PLAN DOCUMENT AND

SUMMARY PLAN DESCRIPTION

FOR

CONSTRUCTION INDUSTRY WELFARE FUND OF ROCKFORD, ILLINOIS

EMPLOYEE GROUP HEALTH BENEFIT PLAN

Restated

April 1, 2018

TABLE OF CONTENTS

INTRODUCTION

This document is the Plan Document and Summary Plan Description of the **Construction Industry Welfare Fund of Rockford, Illinois Employee Group Health Benefit Plan** the ("Plan"). No oral interpretations or representations can change this Plan. The Plan described in this booklet is designed to protect Covered Persons against certain catastrophic health expenses. This booklet contains a summary in English of your rights and benefits under this health care plan. If you have difficulty understanding any part of this booklet, contact the Plan Administrator identified in the General Plan Information section of this booklet.

Nota: *Este libro contiene un sumario en Ingles de sus derechos y beneficios bajo este Plan de salud. Si usted tiene algun problema o no entiende caulquier parte de los beneficios por su lenguaje, o por cualquier razon, por favor de comunicarse con el Administrador del Plan identificado atras de este libro.*

This booklet is intended to help you understand your Plan benefits, which are current as of April 1, 2018. This edition, which includes all Plan changes adopted since the previous edition, replaces and supersedes any previous Plan Document and Summary Plan Description booklet.

Coverage under the Plan will take effect for you and your designated Dependents when you and your Dependents satisfy all of the eligibility requirements of the Plan.

The Construction Industry Welfare Fund of Rockford, Illinois intends to maintain this Plan indefinitely; however, the Trustees of the Fund have the right, at any time to amend, suspend or terminate the Plan in whole or in part, in their sole discretion. This includes amending, suspending or terminating the benefits under the Plan or the Trust agreement (if any).

Changes in the Plan may occur in any or all parts of the Plan, including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like. Failure to follow the eligibility or enrollment requirements of the Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, failure to establish Medical Necessity, failure to timely file a claim or lack of coverage. These provisions are explained in summary fashion in this Plan Document / Summary Plan Description; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses Incurred while this coverage is in force. No benefits are payable for expenses Incurred before coverage began or after coverage terminated, even if the expenses were Incurred as a result of an accident, Injury or disease that occurred, began or existed while coverage was in force.

The Plan Administrator has discretionary authority to interpret and administer the Plan as it may determine in its sole discretion. The Plan Administrator also has discretionary authority to make factual and all other determinations as to whether any individual is entitled to receive any benefits under the Plan.

If the Plan is terminated or amended or benefits are eliminated, your rights as a Covered Person are limited to Covered Charges you Incur before termination, amendment or elimination.

This Plan Document summarizes your rights and benefits and is divided into the following parts:

Eligibility, Funding, Effective Date, and Termination – Explains eligibility for coverage under the Plan, funding of the Plan and when coverage takes effect and terminates.

Schedule of Benefits – Provides an outline of the Plan's reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions – Explains when the benefit applies and the types of charges covered.

Cost Management Services* – Explains the methods used to curb unnecessary and excessive charges.

* *You should read this part carefully since you and your covered Dependents are required to take action to assure that the maximum levels under the Plan are paid.*

Defined Terms – Defines those Plan terms that have a specific meaning.

Plan Exclusions – Shows what charges are not covered.

Claim Provisions – Explains the rules for filing claims and the claim appeal processes.

Coordination of Benefits – Shows the Plan payment order when you or your covered dependents are covered under more than one plan.

Subrogation, Third Party Recovery and Reimbursement – Explains the Plan's rights to recover payment of charges when you or your covered dependents have a claim against another person because of Injuries sustained.

COBRA Continuation Options – Explains when your coverage under the Plan ceases and the continuation options that are available.

ERISA Information – Explains your rights under the Plan.

ELIGIBILITY, EFFECTIVE DATE, TERMINATION AND SPECIAL PROVISIONS

Eligible Classes

ELIGIBLE CLASSES: Covered Employees (Class A), Covered Early Retirees (Class B), Covered Retirees (Class C), Dependents of covered Employees (Class A), Dependents of covered early retirees, Dependents of covered retirees, special Dependents of all classes and other Covered Qualified Beneficiaries.

Spousal Carve Out Provision

This Plan includes a Spousal Carve-Out provision that will affect how benefits are paid for your working spouse (if applicable).

A working spouse of a Covered Employee or Covered Retiree who is eligible to participate in a group health insurance plan sponsored by the spouse's employer, for which the spouse's employer pays 50% or more of the cost of insurance for such employee, MUST secure such coverage under the plan of such working spouse's employer.

If the working spouse fails to secure coverage under the plan of the working spouse's employer, the spouse will not be eligible for benefits under this Plan

When coordinating benefits under this provision, this Plan will not pay more than it would have paid if it had been the primary coverage.

Bargaining Unit Employees

1. **Enrollment:**

   Employees who have met the criteria for eligibility will be enrolled in the Plan.

2. **To Obtain Initial Eligibility:**

   All bargaining unit Employees are eligible to participate in the Plan when:

   A. They have performed work for an Employer who has a collective bargaining agreement with a participating union; and

   B. Contributions are made on their behalf by a contributing Employer; and

   C. They have accumulated a minimum of 350 Hours within a two (2) to three (3) consecutive calendar month period, or they have accumulated a minimum of 500 Hours within a six (6) consecutive calendar month period of work for a contributing Employer.

3. **Effective date of coverage:**

A. Initial Coverage

Once a person becomes eligible for coverage, he or she will be covered by this Plan on the first day of the third month following the last month in which the Employee satisfied the initial eligibility requirements. Once the person becomes covered, he or she will be covered for three consecutive months, which is referred to as a rolling quarter.

The following are examples of when a person becomes eligible for coverage:

Example #1: The Member began working in May and worked the following hours:

Work Month	Work Hours	Effective Date of Coverage
May	175	
June	175	September 1

In this example, the Member worked 350 Hours in a two consecutive month period. The Member would be eligible for benefits on September 1, which is the first day of the third month following the last month (June) in which he satisfied the initial eligibility rule.

Example #2: The Member began working in May and worked the following hours:

Work Month	Work Hours	Effective Date of Coverage
May	120	
June	120	
July	120	October 1

The Member worked 350 Hours in a three consecutive month period. The Member would be eligible for benefits on October 1, which is the first day of the third month following the last month (July) in which he satisfied the initial eligibility rule.

Example #3: The Member began working in May and worked the following hours:

Work Month	Work Hours	Effective Date of Coverage
May	80	
June	80	
July	120	
August	120	
September	75	
October	75	January 1

The Member did not work 350 Hours in a three consecutive month period. The Member did work 500 Hours in a six consecutive month period. The Member would be eligible for benefits on January 1, which is the first day of the third month following the last month (October) in which he satisfied the initial eligibility rule.

B. Continuing Eligibility

Once a bargaining unit Member becomes eligible for coverage, the bargaining unit Member may secure continuing eligibility for coverage for each succeeding three-month period by:

i. Working and having contributions made on his or her behalf for 300 Hours in each succeeding three-month period which is treated as a rolling quarter.

ii. Working and having contributions made on his or her behalf for 1200 Hours within his or her four (4) previous qualifying periods ("the 1200 Hour look back rule") if sufficient Hours have not been reported and paid under (i) above.

iii. Self-payment - If a Member does not satisfy (i.) or (ii.) above, the Member may be offered the ability to make a full or a partial self-payment to maintain coverage. Self-payments will not exceed three consecutive full or partial self-payments. The following rules apply to self-payments:

a. The full or partial self-payment must be received by the Fund prior to the loss of eligibility. The payment is for a three (3) month period of eligibility at the contribution rate set by the Trustees at their discretion.

b. A Member may continue to make full or partial self-payments for up to three consecutive three-month periods. If a Member fails to make a timely quarterly "self-payment" the Member will lose coverage.

c. When an Employer makes contributions to the Fund for a prior work period after the Member has made a full or partial self-payment, the Member will receive credit for the Hours reported and paid by the Member's Employer and the Fund will refund the appropriate amount of the self-payment made by the Member. If the Employer's retroactive contributions satisfy the full quarterly requirements so that no self-payment would have been required, the Member is reinstated and the self-pay time limit is reset. If, however, the Employer's retroactive contributions do not satisfy the full quarterly requirements but only serve to reduce the amount needed for a partial self-payment, the self-pay timer is not reset.

d. The Member must waive COBRA continuation coverage in order to make self-payments.

C. Loss of Continuing Eligibility:

A person loses continuing eligibility when:

i. Insufficient contributions are received on behalf of the Member from a contributing Employer and the Member is not eligible for coverage under the 1200 hour look back provision; and

ii. The Member fails to make the required full or partial self-payment within the specified time.

