Northern Illinois and Iowa Laborers' Health and Welfare Trust Summary Plan Description

for

Participants and Their Eligible Dependents

Effective January 1, 2023

Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund
2837 7th Avenue
Rock Island, Illinois 61201

Dear Participant:

The Board of Trustees of the **Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund** is pleased to provide you with this Summary Plan Description booklet to help you understand your current health benefits. This booklet incorporates all changes to the Plan through January 1, 2023. This booklet supersedes and replaces any prior Summary Plan Description booklet.

This booklet is meant to be an easy-to-understand description of your Plan benefits, but it does not replace the Plan's official Rules and Regulations (Plan Document). If there is any conflict between the wording of this booklet and the Plan Document, the Plan Document will govern.

This booklet describes the Plan's benefits and eligibility rules. It also complies with Federal laws governing the privacy and security of your protected health information.

Please keep this booklet with your other important papers and share this information with your family. If you have questions about information in this booklet, contact the Fund Office at 309-786-3361.

Sincerely,

BOARD OF TRUSTEES

THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THIS PLAN WHENEVER, IN THEIR JUDGMENT, CONDITIONS SO WARRANT. YOU WILL BE NOTIFIED IN WRITING OF ANY CHANGES TO THE PLAN.

OVERVIEW OF CLAIM FILING PROCEDURES

Each person covered by this Plan must file one claim form per calendar year. The Plan may withhold your benefits until the Fund Office receives your completed claim form.

To file a claim for benefits under this Plan, please refer to the back of your ID card, which will indicate where the documentation needs to be submitted. The information you provide must be sufficient for the Plan to determine the benefits available under this Plan.

Generally claims must be submitted to the following:

- Medical Claims – File with Blue Cross Blue Shield of Illinois Claim Dept.
- Prescription Claims – File with Sav-Rx.
- Dental, Vision, Weekly Sickness and Accident Disability, and Life Insurance Claims file with:

Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund
2837 7th Avenue
Rock Island, Illinois 61201
Telephone Number: 309-786-3361

If you use a PPO provider, the provider will file the claim for you. If you use a Non-PPO provider, you must file the claim yourself.

To assure prompt service with Non-PPO medical claims, you should:

1. Secure a claim form from the Fund Office and complete the necessary portions of the form by filling in all requested information, including your Social Security Number, and signing on the line specified.

2. Obtain from the Non-PPO provider, a claim form showing the diagnosis, the services and supplies provided the charge for each item and the date of each charge. If possible, have the provider complete the appropriate portion of the claim form.

3. Forward the completed form, with all attachments, to Zenith American Solutions, or to the Fund Office at the addresses listed above.

Reimbursement for covered charges will be made to the provider of service, unless the bill is clearly marked by the provider "Paid in Full."

Precertification

Please note that you must precertify your inpatient hospitalization, any stay at a facility for treatment of mental and nervous disorders and/or substance abuse, any stay at a skilled nursing facility, and certain outpatient procedures (including imaging, sleep studies, blepharoplasty, breast surgery (other than mastectomies), sclerotherapy, vein legation/stripping, septoplasty/rhinoplasty, and rehabilitation therapy visits that exceed 8 visits per Injury or Illness). See page 26 for additional information.

If you do not precertify these procedures, you will be subject to the reduction in benefits that is listed in the "*Schedule of Benefits*". *(Benefit reduction does not apply to: (i) charges for*

inpatient services and treatment at a PPO facility; or (ii) charges for outpatient surgery services at a PPO facility.)

Contact Information

If You Have A Question About…	Contact…
Eligibility Questions:	■ Fund Administrator: Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund 2837 7th Avenue Rock Island, IL 61201 1-309-786-3361
Medical Benefits: *[Note: To verify benefits, contact the Fund Administrator at 1-309-786-3361.]*	■ For PPO Provider Network information: Blue Cross Blue Shield of Illinois 1-800-810-2583 or www.bcbsil.com ■ For Utilization Review (Precertification): Telligen at 1-888-674-7627 ■ For MDLIVE Virtual Consultations: Blue Cross Blue Shield of Illinois Call MDLIVE at 1-888-676-4204 or www.MDLIVE.com/bcbsil
Vision, Dental, Weekly Sickness and Accident Disability, and Life Insurance Claims:	Fund Administrator: Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund 2837 7th Avenue Rock Island, IL 61201 1-309-786-3361
Prescription Drug Benefits	■ For Retail Card and Mail Order Programs: Sav-Rx 224 North Park Ave Fremont, NE 68025 1-800-228-3108 www.savrx.com

TABLE OF CONTENTS

Page

Schedule of Benefits

BENEFIT	BENEFIT AMOUNT OR BENEFIT LIMITATION	
BENEFITS FOR ACTIVE EMPLOYEES ONLY		
Life Insurance Benefit	$10,000	
Accidental Death and Dismemberment Insurance Benefit	Maximum of $10,000	
This Plan provides life and accidental death & dismemberment insurance to Active Employees through a separate insurance policy. The benefits are described in a separate booklet, which may be obtained through the Fund Office.		
Short-Term Disability Benefit	$300 per Week for a Maximum of 13 Weeks	
Benefits Begin On	First Day of an Accident and Eighth Day of a Sickness *Disabilities will not be considered as beginning more than three days before your first visit to a Physician for treatment of your disability.*	
BENEFITS FOR ACTIVE/RETIRED EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS		
Calendar Year Deductible	*The Deductible does not apply to charges made by a Preferred Provider Physician for an office visit. You pay a $20 copayment ($5 for treatment of a Mental and Nervous Disorder or Substance Abuse) per office visit directly to the Physician. Neither the $20 or $5 office visit copayment nor the remainder of the Physician fees paid by the Plan counts towards your Deductible.*	
Per Individual	$300	
Per Family	Three Individual Deductibles	
Calendar Year Out-of-Pocket Maximum (including Deductible)	In-Network	Out-of-Network
Per Individual	$2,300	$4,300
Per Family	$6,900	$12,900

BENEFIT	**BENEFIT AMOUNT OR BENEFIT LIMITATION**	
Limitations	The Calendar Year out-of-pocket maximum does not include: 1. Copayments you make for Physician office visits; 2. Copayments under the Prescription Drug Program; 3. Emergency Room/IFED Copayment; 4. Vision Care or Dental Care expenses; or 5. Expenses incurred as a result of a noncompliance penalty.	
Benefit Maximums	Per Person	
Calendar Year Maximum	Unlimited for all Essential Health Benefits, as defined by the Affordable Care Act	
Transplant Expense Maximum	$500,000 per Transplant	
Chiropractic Care/Massage Therapy	The Plan pays 80% for in-network providers and 60% for out-of-network providers up to $50 per visit	
Rehabilitation Therapy	A combined limit of 50 visits per calendar year for all inpatient /outpatient: physical, occupational, and speech therapies. Visits for all therapies combined over 8 visits per Injury or Illness must be precertified.	
Home Health Care	*Each visit by a member of the home health team is considered one home health care visit. Four hours of service from a home health aide is considered one home health care visit. Visits under the Sav-Rx M2P Program for the purpose of providing home infusion of prescription drugs shall not be subject to the $40 per visit cap.*	
Per Visit	$40	
Benefit:	***PPO Provider***	***Non-PPO Provider***
Note: Members pay at the PPO cost-sharing level for Protected Services, Continuing Care Services, and Misidentified Provider Services.		
Hospital and Physician Benefits[(1)]	The Plan pays 80% of Covered Charges, after the Deductible	The Plan pays 60% of Reasonable and Customary Expenses, after Deductible
Emergency Room/IFED Copayment[(1)] *(Copayment does not apply to Out of Pocket Maximum)*	$100 (Waived if admitted) then 80% of Covered Charges after the Deductible.	$100 (Waived if admitted), then 60% of Reasonable and Customary Expenses after the Deductible.

BENEFIT	BENEFIT AMOUNT OR BENEFIT LIMITATION	
Doctor's Office Visits[1]	You pay a $20 ($5 for treatment of a Mental and Nervous Disorder or Substance Abuse) copayment; no copayment if visit is for child wellness or adult annual physical exam	60% of Reasonable and Customary Expenses, after the Deductible
Benefit:	***PPO Provider***	***Non-PPO Provider***
Virtual Consultations with MDLIVE	The Plan pays 100% and you do not pay a Deductible or copayment for using BCBSIL's MDLIVE program *(see item 34 of Covered Charges section—Major Medical Expense Benefit for additional information)*	Not applicable
Other Virtual Consultations (NOT with MDLIVE)	The Plan pays the amount that would be payable for an in-person visit	The Plan pays the amount that would be payable for an in-person visit
Treatment of Mental and Nervous Disorders and Substance Abuse	***PPO Provider***	***Non-PPO Provider***
Inpatient Treatment[1]	The Plan pays 80% of Covered Charges, after the Deductible	The Plan pays 60% of Reasonable and Customary Expenses, after the Deductible
Outpatient Treatment[1] Provider Office Visits	You pay a $5 copayment	The Plan pays 60% of Reasonable and Customary Expenses, after Deductible
Provider Facilities	The Plan pays 80% of Covered Charges, after the Deductible	The Plan pays 60% of Reasonable and Customary Expenses, after Deductible

BENEFIT	BENEFIT AMOUNT OR BENEFIT LIMITATION	
Precertification Requirement	You must precertify any hospital stay, any stay at a facility for treatment of mental and nervous disorders and/or substance abuse, any stay at a skilled nursing facility, certain outpatient procedures, and rehabilitation therapy visits in excess of 8 visits per Injury or Illness by calling Utilization Review at the number listed in the "Contact Information" page at the front of this booklet.	
Benefit Reduction for Failure to Precertify Services (Benefit reduction does not apply to: (i) charges for inpatient services and treatment at a PPO facility; or (ii) charges for outpatient surgery services at a PPO facility)	$200	$200
In Vitro Fertilization and Fertility Treatments (see item 25 of the Covered Charges section for additional information regarding covered benefits)	The Plan pays 50% up to the Lifetime Maximum per Person	
Lifetime Maximum	$15,000 per Person	
Transplant Benefits[(1)]		
Blue Distinction Center for Transplants® Provider	The Plan pays 90% of $10,000, after the Deductible, 100% thereafter	
PPO or Non-PPO Provider	The Plan pays 70% of $10,000, after the Deductible, 100% thereafter	
Per Transplant Maximum	$500,000 per Person per Transplant	

[(1)] The amount payable by the Plan for PPO Provider services or Continuing Care Services furnished by a Non-PPO Provider, after the deductible is satisfied, is the applicable percentage of the first $10,000 of the PPO negotiated fee (and, if the PPO negotiated fee exceeds the billed charge, the Plan pays 100% of the difference between the billed charge and the PPO negotiated fee if the PPO contract with the provider requires payment of the higher amount), then at 100%, up to any applicable maximums. The amount you owe for PPO Provider services or Continuing Care Services furnished by a Non-PPO Provider, after satisfying the deductible, is the applicable coinsurance percentage of the next $10,000 of the lesser of (a) the PPO negotiated fee, or (b) the billed charge. Non-PPO Provider services, other than Protected Services and Continuing Care Services, are paid at the percentage shown of the first $10,000 of Reasonable and Customary

Charges after the deductible, then at 100%, up to any applicable maximums. Non-PPO providers may balance bill members for services other than Protected Services and Continuing Care Services. The Amount payable by a member for Protected Services or Misidentified Provider Services by a Non-PPO Provider, after satisfying the deductible, is the applicable PPO coinsurance percentage of the next $10,000 of Reasonable and Customary Charges, determined in accordance with the No Surprises Act. Amounts charged by Non-PPO Providers for Protected Services are subject to the negotiation and dispute resolution process provided for in the No Surprises Act and its implementing regulations.

Prescription Drug Benefits (In-Network Only)	**Retail Card Program**	**Mail Service Program**
Copayment		
Brand Name Medication	$20	$40
Generic Medication	$10	$20
Amount of Supply	30-Day Supply	90-Day Supply
Specialty Drugs	$20 Copayment for up to a 30-day supply in-network only	
Smoking Cessation Medications	$20 Copayment for a 30-day Brand Name supply and $10 Copayment for a 30-day Generic supply, in-network only (a maximum of two 90-day courses of treatment will be covered each calendar year)	
If you choose a brand name drug	*You are responsible for the difference in cost between a brand name and a generic drug, unless your Physician indicates on the prescription "DAW" or "Dispense as Written."*	
Vision Care Expense Benefit		
Calendar Year Maximum	$400 *(The Calendar Year Maximum does not apply to individuals under the age of 18)*	
Annual vision examination (*not subject to calendar year maximum)*	The Plan pays 100% of Covered Charges, limited to one (1) vision examination per calendar year.	
<u>Under Age 18 Limits:</u>		
Vision Exam	Limited to one (1) vision examination per calendar year	
Frames	$200 per prescription (not to exceed one pair of frames per calendar year)	
Lenses	$200 per prescription	
Contacts (in lieu of frames or lenses)	$400 per prescription	

Dental Care Expense Benefit	
Calendar Year Maximum	$750 *(Calendar Year Maximum does not apply to preventive care for individuals under age 18)*
Orthodontic Limit for Individuals Under Age 18	$500 per total course of treatment

Eligibility

Eligibility in General

You are eligible for benefits under the **Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund** if:

1. You perform work under a collective bargaining agreement or other written agreement that requires your employer to contribute to the Plan on your behalf; and
2. Your employer makes the required contributions; and
3. You have met the initial eligibility requirement.

Eligibility for coverage is offered in three-calendar-month intervals, called eligibility quarters, beginning on the first of one of the following dates:

June 1
September 1
December 1
March 1

Once you meet your *initial eligibility requirement* (described in the next section), you will continue to be covered for each subsequent eligibility quarter if the Fund receives the appropriate contributions on your behalf for Covered Work.

The Fund will not accept contributions from an Employer that does not have an effective labor agreement (collective bargaining agreement) with a participating Union, or other written agreement, that requires the payment of contributions to the Fund. In addition, contributions will be accepted only if they are made on behalf of all of the Employees in the collective bargaining unit or other written agreement.

Participation in the Plan or eligibility for benefits is not a guarantee of your continuing employment.

The Plan complies with federal rules governing special enrollment.

In the event that the Fund does not receive contributions from your employer, you may submit, in writing, a request to the Board of Trustees to receive credit for hours that you worked. The crediting of hours by the Board of Trustees shall be in accordance with and subject to the Northern Illinois Iowa Laborers Health and Welfare Trust's Policy and Procedures for the Crediting of Hours, as amended from time to time.

Initial Eligibility Requirement

A new Employee will become initially eligible for benefits once the Plan receives at least 1,000 hours of contributions on their behalf, within any 12 consecutive month period. Coverage will begin on the first day of the 2nd month following the month in which the Employee completes such requirement.

For Example:
The Plan received 1,000 hours of credited employment on John's behalf for the work months February through January. He will be covered by the Plan beginning March 1st.

You should complete a "Participant's Data Update" form when you become eligible for coverage. The Fund Office will provide you with this form, or you may request a form from the Fund Office. You should update the information on this form when:

1. You change your address or telephone number,
2. You marry, divorce or legally separate,
3. Your spouse begins working, changes employers or adds or loses employer group health coverage,
4. You add or lose Dependents, and
5. You wish to change your beneficiary for Life Insurance Benefits.

Continued Eligibility Requirements

Once you meet the *initial eligibility requirement*, you will continue to be covered for subsequent eligibility quarters if the Fund receives 250 hours of contributions on your behalf in the corresponding three-month contribution period. If you do not meet this requirement, the Fund will "look back" to see if the Fund received a specific amount of contributions in previous contribution periods, as outlined below:

ELIGIBILITY QUARTER	CONTRIBUTION PERIODS
You will be eligible for coverage in:	If the Fund receives:
June, July, August	250 hours of contributions in January, February and March; or 500 hours of contributions in October through March; or 750 hours of contributions in July through March; or 1,000 hours of contributions in April through March.
September, October and November	250 hours of contributions in April, May and June; or 500 hours of contributions in January through June; or 750 hours of contributions in October through June; or 1,000 hours in July through June.

ELIGIBILITY QUARTER	CONTRIBUTION PERIODS
December, January and February	250 hours of contributions in July, August or September; or 500 hours of contributions in April through September; or 750 hours of contributions in January through September; or 1,000 hours of contributions in October through September.
March, April and May	250 hours of contributions in October, November and December; or 500 hours of contributions in July through December; or 750 hours of contributions in April through December; or 1,000 hours of contributions in January through December.

