust Agreement which establishes and governs the Fund's operations;
- Are payable only to the extent that in the judgment of the Trustees funds are available considering the desirability of maintaining other benefits.
- Are subject to the provisions of any group insurance policy purchased by the Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

The Funds' Trustees have the power to interpret and apply the terms of this Plan and also the Fund's Trust Agreement.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

A Federal Law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers sponsoring group health plans to offer employees and their families *(if eligible)* the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage would otherwise end (called "qualifying events"). This section outlines your rights and obligations with respect to continuation of the health benefits provided under the Plan.

To be eligible to continue coverage under COBRA, you must be enrolled in the Plan when your coverage ends because of a qualifying event.

COBRA ELIGIBILITY

Qualifying Events for You

COBRA coverage is available to you if coverage would otherwise end if:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.
- You voluntarily or involuntarily terminate your employment for any reason (including retirement) other than gross misconduct.

Qualifying Events for Your Dependents

COBRA coverage is available to your eligible Dependents if coverage would otherwise end if:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.
- You (the active Employee) voluntarily or involuntarily terminate employment for any reason (including retirement) other than gross misconduct.
- You (the active Employee) retire.
- You (the active Employee) die, become divorced, legally separated or become entitled to Medicare.
- Your Dependent Child ceases to be eligible for Fund coverage. For example, he or she reaches the maximum age limit for coverage.

HOW COBRA COVERAGE WORKS

In order to have the opportunity to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "Dependent Child" under the Plan, you and/or a family member must notify the Fund Office in writing of that event no later than 60 days after that event occurs. Notice should be sent to:

Local 731 Welfare Fund
1000 Burr Ridge Parkway, Suite 301
Burr Ridge, IL. 60527

The Fund Office will send you information about COBRA coverage.

You should notify the Fund Office promptly and in writing of termination of employment, reduction in hours, retirement, divorce, legal separation or entitlement to Medicare. Your family members must notify the Fund Office promptly and in writing in the event of your death.

Under Federal Law your employer is required to notify the Fund on your behalf under these circumstances:

Your voluntary/involuntary termination	30 days
Your reduction of hours	30 days
Your death	30 days
Employer's bankruptcy	30 days
Your eligibility for Medicare	14 days of its learning of the event*
Your divorce or legal separation	14 days of its learning of the event*

* You must notify your employer within 60 days of the event.

HOW TO ELECT COBRA CONTINUATION COVERAGE

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or when the Fund Office is notified on a timely basis that you died, divorced, or that a Dependent Child loses Dependent status, the Fund Office will provide you and your COBRA eligible dependents notice of the date that your coverage under the group ends and your rights to elect continuation of coverage under COBRA. Under the law you and or your eligible dependents will have the later of 60 days from the qualifying event or the date that the notice is sent by the Fund office to elect continuation of coverage. If the Fund does not receive election prior to the 60-day period, you will forfeit your rights for continuation.

Each qualified beneficiary has a right to elect continuation coverage. For example, the Employee's Spouse may elect continuation coverage even if the Employee does not. Continuation coverage may be elected for only one, several, or for all Dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any Dependent Children. The Employee or the Employee's Spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

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

THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on the Cost of COBRA Coverage for information about how much COBRA will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situate active Employees and their families; that same change will be made in your COBRA Continuation Coverage.

COST OF COBRA COVERAGE

Individuals who continue full coverage under COBRA pay 102% of the Plan's cost, on an after-tax basis, except in cases of disability. See the section below entitled COBRA Coverage in Cases of Social Security Disability for details.

PAYING FOR COBRA COVERAGE

The amount you, your covered Spouse, and/or your covered Dependent Child(ren) must pay for COBRA coverage will be payable monthly. The Plan is permitted to charge the full cost of coverage for similarly situated active Employees and families, plus an additional 2% (for a total charge of 102%). The COBRA Continuation Coverage charge is different in cases of extended coverage due to Social Security disability. See that section for further information.

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month**. If payment is not received by the end of the applicable grace period, your COBRA coverage will terminate retroactive to the date of the last payment is received. Once coverage has been terminated, you will lose your right to continuation coverage.**

COBRA AT-A-GLANCE

COBRA Coverage May Continue For:	If the Following Event Occurs and Coverage is Lost:	Maximum Length of COBRA Coverage:
You and Your Eligible Dependents	• Your employment ends (for example, you resign) for any reason except gross misconduct • Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program	18 months from the date of loss of coverage (29 months if you or your eligible Dependent is Social Security disabled*).
Your Eligible Dependents Only	• You die • You are divorced or legally separated • Your Child(ren) no longer qualifies as an eligible Dependent under the Plan	36 months from the date of loss of coverage

* See COBRA Coverage in Cases of Social Security Disability for more details.