4. **Termination of Coverage for Active Participants (Class A):**

A bargaining unit Employee will cease to be covered under the Plan on the earliest of the following events (subject to the person's run off of benefits):

A. On the day the Employee enters the Armed Forces of any country on a full-time basis, subject to any rights to continue coverage for a limited period of time in accordance with federal law (this is subject to the rights of Dependents to continue coverage);

B. On the date the Plan terminates;

C. On the date the person dies;

D. On the first day of any Eligibility Period for which any required Contribution is not timely made to maintain coverage;

E. After exhausting any rights to continuation of coverage; or

F. On the date of the withdrawal of the Employee's local union or Employer from participation in the Fund.

5. **Reinstatement of Eligibility:**

A bargaining unit Employee's eligibility will be reinstated if the bargaining unit Employee works and has contributions made on his or her behalf for 300 Hours in any three (3) consecutive month period following termination of coverage. Such reinstatement must occur within two (2) years of the date on which coverage terminated. If reinstated, coverage under the Plan will begin on the first day of the third month following the last month in which the required Hours and contributions are attained.

Eligible Dependents – of Active Participants (Class A)

1. **Enrollment**

A covered Member who has Dependents he wants to enroll in the Plan must complete an application supplied by the Fund and may be required to provide documentation proving that his or her Dependents meet the requirements for Dependent coverage established by the Fund. This must be done even if the Member has the Dependent coverage for other Dependents.

2 **Eligibility**

Each Dependent of an active covered Member who meets the definition of covered Dependent is eligible for coverage under the Plan.

3. **Coverage**

An eligible Dependent will become covered by this Plan on the same date the active eligible Member is covered.

A newborn child or newly adopted child or newly married spouse is covered on the first date the child was born, was adopted, or was married, as applicable.

4. **Termination of Coverage for Dependents of Active Participants (Class A)**

A covered Dependent's coverage will terminate on the earliest of the following:

A. On the date this Plan is terminated;

B. On the date the Covered Employee's coverage terminates for any reason;

C. On the date the Covered Dependent ceases to be a Dependent, as defined by the Plan;

D. Upon the Covered Employee's death, at the end of the coverage period;

E. On the date the Covered Dependent dies;

F. On the date that the Plan is amended to exclude coverage for the category of Dependents into which the Dependent falls;

G. At the end of the Eligibility Period for which any required Contribution is not timely made; or

H. On the date of the withdrawal of the Covered Employee's local union or Employer from participation in the Fund.

Eligible Early Retirees (Class B)

1. **Enrollment**

Employees who have met the criteria to be an Early Retiree will be enrolled in the Plan after they submit a signed application for Enrollment on a form approved by the Fund. The Applicant for early retirement must complete the necessary forms prior to any lapse or loss of coverage to enroll in the Plan or the Employee will not be eligible to enroll in the Plan as an Early Retiree.

2. **Eligibility**

An individual may participate in the Plan as a Class B Early Retiree if he or she meets all of the following requirements:

A. Except as provided below, he or she is a bargaining unit Employee;

B. He or she is between the ages of 62 and 65. For purposes of this rule, individuals are eligible for Class B coverage on the first day of the month in which they attain age 62, and coverage continues until the last day of the month immediately preceding the month in which they attain age 65;

C. He or she has a total of fifteen (15) or more years of eligibility in this Fund as a bargaining unit Employee. For purposes of this rule, years of eligibility are determined by the Trustees or their delegate;

D. He or she has maintained eligibility in this Fund during at least thirty-six (36) of the last sixty (60) calendar months immediately preceding his or her application for Class B eligibility. For purposes of this rule, (i) an Employee who continues his or her eligibility through self-payments or COBRA coverage is considered to have maintained eligibility in this Fund, and (ii) the periods of eligibility in this Fund are as determined by the Trustees or their delegate;

E. He or she waives COBRA continuation coverage;

F. Non-Bargaining Unit Employees may not become Class B Members except in the case of an individual who has fifteen (15) or more years of eligibility in this Fund as a

bargaining unit Employee before becoming a non-bargaining unit Employee. For purposes of this rule, years of eligibility in the Fund as a bargaining unit Employee are determined by the Trustees or their delegate.

An individual who becomes a Class B early retiree may have certain costs subsidized based upon his or her years of eligibility in the Fund as a bargaining unit Employee, as determined above, with this Fund, at a rate determined solely by the Trustees.

Years of Eligibility as a Bargaining Unit Employee	**Subsidy**
30+	Greater Subsidy
20-29	Partial Subsidy
15-19	Full Cost

The Trustees at their discretion may modify the rates charged Class B retirees or they may modify or eliminate this subsidy at any time.

3. **Continuous Eligibility Requirement/Enrollment of Early Retirees**

A Class B Early Retiree who fails to maintain continuous eligibility under the Plan as a Class B Member may not re-enroll for Class B Early Retiree coverage. A Dependent of a Class B Early Retiree who fails to maintain continuous eligibility under the Plan as a Dependent of a Class B Member may not re-enroll for Class B Early Retiree Dependent coverage.

4. **Special Rule Regarding Class B Early Retiree Becoming a Class C Retiree**

A Class B Member can become a Class C Member when they are 65 years of age provided they meet all the requirements for Class C membership. They do not, however, accrue any additional years of service while they are in Class B with regard to the various years of service requirements in Class C.

5. **Special Rule Regarding Class B: Employer Contributions & No Return to Class A**

Any Employer contributions received on behalf of a Class B Member will be retained by the Fund for purposes of offsetting benefit and administrative expenses. Employer contributions will not be credited to Class B Members, except to the extent that the Trustees may elect to allocate funds to a Health Reimbursement card held by the Class B Member. If a Class B Member re-establishes eligibility as a Class A Member, he or she will be returned to Class A status and may not return to Class B.

6. **Termination of Coverage for Early Retirees**

A Class B Early Retiree will cease to be eligible under the Plan (subject to any rights to continue coverage for a limited time under this Plan under federal law and subject to the person's run off of benefits) on the earliest of the following events:

A. On the date the Plan terminates;

B. On the date the person dies;

C. On the date the Early Retiree no longer meets the definition of an Early Retiree under this Plan Document;

D. On the first day of any Eligibility Period for which any required Contribution is not timely made to maintain coverage;

E. On the last day of the month immediately preceding the month in which the Early Retiree turns 65; or

F. On the date of the withdrawal of the Retiree's local union or Employer from participation in the Fund.

Eligible Dependents – Of Early Retirees (Class B)

1. **Enrollment**

A person who is in the process of becoming an early retiree and who seeks to enroll his or her Dependents, must submit a new signed application for enrollment on a form supplied by the Fund (even if the Dependents were previously covered as Dependents when the person was an active Member). The Dependent must also satisfy the requirements for Dependent coverage and the Fund may also require the early retiree to provide documentation proving that his or her Dependents meet the requirements for Dependent coverage established by the Fund. Prior to enrollment of the Dependent, the Member must pay the contributions required by the Fund for an Early Retiree at the rate set by the Trustees, which is based on the Member's length of prior coverage in the Fund.

An early retiree who already has Dependent coverage for his or her Dependents but who acquires any additional Dependent or Dependents must enroll each new Dependent before that Dependent will become covered.

2 **Eligibility**

Each Dependent of an early retiree who meets the definition of covered Dependent is eligible for coverage under the Plan.

3. **Coverage**

An eligible Dependent who was previously enrolled when the early retiree was an active covered Member and has had the necessary application and documentation supplied to the Fund, as set forth above, will be covered by this Plan on the same date the Member is covered as an early retiree.

Any eligible Dependent of an early retiree who has been enrolled during a special enrollment period will be covered by the Plan on the day of the event, subject to the proper contributions being paid.

A newborn Child or newly adopted Child or newly married spouse who is properly enrolled in what is treated as a special enrollment period is covered on the first date the Child was born, was adopted, or was married, as applicable.

4. **Termination of Coverage for Dependents of Early Retirees (Class B)**

A Covered Dependent's coverage will terminate on the earliest of the following:

A. On the date this Plan is terminated;

B. On the date the Early retiree's coverage terminates for any reason;

C. On the date the covered Dependent ceases to be a Dependent, as defined by the Plan;

D. On the date the Dependent dies;

E. Upon the retiree's death, at the end of the coverage period;

F. On the date that the Plan is amended to exclude coverage for the category of Dependents in which Dependent falls;

G. On the first day of any Eligibility Period for which any required Contribution is not timely made to maintain coverage for the Early Retiree; or

H. On the date of the withdrawal of the Retiree's local union or Employer from participation in the Fund.

Eligible Retirees - Class C

1. **Enrollment**

Employees who have met the criteria to be a Class C Retiree will be enrolled in the Plan after they submit a signed application for Enrollment on a form approved by the Fund. The Applicant for retirement into Class C must complete the necessary forms prior to any lapse or loss of coverage to enroll in the Plan or the Employee will not be eligible to enroll in Class C of the Plan.