For example:

After John meets the initial eligibility requirement, the Fund receives 100 hours of contributions on his behalf in January and 70 hours in both February and March. Although the Fund only receives contributions for 240 hours of Covered Work for the current contribution period and John does not meet the minimum 250 hour requirement, he is still eligible for coverage because the Fund received 750 hours of contributions on his behalf in the 9-month period from the beginning of July until the end of March. John is covered for the upcoming June, July and August eligibility quarter.

Dependent Eligibility

Your Dependents are eligible for benefits if you are covered under the Plan. For a definition of Dependent, see pages 68-69. The coverage for your Dependents will be effective on the later of:

1. The date you become eligible;
2. The date your Dependent becomes an eligible Dependent; or
3. The date a Qualified Medical Child Support Order (QMCSO) is determined to be valid.

If (1) your Dependent spouse is employed 30 or more hours per week, (2) your Dependent spouse has employer-provided health coverage available at a cost of less than $150 per month for single coverage, and (3) your Dependent spouse fails to elect that employer-provided health coverage, then this Plan will only pay the amount it would have paid if it were the secondary plan. For this purpose, this Plan assumes that the spouse's primary benefits are equal to the benefits payable under this Plan.

REQUIREMENT TO PROVIDE NECESSARY INFORMATION REGARDING ELIGIBILITY

You and your spouse and children will be covered by the Plan only if you and your spouse and children provide such information as deemed necessary by the Plan administrator to determine eligibility for health coverage under the Plan (such as birth and marriage certificates, proof of adoption, etc.) or to enable the Plan to comply with reporting obligations under applicable law (for example, Social Security number, dates of birth, address, etc.). If you or your spouse or children fail to provide the Plan with information which is necessary to enable the Plan to determine eligibility for coverage, or to comply with reporting obligations under applicable law, then your eligibility or your spouse and children's eligibility under the Plan shall be terminated.

Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order that may require you to provide medical coverage for your children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute.

A QMCSO requires the Fund to cover an alternate recipient who might not otherwise be eligible for coverage. This Plan provides benefits to the extent required by the QMCSO and Federal law. The Plan Administrator will notify affected members and alternate recipients if a QMCSO is received. You may obtain a copy of the Plan's QMCSO procedures, without charge, by calling the Fund Office.

Eligibility During Disability

If you are receiving Short-Term Disability Benefits under the Plan, or workers' compensation benefits due to a certified disability, you will receive 20 hours of work credit each week, or four hours for each day that you are entitled to receive these benefits. You may use your credited hours to continue your eligibility under the Plan.

You may receive up to a maximum credit of 250 hours during a 12-consecutive-month period while you are receiving Short-Term Disability Benefits. If your disability is work-related, you may receive up to a maximum credit of 500 hours during such a 12-consecutive-month period. The Plan will determine whether your disability is work-related or not work-related.

You will not receive any credited hours after your Short-Term Disability Benefits or workers' compensation payments end.

When Coverage Ends

Coverage for you and your Dependents will end on the May 31st, August 31st, November 30th or the last day of February that you do not meet any of the *continued eligibility requirements*. Coverage for you and your Dependents will end if you join active military service for more than 31 days or if the Plan ends. Coverage for a Dependent ends when they no longer qualify as a Dependent, as described on pages 68-69.

When your coverage ends, or when your Dependents' coverage ends, you or your Dependent will be provided with certification of the length of your coverage under this Plan.

If coverage under the Plan ends, you and/or your Dependent may be eligible to continue coverage under the COBRA continuation option. See page 15.

Prohibited Employment Rule

If you terminate employment with a participating employer and begin working with a nonparticipating employer in the same industry, geographic area and trade or craft, you will lose eligibility for all benefits under the Plan. This "prohibited employment rule" specifically provides as follows:

> If an Employee ceases Covered Work and begins work for an employer:
>
> (a) in a category of employment for which contributions are not made to the Plan on his behalf, but would be required if the employer was signatory to a Collective Bargaining Agreement;
>
> (b) in the same industry covering Active Employees;
>
> (c) in the same geographic area of the Plan; and
>
> (d) in the same trade or craft covering the former Employee when he was an Active Employee;
>
> **then** such individual's eligibility under the Plan shall cease as follows:
>
> A written notice will be sent to the former Employee by means of a trackable delivery service.
>
> If the former Employee does not stop working for the employer within 10 days of the date of the written notice, then the former Employee and his Dependents will cease to be eligible hereunder as of midnight on the 10th day after the date of the notice.

Accordingly, if you are thinking of leaving employment with your participating employer and are considering employment with a nonparticipating employer, you should understand this may impact your eligibility for benefits under the Plan. We suggest you contact the Plan Office to review your particular circumstances if you have any questions.

In addition to the above, if an Employee terminates membership with the Union and becomes a member of another union, but continues working in the same industry (construction/ maintenance) in the same geographic area covered by the Plan without having contributions made to the Plan on his behalf for such work, then such individual's eligibility under the Plan shall cease, and his eligibility reserve bank shall be forfeited, both as of the end of the month in which such individual terminates his membership with the Union.

Please contact the Plan Office to review your particular circumstances if you have any questions.

Reinstatement of Coverage

If your coverage ends, it will not be reinstated. To regain Plan coverage, you must meet the requirements contained in the *Continued Eligibility Requirements* section.

Retiree and Widow(er) Eligibility

Special rules apply if you die or retire before you attain age 65. If you retire and are receiving a pension from the Central Illinois Laborers' Pension Plan (other than an occupational disability pension commencing before age 55), you may self-pay for extended coverage under the Plan for yourself and/or your spouse until the first day of the month in which each attains age 65, **provided you are eligible for coverage under this Plan for the two consecutive years prior to your retirement**. If your spouse attains age 65 before you, then your spouse's coverage terminates as of the first day of the month in which she attains age 65, and your coverage may continue until the first day of the month in which you attain age 65. If you attain age 65 before your spouse, then your coverage terminates as of the first day of the month in which you attain age 65, and your spouse's coverage may continue until the first day of the month in which the earlier of the following occurs: (1) your spouse's attainment of age 65, or (2) the date that is ten years after you attained age 65. Your coverage under the special rules for Retirees, and Widow(ers) includes the same coverage that Employees and their Dependents receive, except that Short-Term Disability Benefits are not continued through these options. The self-pay rate for coverage shall be set by the Trustees.

While you are receiving extended coverage under this special rule, your coverage will also terminate on the date you do not make timely payments, the date of your death, the date of termination of the Plan or retiree coverage, the date a Dependent no longer meets the definition of a Dependent under the Plan (including divorce, separation, or a Dependent child reaching age 26).

To maintain your eligibility for retiree benefits, you must be receiving a pension. Any work that you perform after retirement under the rules of the Central Illinois Laborers' Pension Plan will not disqualify you for retiree coverage hereunder, as long as your pension is <u>not</u> suspended. Employer contributions made on your behalf will be credited against your self-payment to a maximum of 39 hours per month in the month you work and will be credited in the following Eligibility Quarter, regardless of how many hours the Employer has reported that month. If your pension benefit is suspended, your hours will count toward reestablishing active eligibility. Your new retiree self-payment rate will be determined in accordance with the date your pension is reinstated.

If you die on or after age 55 or between the ages of 38 and 55 while you are receiving a pension from the Central Illinois Laborers' Pension Plan, your spouse is eligible for continued coverage if you were a participant in the Plan for the two consecutive years before your death. Your spouse is eligible for extended coverage as a surviving spouse by making self-payments at the surviving spouse rate set by the Trustees. Coverage will end as of the first day of the month in which the earlier of the following occurs: (1) your spouse's attainment of age 65, or (2) the date that is ten years after you died. .

Payment Offset for a Laborers Local No. 309 or Masons Local 18, Area 544 Retiree, or Surviving Spouse

If you are a Laborers Local No. 309 or Masons Local 18, Area 544 Retiree, or the surviving spouse of a Laborers Local No. 309 or Masons Local 18, Area 544 Retiree, you are eligible for a Payment Offset if the Retiree is eligible to continue coverage under the preceding section and met the following requirements:

1. The Retiree was a member of Laborers Local No. 309 or Masons Local 18, Area 544 for at least 120 calendar months.
2. At least 750 hours of contributions were made to the Plan on behalf of the Retiree in each of at least ten calendar years (or should have been made but were delinquent and uncollectible), and those ten calendar years occurred during the 15 years preceding retirement.

If you are the surviving spouse of a Retiree who met the above requirements, you will be eligible for the Payment Offset after the death of the Retiree, provided:

- The Retiree was receiving a pension at the time of their death; and
- The Retiree had participated in the Plan for the two years before death.

Your surviving Dependent children are <u>not</u> eligible for the Payment Offset.

Coverage During Military Service

If you are called to active service in any of the uniformed services of the United States, your benefits are protected under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your health care coverage will continue under the Plan if you serve for up to 31 days. If you serve for more than 31 days, you may continue your coverage at your own expense for up to 24 months under USERRA.

You must give advance notice of your military service to the Plan, unless you are unable to do so because of military necessity or when advance notice is impossible or unreasonable under the circumstances.

Coverage under USERRA will run concurrently with COBRA Continuation Coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA Continuation Coverage. The procedures for electing coverage under USERRA will be the same procedures described in the *COBRA Continuation Coverage Option* section beginning on page 15, except that only the Employee has the right to elect USERRA coverage for himself or herself and his/her Dependents, and that coverage will extend to a maximum of 24 months.

Generally, if you return to work within five years after you are called to service, you will be reinstated for Plan benefits as if you had not left for military service if:

1. You notify your employer that you have been called to service;

2. You leave service under conditions that are not dishonorable; and
3. You report back for work or apply for reemployment within the time frame specified in the following chart after you complete your active duty.

Length of Military Service	Reemployment Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

If you are hospitalized or otherwise incapacitated by a service-related illness or injury, your reemployment deadlines may be extended up to two years.

Your USERRA coverage may be terminated if:

1. You do not pay the required premium for continuation of coverage;
2. You exhaust the 24-month coverage period;
3. The Plan ceases to provide group health coverage;
4. You lose your rights under USERRA (for instance, for a dishonorable discharge); or
5. You fail to return to work or apply for reemployment within the time required under USERRA.

Coverage During a Leave under the Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 ("FMLA") enables you, if you qualify, to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child, to care for your seriously ill spouse, parent or child or if you have an urgent need for leave because your spouse, son, daughter or parent is on active duty in the armed services in support of a military operation. The FMLA requires certain Employers to maintain health care coverage during the leave period. If you think that this law may apply to you, please contact your Employer.

Reciprocity with Other Welfare Funds

The Trustees have authorized reciprocal agreements with other Health and Welfare Trusts to provide for transfer of Employer contributions in case you are temporarily transferred outside the jurisdictional area of Laborers' Local 309 and Cement Masons' Local 544. Contributions transferred to this Trust will be converted into hours of work for eligibility purposes by dividing the gross amount transferred for the month by the health and welfare rate in the Quad-City Builders Association-Laborers' Local 309 collective bargaining agreement in effect at the time the hours are worked.

You must apply to the Health and Welfare Trust in the area of temporary transfer to be eligible for reciprocity. Whether or not reciprocity exists with respect to any area is, of course, dependent upon the joint agreement of this Trust and the Trust for the particular area.

COBRA Continuation Coverage Option

Under certain circumstances, coverage for you or your eligible Dependents can be temporarily continued, at your expense, after it would normally end. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, provides you with the right to this continuation coverage.

COBRA Continuation Coverage is identical to the coverage you had under the Health Plan on the day before your coverage ended. Under COBRA, you may continue coverage of the health care benefits (Major Medical, Prescription Drug, Vision, and Dental. Also the Employee may continue Life Insurance and Accidental Death & Dismemberment Insurance) you received under the Plan as a participant. If you elect COBRA Continuation Coverage, the Plan also allows you the option of continuing the Short-Term Disability benefits, but that continuation coverage is separate from COBRA and does not constitute COBRA Continuation Coverage. You will pay the full cost of the COBRA continuation coverage in addition to a small administrative charge. You also pay the cost of the Short-Term Disability benefit if you elect that 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. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage. To enroll your new Dependent for COBRA coverage, you must notify the Fund Office within 31 days of acquiring the new Dependent.

If COBRA Continuation Coverage ends for you before the end of the maximum COBRA coverage period, COBRA coverage will also end for your newly added spouse. However, COBRA Continuation Coverage may 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. Children born, adopted, or placed for adoption or legal guardianship as described above have the same COBRA rights as a spouse or Dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA continuation coverage, their continued coverage depends on timely and uninterrupted payments on their behalf. Check with the Fund Office for details.

You Must Give the Plan Notice of Certain Qualifying Events

In order 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 inform the Plan in writing of that event no later than 60 days after that event occurs. You should send the notice to the Fund Administrator at the address listed in the Contact Information section.

If you do not send such a notice to the Fund Office within the 60-day period, the person affected by the divorce or the Dependent child who no longer qualifies for coverage will not be entitled to choose COBRA Continuation Coverage.

You should notify the Fund Office in the event of your entitlement to Medicare. Your employer should notify the Fund Office of your death, termination of employment, or reduction in hours.

However, you or your family should also notify the Fund Office promptly and in writing if any such event occurs in order to avoid confusion over the status of your health care coverage if there is a delay or oversight in the employer's notification to the Fund Office.

18-Month COBRA Continuation Coverage

If coverage ends because you are no longer eligible for the Health Plan due to one of two qualifying events, you and/or your Dependents may continue coverage under COBRA for 18 months. These qualifying events are your failure to work the required number of hours in the corresponding contribution period(s) or your termination of employment, which is a change from active to inactive work status due to one of the following:

1. You resign;
2. You are discharged (fired);
3. You become disabled;
4. You are on strike;
5. You are laid off by your Employer;
6. You are on a leave of absence (except for a leave under the FMLA);
7. You retire.

When the qualifying event is the end of employment or reduction of your hours of employment, and you became entitled to (qualified for *and* enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. However, your maximum coverage period will be 18 months. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of your Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months) in this example.

Second Qualifying Event

If your eligible Dependents have a second "qualifying event" during the initial 18 months of COBRA coverage, they may purchase COBRA Continuation Coverage for a total of 36 months. A second "qualifying event" includes:

1. Your death;
2. Your divorce or legal separation;
3. Your Dependent child no longer qualifies as a Dependent under the terms of the Plan; or
4. Your becoming entitled to (eligible for and enrolled in) Medicare Part A, Part B or both.

For example:

Bill loses his job (the first COBRA-qualifying event) and Bill enrolls himself and his

covered eligible Dependents for COBRA Continuation Coverage. Three months after Bill's COBRA Continuation Coverage begins, his child turns 26 years old and is no longer eligible for Plan coverage. Bill's child can continue COBRA Continuation Coverage for an additional 33 months, for a total of 36 months of COBRA coverage, as long as the child pays the required premiums.

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

29-Month COBRA Continuation Coverage

If your coverage ends due to one of the above 18-month "qualifying events" and, at the time of the event, or within the first 60 days of COBRA Continuation Coverage, you or one of your eligible Dependents is totally disabled (as determined by the Social Security Administration), COBRA Continuation Coverage for the family members who are covered under COBRA Continuation Coverage is offered for an additional 11 months, for a total of 29 months. This option offers the disabled individual coverage until Medicare coverage becomes effective. Coverage for the additional 11 months will be at a higher cost. The Fund may charge 150% of the full cost for similarly situated participants and dependents.

You must notify the Fund Office of the Social Security Administration's determination of disability within 60 days of the disability determination and before the end of the first 18 months of COBRA Continuation Coverage. You will *not* be eligible for the additional 11 months of coverage if you do not notify the Fund Office accordingly.

When you become entitled to (eligible for and enrolled in) Medicare and you are retired on disability, you are no longer eligible for Plan benefits under COBRA. You should apply for Medicare benefits as soon as you are eligible for them. It is important that you enroll in Medicare as soon as possible.

36-Month COBRA Continuation Coverage

Your eligible Dependents may elect to purchase COBRA Continuation Coverage for up to a total of 36 months if their Health Plan coverage ends for any of the following "qualifying events" or reasons or if one of the following qualifying events occurs during the 18- or 29-month period of coverage:

1. Your death;
2. Your divorce or legal separation;
3. Your Dependent child no longer qualifies as a Dependent under the terms of the Plan; or
4. Your becoming entitled to (eligible for and enrolled in) Medicare Part A, Part B or both.

Electing COBRA Continuation Coverage

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to you and each of your covered Dependents. To elect continuation coverage, you must complete the election form and furnish it according to the directions on the form. You then have 60 days from the later of the date the election notice was received or the date coverage ended due to the qualifying event within which to return your election form to the Plan in accordance with the directions on the election form.