Other Options for Health Coverage

You may be eligible to purchase an individual or family plan through the Health Insurance Marketplace (as created by Health Care Reform). By enrolling in coverage through the Marketplace, you may qualify for lower monthly premiums and lower out-of-pocket costs. Contact www.healthcare.gov for more information.

You may also qualify for a 30-day special enrollment for another group plan for which you are eligible for (such as a spouse's health coverage), even if that plan generally does not accept late enrollees.

You may also qualify for Medicaid.

DURATION OF COBRA COVERAGE

Your COBRA coverage can continue for up to 18, 24, 29, or 36 months depending on the qualifying event.

The Continuation Coverage period begins on the date you and/or your Dependents lose coverage (rather than on the date of the qualifying event).

18 MONTHS

COBRA health coverage can continue for up to 18 months if you lose Fund health coverage because of:

- Your reduction in hours
- Your change from active to inactive work status due to your:
  - Resignation
  - Discharge (except for discharge for gross misconduct)
  - Disability
  - Strike
  - Layoff
  - Retirement
  - Leave of absence (other than leave under the Family and Medical Leave Act)

24 MONTHS

COBRA health coverage can continue for up to a total of 24 months if you and/or your eligible Dependent(s) elect coverage while you are performing Military Service in accordance with the USERRA Section of this SPD.

29 MONTHS

COBRA health coverage can continue for up to a total of 29 months if you or an eligible Dependent becomes permanently disabled (as determined by the Social Security Administration), within the first 60 days of COBRA coverage, and you or your Dependent notifies the Fund Office of the determination no later than 60 days after it was received and before the end of the initial 18month period.

36 MONTHS

COBRA health coverage for your Dependents can continue for up to a total of 36 months from the date any one of the following qualifying events occurs:

- Your death.
- Your divorce.
- Your Dependent is no longer eligible for Fund coverage.

COBRA COVERAGE IN CASES OF SOCIAL SECURITY DISABILITY

If you, your Spouse, or any of your covered Dependent Child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the Covered Person who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage.

- The disabled Covered Person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- The Plan must be notified in writing by you or by the disabled Covered Person or another family member that the determination was received:
    - No later than 60 days after it was received; and
    - Before the 18-month COBRA continuation period ends.

This extended period of COBRA coverage will end at the **earlier** of:

- The last day of the month, 30 days after Social Security has determined that you and/or your Dependent(s) are no longer disabled.
- The end of 29 months from the date of the COBRA qualifying event.
- The date the disabled individual becomes entitled to Medicare.

You must notify the Plan when you are no longer disabled.

COST OF COBRA COVERAGE IN CASES OF SOCIAL SECURITY DISABILITY

If the 18-month period of COBRA Continuation Coverage is extended because of disability, the cost will be 150% of the rate that has been in effect the first 18 months. The Plan will charge Employees and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month period following the 18th month of COBRA Continuation Coverage. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

ACQUIRING A NEW DEPENDENT(S) WHILE COVERED BY COBRA OR OTHER HEALTH INSURANCE COVERAGE

If you acquire a new Dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA Continuation Coverage, you may add that Dependent to your coverage for the balance of your COBRA coverage period.

To enroll your new Dependent for COBRA coverage, you must notify the Fund Office in writing. There may be a change in your COBRA premium amount in order to cover the new Dependent.

If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36 months COBRA coverage period, COBRA coverage also will end for your newly added Spouse. However, COBRA coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time. Check with the Fund for more details on how long COBRA coverage can last.

LOSS OF OTHER GROUP HEALTH PLAN COVERAGE OR OTHER HEALTH INSURANCE COVERAGE

If, while you (the Member) are enrolled in COBRA Continuation Coverage, your Spouse or eligible Dependent lose their coverage under another group health plan, you may enroll them in your COBRA for the remainder of the period of continuation of coverage. However, adding a Spouse or Dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

The loss of other coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause.