2. **Eligibility**

An individual may participate in the Plan as a Class C Retiree if he or she meets all of the following requirements:

A. He or she is at least 65 years of age;

B. He or she has Medicare coverage, Part A and B, which is his or her primary medical Coverage;

C. He or she has maintained eligibility in this Fund during at least thirty-six (36) of the last sixty (60) calendar months immediately preceding his or her application for Class C eligibility. For purposes of this rule, (i) an Employee who continues his or her eligibility through self-payments, COBRA coverage or Class B membership is considered to have maintained eligibility in this Fund, (ii) the periods of eligibility in this Fund are as determined by the Trustees or their delegate, and (iii) an Employee who has 30 or more years of eligibility in the Fund as a Class A member may participate in Class C once he or she attains age 65, regardless of a break in eligibility; and

D. He or she waives COBRA continuation coverage.

An Employee who becomes a Class C retiree may have certain costs subsidized based upon his or her years of eligibility with this Fund as an Active Employee, at a rate determined solely by the Trustees. A Spouse of a deceased Class C retiree may have to pay according to a rate schedule that is based upon the years of eligibility the Class C retiree had in the Fund as an Active Employee (See schedule below). For purposes of this subsidy, years of eligibility as an Active Employee are determined solely by the Trustees or their delegate.

Years of Eligibility as an Active Employee	Class C Member	Class C Spouse	Spouse under age 65
30+ Full Years of Eligibility as an Active Employee	Greater	Greater	Greater
20-29 Full Years of Eligibility as an Active Employee	Partial	Partial	Partial
Less than 20 Full Years of Eligibility as an Active Employee	Full Cost	Full Cost	Full Cost

The Trustees at their discretion may modify the rates charged Class C retirees or spouses, or modify or eliminate this subsidy at any time.

3. **Special eligibility rule regarding a Class C retiree**

Class B and C Members do not accrue any additional years of eligibility while they are in Class B or Class C.

4. **Coverage**

The Fund may contract with a company to serve as their administrator for the Class C medical and prescription benefits as well as a company to administer the claims payments to Class C participants. The Benefits available to the Class C Retirees and their Dependents who are over the age of 65 are different from the benefits set forth in this Plan Document. A separate summary plan description that describes Class C benefits is available upon request to the Fund.

Dependent(s) of a Class C Retiree who are under the age of 65 will be considered an eligible active participant in the Plan and will receive some of the Class A benefits, but will not be eligible for time loss or for any death benefits.

5. **Continuous Eligibility Requirement/Enrollment of Retirees in Class C**

A Class C Retiree who fails to maintain Class C eligibility under the Plan may not re-enroll for Class C Retiree membership.

6. **Termination of Coverage for Retirees in Class C**

A Class C Retiree will cease to be eligible under the Plan (subject to any rights to continue coverage for a limited time under this Plan or federal law, and subject to the person's run off of benefits) on the earliest of the following dates:

A. On the date the Plan terminates;

B. On the date the person dies;

C. On the first date of any Eligibility Period for which a timely required Contribution to maintain coverage has not been made;

D. On the date of the withdrawal of the Retiree’s local union or Employer from participation in the Fund.

Eligible Dependents – Of Retirees (Class C)

1. **Enrollment**

A person who is in the process of becoming a Retiree and who seeks to enroll his or her Dependents must submit a new signed application for enrollment on a form supplied by the Fund (even if the Dependents were previously covered as Dependents when the person was an active Class A or Class B participant). The Dependent must also satisfy the requirements for Dependent coverage and the Fund may also require the Retiree to provide documentation proving that their Dependents meet the requirements for Dependent coverage established in the Fund Rules. Prior to the enrollment of the Dependent, the Member must pay the contributions required by the Fund for both the Retiree and the Retiree's spouse, if applicable, at a rate set by the Trustees.

A Class C Retiree who seeks to enroll a Dependent must complete the necessary forms prior to the applicant having any lapse or loss of coverage in order to enroll the Dependent in the Plan.

2 **Eligibility**

Each Dependent of a Class C Retiree who meets the definition of covered Dependent is eligible for coverage under the Plan.

3. **Coverage for Dependents of Retirees in Class C**

An eligible Dependent who was previously enrolled when the Retiree was an active covered Member or an Early Retiree and has the necessary application and documentation supplied to the Fund, as set forth above, will be covered by this Plan on the same date the Member is covered as a Class C Retiree and the Retiree has paid the required contributions on his or her own behalf. Where the Dependent is the Member's spouse, contributions at a rate determined by the Fund must be paid on behalf of their spouse before the spouse has coverage.

Any eligible Dependent of a Retiree who has been enrolled during a special enrollment period will be covered on the day of the event, subject to the proper contributions being paid.

A newborn Child or newly adopted Child or newly married spouse who is properly enrolled in what is treated as a special enrollment period is covered on the first date the Child was born, was adopted, or was married, as applicable.

A Dependent(s) of a Retiree who is under 65 will be considered an eligible active participant in the Plan and will receive some of the Class A benefits, but is not eligible for time loss or for any death benefits.

4. **Special Coverage rules**

A. Upon the death of a Class C participant, Dependents who are younger than age 65 are offered COBRA continuation coverage.

B. Dependents of a Class C Retiree will have to pay contributions according to a rate schedule determined solely by the Trustees.

5. **Termination of Coverage for Dependents of Retirees in Class C**

A Covered Dependent's coverage will terminate on the earliest of the following:

A. On the date this Plan is terminated;

B. On the date the Retiree's coverage terminates for any reason;

C. On the date the covered Dependent ceases to be a Dependent, as defined by this Plan;

D. On the date the Dependent dies;

E. Upon the Retiree's death, at the end of the coverage period, provided however that the surviving spouse;

   i. Who is under the age of 65 will be offered COBRA continuation coverage.

   ii. Who is 65 years or older may continue to pay into the Plan at a rate determined by the Trustees.

F. On the date that the Plan is amended to exclude coverage for the category of Dependents in which the Dependent falls;

G. On the first day of any Eligibility Period for which any required Contribution is not timely made to maintain coverage for the Retiree;

H. On the date of the withdrawal of the Retiree's local union or Employer from participation in the Fund.

Eligible Disabled Employees

1. **Enrollment**

Employees who have met the criteria to be a disabled Employee will be enrolled in the Plan after they submit a signed application for enrollment on a form approved by the Fund. The Applicant for disabled Employee benefits must complete the necessary forms prior to any lapse or loss of coverage in order to enroll in the Plan or the Employee will not be eligible to enroll in the Plan as a disabled Employee.

2. **Eligibility**

An individual who is a covered Member is eligible to participate in the Plan for a limited period of time as a totally disabled Employee when the individual meets all of the following requirements:

A. The individual was a covered Employee when he or she first became totally and permanently disabled;

B. The individual was covered by the Plan when he or she became totally and permanently disabled; and.

C. The Employee is prevented, because of Illness or Injury, from performing his or her occupational duties and is unable to engage in any work or gainful activity for which he or she is fitted by reason of education, training, experience, or for which he or she could reasonably become fitted and such condition began while the individual was a Covered Employee.

Disability Subsidy. A Member who becomes a totally disabled Employee may have certain costs subsidized based upon his or her years of eligibility with this Fund as an Active Employee, at a rate determined solely by the Trustees (see schedule below). For purposes of these Disability Subsidy rules, years of eligibility as an Active Employee are determined soley by the Trustees or their delegate.

Years of Service	Subsidy
30+	Greater
20-29	Partial
0-19	Full Cost

This subsidy will extend until the participant is eligible for Medicare or for thirty-six (36) months, whichever occurs sooner. The Trustees at their discretion may modify or eliminate this subsidy at any time.

3. **Termination of Coverage for Disabled Employees**

A Disabled Employee's coverage will terminate on the earliest of the following:

A. On the date this Plan is terminated;

B. On the date the Disabled Employee dies; or

C. On the date of the withdrawal of the Disabled Employee's local union or Employer from participation in the Fund.

4. **Continuous Coverage Requirement/Enrollment of Dependents**

A Disabled Employee who fails to maintain coverage under the Plan may not re-enroll for Disabled Employee Coverage. A Dependent of a Disabled Employee who fails to maintain coverage under the Plan may not re-enroll for coverage as a Dependent of a Disabled Employee.