Each qualified beneficiary has a separate 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 determining whether to elect continuation coverage, you should consider the following:

1. You also have the right to purchase coverage through the ACA marketplace exchange in the state where you reside, and you may be eligible for a premium subsidy if you purchase coverage through your exchange.
2. 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. You will also have the same special enrollment rights at the end of continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

Payment for COBRA Continuation Coverage

Generally, each qualified beneficiary who elects COBRA must pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an 11-month extension of continuation coverage due to a disability, 150 percent) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving continuation coverage. The required payment for continuation coverage for each continuation coverage period for each option is described in this notice.

If you have credits based on past employer contributions, these will be applied against the COBRA Continuation Coverage premium.

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after

the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Fund Administrator to confirm the correct amount of your first payment.

Monthly or Quarterly Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to make monthly or quarterly payments for each subsequent coverage period. Each payment is due on the first day of each month for each month of coverage, or on the first day of the quarter for each quarter of coverage. If you make a monthly or quarterly payment on or before the first day of the month or quarter to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send any notices of payments due.

Grace Periods for Monthly or Quarterly Payments

Although monthly payments and quarterly payments are due on the first day of the month to which the coverage period applies, you will be given a grace period of 30 days after the first day of the payment due date to make each payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a monthly or quarterly payment later than the first day of the month or quarter to which it applies, but before the end of the grace period for the coverage, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly or quarterly payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while you are enrolled in COBRA Continuation Coverage, your spouse or Dependent child loses coverage under another group health plan, you may enroll the spouse or Dependent child for coverage for the balance of the period of COBRA Continuation Coverage. The spouse and/or Dependent child must have been eligible but not enrolled for coverage under the terms of this Plan and declined coverage when enrollment was previously offered under this Plan. In addition, the spouse and/or Dependent child must have been covered under another group health plan or had other health insurance coverage.

You must enroll the spouse and/or Dependent child within 31 days after the termination of the other coverage.

The loss of coverage under the other plan must be due to one of the following:

1. Exhaustion of COBRA Continuation under another plan;
2. Loss of eligibility; or

3. Employer contributions towards the other plan decline or are eliminated.

Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums of a timely basis or termination of coverage for cause.

When COBRA Coverage Ends

COBRA Continuation Coverage may end for any of the following reasons:

1. You or your Dependent becomes covered under another group health plan. However, coverage will continue if you or an eligible Dependent has an existing health problem for which coverage is excluded under the other group plan;
2. The required contribution is not paid on time;
3. The Trustees terminate the Health Plan;
4. You or your Dependent reaches the end of the 18-month, 29-month or 36-month continued coverage period and you are not eligible for additional continuation coverage under the rules described above;
5. You become entitled to (eligible for and enrolled in) Medicare; or
6. Your Dependents become entitled to (eligible for and enrolled in) Medicare.

When your coverage ends, you will be provided with certification of your length of coverage under this Plan.

Confirmation of Coverage to Health Providers

Under certain circumstances, the Fund may need to inform your Health Care Providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following two circumstances.

1. If a Health Care Provider requests confirmation of coverage during the COBRA election period and you, your spouse or your Dependent children have not yet elected COBRA Continuation Coverage, then the Fund Office will give a complete response to the Health Care Provider about your and your Dependents' COBRA continuation rights during the election period.

   The Fund cancels your and your Dependents' coverage as of the date coverage ends under the Plan. However, the Fund retroactively reinstates your coverage once COBRA Continuation Coverage is elected. If you have not yet elected COBRA, the Fund Office will inform the Health Care Provider that you do not currently have coverage, but that you and your Dependents would have coverage retroactively to the date coverage was lost if you elect COBRA Continuation Coverage.

2. If after you have elected COBRA Continuation Coverage, a Health Care Provider requests confirmation of coverage for a period for which the Fund Office has not yet received payment, then the Fund Office will give a complete response to the Health Care Provider about your and your Dependents' COBRA continuation rights during that period.

The Fund cancels your and your Dependents' coverage as of the first day of a period of coverage if it has not received your or your Dependents' COBRA payment. However, the Fund retroactively reinstates your coverage once the COBRA payment is timely made. If you and/or your Dependents have not paid the applicable COBRA payment, the Fund Office will inform the Health Care Provider that you do not currently have coverage, but that you and your Dependents would have coverage retroactively to the first day of coverage if timely payment is made.

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the applicable tax provisions, individuals may either take a tax credit or receive advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at http://www.dol.gov/elaws/ebsa/health/employer/C19.htm.

Short-Term Disability Benefit (Active Employees Only)

The Short-Term Disability Benefit is payable if you are disabled due to a non-occupational injury or sickness that prevents you from performing the material duties of your occupation for compensation or profit. You must submit your application for these benefits within 30 days of the date your disability begins, unless circumstances beyond your control prevent you from making a timely application for benefits.

If you are eligible, you will receive up to $300 per week under the Short-Term Disability Benefit. The Short-Term Disability Benefit is paid for a maximum of 13 weeks for any one period of disability.

Payment will be made for as many separate and distinct periods of disability as may occur. A second disability will be considered a separate and distinct disability period if you return to full-time work for at least:

1. Two full work weeks when the disabilities are due to the same or related causes; or
2. One full day of active work when the second disability is due to causes that are unrelated to the prior disability.

When Short-Term Disability Benefits Begin

The Short-Term Disability Benefit begins on the:

- First day of disability due to an accident; or
- Eighth day of disability due to a sickness or illness.

The Plan will not consider any disability to have begun more than three days before your first visit to a physician for treatment of your disability. The Plan will pay your benefits no later than the end of each two-week period.

Filing Short-Term Disability Claims

You should submit your disability claim form after it has been completed by you and your physician to the Fund Office at:

Northern Illinois and Iowa Laborers'
Health and Welfare Trust Fund
2837 7th Avenue
Rock Island, Illinois 61201

For information or for a claim form, call the Fund Office at: 1-309-786-3361.

Limitations on Short-Term Disability Benefits

Benefits will not be paid:

1. For any day of total disability that occurs while you are receiving any compensation.
2. If you retire or go on a paid leave of absence.
3. If you become disabled from an accident or illness related to any employment.
4. If you become disabled due to an accident or illness covered under Workers' Compensation or the Occupational Disease Act or law or a law similar to Workers' Compensation or the Occupational Disease Act.
5. For any disability you incur while engaged in the commission of a felony.
6. For any disability you incur as the result of a war or act of war (declared or undeclared).
7. For any disability sustained in the Armed Forces of any country engaged in a war or other conflict.
8. For any injury or illness caused by the use of any amphetamine, barbiturate, hallucinogen, or narcotic, except when prescribed by a physician and used in accordance with his/her directions.
9. For any injury or illness for which you are not under the regular treatment of a qualified physician or surgeon.

YOUR SHORT-TERM DISABILITY BENEFIT IS SUBJECT TO TAXES. THE FUND WILL DEDUCT THE AMOUNT REQUIRED BY THE INTERNAL REVENUE SERVICE (IRS) FOR FEDERAL INSURANCE CONTRIBUTIONS ACT (FICA) TAXES.

Major Medical Expense Benefit (For ALL Eligible Participants)

Your Major Medical Expense Benefit protects you and your family from potential catastrophic health care expenses.

The Deductible

The deductible is the amount of covered medical charges that you and each of your eligible Dependents pay each calendar year before benefits begin.

The individual deductible, which is listed in the *Schedule of Benefits* on page 1, applies to each member in your family every calendar year. However, once three members of your family satisfy their individual deductibles per calendar year, no additional deductible will be required. In addition, if you or a member of your family incurs an expense that is used to satisfy the deductible during October, November and December, that amount will also be used to satisfy the deductible for the following calendar year.

Percentage of Benefits Payable

Once you pay the annual deductible, the Plan pays a percentage (as specified in the "Schedule of Benefits") of the negotiated fee for eligible in-network PPO physicians and/or hospitals, and of Reasonable and Customary (R&C) charges, up to any Plan maximums, for out-of-network charges.

Out-of-Pocket Maximum

You must pay the coinsurance amount up to the out-of-pocket maximum shown in the *Schedule of Benefits*. Once you reach this annual out-of-pocket maximum, the Plan pays 100% of all covered charges for the rest of the calendar year, subject to certain maximums and limitations.

The following do not count toward satisfying the Out-of-Pocket Maximum:

1. Co-payments for PPO physician office visits;
2. Emergency Room Co-Payment;
3. Co-payments under the Prescription Drug Program;
4. Vision Care or Dental Care expenses; or
5. Expenses incurred as a result of failure to obtain required precertification.

Even after satisfaction of the annual out-of-pocket maximum, you are responsible for your co-payments for PPO physician office visits and those required under the Prescription Drug Program. In addition, Vision Care and Dental Care expenses do not become payable at 100% after satisfaction of the annual out-of-pocket maximum.

Preferred Provider Organization (PPO)

The Health and Welfare Fund has an agreement with a Preferred Provider Organization (PPO) network to help control medical costs. A PPO network is a group of hospitals and providers that agree to provide services at fees that are generally lower than those normally charged by other hospitals or providers. You may use any provider you wish, but, in general, higher benefits are paid when you use a provider in the PPO network.

To minimize your out-of-pocket costs, contact the PPO network, as shown in the *Contact Information* page at the front of this booklet, for information on which hospitals and providers belong to the PPO network. When you use PPO hospitals and providers rather than non-PPO hospitals and providers, you can reduce costs for both you and the Fund. You may use any provider you wish, but the Plan pays a higher percentage of your charges when you use a hospital or provider in the PPO network. However, all Protected Services will be covered at the PPO network level.

When you use a PPO physician and/or hospital, you do not need to file claims. The PPO files the claims for you.

If a provider or facility leaves the PPO network or otherwise becomes an out-of-network provider while you are receiving, or are scheduled to receive, services from the provider or facility, you may be able to continue receiving care from the provider or facility as if they were still in the network for up to 90 days so that you have time to transition to a new PPO provider. Contact the Fund Office for more details.

CALL THE PPO NETWORK LISTED IN THE *CONTACT INFORMATION* SECTION, OR CALL THE FUND OFFICE AT 309-786-3361, TO FIND OUT IF YOUR PHYSICIAN IS A MEMBER OF THE PPO.

You may also visit the website for the PPO network, as listed in the *Contact Information* section, to find a provider online, free of charge.

Blue Distinction Center Transplant® Services

The Health and Welfare Fund has an agreement with Blue Cross Blue Shield of Illinois to provide services through their Blue Distinction Centers for Transplants, if you or a member of your family requires an organ or stem cell transplant. The Blue Distinction Centers program consists of many facilities that specialize in one or more transplant procedures.

Transplant services include compatibility testing, the recipient's medical, surgical and Hospital services, inpatient immunosuppressive medications, and costs for organ or bone marrow/stem cell procurement. Transplant services are covered through the Plan only if the organ transplant meets the guidelines of Medicare. Medicare currently covers the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal, which includes-small bowel, liver or multivisceral. All transplant services received from providers not part of the Blue Distinctions Centers for Transplants are payable at the PPO or Non-PPO Provider level for transplant services (described below). Cornea transplants are not provided by

the Blue Distinctions Centers for Transplants facilities, but the Plan will cover cornea transplants at the PPO or Non-PPO Provider level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor.

Compatibility testing for either living donor solid organ and/or stem cell transplant, when undertaken before procurement is covered if Medically Necessary. Costs related to the identification and search for a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Although you may have your transplant procedure performed at any facility you choose, the Plan encourages you to receive your transplant at a Blue Distinction Centers for Transplants facility by paying higher benefits. The Plan will, therefore, pay 90% of covered charges under this benefit after you meet your Plan deductible if you use a Blue Distinction Centers for Transplants facility. If you do not use a Blue Distinction Centers for Transplants facility, the Plan will pay 70% of covered charges after the Plan deductible is met. Covered expenses include those expenses directly related to the transplant procedure, organ procurement, follow-up treatment, anti-rejection drugs and travel, up to the per person maximum per transplant shown in the *Schedule of Benefits*.

Precertification

The Health and Welfare Fund also has a utilization review agreement with a Utilization Review company to certify elective hospital admissions, any stay at a facility for treatment of Mental and Nervous Disorders and Substance Abuse, or any stay at a Skilled Nursing Facility. An elective admission is one in which your condition permits adequate time to schedule the hospitalization or treatment facility stay. **YOU MUST CALL THE UTILIZATION REVIEW COMPANY LISTED IN THE *CONTACT INFORMATION* PAGE AT THE FRONT OF THIS BOOKLET TO PRECERTIFY YOUR HOSPITAL OR TREATMENT FACILITY STAY**.

Urgent hospital admissions and emergency hospital admissions are reviewed after your admission. **You or someone else must call the Utilization Review company, as listed in the *Contact Information*, within 48-hours of an urgent or emergency hospital admission on a weekday or within 72-hours of an urgent or emergency hospital admission on a weekend.** Although you are encouraged to call to precertify your maternity hospital admission, it is not mandatory that you call for maternity admissions. An urgent admission is one in which you require immediate attention for the care and treatment of your physical or mental condition. Generally, you are admitted to the first available and suitable accommodation. An emergency hospital admission is one in which the sudden onset of severe medical condition requires immediate hospital admission to prevent the patient from:

1. Putting their health in permanent jeopardy;
2. Incurring other serious medical consequences;
3. Having a serious impairment of bodily functions; or

4. Incurring serious permanent dysfunction of any bodily organ.

In addition to precertification for a hospital, mental and nervous disorder and/or substance abuse treatment facility or skilled nursing facility stay, you must obtain precertification for the following outpatient procedures:

1. Imaging through CAT, MRI, and PET scans (Precertification does not apply if these services are performed as part of an emergency room visit or during hospitalization);
2. Sleep studies;
3. Blepharoplasty;
4. Breast surgery, excluding biopsies, lesions and reconstructions related to breast malignancies;
5. Sclerotherapy and vein legation/stripping;
6. Septoplasty/Rhinoplasty; and
7. Rehabilitation therapy visits in excess of 8 visits per Injury or Illness.

If you do not obtain precertification for your hospitalization, stay at a facility for treatment of mental and nervous disorders and/or substance abuse, stay at a skilled nursing facility, or the outpatient procedures listed above, then you will be subject to the reduction in benefits as a penalty for non-compliance. The amount of the benefit reduction is listed in the Schedule of Benefits. The benefit reduction does not apply to: (i) charges for inpatient services and treatment at a PPO facility; or (ii) charges for outpatient surgery services at a PPO facility.

Care Management

Care Management is a service that helps people with short-term and long-term medical conditions. These conditions can be the result of a catastrophic event, a short-term medical need or the result of a chronic disease. The goals and benefits of Care Management services to you and your Dependents include the following:

1. Increased understanding of your condition and, sometimes, the challenges that might continue for a long time or a lifetime,
2. Collaboration and coordination with your health care providers (e.g., physicians, therapy centers, treatment and diagnostic centers, home care services and medical equipment providers),
3. Evaluation of care and service alternatives to ensure that you receive the right care at the right time and in the right place,
4. Assistance in setting, monitoring and achieving health improvement goals that match your specific condition and needs, and
5. Your empowerment through increased understanding and improved management of your medical condition and the factors influencing your improvement.

Care Management services include a broad range of programs, which may include the following:

1. Catastrophic Case Management – care management interventions in the event of catastrophic events – which may include a massive stroke, premature baby or spinal cord injury,
2. Short-term Case Management – care management interventions in the event that home care needs (e.g., IV antibiotic therapy, nurse visits) are necessary after discharge from the hospital,
3. High Dollar Case Management – care management interventions for persons with a high risk for failure who utilize high cost and/or high volume medical services, and
4. Transplant Care Management – care management interventions for persons at risk or in the process of (before and after) an organ or tissue transplant.

It is important for you to remember, that while Care Management programs offer the services described above, your physician is responsible for providing your medical care.

Referrals to these programs are provided by claims information and also from the utilization management or precertification process. You, your Dependent, or your physician can request Care Management services by calling the Utilization Review company at the toll free phone number listed on your identification card, or listed in the *Contact Information* section at the front of this booklet.

Available information from claims and other benefit plan programs will be reviewed to evaluate whether or not Care Management services are appropriate. You will be contacted regarding your desire to participate in a Care Management program and your provider(s) will also be contacted for your medical information. Your information will remain secure and confidential and will only be used for treatment, healthcare operations and payment purposes.

If deemed appropriate, a nurse care coordinator will contact you regarding program participation. The program will be explained and you will be asked if you want to participate. If you agree, a follow-up letter and consent for program participation will be sent to you. After an initial assessment, the nurse care coordinator will contact your providers to gather additional medical information to identify your needs and goals.