NOTICE OF UNAVAILABILITY OF COBRA COVERAGE

In the event the Plan is notified of a qualifying event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Fund Office an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

MULTIPLE QUALIFYING EVENTS WHILE COVERED BY COBRA

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours.

For example, assume you lose your job (the first COBRA-qualifying event), and you enroll yourself and your covered Spouse for COBRA coverage. Three months after your COBRA coverage begins, you and your Spouse divorce and your Spouse is no longer eligible for Plan coverage. Your Spouse can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA coverage.

This extended period of COBRA Continuation Coverage is **not** available to anyone who became your Spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the active Employee) during the 18-month period of COBRA Continuation Coverage.

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of Social Security disability). As a result, if you experience a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

WHEN COBRA COVERAGE MAY BE TERMINATED

Once COBRA coverage has been elected, it may be terminated on the occurrence of any of the following events:

- The first day of the time period for which you don't pay the COBRA premiums within the required time period.
- The date on which the Plan is terminated.
- The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become covered by another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the Covered Person may have.
- The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become entitled to Medicare (usually age 65).
- When active Employee coverage would be terminated for cause (for example, you submit fraudulent claims to the Fund).
- When the Employer that employed you prior to the qualifying event has stopped contributing to the Plan and (1) the Employer establishes one or more group health plans covering a significant number of the Employer's Employees formerly covered under this Plan, or (2) the Employer starts contributing to another multiemployer plan that is a group health plan.

NOTICE OF EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Fund Office determines that COBRA coverage will terminate early.

WHEN COBRA COVERAGE ENDS

Your COBRA coverage ends on the earliest of the date that:

- Any of the above-listed events occurs.
- The COBRA period (18, 29, or 36 months) ends.

IMPORTANT NOTE: YOU MUST PAY THE FUND OFFICE MONTHLY!

The Fund is not required to issue payment notices. Late payment will cause rejection of direct pay benefits. If you have any questions about COBRA continuation coverage, please contact the Fund Office.

NOTE: Payment for COBRA or Self Payment is due before insurance benefits are provided. Payment should be received by the Fund Office no later than the last day of the month in order to be eligible for insurance benefits the following month. For example, payment must be received by June 30th for insurance coverage in July. There is a 30-day grace period for ongoing COBRA premiums or Self Payments, however no claims will be paid until payment is received.

OTHER LAWS

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans and insurance companies that provide coverage for mastectomies to provide certain mastectomy-related benefits or services to plan participants and beneficiaries. The Plan provides the benefits required under the WHCRA, and makes these benefits available to eligible Participants.

Under the WHCRA, a group health plan Participant who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with the mastectomy is entitled to coverage for the following:

- 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 treatment of physical complications at all stages of mastectomy, including lymph edema.

Coverage for these benefits or services will be provided in a manner determined in consultation with the participant's or beneficiary's attending Physician.

If you are a participant in the Plan, and are currently receiving, or in the future receive benefits under the Plan in connection with a mastectomy, you are entitled to coverage for the benefits and services described above in the event that you elect breast reconstruction. Your eligible Dependents are also entitled to coverage for these benefits or services on the same terms. Coverage for the mastectomy-related services or benefits required under the WHCRA will be subject to the same deductibles and co-insurance or co-payment provisions that apply with respect to other medical or surgical benefits provided under the Plan.

If you have any questions about the WHCRA, please contact the Fund Office.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires group health plans and group health insurance issuers to permit an employee or dependent that is eligible for but not enrolled in the plan to enroll when the employee or dependent is covered under Medicaid or CHIP and loses that coverage as a result of loss of eligibility or when the employee or dependent becomes eligible for Medicaid or CHIP assistance with respect to coverage under the group health plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES

A Qualified Medical Child Support Order ("QMCSO") is a judgment, decree or order usually issued as part of a settlement agreement or divorce decree by a court of competent jurisdiction (or through an administrative process established under state law) that provides for child support or health care coverage for the child of a Plan participant. As long as a QMCSO conforms to statutory requirements, a child named in the QMCSO will be eligible for coverage.

If the Fund receives a court order requiring the Plan to provide health coverage to a child, the Fund will follow the order only if it is determined that the order is a QMCSO. When the Fund receives a medical child support order from a court, the Fund will promptly notify, in writing, the participant and each of the children named in the order that the Fund received the order, and will deliver a copy of the Plan's procedures for determining whether the order is a QMCSO to them at the addresses listed on the order. The Fund will also notify each child named in the order of his or her right to designate a representative to receive copies of all notices regarding the order.