5. **Termination of Coverage for Dependents of Disabled Employees**

A Covered Disabled Employee will cease to be covered under the Plan on the earliest of the following dates (subject to the person's run off of benefits):

A. On the date the Plan terminates;

B. On the date the person dies;

C. On the date the individual no longer meets the definition of a Disabled Employee under this Plan Document;

D. On the first date of any coverage Period for which a required contribution is not timely made;

E. On the date the Disabled Employee first becomes eligible for coverage under Medicare;

F. On the date the Disabled Employee first becomes eligible for coverage under another Health Plan, regardless of whether the Disabled Employee actually enrolls in such Health Plan;

G. On the date Trustees have found the Disabled Employee to no longer be totally and permanently disabled;

H. On the date of the withdrawal of the Disabled Employee's local union or Employer from participation in the Fund.

Coverage for Special Dependents

1. **Eligibility**

Each Dependent of a Covered Employee who meets the definition of Special Dependent is eligible for coverage under the Plan beyond the age limits established for Dependents when they meet all of the following requirements:

A. They were a Dependent of a covered Employee prior to their achieving an age that would cause a break in coverage;

B. They are incapable of working or being gainfully employed because of a permanent physical or mental disability;

C. They are unmarried; and

D. They depend on the Employee or the Retiree for more than one-half of their support during the Calendar Year and have the same principal residence as the Employee or Retiree and reside with the Employee or Retiree for more than one-half of the Calendar Year, or if they do not reside with the Employee or Retiree:

i. The Child's parents are (a) divorced or legally separated under a decree of divorce or separate maintenance; (b) separated under a written separation agreement; or (c) 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 and is either a qualifying Child or qualifying relative of one of the parents.

2. **Enrollment**

In order to enroll as a Special Dependent in the Plan, a Covered Employee (or an eligible covered Retiree in "Class C") must submit a signed application for enrollment on a Form approved by the Fund along with documents and information required by the Fund to establish the person's status as a special Dependent. The Applicant who seeks to enroll a Special Dependent must complete the necessary forms within thirty-one (31) days of the date the Special Dependent would otherwise lose his or her status as a Dependent under this Plan.

3. **Continuous Coverage Requirement/Enrollment of Special Dependents**

A. The Fund may require a Special Dependent to submit to examination by a Physician or Physicians designated by the Fund at its expense to confirm that the person continues to meet the definition of a Special Dependent.

B. The Fund may not require such exam or proof of continued status as a Special Dependent more often than once each year and not until after two (2) years have elapsed from the date such Special Dependent attained the limiting age.

4. **Termination of Coverage for Special Dependents**

A Special Dependent's coverage will terminate on the earliest of the following dates:

A. On the date this Plan is terminated;

B. On the date the Covered Employee's (or eligible covered Class C retiree's) coverage ends for any reason;

C. On the date the Special Dependent ceases to meet the definition of a Special Dependent;

D. On the day the Special Dependent enters the Armed Forces of any country on a full-time basis;

E. Upon the death of the Covered Employee (or eligible covered Class C retiree), at the end of the coverage period;

F. On the date the Special Dependent dies;

G. On the date that the Plan is amended to exclude coverage for the category of Special Dependent; or

H. Within thirty (30) days of the Special Dependent failing to submit to an examination required by the Trustees to confirm the individual's status as a Special Dependent;

I On the date of the withdrawal of the Covered Employee's local union or Employer from participation in the Fund.

Non-Bargaining Unit Employees

1. **Enrollment**

A. NON-BARGAINING UNIT Employees who have met the criteria for eligibility will be enrolled in the Plan.

B. An Employer who seeks to enroll a group of non-bargaining unit employees will be required to execute a Participation Agreement with the Fund and the Participation Agreement has been approved by the Trustees in their sole discretion. An Employer may be required to submit information to an underwriter to assist the Trustees in determining whether to permit the group to enroll in the Plan.

C. An Employer who seeks to enroll non-bargaining unit employees must enroll all full-time non-bargaining unit employees, as defined by the Trustees, unless the individual elects to opt out of participating in the Plan and has coverage from a plan maintained by another employer. A person cannot opt out to accept another plan offered by the same employer.

D. Owners and Employees who perform bargaining unit work may enroll in the Plan as non-bargaining unit employees, provided they have met the criteria for eligibility in the Plan. Any such individuals who are enrolled as non-bargaining unit employees will be

provided coverage in the Plan as non-bargaining unit employees. Any Employer contributions for bargaining unit work that are received on behalf of such an owner or employee will be retained by the Fund for purposes of offsetting benefit and administration expenses. Employer contributions will not be credited to non-bargaining unit Members, except to the extent that the Trustees may elect to allocate funds to a Health Reimbursement card held by the non-bargaining unit Member.

2. **Eligibility**

All non-bargaining unit Employees are eligible to participate in the Plan when they meet all of the following requirements:

A. They have performed work for an Employer who has a collective bargaining agreement with a participating union; and

B. Their Employer has signed a separate "Participation Agreement" with the Fund; and

C. They have worked for two (2) consecutive months and their Employer has paid contributions for 173 Hours (or such other amount as the Trustees may determine) at the contribution rate determined by the Trustees; and

D. Their Employer complies with other requirements established by the Fund, including the execution of a Participation Agreement and approval of the Participation Agreement by the Trustees in their sole discretion.

3. **Effective Date of Coverage**

An eligible non-bargaining unit Employee who has enrolled as provided in this section will become covered by this Plan on the last to occur of the following dates:

A. Once a person becomes eligible by working 2 consecutive months at the required 173 Hours, they will be covered by this Plan on the first day of the second month following the last month the Employee completed the eligibility requirement.

B. If the Employee enrolls during a special enrollment period, they will be covered by this Plan on the first day of the first calendar month beginning after the date the completed request for enrollment is received.

The following is an example of when a non-bargaining unit Employee becomes eligible for coverage:

Work Month	**Work Hours**	**Effective Date of Coverage**
May	173	
June	173	August 1

A non-bargaining unit Employee is eligible after working two months and having 173 Hours contributed for 2 consecutive months. The non-bargaining unit Employee has coverage after three months of work. If the Employee leaves after two months, the Employee has a two month run off after the last month the Employee worked. If the Employee works three or more months, the Employee has a three month run off after the last month they work.

4. **Amount of contributions required for non-bargaining unit Employees**

A. Generally, contributions for a non-bargaining unit Employee must be made monthly at 173 Hours per month at the rate established by the Trustees. These contributions are due for each month regardless of whether the non-bargaining unit Employee is working or performing bargaining unit work during the month.

B. The contributions required for a non-bargaining unit Employee who enrolls during a special enrollment period are, for the first calendar month beginning after the date the completed request for enrollment is received, 519 Hours at the rate established by the Trustees. Thereafter, contributions for the non-bargaining unit Employee are 173 Hours per month at the rate established by the Trustees.

5. **Limitations on benefits**

A. A non-bargaining unit Employee cannot make self-payments to maintain eligibility and coverage.

B. A non-bargaining unit Employee does not qualify to receive the 1200 hour look back rule to maintain eligibility.

C. A non-bargaining unit Employee does not receive a time loss pay check, and does not receive the 100 Hours per month credit afforded bargaining unit Employees who qualify for time loss.

D. A non-bargaining unit Employee cannot enter Class B as an early retiree, except in the case of an individual who has fifteen (15) or more years of eligibility in this Fund as a bargaining unit Employee before becoming a non-bargaining unit Employee. For purposes of this rule, years of eligibility are determined by the Trustees or their delegate.

E. A person who is a bargaining unit Employee and subsequently becomes a participant as a non-bargaining unit Employee:

i. Must continue to work for a company that is bound to a collective bargaining agreement requiring contributions to the Fund on behalf of bargaining unit Employees.

ii. Must begin making contributions in the month they first are covered by a “Participation Agreement” with the Fund at 173 Hours and comply with other requirements of a non-bargaining unit Employee to be classified as a non-bargaining unit Employee.

iii. Continues to be covered as a bargaining unit Employee for the quarter that they last qualified for benefits as a bargaining unit Employee. Thereafter, coverage is as a non-bargaining unit employee.

iv. Does not qualify to receive the 1200 Hour look back rule.

v. Cannot make any self-payments to maintain coverage.

vi. May qualify for early retirement provided there is no break in coverage. When they retire early, they may receive a subsidy for the period of time they received sufficient Hours to qualify as a bargaining unit Employee; however, the time spent as a non-bargaining unit Employee will not be counted in computing the subsidy.

vii. May terminate their participation as a non-bargaining unit Employee and reestablish eligibility as a bargaining unit Employee.