Covered Charges

Covered charges are the reasonable and customary (R&C) charges for the following medically necessary services and supplies received for the treatment of a non-occupational injury or sickness when ordered and prescribed by a physician and received while covered by the Plan.

1. Hospital services and supplies for:

    a. Room and board charges up to:

        i. The hospital's regular daily semi-private rate;

        ii. The hospital's charges for a private room, when required; or

        iii. The hospital's intensive care or coronary care rate, when required.

    b. Drugs, medicines and other hospital services for medical care and treatment exclusive of professional services, while hospitalized,

    c. Outpatient hospital charges including charges incurred for:

        i. Outpatient surgical procedures; and

        ii. Emergency treatment for an injury or sickness.

    This Plan complies with the Federal law that prohibits group health plans and health insurance issuers generally from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarian section. However, pursuant to Federal law, this Plan, generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, as provided by Federal law, this Plan will not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

2. Medical care and treatment (visits) made by a physician while the patient is confined in a hospital.

3. Charges for chemotherapy, radiation therapy and oncology drugs for treatment of cancer.

4. Charges for professional and facility fees for diagnostic tests made or recommended by a physician.

5. Charges made for professional fees for a surgical procedure. Hospital confinement is not required.

6. Charges incurred for a hospital confinement and surgical operation performed by a physician for the purpose of sterilization of the reproductive system.

7. Charges incurred for diagnosis, treatment and surgery, made by a physician for emergency medical care due to an injury.

8. All professional charges incurred within 48 hours of an injury are covered regardless of place of treatment.

9. Injuries to sound, natural teeth, except for injuries occurring as a result of biting or chewing.

10. As required by Federal law, this Plan provides medical and surgical benefits for mastectomies to pay for the following, when requested by the patient in consultation with her physician:

    a. Reconstruction of the breast on which the mastectomy has been performed;

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    c. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

11. Charges for artificial limbs, eyes and other prosthetic devices. The Plan will pay for replacement of prosthetic devices if it is Medically Necessary.

12. Charges made for allergy testing.

13. Charges for rental or purchase of durable medical equipment, whichever is economically justified, which is:

    a. Medically Necessary and prescribed by the attending Physician;

    b. for therapeutic use or specifically used for treatment of an injury or sickness;

    c. suitable for use in the home; and

    d. exclusively for the use of the individual being treated.

14. Charges for ambulance services are covered only when those services are for Emergency. Ambulance services include ground vehicle transportation to the nearest appropriate facility as medically necessary for treatment of a medical emergency, acute illness or inter-health care facility transfer to and from a local hospital. Air transportation is covered only if medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status. A licensed ambulance must be used and includes a vehicle, helicopter, airplane or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

15. Home health services by a home health agency under a home health care plan. The plan must have been established in lieu of hospital confinement, up to the maximums shown in the *Schedule of Benefits*.

16. Charges for child wellness care from birth to 19 years of age. Child wellness care includes:

    a. Physical examinations;

    b. Medical histories; and

    c. Immunizations and laboratory tests in keeping with prevailing medical standards.

17. Charges for one routine physical examination per adult, per calendar year, including:

    a. Complete physical examination;

    b. Complete medical history;

    c. Cholesterol screening; and

    d. Routine tests (such as pap smears, routine mammograms, and prostate tests) and routine immunizations associated with a routine annual physical.

    Any additional cholesterol screenings during the year will be subject to the deductible and copayment requirements. Routine physical charges will not include routine eye or dental examinations.

18. Hospice Care for a terminally ill patient whose life expectancy is six months or less, as determined by the patient's physician.

19. Charges for outpatient rehabilitation services performed by a qualified therapist for physical therapy, occupational therapy and speech therapy to restore or rehabilitate an established physical function that is lost or impaired, both inpatient and outpatient services, are covered, up to the calendar year maximum shown in the *Schedule of Benefits*. Visits exceeding eight per Injury or Illness must be precertified, as indicated in the *Schedule of Benefits*; if visits exceeding eight per Injury or Illness are not precertified, such benefits will be subject to the penalty for failure to precertify that is shown in the *Schedule of Benefits*. Rehabilitation services are subject to the following limitations:

    a. Services include short-term active, progressive rehabilitation services, and inpatient rehabilitation services in an acute Hospital, rehabilitation unit or facility, or Skilled Nursing Facility for short term, active, progressive rehabilitation services that cannot be provided in an outpatient or home setting.

    b. Rehabilitation service visits over 8 visits per Injury or Illness must be precertified.

    c. Rehabilitation services are covered only when ordered by a Physician and performed by a licensed or duly qualified therapist.

d. Physical therapy performed in conjunction with chiropractic care, including massage therapy, is subject to the Plan's limitations for chiropractic care as shown in *Schedule of Benefits*.

e. Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagic or swallowing defects and disorders.

20. Charges for chiropractic care, including massage therapy, up to the per visit maximum shown in the *Schedule of Benefits*. Your physician or chiropractor must submit a written prescription for massage therapy to the Fund Office.

21. Treatment of mental and nervous disorders.

22. Treatment for outpatient substance abuse.

23. Services and supplies recommended by the Care Management provider in conjunction with the attending physician as an alternative treatment plan to best meet the continuing care and treatment needs of participants with catastrophic or chronic conditions. Such services and supplies will be covered, even when the alternative treatment plan includes items that are not usually covered by the Plan. Such services and supplies may exceed the Plan's treatment maximums (number of visits, number of days of treatment or dollar maximums) if the Trustees approve the excess services or supplies.

24. Charges incurred for organ transplants that meet the guidelines of Medicare. Coverage includes charges directly related to the transplant procedure, organ procurement, follow-up treatment, and travel, up to the lifetime maximum for Organ Transplants shown in the *Schedule of Benefits*.

25. Charges for in vitro fertilization and fertility treatments, as noted below, payable at the percentage and up to the lifetime maximum shown in the *Schedule of Benefits*. Covered services include: diagnostic procedures; prescription drugs through the prescription drug program (presently provided by Sav-Rx); artificial insemination; conventional treatment of uterine anomalies, conventional treatment of male factors such as varicocele; medical cost of oocyte or invasive sperm retrieval and medical cost of egg or sperm donation. In addition, covered infertility treatment or various assistive reproductive procedures include but are not limited to embryo transfer; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); in vitro fertilization (IVF); low tubal ovum transfer; assisted hatching; intracytoplasmic sperm injection (ICSI); frozen tubal embryo transfer; donor egg and donor embryo transfer; zona dissection and subzonal insertion of sperm.

26. Charges for injectable contraceptives, such as Depo-Provera, and the administration of the injections by a Physician, nurse or clinician.

27. Charges incurred for specialty drugs that may be oral medications or injectable medications, including, but not limited to, drugs used for treatment of cancer, treatment of pain, and anti-rejection medications used after you receive an organ transplant. You may obtain up to a 30-day supply of specialty drugs. If you do not obtain the specialty

drugs in your treating Physician's office, you must obtain them from a Sav-Rx specialty pharmacy. Specialty drugs are not subject to the calendar year deductible, but are subject to your calendar year maximum medical benefit amount.

28. Bariatric surgery expenses are covered if all of the following conditions are satisfied, and will only be covered once during a Covered Person's lifetime:

    a. You have been continuously eligible for benefits from the Plan for a period of five years prior to the bariatric surgery.

    b. The Plan's medical consultant has approved the bariatric surgery as a medically appropriate treatment of your obesity.

    c. The Plan will cover follow-up medical treatment after an eligible bariatric surgery.

    d. Notwithstanding the language in item 4 under the *Charges Not Covered* subsection below, the Plan will not cover cosmetic or reconstructive surgery to remove excess skin following weight loss.

29. Cardiac/pulmonary rehabilitation expenses are covered if Medically Necessary, up to 30 sessions per Calendar Year. This rehabilitation benefit is separate and apart from the "Rehabilitation Therapy" listed in the *Schedule of Benefits*, which covers rehabilitation services for physical, occupational and speech therapy.

30. Charges made for cholesterol screenings in excess of the screening provided under the adult wellness benefit.

31. Charges incurred for a second opinion relating to an Illness or Injury for which a first opinion was eligible for coverage; provided, however

    a. the opinion must be provided by a physician who is independent of the physician who originally provided the service relating to the condition involved; and

    b. the physician providing the opinion must be board certified or eligible for certification in the field of medical specialization concerned with the condition involved.

32. Immunizations (such as a shingles vaccine) which can be obtained at a pharmacy instead of a doctor's office in accordance with applicable guidelines (which includes guidelines specified by the Centers for Disease Control and Prevention).

33. Charges for purchase of an oxygen concentrator (including related supplies and maintenance). Coverage of oxygen concentrators will include nonportable units and, if medically necessary, portable units. Coverage for the rental of an oxygen concentrator is limited to 30 days.

34. Charges for virtual non-emergency consultations with a Physician, licensed counselor, therapist or psychiatrist in a telemedicine program approved by the Trustees (MDLIVE or any successor telehealth program), and virtual visits with a Physician, licensed counselor, therapist or psychiatrist outside of the Trustees' approved telemedicine program. Virtual consultations through the Trustees' telehealth vendor are paid by the Plan at 100%, and virtual visits with a provider outside of the Trustees' approved telehealth program shall be paid under the Plan's normal plan of benefits that would be payable for an in-person visit with the provider.

35. Charges for colonoscopies performed according to medical guidelines for timing and frequency. If a colonoscopy is performed In-Network and according to medical guidelines for timing and frequency, then the Plan will cover 100% of charges, regardless of whether you have paid the annual deductible. If a colonoscopy is performed Out-of-Network and according to medical guidelines for timing and frequency, then the Plan will cover 60% of charges, subject to the annual deductible.

36. Gene therapy treatment prescribed by a physician. The gene therapy must be approved by the federal Food and Drug Administration for the use for which it is prescribed at the time the gene therapy treatment is provided. Coverage is provided for all phases of related gene therapy treatment including, but not limited to, genetic testing, treatments, procedures, services, supplies and medicines provided in connection with admission, the extraction of cells, the administration of the gene therapy treatment and follow-up care.

Charges Not Covered

Coverage is not provided for services, supplies or equipment for which a charge is not customarily made in the absence of medical coverage. No coverage is provided under this Major Medical Benefit for loss caused by or resulting from:

1. Injury or sickness arising out of or in the course of employment; or which is compensable under any Workers' Compensation or Occupational Disease Act or Law.

2. Declared or undeclared war or act of war.

3. Expenses that are not approved by a physician.

4. Cosmetic surgery, except for:

    a. Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or

    b. Reconstructive surgery because of a congenital disease or anomaly of the covered person or as required by the Women's Health and Cancer Rights Act.

5. Eye examination for the purpose of prescribing corrective lenses or for the fitting of glasses. Coverage for eye examinations is provided under the *Vision Care Expense Benefit* on page 41.

6. Glasses, hearing aids, or contact lenses except contact lenses when required because of surgery. Coverage for glasses or contact lenses are provided under the *Vision Care Expense Benefit* on page 41.

7. Charges made by a health care provider if the provider is related to the covered person or living with the person requiring treatment.

8. Confinement in a hospital or skilled nursing facility primarily for custodial care.

9. Services, supplies or treatment in a hospital, unless hospital confinement and the continuation of such confinement were recommended and approved by a physician.

10. Dental work or treatment, except as provided under the *Dental Care Expense Benefit* on page 43.

11. Eye refractions. Coverage for eye examinations is provided under the *Vision Care Expense Benefit* on page 41.

12. Induced abortion unless the abortion:

    a. Is, in the opinion of the physician, necessary to avert the death of the woman;

    b. Is performed to terminate a pregnancy caused by rape or incest; or

c. Involves complications resulting from a natural or spontaneous abortion.

The Plan covers complications resulting from abortion, however.

13. Sterilization reversal, or medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.

14. Charges for care and services related to genetic testing and counseling except as required by the Affordable Care Act and as provided at item 36 of Covered Charges on page 34 relating to gene therapy treatment prescribed by a physician.

15. Charges for prescription drugs or medicines other than those received during a period of hospital confinement, except that the Plan covers specialty drugs, as provided at item 27 of Covered Charges on page 32, and injectable contraceptives and their administration, as provided at item 26. The Prescription Drug Benefit provides coverage for outpatient prescription drugs, as described on page 38.

16. Transplant services not considered "approved" by Medicare.

17. All services not listed under Covered Charges.

18. Charges for an Injury or injuries received while engaged in the commission of a felony.

19. Medical care that is provided when a Dependent who has primary coverage under a Health Maintenance Organization (HMO) or similar organization fails to use the HMO or similar organization.

20. The following rehabilitation services are excluded from coverage:

    a. Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.

    b. Expenses for massage therapy (unless covered under the chiropractic benefit), rolfing, and related services.

    c. Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to coma stimulation programs and services.

    d. Expenses for maintenance rehabilitation. Maintenance rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation, so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may

reasonably be prescribed to maintain, support, and/or preserve the patient's functional level.

21. Physical, occupational or speech therapy to learn a physical function (habilitation services) are excluded from coverage, including expenses for educational, job training and special education.

22. Cologuard cancer screening test.

23. Lung cancer screening (traveling screening providers).

24. Insertion and removal of intrauterine devices (IUDs).

25. Breast pumps.

NOTE: THIS LIST IS NOT MEANT TO BE ALL-INCLUSIVE. ANY EXCLUSION/ LIMITATION STATED DOES NOT NECESSARILY INCLUDE ALL CHARGES THAT ARE EXCLUDED OR LIMITED. ONLY THOSE CHARGES LISTED AS COVERED CAN BE ASSUMED PAYABLE.

Prescription Drug Benefit (For ALL Eligible Participants)

The Prescription Drug Benefit is administered by a pharmacy benefit manager, as listed in the *Contact Information* section. Two programs are available under the Prescription Drug Benefit, the Retail Card Program, and the Mail Service Program. These benefits are subject to the copayments, supply limits, calendar year maximum and other cost limitations listed in the *Schedule of Benefits*.

Covered Drugs

Both parts of the program cover prescriptions for the following:

1. All Federal legend drugs (except those listed in the *Drugs Not Covered* section below).
2. Diabetic care: disposable blood/urine glucose/acetone testing agents, disposable needles/syringes, insulin and lancets.
3. Oral contraceptives and the contraceptive patch. No other forms of contraceptives are covered through the Prescription Drug Benefit; however, injectable contraceptives, such as Depo-Provera, and their administration, are provided under the Major Medical Expense Benefit, as described at item 26 on page 32.
4. Tretinoin topical (e.g. Retin-A) for individuals through the age of 25 years.
5. Compound medications of which at least one ingredient is a legend drug.
6. Any other drug that, under applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber.
7. FDA-approved smoking cessation medications prescribed by a Physician. A maximum of two 90-day courses of treatment will be covered each calendar year.

Drugs Not Covered

The following are excluded from coverage under this Prescription Drug Benefit, unless specifically listed under Covered Drugs above:

1. Anti-wrinkle agents.
2. Non-oral forms of contraceptives, except that the contraceptive patch is covered, and injectable contraceptives, such as Depo-Provera, are covered under the Major Medical Expense Benefit, as provided at item 26 on page 32.
3. Growth Hormones.
4. Hair growth stimulants.
5. Immunization agents, blood or blood plasma.
6. Levonorgestrel (Norplant).
7. Nystatin oral powder.
8. Therapeutic devices or appliances unless listed as a covered product.

9. Charges for the administration or injection of any drug.
10. Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
11. Anti-rejection medication, except as provided under the Major Medical Expense Benefit at item 27 on page 32.
12. Amphetamines or anorexiants for weights loss.
13. Over the counter drugs or items except as expressly covered herein.

The Retail Card Program

The Retail Card Program offers benefits for short-term prescriptions (e.g., 30 days or less). When you become eligible for benefits under the Prescription Drug Benefit, you will receive a prescription drug card. You and any of your Dependents who are covered by the Prescription Drug Benefit will be listed on the card.

You must obtain all prescriptions through a Network pharmacy. Participating pharmacies include, among others, all CVS and Walgreen locations nationwide. For a listing of Network pharmacies, visit the pharmacy benefit managers' website as indicated in the *Contact Information* page at the front of this booklet.

PRESCRIPTION DRUGS NOT OBTAINED THROUGH A NETWORK PHARMACY ARE NOT COVERED BY THE PLAN, UNLESS SPECIFICALLY INCLUDED.

Present your prescription drug card and your prescription to your pharmacist. The pharmacist will fill your prescription with a generic drug if a generic drug is available, unless your doctor specified that a generic drug may not be substituted. When you use a participating pharmacy, you pay only the generic drug copayment amount that is listed in your *Schedule of Benefits* per prescription or refill for up to a 30-day supply.