Within a reasonable period of time, the Fund will determine whether the order is a QMCSO and notify the participant and each child named in the order of the determination in writing. If claims are submitted to the Plan on behalf of the child or children named in the order while the Fund is determining whether the order is a QMCSO, the Plan will suspend payment of any benefits that are due until the order is determined to be a QMCSO. If the order is determined to be a QMCSO, children covered by the QMCSO will become covered Dependents of the participant named in the QMCSO as of the first date to which the QMCSO applies, as if the participant enrolled them in the Plan and paid any required payments as of that date.

For a free copy of the Plan's QMCSO procedures, contact the Welfare Fund office.

FAMILY AND MEDICAL LEAVE ACT OF 1993 ("FMLA")

The FMLA provides an entitlement of up to 12 weeks of job-protected, unpaid leave during any 12-month period for the following reasons:

- Birth and care of the employee's child, or placement for adoption or foster care of a child with the employee;
- Care of an immediate family member (Spouse, child, parent) who has a serious health condition; or
- Care of the employee's own serious health condition.

The emergency leave benefit (of up to 12 weeks) now will be available to family members of active duty service members in the Armed Forces who are deployed to a foreign country.

In addition, under the Act, the caregiver leave benefit (of up to 26 weeks) now includes leave to take care of a child, Spouse, parent or next of kin who (1) is a veteran, (2) is undergoing medical treatment, recuperation or therapy for serious injury or illness, and (3) was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the five years preceding the date of treatment. The medical treatment must be related to a serious injury or illness incurred while in the line of duty on active duty in the Armed Forces or which existed before the beginning of military service, and which was aggravated by service in the line of duty while on active duty.

If an employee was receiving group health benefits when leave began, an employer must maintain them at the same level and in the same manner during periods of FMLA leave as if the employee had continued to work. Usually, an employee may elect (or the employer may require) the use of any accrued paid leave (vacation, sick, personal, etc.) for periods of unpaid FMLA leave.

Employees may take FMLA leave in blocks of time less than the full 12 weeks on an intermittent or reduced leave basis when medically necessary. Taking intermittent leave for the placement, adoption, or foster care of a child is subject to the employer's approval. Intermittent leave taken for the birth and care of a child is also subject to the employer's approval except for pregnancy-related leave that would be leave for a serious health condition.

When the need for leave is foreseeable, an employee must give the employer at least 30 days notice, or as much notice as is practicable. When the leave is not foreseeable, the employee must provide such notice as soon as possible.

An employer may require medical certification of a serious health condition from the employee's health care provider. An employer may also require periodic reports during the period of leave of the employee's status and intent to return to work, as well as "fitness-for-duty" certification upon return to work in appropriate situations.

An employee who returns from FMLA leave is entitled to be restored to the same or an equivalent job (defined as one with equivalent pay, benefits, responsibilities, etc.). The employee is not entitled to accrue benefits during periods of unpaid FMLA leave, but the employer must return him or her to employment with the same benefits at the same levels as existed when leave began.

Employers are required to post a notice for employees outlining the basic provisions of FMLA and are subject to a $100 civil money penalty per offense for willfully failing to post such notice. Employers are prohibited from discriminating against or interfering with employees who take FMLA leave.

Employee Rights

The FMLA provides that eligible employees of covered employers have a right to take up to 12 weeks of job-protected leave in any 12-month period for qualifying events without interference or restraint from their employers. The FMLA also gives employees the right to file a complaint with the Wage and Hour Division of the Department of Labor's Employment Standards Administration, file a private lawsuit under the Act (or cause a complaint or lawsuit to be filed), and testify or cooperate in other ways with an investigation or lawsuit without being fired or discriminated against in any other manner.

Compliance Assistance Available

The Wage and Hour Division of the Employment Standards Administration administers FMLA. More detailed information, including copies of explanatory brochures, may be obtained by contacting your local Wage and Hour Division office. In addition, the Wage and Hour Division has developed the *elaws* Family and Medical Leave Act Advisor, which is an online resource that answers a variety of commonly asked questions about FMLA, including employee eligibility, valid reasons for leave, notification responsibilities of employers and employees, and rights and benefits of employees. Compliance assistance information is also available from the Wage and Hour Division's Web site. For additional assistance, contact the Wage and Hour Division at 1-866-4USWAGE.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. This law applies both to the mother and the newborn covered by this Plan. In general, this plan may NOT restrict benefits for a Hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If you deliver in the Hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver outside the Hospital and you are later admitted to the Hospital in connection with childbirth, the period begins at the time of the admission.