6. **Termination of Coverage for non-bargaining unit Employees**

A. General Conditions:

Non-bargaining unit Employees will cease to be covered under the Plan (subject to any rights to continue coverage for a limited time under this Plan as a Disabled Employee, or to continue coverage under Federal Law), on the earliest of the following dates (subject to the person's run off of benefits):

i. On the last day of the third month after the Fund has failed to receive timely and adequate contributions on behalf of the non-bargaining unit Employee;

ii. On the day he (or she) enters the Armed Forces of any country on a full-time basis, subject to any rights to continue coverage for a limited period of time in accordance with Federal Law (this is subject to the rights of their Dependents to continue coverage);

iii. On the date the Plan terminates;

iv. On the date he (or she) dies;

v. On the first day the Employer of the non-bargaining unit Employees fails to have a collective bargaining agreement with a participating union;

vi. On the date his or her Employer's Participation Agreement with the Fund terminates;

vii. On the date of the withdrawal of the Employer of its non-bargaining unit Employees from participation in the Fund.

7. **Reinstatement after Loss of Coverage:**

A non-bargaining unit Employer who failed to pay contributions on a timely basis will only be entitled to reinstatement upon re-application to the Fund, and only after the company has paid all contributions, liquidated damages, and legal fees incurred in collecting the delinquent contributions.

Enrollment Provisions

1. **Initial Enrollment:**

Employees who have met the criteria within their classification for eligibility will be enrolled in the Plan as set forth with regard to their classification. On the date Members become covered by the Fund they may enroll themselves and their Dependents; and designate their beneficiaries.

2. **Special Enrollment Periods:**

Eligible Employees, eligible Dependents and eligible Qualified Beneficiaries who experience certain changes in circumstances will be provided a Special Enrollment Period in which they may enroll. Generally speaking, a Special Enrollment Period will be provided in the following circumstances:

i. If an eligible Employee marries, has a Child, has a Child placed for adoption, or becomes the guardian of the person of a Child, the eligible Employee (if not enrolled already) and any individual who becomes an eligible Dependent of such Employee as a result of such marriage, birth, adoption or guardianship proceeding, all are eligible to enroll during this Special Enrollment Period; or

ii. If an enrolled Retiree marries, has a Child, has a Child placed for adoption, or becomes the guardian of the person of a Child, any individual who becomes an eligible Dependent of such enrolled Retiree as a result of such marriage, birth, adoption or guardianship proceeding, is eligible to enroll during this Special Enrollment Period.

The Special Enrollment Period in any of these situations is a period lasting thirty-one (31) days, which begins on the date the individual experiences the change of circumstances (i.e., the date the individual loses eligibility for other coverage, becomes married, or acquires a Dependent, as applicable). Special Enrollment Periods may be used only to enroll individuals who are not already enrolled in any Health Plan maintained by the Fund, and cannot be used to switch from one Plan option to another. In order to enroll during a Special Enrollment Period, the eligible Employee must submit a request to enroll in writing, on a form approved by the Fund, within the Special Enrollment Period.

You and your Dependents may also enroll in this Plan if you or your Dependents have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you or your Dependents lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your Dependents may also enroll in this Plan if you or your Dependents become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you or your Dependents are determined to be eligible for such assistance.

If an eligible Employee properly enrolls himself or an eligible Dependent during a Special Enrollment Period, coverage will be effective for the newly enrolled individual on the day of the special enrollment event.

If an Employee of Dependent lost other coverage as a result of the individual's failure to pay premiums, required contributions or for cause (such as making a fraudulent claim) that individual does not have a Special Enrollment right.

The Employee or Dependent is not required to elect COBRA continuation under another employer's plan in order to become eligible for Special Enrollment under this Plan.

Effective Date of Coverage

Bargaining Unit Employee:

Once a person becomes eligible for coverage, they will be covered by this Plan on the first day of the third month following the last month the Employee completed working the 350 Hours in a 2-3 consecutive month period or 500 Hours in a 6 consecutive month period. Once the person becomes covered, they are covered for three consecutive months (this is referred to as a rolling quarter).

Non-Bargaining Unit Employee:

1. Once a person becomes eligible by working 2 consecutive months at the required 173 Hours, they will be covered by this Plan on the first day of the second month following the last month the Employee completed the eligibility requirement.

2 If the Employee enrolls during a special enrollment period, they will be covered by this Plan on the first day of the first month beginning after the date the completed enrollment is received.

Notwithstanding the foregoing, a newborn Child or newly adopted Child or newly married spouse who is properly enrolled in what is treated as a special enrollment period is covered on the date the Child was born, was adopted, or the Dependent spouse was married, as applicable.

No Dual Coverage

No person may be covered under the Plan as both an Employee and Dependent, or as a Dependent of more than one Employee. However, based upon the spousal carve out provisions, where there are two active covered Members in the Plan who each have sufficient contributions paid on their behalf to be eligible and covered for benefits they may be both an Employee and a Dependent. In such cases, the benefits provided will be the greater of the benefits allowed as an Employee or the benefits allowed as a Dependent.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person was covered continuously under this Plan before the change in status, credit will be given for deductibles and all amounts applied to maximums to the extent they have already been met.

If both mother and father are Employees, their Children will be covered as Dependents of the mother or father, but not both.

If husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating Spouse and any eligible and enrolled Dependents will immediately be transferred to the remaining Employee's coverage.

Special Eligibility Provisions

Late Enrollment

An enrollment is "late" if it is not made on a "Timely Enrollment Basis" or due to a Special Enrollment. A Timely Enrollment is an enrollment that takes place when a person is first eligible to enroll in the Plan, or at such other time as the Trustees may direct. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment (if applicable).

Medicaid and Children's Health Insurance Special Enrollment 60-day Election Period

An Employee and Dependent, or the Dependent of an enrolled Employee may elect to enroll in the Plan if the following occurs:

1. Medicaid or Children's Health Insurance Program (CHIP) terminates as a result of loss of eligibility and the Employee requests enrollment in the Plan within 60 days after the date of termination or loss of eligibility under the state program; or

2. The Employee becomes eligible for a state premium assistance subsidy under Medicaid or CHIP and the Employee requests enrollment in the Plan within 60 days after the date of eligibility for the subsidy.

Continuation during Family and Medical Leave

Regardless of the established leave policies mentioned above, this Plan will at all times comply with the provisions of the Family and Medical Leave Act of 1993 ("FMLA") as amended and as promulgated in regulations issued by the Department of Labor. Requirements of the Act should be addressed with your Employer. An Employee who is on FMLA leave must pay any required Employee contribution.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Eligible Employee and his or her covered Dependents if the Eligible Employee returns to work in accordance with the terms of the FMLA. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when the coverage terminated.

Plan Selection Period

Members who wish to change between Plan coverage options may do so during the Plan Selection Period. There is no Waiting Period for a change in Plan coverage options.

Enrollment elections made during this time will become effective January 1.

Covered Persons who do not make an election during this period will automatically retain their present coverage.

Withdrawal of Participating Union or Employer

Where a collective bargaining agreement is amended or terminated so that Employer contributions to the Fund are no longer required on behalf of the bargaining unit, a withdrawal from the Fund occurs. The bargaining parties to the agreement must notify the Fund in writing of the withdrawal at least ninety (90) days before the effective date of the withdrawal. The Fund must receive all Employer contributions due but unpaid through the effective date of the withdrawal.

In the event of a withdrawal, then each and every Employee who regularly performed work for the Employer as part of the bargaining unit under the jurisdiction of the agreement shall forfeit and terminate all rights as a Participant in this Fund, notwithstanding any other provisions in the Trust Agreement, the Plan, or any eligibility rules to the contrary, or any past or current contributions received or eligibility accumulated. This forfeiture includes all accumulated eligibility and all benefit rights of the Employee and his or her dependents, and is effective as of midnight on the effective date of the withdrawal. Nothing in this Section shall apply in the event continued coverage is mandated by federal law.

No individual Union, Employer, Participant, or Employee shall have any right or claim to any assets of the Fund or to any part of the assets of the Fund as a result of a withdrawal.

HEALTH REIMBURSEMENT CARD

1. **Eligibility**

   Employees who have become eligible for benefits under the Plan may qualify for an additional benefit in the form of a health reimbursement card to be used in compliance with IRS Code, Section 213(d) once they have achieved a $150.00 threshold amount. Contributions received before a person is eligible to participate in the Plan are not counted toward the $150.00 threshold requirement. The amount of the contributions considered applicable toward the health reimbursement card will be determined solely by the Trustees.

2. **Enrollment:**

   After an eligible Employee has accumulated the required $150.00, the Employee will be enrolled and will be issued a health reimbursement card to be used solely for medical benefits as permitted under IRS Code Section 213(d), that are Incurred by the Employee or the Employee's spouse and Dependent Children.