You will be responsible for paying the difference in cost between a brand name drug and a generic drug. However, *this does not apply to* a brand-name prescription if your doctor specifies "May Not Substitute," "Dispense as Written" or "DAW" on the prescription form or otherwise specifically indicates that the brand name drug must be used. In the case of this exception, you will pay only the generic drug copayment amount listed in your *Schedule of Benefits*.

If you request a brand name drug for your own personal reasons, you will have to pay the difference between the cost of the generic drug and the brand name drug.

You will receive the quantity prescribed by your physician, up to maximum of a 30-day supply. No forms, receipts, or submissions of claims are necessary. The pharmacist will submit the claim. You simply pay the necessary copayment when you fill your prescription. The

copayments and other costs for the medication are not reimbursable under the Major Medical Expense Benefit and do not count towards your out-of-pocket maximum explained on page 24.

The Mail Service Program

You may order through the mail up to a 90-day supply of any covered medication that your physician prescribes for you or your eligible Dependent. It is recommended that you use the Mail Service Program for maintenance medications. The Mail Service Program is more convenient and is the most cost-effective way to obtain your prescriptions. Maintenance medications are medications you or your Dependents take for long periods for such chronic conditions as high blood pressure, heart condition, diabetes, asthma and arthritis.

If your physician prescribes a long-term medication that you need right away, ask the physician to write two prescriptions: one prescription to be filled at a participating pharmacy using the Retail Card Program, and one prescription for the remainder of the medication, to be submitted to the Mail Service Program.

You will be responsible for paying a co-payment for each prescription or refill ordered through the Mail Service Program. You may send a check (or money order) or put the charges on your credit card. You must pay the cost difference between the generic equivalent and the charge of the brand name drug, if you choose a brand name drug for your own personal reasons. There is no delivery charge for standard postal delivery. If you want Next Business Day or 2nd Business Day Service, you will be asked to include the additional delivery charges with your Order. The copayment and other costs for the medication (including the delivery cost, if any) are not reimbursable under the Major Medical Expense Benefit and do not count towards your out-of-pocket maximum explained in the *Schedule of Benefits*.

Follow these steps to obtain prescriptions through the Mail Service Program:

1. Request a mail order form from the Fund Office.
2. Complete all required information on both sides of the order form that is attached to the mail order envelope.
3. Enclose the original prescriber (physician) signed prescription for a three-month supply of medication, plus refills.
4. Mail your completed order form to the address on the envelope:
5. For refills, you may:
    a. Call the number listed on your prescription drug card or on the *Contact Information* page at the front of this booklet, or
    b. Use the new order form and envelope that was included with your last order and have your prescription number, zip code and credit card information available, or
    c. Visit the pharmacy benefit managers' website, as listed on the *Contact Information* page at the front of this booklet, and have your prescription number, date of birth and credit card information available.

Vision Care Expense Benefit (For ALL Eligible Participants)

Under the Vision Care Expense Benefit, the Plan pays benefits for the actual cost of your eligible Vision Care Expenses up to the calendar year maximum of $400 per person. *(The calendar year maximum does not apply to individuals who are under age 18.)*

Covered Vision Care Charges

Covered Vision Care Charges include the following:

1. Complete vision examination, including dilation of pupil and/or relaxing of focusing muscles by drops, once per calendar year when performed by a legally qualified ophthalmologist or optometrist (*not subject to the calendar year maximum*); and
2. New or replacement prescribed lenses, including the fitting of contact lenses, and frames.

For individuals who are under the age of 18, the following limits apply:

a. Exam: Limited to one (1) vision exam per calendar year.

b. Frames: $200 per prescription (not to exceed one pair of frames per calendar year).

c. Lenses: $200 per prescription.

d. Contacts (in lieu of frames/lenses): $400 per prescription.

Exclusions from Vision Care Coverage

No coverage is provided under this *Vision Care Expense Benefit* for loss or expense caused by, incurred for, or resulting from:

1. Surgical or medical care for treatment of eye disease and/or injury.
2. Injury or sickness arising out of or in the course of employment or which is compensable under Workers' Compensation or Occupational Disease Act or Law.
3. Declared or undeclared war, or act of war.
4. Vision care services, screening services or supplies received from a medical department maintained by:
   a. A mutual benefit association
   b. Labor union
   c. Trustee
   d. Employer or
   e. A similar group.
5. Orthoptics, vision training or aniseikonia.
6. Expenses incurred for cosmetic or fashion reasons.

7. Non-corrective sunglasses, safety lenses or goggles.

Filing Vision Claims

Follow these steps to obtain reimbursement:

1. Have your eyes examined and/or obtain frames and/or lenses from the provider of your choice.
2. Pay the bill in full when the services are rendered or the supplies are received.
3. Obtain a claim form from the Fund Office.
4. Complete the form and sign in the space provided.
5. Send the completed form and your paid receipt and mail to the Dental/Vision Claims Administrator as listed in the *Contact Information* section.

For additional information about claims procedures, see page 53.

REIMBURSEMENT WILL BE MADE TO YOU BY THE PLAN.

Dental Care Expense Benefit (For ALL Eligible Participants)

The Plan imposes an annual limit on dental care. The limit applies as follows:

Adults.

Under the Dental Care Expense Benefit, if you are age 18 or older, the Plan pays benefits for the actual cost of your eligible Dental Care Expenses up to the calendar year maximum of $750 per person.

Children.

The following rules apply to individuals under age 18:

- Preventive Care. The Plan will pay 100% of the actual cost of two preventive dental examinations (including cleanings) per calendar year and one set of dental x-rays per calendar year. This 100% coverage does not include sealants or fluoride treatment. This preventive care benefit is not subject to the $750 annual limit on nonpreventive benefits.

- Nonpreventive Care. The Plan will pay benefits for the actual cost of eligible nonpreventive Dental Care Expenses provided; however, benefits will only be payable for nonpreventive care until the total amount paid for both preventive and nonpreventive dental care totals $750 during each calendar year.

- Orthodontia. The Plan will pay benefits for an entire course of orthodontic treatment not to exceed $500 per person.

Covered Dental Care Charges

The Dental Care Expense Benefit provides reimbursement for any non-cosmetic dental expenses, including orthodontia, up to the maximum listed in the Schedule of Benefits. Services must be performed by a dentist, oral surgeon, orthodontist, or oral hygienist, and must not be payable under the medical benefits program.

Exclusions from Dental Care Coverage

No coverage is provided under this *Dental Care Expense Benefit* for loss or expense caused by, incurred for, or resulting from:

1. Surgical or medical care for treatment of gum or mouth disease and/or injury.
2. Injury or sickness arising out of or in the course of employment or which is compensable under Workers' Compensation or Occupational Disease Act or Law.
3. Declared or undeclared war, or act of war.
4. Dental care services, screening services or supplies received from a medical department maintained by a mutual benefit association, labor union, Trustee, Employer, or a similar group.
5. Expenses incurred for cosmetic or fashion reasons.

Filing Dental Claims

Follow these steps to obtain reimbursement:

1. Receive dental services from the provider of your choice.
2. Pay the bill in full when the services are rendered or the supplies are received.
3. Obtain a claim form from the Fund Office.
4. Complete the form and sign in the space provided.
5. Send the completed form and your paid receipt and mail to the Dental/Vision Claims Administrator as listed in the *Contact Information* section.

For additional information about claims procedures, see page 53.

REIMBURSEMENT WILL BE MADE TO YOU BY THE PLAN.

Coordination Of Benefits

Under the Health & Welfare Plan, your benefits may be coordinated if another group plan or source is obligated to make benefit payments for you or your Dependents.

Another group plan or source refers to any plan providing benefits or services for or by reason of actual expenses which benefits or services are provided by:

1. Group and nongroup insurance, including health maintenance organization (HMO) contracts;
2. Group practice, group Blue Cross or group Blue Shield coverage individual practice offered on a group basis or other group prepayment coverage;
3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans;
4. Medicare;
5. Any coverage under governmental programs including Tricare (for members serving in the U.S. armed forces) or a program of the U.S. Department of Veterans Affairs, motor vehicle insurance including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, any coverage provided by a federal, state or local government or agency or any coverage required by statute;
6. Medical care components of long-term care contracts; or
7. Group insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution.

The term group insurance or group plan does not include coverage under Medicaid programs.

How Benefits are Paid

By coordinating benefits, the Plan ensures that you receive the maximum benefits, but that benefits are not paid for more than 100% of the actual charges incurred.

The primary plan pays benefits first when health care coverage is available from more than one group plan. Your primary plan determines benefits as if that plan was the only coverage available. Then the secondary plan pays according to their coordination of benefits rules. When secondary, this Plan pays the difference between your *allowable expenses* and what your primary plan(s) paid. In addition, when this Plan pays secondary, it will never pay more than the amount this Plan would have paid if this Plan was primary and paid benefits first. This Plan defines an allowable expense as any necessary, reasonable and customary item of expense for medical care or treatment, which is covered under at least one of the plans covering the eligible claimant. If a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

If (1) your Dependent spouse is employed 30 or more hours per week, (2) your Dependent spouse has employer-provided health coverage available at a cost of less than $150 per month for

single coverage, and (3) your Dependent spouse fails to elect that employer-provided health coverage, then this Plan will only pay the amount it would have paid if it were the secondary plan. For this purpose, this Plan assumes that the spouse's primary benefits are equal to the benefits payable under this Plan.

If you are covered or if your Dependent is covered by another group plan or source, in addition to the **Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund**, the order of benefit payment will be determined according to the guidelines outlined below.

Order of Benefit Payment

For coordination with other plans, the first of the following rules that apply to the person will determine the order of Benefit Payment.

1. A plan without coordination of benefits rules will always be primary and will pay benefits before this Plan.
2. If one plan covers the person as a dependent and the other plan covers the person "other than as a dependent," then the plan that covers the person as "other than a dependent" is primary and pays benefits before a plan that covers the person as a dependent.
3. For claims on behalf of dependent children whose parents are not divorced or separated, or whose parents are divorced or separated but who share custody and no court order determines who has financial responsibility for medical expenses, the plan that covers the parent whose birthday (month and day) falls first in the calendar year is primary and will pay benefits first. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary and pay benefits first. However, if your dependent child is covered as both a dependent spouse and as a dependent child, the plan that covers the claimant as a dependent spouse shall be primary, provided the other plan includes this rule.
4. For claims on behalf of dependent children whose parents are divorced or separated, the following rules apply:
    a. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility will be primary.

    b. If there is no court decree and the parent with physical custody has not remarried, the plan that covers the parent with custody will be primary.

    c. If there is no court decree and the parent with physical custody has remarried, the order of benefit coordination will be as follows:

        i. The plan, if any, of the parent with physical custody is primary and pays benefits first;

        ii. The plan, if any, of the step-parent with physical custody pays benefits second;

iii. The plan, if any, of the parent without physical custody pays benefits third; and

iv. The plan, if any, of the step-parent without physical custody pays benefits fourth.

d. The Plan shall pay secondary if:

i. A court decree requires the parent who is not the Employee to obtain and maintain health benefit coverage on behalf of the Dependent children;

ii. Such parent fails to maintain the court-required coverage; and

iii. The Plan would have paid secondary if such parent had maintained the required coverage.

iv. In this circumstance, the Plan shall pay no more than the amount that it would have paid on a secondary basis as if the other parent had obtained the required primary coverage and as if the other required primary coverage had benefits equivalent to the benefits of this Plan.

v. If the foregoing rules of subsections (d)(i) through (iv) do not determine priority, then the plan which covers the parent whose birthday (month and day) falls first in the Calendar Year shall pay first, and the plan of the parent whose birthday falls later in the year shall pay second. However, if both parents have the same birthday, the plan covering the parent for the longer period of time shall pay first.

e. If the specific terms of the court decree state that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses for the child, the order of benefit determination rules outlined in item 3, for dependent children whose parents are not divorced or separated, will determine which plan is primary and pays benefits first. However, if your dependent child is covered as both a dependent spouse and as a dependent child, the plan that covers the claimant as a dependent spouse shall be primary, provided the other plan includes this rule.

5. When a person is covered as both an employee and either a laid-off or retired employee, the plan that covers the employee as neither a laid-off, inactive former, nor retired employee is primary and pays benefit before a plan that covers that person as a laid-off, inactive former, or retired employee. The same rule applies if a person is covered as the dependent of an employee and the dependent of a laid-off or retired employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefit payment, this rule will be ignored.

6. Claims of a person whose coverage is provided under a "right of continuation" pursuant to Federal or State law and who is also covered under another plan, the following order of benefit determination will apply:

a. The plan covering the person as an employee is primary and pays benefits first.

b. The plan paying benefits under the continuation coverage pays after the primary plan. The same rules apply to dependents who are covered as dependents of an employee and as dependents of a person covered under the "right of continuation."

If the other plan does not have this rule and if, as a result the plans do not agree on the order of benefit payment, this rule will be ignored.

7. If none of the above rules apply, the plan that has covered the claimant for the longer period of time will be primary and pay benefits first.
8. If the rule noted in item 7 above does not apply, the plans will share the allowable expenses equally.

If the member is the spouse of another member of this Plan, benefits will be coordinated as if this Plan was two separate plans. Claims for children of two covered members will be coordinated as if this Plan was two separate plans. This Plan will pay up to 100% of Covered Charges for such members and their children, once the deductible has been satisfied.

If the other plan reduces benefits or excludes an otherwise eligible person from coverage due to the person's coverage under this Plan, then this Plan will not recognize such a provision and shall pay benefits as if such a provision did not exist.

Implementation Rules

In order to implement the *Coordination of Benefits* rules, the Trustees, without consent of any person, will have the following rights:

1. To release or obtain information considered necessary, subject to the privacy rules of the Health Insurance Portability and Accountability Act (HIPAA);
2. To authorize payment directly to another group plan or source that paid claims which should have been paid by this Plan; and
3. To recover payments in excess of the amount that should have been paid by this Plan.

If you are claiming benefits under this Plan, you must furnish to the Trustees such information as may be reasonably necessary to implement these coordination of benefits rules. **THE TRUSTEES ARE UNDER NO OBLIGATION TO FURNISH ANY BENEFITS UNDER THIS PLAN UNTIL SUCH INFORMATION HAS BEEN RECEIVED.**

Whenever payments have been made under any other plans that should have been paid by this Plan, the Trustees have the right, in their sole discretion, to pay the other Plan any amount determined to be warranted. Such payments will be deemed benefits paid under this Plan and the Plan will be fully discharged from liability for such charges.

Benefit Reserve

When this Plan is secondary, the Plan will establish a "benefit reserve" for each person for whom there is a balance over what this Plan pays and what this Plan would have paid if this Plan was

primary. The benefit reserve account is maintained individually for each covered person for the calendar year. Each January 1st, the benefit reserve account is erased and starts over. This benefit reserve account is used to pay "allowable charges" not paid by either plan (such as deductibles and co-payments).

Coordination of Benefits With Medicare

Generally, if you are an active employee age 65 or over and you are eligible for Medicare, the Plan has primary responsibility for your claims and the claims of your Dependents. If you are entitled for Medicare because of an end-stage renal disease (ESRD), this Plan has primary responsibility for your claims for the first 30 months and Medicare is secondary. After 30 months, Medicare has primary responsibility and this Plan is secondary. Medicare also has primary responsibility for your claims if you are an eligible employee who is disabled and entitled to Medicare because you have received Social Security Disability Income for 24 consecutive months.

You should note that if you are eligible for Medicare and you do not enroll in or apply for benefits under Medicare Parts A, B or D, or you have failed to take any action required by Medicare to qualify for benefits, the Plan will treat you as though you had enrolled, and will coordinate benefits as though you are enrolled in Medicare Parts A, B or D.

If either you or your spouse are eligible for Medicare, your prescription drug coverage under the Plan may or may not constitute creditable coverage, for purposes of Medicare Part D that governs Medicare prescription drug programs. Each year, you will receive a Notice of Creditable Coverage or Notice of Non-Creditable Coverage from the Plan that informs you whether your prescription drug coverage is creditable coverage. If coverage is creditable, you do not need to enroll in Medicare Part D until you are no longer eligible for coverage under the Plan. However, if coverage is not creditable, in order to avoid a penalty for late enrollment in Medicare Part D, you would need to enroll in Medicare Part D coverage as soon as you are eligible for it. You should read your annual notice carefully.

Subrogation or Reimbursement

Subrogation gives the Plan the right to recover all of the benefits it has paid to you, or to those who provided your medical treatment, from another payment source or from you if you have received the payment directly. The Plan has the right to recover those payments, whether or not you have been fully paid for your treatment or other expenses from the same Injury.

Throughout this section, the term "you" refers to you or a covered Dependent.