Although the NMHPA prohibits this Plan from restricting the length of a hospital stay in connection with childbirth, this Plan does not have to cover the full 48 or 96 hours in all cases. If an attending provider, after speaking with you, determines that either you or your child can be discharged before the 48-hour (or 96-hour) period, this Plan does not have to continue covering the stay for whichever one of you is ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to you or your newborn child. In addition to Physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider. This Plan, Hospital, insurance company, or HMO would NOT be an attending provider.

The Plan benefits relating to this Act are found in the benefits section of this SPD. Your health coverage provided by this Fund complies with NMHPA standards.

MENTAL HEALTH PARITY ACT

The Mental Health Parity Act (MHPA), signed into law on September 26, 1996, requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan.

The law:

- Generally requires parity of mental health benefits with medical/surgical benefits with respect to the application of aggregate lifetime and annual dollar limits under a group health plan
- Provides that plan sponsors retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity)

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information.

GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA prevents a plan or issuer from imposing a pre-existing condition exclusion provision based solely on genetic information, and prohibits discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information).

GINA provides that group health plans and health insurance issuers cannot base premiums for an employer or a group of similarly situated individuals on genetic information. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan).

GINA also generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. Additionally, genetic testing information may be requested to determine payment of a claim for benefits, although the regulations make clear that the plan or issuer may request only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer to request (but not require) that a participant or beneficiary undergo a genetic test.

STATEMENT OF PRIVACY PRACTICES

This section describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

The Trustees and the Fund office have always made the protection of your personal information a very important priority. We want you to have a clear understanding of how we use and safeguard your information.

This section describes how the Welfare Fund may use and disclose your Protected Health Information ("PHI"), defined below, in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law. It also describes you rights to access and control you PHI.

Federal legislation known as the Health Insurance Portability and Accountability Act ("HIPAA") requires the Fund to establish a formal policy and procedures for maintaining the privacy of your PHI.

This section is effective beginning in April 2003, and the Welfare Fund is required to comply with its terms. However, the Welfare Fund reserves the right to change its privacy practices and this section and to apply the changes to any PHI received or maintained by the Welfare Fund prior to that date. If a privacy practice is materially changed, a revised version of this section will be provided to Employees via first class mail, and to all other persons upon request. Any revised version of this section will be distributed within 60 days of the effective date of any material change to the Welfare Fund's policies.

PROTECTED HEALTH INFORMATION

The term "Protected Health Information" includes all individually identifiable health information related to an individual's past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Welfare Fund in oral, written, or electronic form.

USES AND DISCLOSURES OF HEALTH INFORMATION

Disclosure of Your PHI Generally Requires Your Written Authorization.

Except as provided in this section, any use and disclosure of PHI will be made only with your written authorization. Once you give the Fund authorization to release your PHI, the Fund cannot guarantee that the person or organization to whom the information is provided will not disclose such information. You may revoke your authorization at any time in writing, except if the Fund has already acted based on your authorization.

There are circumstances in which the Welfare Fund will disclose your PHI in the absence of a written authorization. Under the law, the Welfare Fund may disclose your PHI without your authorization or without giving you the opportunity to agree or object, in the following cases:

- At your request. If you request it, the Welfare Fund is required to give you access to certain of your PHI in order to allow you to inspect and/or copy it. Your right to this information is detailed later in this section.
- For treatment, payment or health care operations. The Welfare Fund and its business associates may use PHI in order to carry out treatment, payment or health care operations.
- "Treatment" is defined as the provision, coordination, or management of health care and related services. For example, the Welfare Fund may disclose PHI to providers to provide information about alternative treatments.
- "Payment" includes but is not limited to actions to make coverage determinations and payment for services and items you receive. For example, the Welfare Fund may disclose to a doctor whether you are eligible for coverage or the amount that the Welfare Fund will reimburse a provider for certain services. If the Welfare Fund contracts with third parties to help us with payment

operations, such as a Physician who reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