3. **The following rules apply to the use of the health reimbursement card under this benefit:**

   A. After the health reimbursement card is issued, any additional contributions designated by the Trustees as payments for this card will result in the additional amount being added to the current card balance as soon as administratively feasible.

   B A person must become eligible for Plan benefits before any money will be applied to reach the threshold amount for the card.

   C. The health reimbursement card may be used with merchants having approved inventory control systems, only for expenses for medical care as defined in IRS Code Section 213(d). The card also may be used to make self-payments for Plan coverage.

   D. If a person loses eligibility after the issuance of the card, he or she may continue to use the card until the card terminates under these rules. Effective November 1, 2011, additional contributions designated by the Trustees as payments for this card will be added to the card during periods of ineligibility, until the card terminates in accordance with these rules.

   E. The card will terminate when there are no contributions for a continuous one (1) year period, if the balance at the end of the one (1) year period is less than $10.00. The card also will terminate upon the withdrawal of the Employee's Union or Employer from participation in the Fund.

   F. Any amounts remaining on the card at the time of its termination will be forfeited. Once a person's card terminates, eligibility must be re-established and a new $150.00 threshold must be met before a new card will be issued.

   G. If a person dies, the spouse and eligible Dependents may use the card in conformity with IRS Code Section 213(d) for a period of one (1) year following the date of death and after that time the card will terminate.

   H. If a person loses eligibility before reaching the activation threshold of the card, the Fund will maintain the balance existing at the time eligibility is lost until eligibility is re-

established, for a period of up to a maximum of one year. If eligibility is not re-established within one year, the balance will be forfeited.

4. The following rules apply to the use of the Health Reimbursement Card as a Health Reimbursement Account (HRA):

A. Eligibility:

i. You are enrolled in coverage through this Plan or another group health plan (other than an HRA) that does not consist solely of excepted benefits.

ii. If you have an HRA Account balance, you will be allowed, at least annually, to permanently opt out of HRA coverage and waive future reimbursements from your HRA.

iii. When you terminate employment, you may elect, effective on the date of employment termination or later, to forfeit your HRA Account balance.

B. Termination of Covered Employment: You will continue to be eligible for reimbursement of Medical Care Expenses until the earlier of (a) the date that funds in your HRA Account are exhausted, (b) the date the HRA is terminated, (c) the date you waive or forfeit the balance in your HRA under item (1) above, or (d) the date in item (3)(D) above.

C. FMLA and USERRA Leaves of Absence: Notwithstanding any provision to the contrary in this HRA, if you go on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Fund will continue to maintain your Benefits on the same terms and conditions as if you were still an Active Employee. If you go on a leave of absence that is not subject to FMLA or USERRA, you will be treated as having terminated participation.

D. Medical Care Expenses means, for purposes of the HRA, only those expenses listed in item (3)(C) above.

E. Funding: Employer contributions that are made pursuant to an applicable Collective Bargaining Agreement or Participation Agreement will fund the full amount of the HRA. You may not make contributions to the HRA. Under no circumstances will HRA benefits be funded with salary reduction contributions, Employee contributions (e.g., flex credits) or otherwise under a cafeteria plan pursuant to Code §125, nor will salary reduction contributions or Employer contributions under a cafeteria plan be treated as Employer contributions for the purposes of the HRA. No contributions will be made to your HRA after you terminate participation.

F. No reimbursement from another source: Medical Care Expenses can only be reimbursed to the extent that you or your Dependent incurring the expense is not reimbursed for the expense nor is the expense reimbursable through another health insurance plan, other insurance, or any other accident or health plan (unless the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere, the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Section.

G. Health Flexible Spending Account (FSA) to Reimburse First under Coordination of Benefits: Benefits under this HRA are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another

source, that other source will pay or reimburse prior to payment or reimbursement from the HRA. Without limiting the foregoing statement, if your Medical Care Expense is covered by both the HRA and by a Health FSA, then the HRA is not available for reimbursement of such Medical Care Expense until after amounts available for reimbursement under the Health FSA have been exhausted.

H. COBRA: Notwithstanding the previous provisions, to the extent required by COBRA, if your coverage terminates under the Plan because of a COBRA qualifying event, you will be given the opportunity to continue on a self-pay basis the same coverage (with the exception of Life Insurance and AD&D Benefits) you had under the Plan on the day before the qualifying event for the periods prescribed by COBRA and governed by the conditions and limitations of COBRA.

I. The Trustees reserve the right to discontinue this benefit at any time, based on the financial condition of the Welfare Fund. You may contact the Fund Office if you have any questions.

SCHEDULES OF BENEFITS

Medical Benefits (Class A and B Participants Only)

Verification of Eligibility: Please refer to the number on your ID card. Call this number to verify eligibility for Plan benefits **before** you Incur any charges.

Listing Of Network Providers: Please refer to the PPO number on your ID card, or contact the Claims Administrator for a listing at no charge.

Mandatory Pre-Certification Program: The pre-certification program verifies the need for all non-urgent elective Hospital confinements and Outpatient surgery and reviews the number of days requested for your Hospital stay by the Physician.

***Note*: The following services must be pre-certified, or reimbursement from the Plan may be reduced:**

HOSPITALIZATIONS*
OUTPATIENT SURGERY

You or your Physician should call Hines during regular business hours to pre-certify a normal or elective Inpatient Hospital confinement or Outpatient surgery recommended by a Physician (Regular office hours are 8:00 AM to 5:00 PM Central Time, Monday through Friday. However, messages can be taken 24 hours a day).

Hines 1-888-236-2652

Hines should be called prior to admission.

IT IS MANDATORY THAT YOU CALL TO PRECERTIFY AT LEAST 72 HOURS BEFORE YOUR ADMISSION.

Hines will contact your Physician and review any additional days requested, if you are to be hospitalized longer than the amount of time certified.

When your Physician admits you to the Hospital suddenly, or in an emergency situation, the first and only priority is to seek the necessary medical attention as quickly as possible. However, you or your representative, such as a family member, doctor or Hospital staff member, should call Hines within 48 hours of your admission, or as soon as reasonably possible.

Please note that pre-admission certification does not constitute a determination of Medical Necessity or coverage under the Plan. Whether Expenses are covered by the Plan will always depend upon whether they are:

1. Within the coverage of the Plan; and

2. Not excluded by any provision of the Plan.

Note that these determinations are not made at the time of a pre-admission certification.

Note: *Any reduced reimbursement due to failure to follow Cost Management procedures will not accrue toward the 100% maximum out-of-pocket payment.*

Medical Benefits

All benefits described in this schedule are subject to the provisions, exclusions and limitations described more fully in this booklet including, but not limited to, the Plan Administrator's determination that:

1. Care and treatment is Medically Necessary;

2. Charges are Reasonable and Customary Charges; and

3. Services, supplies and care are not Experimental and/or Investigational.

The meanings of these capitalized terms are in the "Defined Terms" section of this Plan Document. If you require additional information, contact the Claims Administrator and it will be provided to you at no cost.

The Plan Administrator has discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual and all other determinations as to whether any individual is entitled to receive any benefits under the Plan.

Group health plans and health insurance issuers generally may not, under Federal law, restrict 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 cesarean section. However, Federal law 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Plan contains a Network Provider Organization (PPO).

This Plan has entered an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when you use a Network Provider, you will receive a higher payment from the Plan than when you use a Non-Network Provider. It is your choice as to which provider to use.

Additional information about this option, as well as a list of Network Providers will be provided to Covered Employees and updated as needed.

Deductibles, Co-Payments and Out-of-Pocket Maximums You Pay

Deductibles and Co-payments are dollar amounts that you, as a Covered Person, must pay before the Plan pays.

A deductible is an amount of money that is paid once each Calendar Year per Covered Person and per Family Unit. Typically, there is one deductible amount for each Plan (per Covered Person and Per Family Unit) and it must be paid before the Plan pays any money for any of your Covered Charges.

A co-payment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services but not others.

The out-of-pocket maximum is the maximum cost a participant will incur (excluding the penalty for failure to pre-certify Hospital admissions, and benefit limitations) for covered expenses in a Calendar year.

A spouse of a Covered Employee or Covered retiree who is eligible to participate in a group health insurance plan sponsored by the spouse's employer, for which that employer pays a minimum of 50% of the insurance premium and for which this Fund is secondary may not have to pay the deductible or the co-pay which will be paid by this Fund.