For instance, if you are in an automobile accident, you may receive payment for your medical treatment from an automobile insurance company or from the person who was at fault for the accident. If the Plan paid for your expenses that the automobile insurance company is responsible for, the Plan has the right to recover those expenses from the automobile insurance company or from you if they were paid to you.

Plan's Rights to Subrogation and Reimbursement. The Plan shall be entitled to subrogation or reimbursement with regard to all rights of recovery of an Eligible Person or representatives, guardians, beneficiaries, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trusts, and any other agents, persons or entities that may receive a benefit on behalf of the Eligible Person (collectively, for purposes of this section, "Individual"), to the extent of any amount which the Plan has paid or may become obligated to pay on account of any claim against any person, organization or other entity in connection with the Injury, Illness, Sickness, Accident or condition, including accidental death and dismemberment, to which the claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, medical payments coverage, financial responsibility, and any employer of the Individual under the provisions of a Worker's Compensation or Occupational Disease Law and an individual policy of insurance maintained by the Individual, including uninsured or underinsured insurance coverage. The Plan shall also be entitled, to the extent of payments made or to be made on account of the claim, to reimbursement from the proceeds of any settlement, judgment or payments from any Source that may result from the exercise of any rights of recovery by the Individual. Such subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether an Individual is made whole and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses, and regardless of whether liability is admitted to or contested by any Source. Once the Plan makes or is obligated to make payments on behalf of an Individual on account of the claim, the Plan is granted, and the Individual consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Individual from any Source.

Action Required of Individual. If requested in writing by the Trustees, the Individual shall take, through any representatives designated by the Trustees, such action as may be necessary or appropriate to recover payments made or to be made by the Plan from any Source and shall hold that portion of the total recovery from any Source which is due for payments made or to be made in trust for the benefit of the Plan to be paid to the Plan immediately upon recovery thereof. The

Individual shall not do anything to impair, release, discharge or prejudice the rights referred to in this section. The Individual shall assist and cooperate with representatives designated by the Plan to recover payments made by the Plan and shall do everything that may be necessary to enable the Plan to exercise its subrogation and reimbursement rights described herein.

The Trustees may require the Individual to complete and/or execute certain documentation to assist the Plan in the enforcement of its subrogation and reimbursement rights including, but not limited to, a questionnaire and a Subrogation and Reimbursement Agreement ("Agreement"), in a form provided by and acceptable to the Trustees as a condition to receiving benefits for a claim. If the Agreement is not executed by the Individual(s), at the Plan's request, or if the Agreement is modified in any way without the consent of the Plan, the Plan may suspend all benefit payments. However, in its sole discretion, if the Plan advances claims in the absence of an Agreement, or if the Plan advances claims in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights to reimbursement or subrogation. If the Individual is a minor or incompetent to execute the Agreement, that person's parent, the Individual (in the case of a minor dependent child), the Individual's spouse, or legal representative (in the case of an incompetent adult) must execute the Agreement upon request of the Plan. An Individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Plan. In this regard, the Individual agrees that out of any Source, as described in subsection (a) above, the identified amount that the Plan has advanced or is obligated to advance in benefits will be immediately deposited into a trust for the Plan's benefit and that the Plan shall have an equitable lien by agreement which shall be enforceable if necessary under legal, equitable and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Plan's subrogation and reimbursement rights shall apply regardless whether the Individual executes an Agreement.

Enforcement of Rights. The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests under this section through any appropriate legal or equitable remedy, including, but not limited to the initiation of a recognized cause of action under ERISA section 502(a)(3), including injunctive action to ensure the claim amounts that the Plan has advanced are preserved and not disbursed, or applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered from any Source, whether through settlement, judgment or otherwise. The Plan's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

The Plan's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Individual, as opposed to the general assets of the Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the Individual.

Further, in the event an Individual receives monies as the result of an Injury, Illness, Sickness, Accident or condition, and the Plan is entitled to such monies in accordance with this section and is not reimbursed the amount it has paid for such Injury, Illness, Sickness, Accident or condition, the Plan shall have the right to reduce future payments due to such Individual or the Employee of whom such Individual is a Dependent or any other Dependent of such Employee, by the amount

of benefits paid by the Plan. The right of offset shall not, however, limit the rights of the Plan to recover such monies in any other manner described in this section.

Individual's Attorney's Fees. The Plan's subrogation and reimbursement rights apply to any recovery by the Individual without regard to legal fees and expenses of the Individual. The Individual shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying Injury, Illness, Sickness, Accident or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses, unless the Trustees, in their sole discretion, have agreed in writing to discount the Plan's claim by an agreed upon amount of such fees or expenses.

Disavowal of Common Law Defenses. The Plan specifically disavows any claims that an Individual may make under any federal or state common law defense, including but not limited to, the common fund doctrine, the double-recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. Accordingly, the Plan's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery of the Individual from any Source without regard to legal fees and expenses of the Individual and the Individual will be solely responsible for paying all legal fees and expenses. The Plan shall have a priority, first-dollar security interest and a lien on any recovery received from any Source, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such Injury, Illness, Sickness, Accident or condition.

Filing Claims and Appeals

Definition of a Claim

A claim for benefits is any request for Fund benefits that you make in accordance with the Fund's claims procedures. In order to file a claim for benefits offered under this Fund, you must submit a completed claim form. If you make a simple inquiry about the Fund's provisions without a claim form that is unrelated to any specific benefit claim, the Fund will not treat your inquiry as a claim for benefits. If you or your provider inquire about your coverage under the Plan, that is not a claim. In addition, if you request precertification for a benefit that does not require precertification by the Fund, that will not be treated as a claim for benefits. If you use the services of a PPO network provider, the provider will generally file your claim for you.

When you present a prescription to a participating pharmacy to be filled under the terms of this Fund, that request is not 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 regarding the denial by using these procedures.

All claims under this Plan are post-service claims. A post-service claim is a request for benefits under the Plan for services that have already been provided. Examples of a post-service claim include a standard paper claim or electronic bill submitted for payment after services have been provided.

Although the Plan requires that you precertify your hospital stay, stay at a facility for treatment of mental and nervous disorders and/or substance abuse or stay at a skilled nursing facility, the precertification process is not a claim or pre-approval process, but a notice program only. If you do not precertify a hospital stay, stay at a facility for treatment of mental and nervous disorders and/or substance abuse or stay at a skilled nursing facility in accordance with the rules on page 26, benefits will still be provided by the Plan, but will be subject to a benefit reduction (a penalty) for not following the precertification process. The benefit reduction for failure to precertify services is listed in the *Schedule of Benefits*.

How to File a Claim

You or your Dependent must file a claim if you use the services of providers outside of the PPO network. You may obtain a claim form from the Fund Office by calling 1-309-786-3361. If you use the services of a PPO or other network provider, the provider will generally file your claims for you. In addition, you should contact the Fund Office about how to file a claim for the Life Insurance Benefit or Accidental Death and Dismemberment Insurance Benefits.

The following information must be completed by you and the provider in order for your request for medical benefits to be a claim and for the Fund Office to be able to decide your claim.

1. Employee's name;
2. Patient's name;
3. Patient's Date of Birth;

4. Social Security Number of employee or retiree;
5. Date of Service;
6. CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition,* as maintained and distributed by the American Medical Association);
7. ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services);
8. Billed charge;
9. Number of Units (for anesthesia and certain other claims);
10. Federal taxpayer identification number (TIN) of the provider;
11. Billing name and address; and
12. Itemized medical bills attached.

For additional information call 1-309-786-3361. The Plan will pay the reimbursement for covered charges directly to the provider of service unless the bill is clearly marked "Paid-in-Full" by the provider.

PPO PROVIDERS HANDLE ALL THE PAPERWORK FOR YOU. THE PROVIDER WILL BE PAID DIRECTLY AND YOU WILL BE BILLED THE CO-PAYMENT AND DEDUCTIBLE, IF APPLICABLE.

If benefits are not paid directly to the provider of service, unpaid benefits for outstanding hospital, nursing, medical or surgical claims are payable to you, if living. Otherwise, any outstanding claims will be payable to your estate.

When Claims Must Be Filed

You must file your Healthcare Claim for benefits as soon as possible following the date you incur the charges. You must submit your Weekly Sickness and Accident Disability Claims no later than 30 days after the start of the disability. You must submit medical, prescription, dental and vision claims no later than one year from the date you incurred the charges unless you can show good cause for filing a claim beyond the one-year deadline. The Board of Trustees will determine whether you have shown good cause. You must submit Life and Accidental Death and Dismemberment Claims within 90 days from date of death or dismemberment.

Where To File Claims

The Fund will consider your claim to have been filed as soon as it is received at the Fund Office.

PPO network hospital and physician claims will be filed for you. No claim form is necessary.

You should file your Vision, Dental, Weekly Sickness and Accident Disability, Accidental Death and Dismemberment, and Life Insurance claims at the following address:

Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund
2837 7th Avenue
Rock Island, Illinois 61201

Authorized Representative/Personal Representative

An authorized representative/personal representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the authorized or personal representative to act on your behalf and to receive your protected health information. You may obtain a form from the Fund Office to designate an authorized/personal representative. The Fund may request additional information to verify that this person is authorized to act on your behalf. The Fund reserves the right to withhold information from your representative if the Fund has suspicions about the qualifications of the individual claiming to be your authorized/personal representative.

Once you name an authorized/personal representative, the Fund will route all future correspondence related to claims and appeals to your authorized/personal representative and not to you, unless you specify otherwise in writing. The Fund will honor your authorized/personal representative designation until the designation is revoked in writing or as mandated by a court order. You may revoke an appointment of an authorized/personal representative by submitting a signed statement.

Benefit Payment to an Incompetent Person

Benefit payments under the Fund may become payable to a person who is adjudicated incompetent or to a person who, by reason of mental or physical disability, in the opinion of the Trustees, is unable to administer such payments properly. In that event, the Trustees may make payments for the benefit of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose or purposes for which paid if they are paid:

1. Directly to such person;
2. To the legally appointed guardian or conservator of such person;
3. To any spouse, child, parent, brother, or sister of such person for the welfare, support, and maintenance of that person; or
4. By the Trustees directly for the support, maintenance, and welfare of such person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Fund, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

Claim Rules for Comprehensive Major Medical, Vision, Dental and Prescription Drug Benefits (Healthcare Claims)

The following procedures apply to Healthcare Claims. You should:

1. Obtain a claim form (or a claim may be filed for you by a PPO or other network provider);
2. Complete your (the employee's) portion of the claim form;
3. Have your Physician either complete the provider's section of the claim form, submit a completed HCFA health insurance claim form, or submit a HIPAA-compliant electronic claims submission; and
4. Attach an itemized Hospital bill or doctor's statement that describes the services rendered.

To speed the processing of your claim, check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. If the claim forms have to be returned to you for information, delays in payment will result.

Ordinarily, the Fund will notify you of the decision on your Health Claim within 30 days from the Fund's receipt of the claim. The Fund may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the Fund will notify you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Fund has at the time and may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Fund will make a decision on the Health Claim and notify you of the determination within 15 days of the earlier of the date you responded to the request or the end of the 45 day period.

Weekly Sickness and Accident Disability Claims

The following procedures apply to Weekly Sickness and Accident Disability Claims and all other claims. You should:

1. Obtain a claim form from the Fund Office.

2. Complete your (the employee's) portion of the claim form.
3. Have your physician complete the provider's section of the claim form.
4. Submit the completed, signed and dated claim form to the Fund Office.

The Fund will make a decision on your Weekly Sickness and Accident Disability Claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond the control of the Fund, the Fund may extend the time for making a decision by 30 days. The Fund will notify you (within the 45-day period) of the reason for the delay and the time when the decision will be made. The Fund may delay the period for making a decision for an additional 30 days, provided the Fund Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Fund has at the time and may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information or at the expiration of the 45 days if you do not respond, the Fund will make its decision on the claim and notify you within 30 days.

Life Insurance and Accidental Death and Dismemberment Insurance Benefit Claims

The following procedures apply to Life Insurance and Accidental Death and Dismemberment Insurance Benefit claims. You should:

1. Obtain a claim form from the Fund Office.
2. Complete your (the employee's) portion of the claim form.
3. Have your physician complete the provider's section of the claim form.
4. Submit the completed, signed and dated claim form to the Fund Office.

Claims must be submitted to the Insurance Company within 90 days after the date of loss of life or dismemberment, so you should be sure to obtain the claim form from the Fund Office and submit it to the Fund Office within the 90-day period. If you have questions, you may call the Fund Office at 309-786-3361.

Once the Insurance Company receives your claim, they will make a decision on your Life Insurance or Accidental Death and Dismemberment Insurance Benefit Claim and notify you of the decision within 60 days. If the Insurance Company requires an extension of time due to matters beyond its control, the Insurance Company may extend the time for making a decision by 30 days. The Insurance Company will notify you (within the 60-day period) of the reason for the delay and the time when the decision will be made.

The Insurance Company has the right, at its own expense, to have you examined by the Physician of its choice, and to perform an autopsy, if it is not prohibited by law.

You may not take legal action with respect to a Life Insurance or Accidental Death and Dismemberment Insurance Claim until 60 days after you submit your proof of claim, or more than three years after the time that you were required to submit your proof of claim.

Notice of Denial of Claim

The Trustees shall provide you with a notice of their initial determination about your claim within certain timeframes after they receive your claim.

If your Healthcare Claim is denied, the notice shall provide:

1. Information sufficient to identify the claim involved, including date of service; provider; claim amount; and a statement that you may request, free of charge, any diagnosis, treatment, and denial codes and their respective meanings;
2. The specific reason or reason(s) for the decision;
3. A specific reference to the pertinent provisions of the Plan upon which the decision is based;
4. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
5. A copy of the Fund's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following review of your claim;
6. If an internal rule, guideline, protocol or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol or similar criteria or a statement that a copy is available to you at no cost upon request; and
7. If your claim was denied on the basis of medical necessity, experimental treatment or similar exclusion, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on your claim or a statement that it is available to you at no cost upon request.
8. For Eligible Denied Healthcare Claims, the notice shall also indicate that you can request an external review with an independent review organization after the Fund's claims and appeals procedures have been exhausted.

If your Weekly Sickness and Accident Disability Claim is denied, the notice shall provide:

1. The specific reason or reason(s) for the decision, including a discussion of the decision and the basis for disagreement with or not following:
    a. The views of a health care professional who treated or evaluated the claimant;
    b. A medical or vocational expert whose advice was solicited by the Plan in connection with the decision; and

c. A disability determination made by the Social Security Administration;

2. A specific reference to the pertinent provisions of the Plan upon which the decision is based;

3. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;

4. A copy of the Fund's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following review of your claim;

5. A statement that you have the right to receive, upon request and free of charge, reasonable access to, or copies of, all documents, records or other information relevant to your claim;

6. A copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that no such rule, guideline, protocol or similar criteria was considered in the decision; and

7. If the decision was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement that you are entitled to receive, free of charge upon request, an explanation of the scientific or clinical judgment for the decision that applies Plan terms to the medical circumstances of your claim.

Your Right to Request a Review of a Denied Claim

You have the right to a full and fair review if your claim for benefits is denied by the Fund. You must file your appeal in writing. You must file your written appeal of a Healthcare Claim or Weekly Sickness and Accident Disability Claim with the Fund Office within 180 days after you receive the initial denial notice. You must file a request for an appeal of the denial of a Life Insurance Benefit or Accidental Death and Dismemberment Insurance Benefit Claim within 60 days after you receive notice of the denial.

Your application for appeal must be in writing and it must include the specific reasons as to why denial was improper. You may submit any additional comments or documents you feel appropriate, as well as submitting your written statement. In the course of review of your appeal for a Healthcare Claim or Weekly Sickness and Accident Disability Claim, you will receive copies of any new or additional evidence considered, relied upon, or generated during the appeal, as well as any new or additional rationale for the denial, if any. Any new or additional evidence or rationale will be provided as soon as possible and sufficiently in advance of the final decision to give you a reasonable opportunity to respond.

Review Process

The review process works as follows:

1. You have the right to review documents relevant to your claim. A document, record or other information is relevant if:

a. It was relied upon by the Fund in making the decision;

b. It was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon);

c. It demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or

d. It constitutes a statement of Plan policy regarding the denied treatment or service.

2. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard to whether their advice was relied upon in deciding your claim.
3. A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial decision. The decision will be made on the basis of the record, including such additional documents and comments that you may submit.
4. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal

Ordinarily, decisions on appeals of Healthcare Claims, Weekly Sickness and Accident Disability Claims, and Life Insurance and Accidental Death and Dismemberment Insurance Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. The Fund will advise you in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the meeting at which the decision has been reached.