- "Health care operations" are the operations of the Welfare Fund relating to such things as underwriting and quality assessment and other insurance activities relating to creating or renewing insurance contracts. They also include auditing functions, including fraud compliance programs, business planning and development, business management and general administrative activities. For example, the Welfare Fund may use PHI to audit the accuracy of its claims processing functions.
- Disclosure to Trustees. The Welfare Fund may also disclose PHI to the Trustees as Plan sponsor, for plan administrative functions. For example, the Welfare Fund may disclose information to the Trustees to allow them to decide an appeal or review a subrogation claim.
- In addition, the Welfare Fund may disclose "summary health information" to the Trustees for obtaining premium bids or modifying, amending or terminating the Welfare Fund's group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor such as the Trustees has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.
- Disclosure to Family and Friends. The Welfare Fund may release PHI to friends or family members that you have identified who are involved in caring for you or involved in paying for your care unless you notify the Welfare Fund's Privacy Officer in writing (contact information below) that you object. The Welfare Fund will disclose only PHI that is directly relevant to that person's involvement. In an emergency or if you become incapacitated, the Welfare Fund may also disclose your PHI to other family members, relatives or close friends under certain circumstances as permitted in the Welfare Fund's procedures, unless you have previously notified the Welfare Fund's Privacy Officer in writing that you do not want your information shared under those circumstances.
- If you want the Welfare Fund to disclose routinely your PHI to specific persons, then you must complete an authorization from designating that person as authorized to receive your PHI. Authorization forms are available from the Privacy Officer at the Welfare Fund office.
- Additional Disclosures. In addition to the above permitted uses and disclosures, the Welfare Fund may also use and disclose your PHI under the following unique circumstances:
    - When required by applicable law.
    - As required by HHS. Disclosure of your PHI may be required by the U.S. Department of Health and Human Services to investigate the Welfare Fund's compliance with the privacy regulations.
    - For public health purposes. Disclosure of your PHI to an authorized public health authority may be necessary if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, it authorized by law.
    - In the event of domestic violence or abuse. Your PHI may be disclosed when authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect, or domestic violence. In such case, the Welfare Fund will promptly inform you that such a disclosure has been or will be made unless so informing you would cause a risk of serious harm.
    - Health oversight activities. Your PHI may be disclosed to a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).

- Legal proceedings. Your PHI may be disclosed when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or court ordered discovery request. In the case of subpoenas and discovery requests which are not court ordered, the Welfare Fund will disclose your PHI only if certain conditions are met.
- Law enforcement purposes. Your PHI may be disclosed for certain law enforcement purposes, such as identification or location of a suspect, fugitive, material witness or missing person, and reporting a crime.
- To a coroner, medical examiner, or funeral director related to information about a deceased individual.
- For organ, eye, or tissue donation purposes.
- Research. Your PHI may be disclosed for research, subject to certain conditions.
- Health or safety threats. Your PHI may be disclosed when, consistent with applicable law and standards of ethical conduct, the Welfare Fund in good faith believes the use or disclosure of PHI is necessary to prevent a serious and imminent threat to the health or safety of a person or the public. Under these circumstances, the Welfare Fund will limit the disclosure to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- Government Functions. Your PHI may be disclosed in connection with certain government functions, such as military service or national security.
- Correctional/Law Enforcement. Your PHI may be disclosed to correctional institutions or law enforcement officials if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
- Business Associates. The Welfare Fund may disclose your PHI to business associates of the Fund that perform functions or services on the Fund's behalf. The business associates are under contract with the Fund to protect your PHI and are not allowed to use such information other than as specified in the contract.
- Data breach notifications. The Fund may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your PHI.
- Workers' Compensation Programs. Your PHI may be disclosed to the extent necessary to comply with Workers' Compensation or other similar programs established by law.
- Marketing. The Fund will not disclose PHI to any other company for their use in marketing their products to you and will not sell your PHI, unless the Fund first obtains your written authorization.
- Genetic Information. The Fund will not use or disclose your genetic information that falls under the definition of PHI for underwriting purposes.

BREACH NOTIFICATION

In the event that the Fund discloses PHI and such disclosure is not permitted by this policy or the HIPAA Privacy Rule, the Fund is required to notify you of the breach unless certain exceptions apply. The disclosure of "secured" PHI (i.e. PHI that is encrypted) is not subject to this requirement.