Integrated Annual Maximum Benefit Amount

The Plan does not have a Maximum Lifetime Benefit. The Plan Schedule of Benefits may have an Annual Maximum Benefit that applies only to certain Non-Essential Health Benefits, as permitted under the Patient Protection and Affordable Care Act (PPACA). When a Plan has more than one Schedule of Benefits, each Schedule of Benefits is a Benefit Option under the Plan. All Benefit Options are integrated under the Plan, and are subject to a single Annual Maximum Benefit for those Non-Essential Benefits. Once the Annual Maximum Benefit Amount has been met, the Covered Person is not eligible for a new Annual Maximum Benefit Amount under any other Plan Benefit Option until the start of the next Calendar Year. The Covered Person may continue to be eligible for non-essential benefits under the Plan Schedule of Benefits in which they are enrolled at the time they meet the Annual Maximum Benefit Amount.

The following categories of Essential Benefits are no longer subject to any Annual Maximum Benefit Amount: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorders including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; pediatric services including oral and vision care. The PPACA does not require the Plan to offer all of the Essential Benefits listed; however, if one or more of these benefits is shown on the Plan's Schedule of Benefits the benefit is not subject to any Annual Maximum Benefit limitation.

Schedule of Benefits – Class A and Class B Members

ELIGIBLE CLASSES: **Class A and B:**

Covered Employees, Covered Dependents, Covered Qualified Beneficiaries, Early Retirees and Disabled.

***Note*: The following services must be pre-certified, or reimbursement from the Plan may be reduced:**

HOSPITALIZATIONS*
OUTPATIENT SURGERY

MEDICAL BENEFITS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	UNLIMITED	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$400.00	$800.00
Per Family Unit	$800.00	$1,600.00
CO-PAYMENTS		
• **Physician Visits**	$25.00	N/A
• **Emergency Room**	$150.00	$150.00
The Emergency Room co-payment is waived if the patient is admitted to the Hospital. The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
MAXIMUM MEDICAL OUT-OF-POCKET AMOUNT PER CALENDAR YEAR INCLUDING DEDUCTIBLE		
Per Covered Person	$3,000.00	$7,150.00
Per Family Unit	$6,000.00	$14,300.00
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Medical Charges for the rest of the Calendar Year, unless stated otherwise. Note that Prescription Drugs are subject to a higher out-of-pocket maximum, which also includes this out-of-pocket maximum. *Medical co-pays and prescription drug co-pays do not count towards the out-of-pocket maximums noted above, but do count towards the overall maximum of $7,150.00 and $14,300.00.*		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: • **Cost containment penalties** • **Penalty for failure to pre-certify a Hospital admission** • **Charges above Reasonable & Customary** • **Excluded Charges**		

Effective for Out-of-Network (ONN) medical claims incurred January 1, 2017 and after the Reasonable & Customary (R&C) determination will be based on 120% of the allowable Medicare rate for the service performed. Amounts in excess of the Reasonable & Customary (R&C) determination may be balanced billed to you by the provider.

MEDICAL BENEFITS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
COVERED CHARGES		
HOSPITAL AND FACILITY SERVICES		
When a Network Hospital and Physician have been selected and a Non-Network anesthesiologist, radiologist, pathologist or assistant surgeon is assigned, these providers will be paid at the Network level of benefits, subject to the Reasonable and Customary Charge. If a Network Hospital is utilized for services for an Emergency Medical Condition, the emergency room Physician will be payable at the Network level of benefits subject to the Reasonable and Customary Charge. ***Note*: Failure to pre-certify a Hospital admission or an Outpatient Surgery will result in a penalty of $300.00***.		
• **Ambulatory Surgical Center Facility Fee**	80% after deductible	50% after deductible
• **Emergency Room Services**	100% after $150 co-payment	100% after $150 co-payment
• **Intensive Care Unit**	80% after deductible Hospital's ICU charge	50% after deductible Hospital's ICU charge
• **Non-Emergency Room Services**	80% after deductible	50% after deductible
• **Organ Transplants**	80% after deductible	50% after deductible
• **Outpatient Services** *Not including Emergency Room Care*	80% after deductible	50% after deductible
• **Pre-Admission Testing Services**	100% deductible waived	50% after deductible
• **Pregnancy**	80% after deductible	50% after deductible
• **Room and Board**	80% after deductible *the semiprivate room rate*	50% after deductible *the semiprivate room rate*
• **Skilled Nursing Facility**	80% after deductible 45 days Calendar year maximum	50% after deductible 45 days Calendar year maximum
PREVENTIVE CARE		
• **Routine Well Adult Care**	100% when primary purpose of Office Visit is Preventive Care	Not Covered
Routine Well Adult Care includes Preventive Care Services and routine immunizations recommended for adults under the Patient Protection and Affordable Care Act.		
Frequency limits for mammogram: • **All Ages – Annually**		
• **Routine Well Baby Care** From birth to age 2	100% when primary purpose of Office Visit is Preventive Care	Not Covered
• **Routine Well Child Care** From age 2 through 18	100% when primary purpose of Office Visit is Preventive Care	Not Covered

MEDICAL BENEFITS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• **Contraceptive Coverage** At least one method in each of the 18 categories of contraceptives described in the Women's Preventive Services Section of the SPD will be covered at no cost to the Participant; oral contraceptives are covered under the Prescription Drug Program.	100% of the cost	Not covered
Routine Well Child Care includes Preventive Care Services and routine immunizations recommended for infants, children and adolescents under the Patient Protection and Affordable Care Act (PPACA).		
PHYSICIAN SERVICES		
• **Allergy Treatment and Testing**	80% after deductible	50% after deductible
• **Ambulance Service**	80% after deductible	80% after deductible
• **Anesthesia**	80% after deductible	50% after deductible
• **Assistant Surgeon** *Benefits are subject to surgeries where an Assistant Surgeon is Medically Necessary.*	80% after deductible	50% after deductible
• **Bereavement Counseling**	Not Covered	Not Covered
• **Chemo Therapy**	80% after deductible	50% after deductible
• **Chiropractic Services**	80% after deductible $1,500.00 maximum per Calendar year	50% after deductible $1,500.00 maximum per Calendar year
• **Developmental Delays and Learning Disorders**	Not Covered	Not Covered
• **Dialysis**	80% after deductible	50% after deductible
• **Durable Medical Equipment**	80% after deductible	50% after deductible
• **Emergency Room**	100% after ER co-pay *(only one ER co-pay needs to be satisfied for both the facility and physician charges)*	100% after ER co-pay *(only one ER co-pay needs to be satisfied for both the facility and physician charges)*
• **Foot Orthotics**	80% after deductible	50% after deductible
• **Gastric Bypass**	Not Covered	Not Covered
• **Genetic Testing limited to diagnosing a specific illness or determining a specific course of treatment**	80% after deductible	50% after deductible
• **Hearing Aid**	80% after deductible $1,500.00 maximum per ear every 5 years	80% after deductible $1,500.00 maximum per ear every 5 years
• **Home Birth**	Not Covered	Not Covered

MEDICAL BENEFITS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• **Home Health Care**	80% after deductible 60 visits maximum per Calendar year	50% after deductible 60 visits maximum per Calendar year
• **Hospice Care**	100% deductible waived	100% deductible waived
• **Imaging (CT/PET Scans, MRIs)**	80% after deductible	50% after deductible
• **Immediate Care**	100% after office visit co-pay	50% after deductible
• **Infertility, Reproductive Enhancement, Genetic Manipulation**	80% after deductible *limited to Covered Charges Incurred to diagnose this condition.*	50% after deductible *limited to Covered Charges Incurred to diagnose this condition.*
• **Inpatient Visits**	80% after deductible	50% after deductible
• **Jaw Joint/TMJ**	See Dental Benefits Section	See Dental Benefits Section
• **Laboratory/X-Ray Services**	80% after deductible *if a Network Hospital and Network Physician are utilized*	50% after deductible
• **Lasik Eye Surgery**	Payable at 50% deductible and co-pay waived *utilization of this benefit forfeits vision benefits for a period of four (4) years*	Payable at 50% deductible and co-pay waived *utilization of this benefit forfeits vision benefits for a period of four (4) years*
• **Maternity/Newborn Care**	80% after deductible	50% after deductible
• **Mastectomy/Breast Reconstruction**	80% after deductible	50% after deductible
• **Morbid Obesity**	80% after deductible	50% after deductible
• **Occupational Therapy** *Does not include charges for developmental delays or learning disorders.*	80% after deductible 60 visits maximum per Calendar year *visit limit is combined with Occupational, Physical and Speech Therapy*	50% after deductible 60 visits maximum per Calendar year *visit limit is combined with Occupational, Physical and Speech Therapy*
• **Office Visits**	100% after $25.00 office visit co-payment	50% after deductible
• **Office Visit – Laboratory/X-Ray Services**	100% after $25.00 office visit co-payment	50% after deductible
• **Office Visit Surgery - All services must be performed in Physician's office**	100% after $25.00 office visit co-payment	50% after deductible
• **Oral Surgery**	80% after deductible	50% after deductible
• **Outpatient Private Duty Nursing**	Not Covered	Not Covered
• **Physical Therapy** *Does not include charges for developmental delays or learning disorders.*	80% after deductible 60 visits maximum per Calendar year *visit limit is combined with Occupational, Physical and Speech Therapy*	50% after deductible 60 visits maximum per Calendar year *visit limit is combined with Occupational, Physical and Speech Therapy*