Notice of Decision on Review

The Fund will provide you with a written decision upon review of your claim.

If your appeal of a Healthcare Claim is denied, the notice of denial will contain:

1. Information sufficient to identify the claim involved, for example, the date of service, health care provider, claim amount (if applicable);
2. A statement that you may receive, upon request and free of charge, the diagnosis code and/or the treatment code, and their corresponding meanings;

3. The specific reason(s) for the decision as well as any Plan standards used in denying the claim;
4. A reference to the specific plan provision(s) on which the decision is based;
5. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
6. A statement of your right to bring a civil action under ERISA Section 502(a);
7. If an internal rule, guideline or protocol was relied upon by the Fund, either a copy of the rule or a statement that it is available upon request at no charge;
8. If the determination was based on medical necessity or because the treatment was experimental or investigational or other similar exclusion, the Fund will provide you with an explanation of the scientific or clinical judgment for the decision applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
9. A statement that you have a right to receive, upon request and free of charge, reasonable access to, or copies of, all documents, records, or other information relevant to your claim.
10. For Eligible Denied Healthcare Claims, the notice of denial will also indicate that you can request an external review with an independent review organization after the Fund's claims and appeals procedures have been exhausted.

If your appeal of a Weekly Sickness and Accident Disability Claim is denied, the notice of denial will contain:

1. The specific reason(s) for the decision;
2. Reference to the Plan provision(s) on which the decision was based;
3. A statement that you have a right to receive, upon request and free of charge, reasonable access to, or copies of, all documents, records, or other information relevant to your claim.
4. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    a. The views of a health care professional or vocational professional who treated or evaluated the claimant;
    b. A medical or vocational expert whose advice was solicited by the Plan in connection with the claim; and
    c. A disability determination made by the Social Security Administration;
5. Copies of any internal rule, guideline, protocol or similar criteria relied on by the Fund, or a statement that no such rule, guideline, protocol or similar criteria was considered;
6. If the decision was based on medical necessity, experimental treatment, or similar exclusion or limitation, a statement that you may receive, free of charge upon request, an

explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances; and

7. A statement of your right to bring a civil action under ERISA Section 502(a).

External Review of Eligible Denied Healthcare Claims

The Plan offers you the right to request an external review of certain claims in accordance with, and to the extent required by, available guidance issued by the Department of Health and Human Services, Department of Labor, and the Internal Revenue Service. External review is only available for Healthcare claims for which the Fund is required to offer external review pursuant to 26 Code of Federal Regulations Part 54.9815-2719T ("Eligible Denied Healthcare Claim"). Examples of Eligible Denied Healthcare Claims include claims which implicate the protections offered under the No Surprises Act and its implementing regulations, including adverse benefit determinations involving items and services furnished by a Non-PPO provider for Emergency Services or non-Emergency Services. All other welfare benefit claims are never eligible for external review.

If you want to have the Eligible Denied Healthcare Claim reviewed, you must send a written request for an external review of the claim denial to the Plan no later than four months after the date you receive the notice of denial on review.

Within five business days following receipt of the external review request, the Plan will determine whether:

1. You are or were covered under the Plan at the time the Eligible Denied Health Claim was requested, or in the case of a retrospective review, if you were covered under the Plan at the time the Eligible Denied Healthcare Claim was provided.

2. The adverse benefit determination or final adverse benefit determination involves an Eligible Denied Healthcare Claim.

3. You have exhausted the Plan's internal claims and appeals procedures, unless you are not required to do so under the appeals rules.

4. You have provided all the information and forms required to process an internal review.

The Plan will notify you in writing within one business day after completing its preliminary review if your request is eligible for external review. If applicable, the notice will inform you that the request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (EBSA) (toll-free number 866-444-EBSA (3272)). If your request is not complete, the notice will describe the missing information and materials needed to make the request complete. You will have until the expiration of the four-month filing period or 48 hours, whichever date is later, to correct the request.

If the Plan determines that your request is eligible for external review, your appeal will be assigned to an Independent Review Organization ("IRO"). 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 adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and reverse the Plan's adverse benefit determination. Within one business day after making such decision, the IRO will notify you and the Plan.

Once the request is submitted to an IRO, the following procedures will apply:

1. If additional information is needed, the IRO will notify you in writing of how you may submit additional information regarding your claim. You will then have 10 business days to following receipt of such notice to submit the information.
2. If you submit additional information related to the claim, the IRO will, within one business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination that is the subject of the external review. If upon reconsideration the Plan reverses its adverse benefit determination, it will provide written notice of its decision to you within one business day after making that decision.
3. The IRO will review all information and documents received in a timely manner. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following information, including:

    a. your medical records;

    b. the attending health care professional's recommendations;

    c. any other information from you or the Plan;

    d. reports from other appropriate health care professionals;

    e. appropriate practice guidelines; or

    f. the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewers.

4. In reaching a decision, the IRO will review the claim as if it is new and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. After receiving the request for review, the IRO will provide written notice of its final external review decision to you and the Plan within 45 days. The notice will contain:

    a. 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; the diagnosis and treatment codes and their corresponding meanings (if applicable); and the reason for the previous denial.

b. The date the IRO received the assignment to conduct the external review and the date of the IRO decision.

c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision.

d. A discussion of the principal reason(s) for its decision, including the rationale for the decision and any evidence-based standards that were relied upon in making its decision; including a statement that the determination is binding except to the extent that other remedies may be available under applicable state or federal law; a statement that judicial review may be available to you; and current contact information, including phone number, for the health insurance consumer assistance or ombudsman established under law to assist with the external review process.

The IRO's decision is binding on the you and the Plan, except to the extent that other remedies are available under state or federal law. If the IRO approves your appeal, the Plan will provide benefits without delay and regardless of whether the Plan intends to seek a judicial review of the external review decision and unless or until there is a judicial review otherwise.

Exhaustion of Plan Remedies

You must exhaust all of the claims and appeals procedures of the Plan before you bring any action in court or administrative action for benefits. After you have exhausted all of the procedures in this section and if you are dissatisfied with the written decision of the Board of Trustees on review, you may institute legal action, including actions or proceedings before administrative agencies. No lawsuit or other action against the Plan or its Trustees may be filed after one (1) year from the date the participant or beneficiary has been given written notice of the Trustees' decision on their appeal.

When Benefits Are Paid

The Plan will pay benefits for a Weekly Sickness and Accident Disability Claim no later than the end of each two-week period. The Plan will pay all other benefits within 15 days after the Plan receives acceptable proof of your claim.

Payment of Claims

The Plan may pay all or a portion of any benefits provided for health care services to the provider, unless directed otherwise in writing by the time you file your claim. The Plan does not require that the services be rendered by a particular provider.

Benefits accrued on your behalf or on behalf of your Dependent upon death will be paid, at the Plan's option, to the first surviving class of the following:

1. Your spouse;

2. Your Dependent children, including legally adopted children;
3. Your parents;
4. Your brothers and sisters;
5. Your estate.

The Plan will rely upon an affidavit to determine benefit payments, unless it receives written notice of a valid claim before the Plan makes payment. The affidavit will release the Plan from further liability.

Any payment made by the Plan in good faith will fully discharge the Plan, to the extent of such payment.

Definition Of Plan Terms

The following terms that are used in this Summary Plan Description and in any supplements or revisions are defined in this section for your convenience.

Accident or Injury

The term **accident** means an injury, such as a cut, break, sprain or bruise, caused by a sudden unexpected, undesirable and unavoidable act. The term **accident** does not include strained or aching arms and/or legs resulting from the overuse of muscles.

Allowable Expense

The term **allowable expense** means any necessary Reasonable and Customary Charges incurred by an Eligible Person during a Calendar Year and while Eligible under this Plan for Medical Care or treatment, part or all of which would be covered under at least one of the "plans." However, this Plan will only pay expenses required by a managed care or a Health Maintenance Organization (HMO) plan as described:

1. If a covered Dependent has primary coverage under a managed care or a HMO plan, this Plan will only consider out-of-pocket expenses required by that plan as Allowable Expenses.
2. If a covered Dependent has primary coverage under a managed care or HMO plan and the covered Dependent does not follow the rules for obtaining care outside the managed care or HMO plan, the expenses incurred will not be considered Allowable Expenses under this Plan.
3. If an Employee is covered as a Dependent under a managed care or a HMO plan and incurs Expenses while utilizing the HMO, this Plan will only consider out-of-pocket expenses required by the plan as Allowable Expenses.

Board of Trustees and/or Trustees

The terms **Trustees** and/or **Board of Trustees** mean those individuals, collectively, who are designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement for the **Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund**. The **Trustees**, collectively, are the "administrator" of this Plan as that term is used in the Employee Retirement Income Security Act of 1974 and as the "administrator," "Plan Sponsor" and the "Named Fiduciaries" of the Employee Benefit Plan established and maintained under the Trust Agreement.

Continuing Care Patient

The term **Continuing Care Patient** means an individual who, with respect to a provider or facility:

1. Is undergoing a course of treatment for a serious and complex condition from the provider or facility, with "serious and complex condition" meaning (1) in the case of an

acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time;

2. Is undergoing a course of institutional or Inpatient care from the provider or facility;

3. Is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

5. Was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

Continuing Care Services

The term **Continuing Care Services** means:

In the case of an Eligible Person and with respect to a provider or facility that has a contractual relationship with the Plan for furnishing items and services under the Plan (including a PPO Provider or PPO facility), if, while such Eligible Person is a Continuing Care Patient with respect to such provider or facility: (1) such contractual relationship is terminated; (2) benefits provided under the Plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility; or (3) a contract between the Plan and a health insurance issuer offering health insurance coverage in connection with the Plan is terminated, resulting in a loss of benefits provided under the Plan with respect to such provider or facility; the Plan will meet the following requirements with respect to such Eligible Person:

a. Notify each Eligible Person who is a Continuing Care Patient with respect to such a provider or facility of the termination and the individual's right to elect continued transitional care from such provider or facility;

b. Provide the Eligible Person with an opportunity to notify the Plan of the Eligible Person's need for transitional care; and

c. Permit the Eligible Person to elect to continue to have benefits provided under the Plan, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under the Plan had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a Continuing Care Patient during the period beginning on the date on which the Plan's notice of the termination is provided and ending on the earlier of the 90-day period beginning on such date or the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.

Contributing Employer

The term **contributing employer** means:

1. An employer who is a member of, or is represented in collective bargaining by, the Association and who is bound by the Collective Bargaining Agreement with the Union to make payments to the Trust Fund with respect to employees represented by the Union;
2. An employer who is not a member of, nor represented in collective bargaining by the Association, but who is bound by a Collective Bargaining Agreement with the Union to make payments to the Trust Fund with respect to employees represented by the Union;
3. The Union, for the purpose of making the required contributions into the Trust Fund for the employees of the Union;
4. An employer who is required to make payments or contributions to the Trust Fund by any law or ordinance applicable to the State of Illinois or to any political subdivision or municipal corporation thereof, or because of any written agreement entered into by an employer with such State or political subdivision or municipal corporation thereof.
5. An employer that enters into a participation agreement with the Trustees requiring contributions to be made to the Trust Fund on behalf of its employees.

Dependent

The term **Dependent** means any one of the following individuals:

1. The Employee's spouse;
2. The Employee's child (as defined herein) who is under 26 years of age;
3. The Employee's unmarried child who has attained age 26 and who is permanently and totally disabled, which means that the child is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more who:

   a. Is incapable of self-sustaining employment because of such disability; and

   b. Is dependent on the Employee for more than one-half of his or her support during the calendar year; and

   c. Has his or her principal place of residence with the Employee during more than one-half of the calendar year.

   Coverage will be continued, provided the disability began before the child reached age 26. Proof of the Dependent child's incapability must be submitted to this Welfare Fund no later than 60 days after the child reaches the age at which the coverage would otherwise terminate. Proof of the continued existence of such incapability may be requested from time to time upon request.

4. For children who [a] are age 26 or older and disabled or [b] for whom the Employee has been appointed permanent legal guardian by the court, if the child does not have his or

her principal place of residence with the Employee, the child will be a Dependent child, provided the child meets the other (non-residence-related) requirements of section (3) above, or section (6) below, as applicable and satisfies either of the following conditions:

a. In the divorce/separation context:

   i. The child's parents are: 1) divorced or legally separated under a decree of divorce or separate maintenance; 2) separated under a written separation agreement; or 3) live apart at all times during the last six months of the calendar year;

   ii. The child's parents provide over one-half of the child's support; and

   iii. The child is in the custody of one or both of his or her parents for more than one-half of the calendar year; or

b. The Employee provides over half the child's support and the child is not a "qualifying child" (within the meaning of Internal Revenue Code section 152) of any other person.

5. Dependents will become Eligible on the same date as the Employee or on the date they meet the definition of Eligibility.
6. Child includes natural-born children, stepchildren, legally adopted children and children placed in the Employee's home for adoption. In addition, child includes children for whom the Employee has been appointed permanent legal guardian by the courts may be included as Dependent children, provided the Employee provides more than 50% of their financial support during the calendar year and the children were reported to the Fund Office with the required proof prior to submitting a claim. Children for whom the Employee has legal guardianship must:

   a. Have a principal place of residence with the Employee and be a member of the Employee's household for the entire calendar year; and

   b. Not be claimed as any other person's Dependent child during the calendar year.

7. This Plan also considers children who are named as alternative recipients in a Qualified Medical Child Support Order (QMCSO) as Dependents under this Plan.
8. If both parents are Eligible as Employees under this Plan, each will be considered the Dependent of the other. In this case, any Dependent children will be considered Dependents of both parents. Benefits will be coordinated as described in the *Coordination of Benefits* section contained in this Booklet.
9. A spouse will not be eligible as a Dependent during any period that the spouse is in the military, naval or air force of any country, except as required under USERRA.

Durable Medical Equipment

The term **durable medical equipment** means equipment that:

1. Can withstand repeated use; and
2. Is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and
3. Is not disposable.

Emergency

The term **emergency** means the sudden unexpected onset of a medical condition manifesting itself by acute symptoms, including severe pain, which symptoms are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

1. The patient's life or health would be placed in serious jeopardy.
2. There would be a serious dysfunction or impairment of a bodily organ or part.
3. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Service

The term **Emergency Service** means:

1. A medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

3. Subject to the exception described in subsection 4. below, if an Eligible Person is furnished the services in subsections 1. or 2. above with respect to an emergency medical condition, the term Emergency Services will also include items and services that the Plan would cover if furnished by a PPO Provider, which are furnished by a Non-PPO Provider (regardless of the department of the Hospital in which such items and services are furnished) after the Eligible Person is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services described in subsections 1. and 2. above are furnished (for purposes of this definition, these items and services are "Post-Stabilization Services").

4. Post-Stabilization Services will not be considered Emergency Services if all of the following conditions are met:

a. The attending emergency Physician or treating provider determines the Eligible Person is able to travel using nonmedical transportation or nonemergency medical transportation to an available PPO Provider or PPO facility located within a reasonable travel distance, taking into account the individual's medical condition;

b. The Non-PPO Provider or Non-PPO facility furnishing such additional items and services satisfies the notice and consent criteria of Public Health Service Act section 2799B–2(d) and its implementing regulations with respect to such items and services;

c. The Eligible Person (or a person authorized by law to provide consent on behalf of the Eligible Person) is in a condition to receive the information described in such notice and to provide informed consent; and

d. The Non-PPO Provider satisfies any additional requirements or prohibitions imposed under state law.

Employee and/or Member

The terms **employee** and/or **member** means a person on whose behalf contributions are required to be made to the Fund by a contributing employer.

Employer

The term **employer** means a contributing employer who is required to make contributions to the Plan on your behalf under the terms of a collective bargaining agreement or a participation agreement.

Experimental or Investigative Treatments and Procedures

Services, procedures, drugs, devices or treatment modalities for a specific diagnosis are considered **experimental or investigative treatments and procedures** if:

1. The drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The drug, device, medical treatment or procedure, or the patient's informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility "institutional review board" or other body serving a similar function, or if Federal law requires such review or approval; or
3. *Reliable evidence* shows that the drug, device, medical treatment or procedure:
   a. Is the subject of ongoing phase I or phase II clinical trials;
   b. The research, experimental study or investigational arm of on-going phase III clinical trials; or

c. Otherwise under study to determine its maximum tolerated dose, its efficacy, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. *Reliable evidence* shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only:

1. Published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility; or
3. Protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

The Trustees have the authority to determine whether a service, procedure, drug, device or treatment modality is experimental or investigative. The fact that a physician has prescribed, ordered, recommended or approved the service, procedure, drug, device or treatment does not, in itself, make it eligible for payment.