YOUR INDIVIDUAL PRIVACY RIGHTS

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," defined below, for as long as the Welfare Fund (Fund) maintains the PHI. You or your personal representative will be required to request access to the PHI in your designated record set in writing.

A reasonable fee for copying may be charged. Requests for access to PHI should be made to the Fund's Privacy Officer.

The Fund must provide the requested information within 30 days. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Welfare and HHS.

A "designated record set" includes your medical or billing records that are maintained by the Fund. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by the Fund or other information used in whole or in part by or for the Fund to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Fund is also required to provide you with access to electronically stored PHI (electronic PHI) maintained in a designated record set in the electronic form and format you request, if it is readily producible and, if not, in the form and format agreed to by you and the Fund. Additionally, you may request in writing that the Fund transmit your electronic PHI directly to another person designated by you. The Fund must provide the requested electronic PHI in the same manner and time frame as it is required to provide all other PHI.

If you feel that any PHI kept by the Fund is incorrect or incomplete, you may request that the Fund amend it subject to certain exceptions. PHI is not subject to amendment if it was not created by the Fund, is not part of the designated record set you are permitted to inspect and copy, or if it is not kept by the Fund. The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI. You should make your request to amend PHI to the Fund's Privacy Officer, in writing, at the address below.

At your request, the Fund will also provide you with a list of certain disclosures by the Fund of your PHI made after April 14, 2003. This accounting is not required to include disclosures related to treatment, payment for treatment, or health care operations, or disclosures made to you or authorized by you in writing. The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. The first accounting you request in a 12-month period will be provided free of charge. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable cost- based fee for each subsequent accounting. You or your personal representative must submit your request for restrictions on uses and disclosures of your PHI in writing to the Fund's Privacy Officer at the address below.

You may request that the Fund restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations. In addition, you may restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund is not required to agree to your request. You or your personal representative must submit your request for restrictions on uses and disclosures of your PHI in writing to the Fund's Privacy Officer at the address below.

You may also request to receive communications of PHI confidentially by alternative means or solely at an alternative location (for example, mailing information somewhere other than your home address) if it is feasible and reasonable. Make such requests to the attention of the Fund's Privacy Officer at the address below. Please note that the Plan must grant this request only if the individual states he or she would be in danger. You or your personal representative may request confidential communications of your PHI orally or in writing. However, requests to modify or cancel a previous confidential communication request must be made in writing.

You may exercise your rights through a personal representative. Except as provided below in connection with parents of unemancipated minor children, your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without completion of an Appointment of Personal Representative form. For example, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable state law requires otherwise. Unemancipated minors may, however, request that the Fund restrict information that goes to family members if permitted by applicable state laws. Other documentation that may substitute for this form would include other official legal documentation that demonstrates that under relevant state law the representative is authorized to make health care decisions for you (for example, appointment as a legal guardian, or a health care power of attorney).

HIPAA PRIVACY RULE AMENDMENT

The Board of Trustees has determined that the Plan is a "group health plan" within the meaning of the HIPAA Privacy Rule, and the Board of Trustees has agreed to take all actions required to be taken in connection with the HIPAA Privacy Rule (e.g., entering into Business Associate contracts; accepting certification from the Plan Sponsor). Such responsibility may be delegated by the Board to the Plan's administrator.

All terms in the subsection shall have the same meaning as those terms are defined in the HIPAA Privacy Rule. The following additional definitions apply to the provisions of this subsection:

a. "Plan" means this Plan.

b. "Plan Sponsor" is the Board of Trustees of this Plan.

Except as provided below with respect to the Plan's disclosure of summary health information, the employees of the Plan may: (a) disclose Protected Health Information to the Plan Sponsor and (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor with respect to the Plan because the Plan Sponsor has executed an amendment and certified to the Administrator that:

a. The Plan has been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;

b. The Plan has been amended to incorporate the Plan provisions set forth in this subsection; and

c. The Plan Sponsor agrees to comply with the Plan provisions as modified by this subsection.

The Plan (and any Business Associate acting on behalf of the Plan, or any health insurance issuer, HMO, PPO, health care provider, etc., as applicable, servicing the Plan) will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions, unless authorized by the individual or as allowed by law. Such disclosure will be consistent with the provisions of this subsection. All disclosures of the Protected Health Information of the Plan's individuals by the Plan's Business Associate, health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to the Plan Sponsor will comply with the restrictions and requirements set forth in this subsection.

The Plan (and any Business Associate acting on behalf of the Plan), may not, and may not permit a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law. The Plan Sponsor will not use or further disclose individuals'

Protected Health Information other than as described in the Plan, unless authorized by the individual or as allowed by law.

The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's health insurance issuer, HMO, PPO, health care provider, etc., as applicable), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law. The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan, of which the Plan Sponsor becomes aware. The Plan, or a health insurance issuer, HMO or PPO with respect to the Plan, may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

a. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

b. Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer, HMO or PPO with respect to the Plan, may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer, HMO, PPO offered by the Plan, as applicable. The Plan shall provide all Protected Health Information needed by the Board of Trustees to review and decide appeals of claims denials.

The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. §164.524 and will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. §164.526. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F. R. §164.528.

The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule. The Plan Sponsor will, if feasible, return to the Administrator or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Board of Trustees represents that adequate separation exists between the Plan and the Board of Trustees, and that reasonable and appropriate security measures have been taken to ensure this separation, so that Protected Health Information will be used only for Plan administration purposes.

The Plan Sponsor may provide all Protected Health Information needed by the Fund's consultants or Fund Counsel to assist the Board of Trustees in the investigation and review of claims of appeals, communication to appellants and the defense of the decisions of the Board of Trustees.

In accordance with the "504" provisions, this subsection describes the employees or classes of employees of workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer, HMO, PPO, etc., as applicable, servicing the Plan:

a. The Plan's Administrator

b. Claims supervisors, processors and clerical support staff, including employees of a third party administrator (if one is retained).

c. Information technology personnel

d. Any other employees, or classes of employees, as needed, that may be designated by the Trustees

This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment, health care operations of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with the provisions of this subsection. The Plan Sponsor will promptly report any such breach, violation, or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any harmful effect of the violation or noncompliance.

THE WELFARE FUND'S DUTIES

The Welfare Fund is required by law to maintain the privacy of your PHI and to provide you with this notice of its legal duties and privacy practices.

If you believe that your privacy rights have been violated, you may file a complaint with the Welfare Fund in care of the Privacy Officer at the following address:

Richard Clarson, CEBS, Privacy Officer
Local 731 Welfare Fund
1000 Burr Ridge Parkway, Suite 301
Burr Ridge, IL 60527

You may also file a complaint with:

Secretary of the U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Ave. S.W.
Washington, D.C. 20201

The Welfare Fund will not retaliate against you for filing a complaint.

If you have any questions regarding this section or the subjects addressed in it, you may contact the Privacy Officer at the Welfare Fund office.

STATEMENT OF ERISA RIGHTS

As a Participant in this Plan 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 Plan Administrator's office and at other specified locations, such as work sites and Fund Office, 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 Benefit Security Administration.

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

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The benefits available to you under this Welfare Plan are generally intended to be tax free and are described briefly in this Summary Plan Description (SPD), which also serves as Plan Document.

All provisions of the insured benefits are contained in the policies issued by the various insurance companies. Since the policies contain complete details, the final interpretation of any specific provision is governed by them.

When you become insured, you will receive an identification card or certificate summarizing the provisions of the group policy that principally affects you.

LOCAL 731, I. B. OF T., GARAGE ATTENDANTS, LINEN AND LAUNDRY HEALTH AND WELFARE FUND

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BOARD OF TRUSTEES

UNION TRUSTEES	EMPLOYER TRUSTEES
John Lisner	Michael Richardson
Dale Bolt	James Buik
Tim Dunlap	Ed DeNormandie
Walter G. Thiede	Brad Webb

To **Write to the Board of Trustees**, address your letter to:

Board of Trustees
c/o Fund Administrator
1000 Burr Ridge Pkwy, Suite 301
Burr Ridge, IL 60527

FUND PROFESSIONALS

FUND ADMINISTRATOR

Board of Trustees
Local 731, I.B. of T., Garage Attendants, Linen and Laundry Health and Welfare Fund
1000 Burr Ridge Pkwy, Suite 301
Burr Ridge, IL 60527
Telephone: (630) 887-4150

ADMINISTRATOR

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ASSISTANT ADMINISTRATOR / COMPTROLLER

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FUND CONSULTANT

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Two Mid America Plaza, Suite 800
Oakbrook Terrace, IL 60181
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AGENT FOR SERVICE OF LEGAL PROCESS

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