Hospital

The term **hospital** means a lawfully operating institution that meets all of the following requirements:

1. Holds a license as a **hospital** (if required in the state);
2. Operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
3. Provides around the clock nursing service;
4. Has a staff of one or more physicians available at all times;
5. Provides organized facilities for diagnosis and surgery (mental hospitals do not need to have these facilities);
6. Is not primarily a clinic, nursing, rest or convalescent home or a skilled nursing facility or a similar establishment; and
7. Is not, other than incidentally, a place for treatment of drug addiction or substance abuse.

The nursing service must be by registered or graduate nurses on duty or call. The surgical facilities may be either at the **hospital** or at a facility with which it has a formal arrangement. Confinement in a special unit of a **hospital** used primarily as a nursing, rest or convalescent home or skilled nursing facility will not be deemed to be a confinement in a **hospital**.

Hospital also includes a licensed birthing center or licensed ambulatory surgical center. Ambulatory surgical centers must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures. The type of procedures performed must permit discharge from the center in the same "working day." The center will not qualify as a **hospital** if:

1. Its primary purpose is performing abortions;
2. It is maintained as an office by a physician for the practice of medicine; or
3. It is maintained as an office for the practice of dentistry.

Home Health Care Agency

The term **home health care agency** means:

1. A service or agency which holds a valid certificate of approval, or license, as a public **home health care agency**;
2. A hospital holding a valid operating certificate authorizing it to provide home health care services; or
3. An establishment approved as a **home health care agency** under Medicare.

Home Health Care Plan

The term **home health care plan** means a program for care and treatment of a sick or injured patient in his home by a home health care agency. The program must be established by the patient's attending physician. The physician must approve the program in writing prior to the start of home health care services. The physician must also certify that confinement in a hospital or skilled nursing facility would be required if home care is not provided.

Independent Freestanding Emergency Department

The term **Independent Freestanding Emergency Department** or "**IFED**" means a health care facility that provides Emergency Services and is geographically separate and distinct from a Hospital, and is separately licensed as such by a state, even if the facility is not licensed under the term "independent freestanding emergency department."

Inpatient

The term **inpatient** means a person who, while confined in a hospital or skilled nursing care facility, is assigned a bed in any department of a hospital or skilled nursing care facility other than in its out-patient department and for whom a charge for room and board is made by hospital or skilled nursing care facility.

Intensive Care Unit

The term **intensive care unit** means a section within a hospital that is operated exclusively for critically ill patients. It must provide special supplies, equipment and constant observation and care by registered nurses or other highly trained hospital personnel. It does not include any

hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Medically Necessary

The term **medically necessary** means a service or supply that the Trustees and/or an independent review panel believe meet the following criteria:

1. Is appropriate and consistent with the diagnosis and treatment of the person's injury or sickness as recognized by community standards; and
2. Could not have been omitted without adversely affecting the person's condition or the quality of medical care.

Medicare

The term **Medicare** means the Hospital and Supplementary Medicare Insurance Plans established by Title XVIII of the Social Security Act of 1965, as then constituted or as later amended.

Mental and Nervous Disorder

A mental and nervous disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Misidentified Provider Services

The term **Misidentified Provider Services** means items or services furnished to an Eligible Person by a Non-PPO Provider or a Non-PPO facility, if such item or service would be covered under the Plan if furnished by a PPO Provider or PPO facility and if the Eligible Person received through the PPO Provider directory or a written response from the Plan information with respect to such item and service to be furnished indicating that the provider was a PPO Provider or the facility was a PPO facility for furnishing such item or service.

Outpatient

The term **outpatient** means hospital services and treatments incurred by a person who is not an inpatient and/or is not charged room and board.

Participant

The term **Participant** means an Employee, Spouse, Dependent child and other person who is eligible for benefits under this Plan.

Physician

The term **physician** means a licensed practitioner of the healing arts acting within the scope of his/her license. The physician may not be an employee or a member of the employee's

immediate family. The term immediate family means the spouse, children, brothers, sisters or parents of a member.

The term **Physician** includes a duly certified nurse midwife with respect to treatment, service or care rendered by such nurse midwife within the lawful scope of practice of a duly certified nurse midwife.

Plan and/or Welfare Plan

The terms **Plan** and/or **Welfare Plan** mean the Plan document as adopted by the Trustees and as amended by the Trustees for the administration of the Trust Fund and Plan. This Plan was established on August 1, 1965 in accordance with the Agreement and Declaration of Trust.

Protected Services

The term **Protected Services** means:

1. Emergency Services furnished by a Non-PPO Provider;

2. Air ambulance services furnished by a Non-PPO Provider, if the Plan provides or covers any benefits for air ambulance services; or

3. Items and services (other than Emergency Services) furnished by a Non-PPO Provider with respect to a visit at a PPO hospital (as defined in section 1861(e) of the Social Security Act), hospital outpatient department, critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act), or ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act) if such items and services would be covered by the Plan if furnished by a PPO Provider. For the purposes of this definition, in addition to items and services furnished by a Non-PPO Provider at the facility, a "visit" includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the Non-PPO Provider furnishing such items or services is physically at the facility. However, the term "Protected Services" will not include these items and services if the Non-PPO Provider satisfies the notice and consent criteria of Public Health Service Act section 2799B–2(d) and its implementing regulations with respect to such items and services, and the Eligible Person consents to receive the items or services from the Non-PPO Provider.

Amounts charged by Non-PPO Providers for Protected Services are subject to the negotiation and dispute resolution process provided for in the No Surprises Act and its implementing regulations.

Reasonable and Customary (R&C) Charge

The term **reasonable and customary charge** means (1) for Non-PPO Providers furnishing services other than Protected Services or Continuing Care Services, the charge for the service or supply that is no higher than the usual amount charged in the locality where the charge is incurred for similar services or supplies, or (2) for PPO Providers, the fee for such service or

supply as negotiated with the PPO. In determining a reasonable and customary charge for Non-PPO Providers furnishing services other than Protected Services or Continuing Care Services, the Fund also considers the complexity of the service. For Non-PPO Providers, the Plan may decline to pay flat rate charges when procedures, fees and/or time involved are not itemized. With respect to a Non-PPO provider furnishing Protected Services, Reasonable and Customary Charge means the amount that the Plan uses to determine the Eligible Person's cost sharing and the amount the Plan pays in total. With respect to a Non-PPO Provider furnishing Continuing Care Services, Reasonable and Customary Charge means the fee that would have been required pursuant to the agreement between the Plan's PPO network and the Plan had the agreement continued to apply.

Sickness or Illness

The term **sickness** means illnesses, pain or fever not caused by an accident. This term also includes pregnancy and childbirth. Illnesses or sicknesses resulting from and consequences of intentional acts, such as overdose of drugs, are excluded, unless due to an underlying physical or mental health condition. Also excluded are voluntary, elective medical or surgical procedures other than elective sterilization.

Skilled Nursing Care Facility

The term **skilled nursing care facility** means a lawfully operated institution for the care and treatment of persons convalescing from a sickness or injury that provides room and board and 24-hour nursing service by registered licensed nurses and is under the full-time supervision of a legally qualified physician or surgeon or a registered nurse (RN).

Supplies

The term **supplies** includes items that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. Only those **supplies** listed as Covered Charges are paid under this Plan.

Union

The term **union** includes employees represented by the Laborers International Union of North America, Union No. 309, AFL-CIO or Operative Plasterers and Cement Masons Local 18, Area 544.

Welfare Fund and/or Fund and/or Trust Fund

The terms **Welfare Fund** and/or **Fund** and/or **Trust Fund**, mean the **Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund**, as it may from time to time be constituted, including, but not limited to, policies of benefit coverage, investments and income from any and all investments, employer contributions and any and all other assets, property or money received by or held by the Trustees for the uses and purposes of this Fund.

Administrative Information About The Plan

Plan Name

The name of the Plan is the Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund.

Board Of Trustees

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of employer representatives and union representatives. Union representatives are selected by the employees and the union, which have entered into collective bargaining agreements relating to this Plan. These collective bargaining agreements are described below. If you wish to contact the Board of Trustees, you may use the address and the telephone number below:

BOARD OF TRUSTEES
Northern Illinois and Iowa Laborers' Health
and Welfare Trust Fund
2837 7th Avenue
Rock Island, Illinois 61201

Union Trustees

Mr. Brad Long
Laborers' Local 309
2835 7th Avenue
Rock Island, IL 61201

Mr. David Adams
Quad Cities Foundation for Fair Contracting
420 34th Avenue
Rock Island, IL 61201

Mr. Tim Foster
Laborers' Local 309
2835 7th Avenue
Rock Island, IL 61201

Employer Trustees

Mr. P.J. Foley
AGC of the Quad Cities
520 24th Street
Rock Island, IL 61201

Mr. Mike Howard
General Contractors, Inc.
480 42nd Street
Bettendorf, IA 52722

Mr. Clint Hoeger
Estes Construction Company
131 West 2nd Street, Suite 400
Davenport, IA 52801

Plan Sponsor and Administrator

The Board of Trustees is the Plan sponsor and Plan Administrator. The Plan Administrator has broad discretion to determine eligibility for benefits, interpret Plan language and amend or terminate the Plan. The Plan Administrator's decisions will receive judicial deference to the extent they are not arbitrary and capricious, and do not constitute an abuse of discretion.

Claims Administrator

Zenith American Solutions, 5200 West Loomis Road, Greendale, WI 53129, pursuant to a contract with the Board of Trustees.

Plan Identification Numbers

The EIN number assigned to this Fund by the Internal Revenue Service is 36-6157689. The Plan number assigned to the Plan by the Internal Revenue Service is 501.

Agent for Service of Legal Process

Service of Legal Process may be made on the Board of Trustees or any individual Trustee at the Fund Office address listed above.

Source of Contributions

The benefits described in this Welfare Fund booklet are provided solely through employer contributions or self-contributions for COBRA continuation coverage. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements and the amount of monies necessary to provide the coverage required by the Plan.

Collective Bargaining Agreement

The Plan is maintained in accordance with a collective bargaining agreement between the participating Laborers' and Cement Masons' Unions and the Association. Other agreements may be in effect from time to time. The agreements specify the contributions required.

The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Fund on behalf of participants working under a collective bargaining agreement or with a list of such employers.

Trust Fund

The Trust Fund consists of all assets that are accumulated under the provisions of the collective bargaining agreement and the Trust Agreement and held for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. All of the benefits in this Plan are provided on a self-funded basis except for life insurance and accidental death and dismemberment benefits. The Plan's assets are managed by a professional asset manager selected by the Board of Trustees.

Plan Year

The fiscal records of the Plan are kept separately for each Plan Year. The Plan Year begins on January 1st and ends on December 31st. Benefits are determined on a calendar year basis.

Type Of Plan

This Plan is maintained for the purpose of providing Life Insurance, Accidental Death and Dismemberment Insurance, short-term disability, and medical benefits (including prescription drugs, vision care, and dental care), in the event of death, sickness or accident. The Plan benefits are shown in the *Schedule of Benefits* on pages 1 through 6 of this booklet. All benefits provided by the Plan are self-insured, except the life insurance and accidental death and dismemberment benefit which is insured by Symetra Life Insurance Company, 777 - 108th Avenue NE, Suite 1200, Bellevue, WA 98004-5135, telephone 800-796-3872.

Physical Examination and Autopsy

The Trustees have the right and opportunity, at the Fund's expense, to have a physician they designate examine you or your Dependent whose injury or sickness is the basis of a claim for Plan benefits, as often as they may reasonably require during the pendency of a claim. The Trustees also have the right to request an autopsy in case of death where it is not forbidden by law.

Gender

Except as the context may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders.

Amendment and Termination

The Trustees expressly reserve the right, in their sole discretion, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time. You will be notified in writing of any changes to the Plan.

In the event of a termination, any and all assets remaining after the payment of all obligations and expenses will be used, in accordance with a plan for dissolution adopted by the Trustees, to continue the benefits provided by the Plan until such assets have been exhausted or in such manner as will best serve the purposes of the Fund. In no event will assets be paid to or be recoverable by any contributing employer, association, or labor organization.

Recovery of Overpayments

If this Plan has improperly paid a claim (e.g. in the wrong amount or to the wrong provider), then the Plan Administrator has the right to: (i) recover the excess payments from any person to whom or for whom the payments were made or from any organization or plan which in fact owes the benefits or (ii) to offset payments due or which may become due in the future to a participant or any of his Dependents under this Plan to the extent of the overpayment for that individual or any family members.

Assignments of Rights or Benefits

Neither you nor your Dependents have the right to anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any interest in benefits under the Plan. In addition, neither you

nor your Dependents have the right to anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any right available by virtue of Plan coverage. Any such action will be void for all purposes of the Plan.

The Plan may pay benefits directly to an institution or to a provider. The Plan's direct payment does not validate any attempted assignment or other prohibited action. The Plan may also pay benefit claims directly to a Participant regardless of any purported assignment, other prohibited action, or directive.

Privacy Policy

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

Effective Date of Notice
September 23, 2013

The Northern Illinois and Iowa Laborers' Health and Welfare Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

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

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

Section 1.
Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

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

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

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

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

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

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

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

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

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

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

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

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

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

(1) For treatment, payment and health care operations.

(2) Enrollment information can be provided to the Trustees.

(3) Summary health information can be provided to the Trustees for the purposes designated above.

(4) When required by law.

(5) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

(6) When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(7) The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints

against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(8) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

(9) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(10) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(11) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

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

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2
Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

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

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

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

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

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

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

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

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

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

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

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

Right to Receive an Accounting of PHI Disclosures

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

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

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice.

Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

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

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

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

Section 3
The Plan's Duties

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

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary

to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

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

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

De-Identified Information

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

Summary Health Information

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

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4
Your Right to File a Complaint With the Plan or the HHS Secretary

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

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

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

Section 5
Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at: Laborers' Local 309, 2837 7th Avenue, Rock Island, Illinois 61201.

Conclusion

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

Statement of ERISA Rights

Benefits are paid in accordance with Plan provisions out of a Trust Fund that is used solely for that purpose. If you have any questions or problems regarding benefit payments, you have had the right to get answers from the Trustees who administer the Plan. The same basic rights are now incorporated in the Employee Retirement Income Security Act (ERISA), adopted by Congress in 1974, and as amended, for all benefit plans.

As a participant in Northern Illinois and Iowa Laborers' Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information About Your Plan And Benefits

You have the right to:

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include 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

You also have the right to:

- 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.

- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:

  - You lose coverage under the Plan;

  - You become entitled to elect COBRA continuation coverage; or

- Your COBRA continuation coverage ceases.

  You must request the certificate of creditable coverage before losing coverage or within 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the 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 Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. For single copies of publications, contact the Employee Benefits Security Administration Brochure Request Line at 866-444-3272 (EBSA) or contact the EBSA field office nearest you.

You may also find answers to your Plan questions at the website of the EBSA at http://www.dol.gov/ebsa/.

Nothing in this Summary Plan Description is meant to interpret or extend or change in any way the provisions expressed in the Plan Document or insurance policies. If there is a conflict between the wording of this Summary Plan Description and the Plan Document, the Plan Document will govern.

The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever, in their judgment, conditions so warrant and in accordance with the terms of the Plan Document and Trust Agreement. You do not earn any vested right to health benefits under the Plan. You will be notified in writing of any Plan changes.

Subject to the stated purposes of the Fund and the provisions of the Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They have full power to construe the provisions of this Summary Plan Description, the terms used in this booklet and the bylaws and regulations issued under this booklet and the Plan Document. Any determination or construction adopted by the Trustees in good faith is binding upon all Plan participants and beneficiaries. Such decisions and determinations will not be subject to the grievance or arbitration procedure established in any collective bargaining agreement between the Association and the Union. However, this provision does not affect the rights and liabilities of any of the parties under any of such collective bargaining agreements.

If is the intent of the drafters of this Summary Plan Description that the Trustees possess the discretion to determine eligibility for benefits and to construe the terms of the Trust and/or Plan governing benefits. It is also the intent of the drafters of the Trust and Summary Plan Description, by adopting the discretionary power specified above, that the decisions of the Trustees as to the granting or denial of benefits and the construing of terms of the Trust and benefit plan, are reviewed pursuant to an "arbitrary and capricious" standard by a reviewing court, as enunciated by the United States Supreme Court in Firestone Tire and Rubber Company et al. V. Richard Bruch, 57 L W 4194 (Feb 21, 1989). This means that the decisions of the Trustees will be given deference if they are challenged in an administrative or court proceeding, unless the decisions are found to be arbitrary or capricious.