MEDICAL BENEFITS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• **Podiatric Services**	80% after deductible $500.00 maximum per Calendar year*	50% after deductible $500.00 maximum per Calendar year*
* *The $500.00 Calendar year maximum applies to all services provided by a podiatrist, including foot orthotics. The $500.00 Calendar year maximum does not include surgical procedures.*		
• **Prosthetics**	80% after deductible	50% after deductible
• **Radiation Therapy**	80% after deductible	50% after deductible
• **Second Surgical Opinion**	100% deductible waived	50% after deductible
• **Speech Therapy** *Does not include charges for developmental delays or learning disorders.*	80% after deductible 60 visits maximum per Calendar year *visit limit is combined with Occupational, Physical and Speech Therapy*	50% after deductible 60 visits maximum per Calendar year *visit limit is combined with Occupational, Physical and Speech Therapy*
• **Sterilization**	80% after deductible	50% after deductible
• **Surgery – Inpatient**	80% after deductible	50% after deductible
• **Surgery – Outpatient**	100% of the first $1,000.00 thereafter; 80% after deductible	50% after deductible
• **Urgent Care Visit**	$25.00 co-payment per visit	50% after deductible
• **Wig After Chemotherapy**	80% after deductible one per Lifetime	80% after deductible one per Lifetime
MENTAL DISORDERS/ SUBSTANCE ABUSE/CHEMICAL DEPENDENCY		
• **Inpatient**	80% after deductible	50% after deductible
• **Outpatient**	80% after deductible	50% after deductible
• **Individual Outpatient Office Visit**	100% after $25.00 office visit co-payment	50% after deductible
***Note*: Failure to pre-certify a Hospital admission will result in a penalty of $300.00.**		

PRESCRIPTION DRUG BENEFITS		
Prescription drug coverage is available through the Prescription Drug Vendor and participating pharmacies only. Please show your identification card at participating pharmacies.		
MAXIMUM PRESCRIPTION DRUG OUT-OF-POCKET AMOUNT PER CALENDAR YEAR (Includes Maximum Network Provider Medical Out-of-Pocket Amount)		
Per Covered Person	$7,150.00	
Per Family Unit	$14,300.00	
CO-PAYMENTS, PER PRESCRIPTION		
Retail Pharmacy	Co-payment	Supply Amount
Generic	$7.00	Up to 30-day supply
Preferred Brand	$35.00	Up to a 30-day supply
Brand	$50.00	Up to 30-day supply
Specialty	$50.00	Up to a 30-day supply
Mail Order		
Generic	$14.00	Up to 90-day supply
Preferred Brand	$70.00	Up to a 90-day supply
Brand	$100.00	Up to 90-day supply
Specialty	$100.00	Up to a 90-day supply
Note: Medicare Part B drugs are excluded under prescription drug benefits.		

VISION BENEFITS

Network Vision services are provided by Spectera providers.
Consult with you vision provider as to whether they participate in the Spectera vision program.
Show your identification card to access these services.
To locate a Spectera provider call: 1-800-839-3242 or www.spectera.com

IMPORTANT NOTICE
When selecting items please confirm with your provider that the items you are selecting are within the Spectera allowance.
Higher priced items may require an additional payment on your behalf.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	No Deductible	No Deductible
COVERED CHARGES		
• **Exam**	$10.00 co-payment 100% thereafter	Up to $50
• **Lenses**		
• **Single Vision**	$25.00 co-payment; one pair every 12 months	Up to $60
• **Bifocal Vision**	$25.00 co-payment; one pair every 12 months	Up to $70
• **Trifocal Vision**	$25.00 co-payment; one pair every 12 months	Up to $90
• **Frames**	$25.00 co-payment; one pair every 12 months *Receive a $50.00 wholesale frame allowance applied toward the wholesale price of a frame at private practice providers, or a $130 retail frame allowance at retail chain providers.*	Up to $70
• **Contact Lenses Elective**	$25.00 co-payment** one pair every 12 months	Up to $175
• **Contact Lenses Necessary*** **	$25.00 co-payment one pair every 12 months	Up to $210
• **Lasik Surgery Benefit**	See Medical Schedule of Benefits	See Medical Schedule of Benefits

THE PLAN WILL PAY FOR EITHER LENSES AND FRAMES OR CONTACT LENSES – ONE OR THE OTHER, BUT NOT BOTH.

** LESS ANY NETWORK FITTING OR EVALUATION FEE

*** NECESSARY CONTACT LENSES ARE DETERMINED AT THE PROVIDER'S DISCRETION. PLEASE CONSULT WITH YOUR PROVIDER.

Note: In the event there are any inconsistencies between the above schedule and the Spectera schedule, the Spectera schedule will control.

DENTAL BENEFITS		
This dental plan offers the Delta Dental PPO Network. Please show your dental ID card to your provider.		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
MAXIMUM BENEFIT PER CALENDAR YEAR		
Per Covered Person	$1,500.00	$1,000.00
TMJ MAXIMUM PER LIFETIME		
Per Covered Person	$1,500.00	$1,500.00
ORTHODONTIC MAXIMUM PER LIFETIME		
Per Covered Person	$3,000.00	Not covered
DEDUCTIBLE PER CALENDAR YEAR PER PERSON		
Type I services (Preventive)	No Deductible	No Deductible
Type II services (Basic)	$50.00	$50.00
Type III services (Major)	$50.00	$50.00
Type IV services (TMJ)	$50.00	$50.00
Type V Services (Orthodontic)	$50.00	Not covered
BENEFIT PERCENTAGES		
• **Type I – Preventive Services**	100% of Covered Expenses	100% of Usual & Customary Expenses
• **Type II – Basic Services**	80% of Covered Expenses	80% of Usual & Customary Expenses
• **Type III – Major Services**	50% of Covered Expenses	50% of Usual & Customary Expenses
• **Type IV - TMJ Services**	80% of Covered Expenses	80% of Usual & Customary Expenses
• **Type V – Orthodontic Services**	50% of Covered Expenses	Not covered
Note: In the event there are any inconsistencies between the above schedule and the Delta Dental schedule, the Delta Dental schedule will control.		

Schedule of Benefits – Class C Members

ELIGIBLE CLASSES:	**Class C:** **Covered Retirees and their Covered Dependents over age 65 who meet the requirements for participation as outlined in the Eligibility Section of this Plan Document.**

This Plan will always pay secondary to Medicare Parts A and B. A Class C Member and the Member's Dependents are required to enroll in Parts A and B of Medicare. Class C is not available to Members or their Dependents who have not enrolled in Medicare Parts A and B.

MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD*

* *A benefit period begins on the first day you receive service as an inpatient in a Hospital and ends after you have been out of the Hospital and have not received skilled care in any other facility for 60 days in a row.*

The Medicare payments, limits, deductibles and coinsurance listed below are based on 2016 costs and are used for illustration purposes only.

Services	Medicare Pays	Plan Pays	You Pay
• **Hospitalization*** Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,340	(Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$1,005 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All costs
• **Skilled Nursing Facility Care*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
• **Blood**			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD*			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
• **Hospice Care** Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance
The above Medicare payments, limits, deductibles and coinsurance are based on 2018 costs and are used for illustration purposes only.			

MEDICARE (PART B) - MEDICAL SERVICES – PER CALENDAR YEAR*			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
• **Medical Expenses** – In or Out of the Hospital and Outpatient Hospital Treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $166 of Medicare Approved Amounts*	$0	$166 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	20%	0%
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
• **Blood**			
First 3 pints	$0	All costs	$0
Next $155 of Medicare Approved Amounts*	$0	All costs	$0
Remainder of Medicare Approved Amounts	80%	20%	0%
• **Mental Health**			
Outpatient Mental Health	80%	20%	0%
• **Clinical Laboratory Services**			
Blood tests for Diagnostic Services	100%	$0	$0
• **Preventive Care**			
U&C for one cancer screening per calendar year of mammography, cervical cancer and prostate cancer	100%	0%	0%

MEDICARE (PART B) - MEDICAL SERVICES – PER CALENDAR YEAR*			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
• **Home Health Care** Medicare Approved Services: Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $166 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
Remainder of Medical Approved Amounts	80%	20%	0%

OTHER BENEFITS – NOT COVERED BY MEDICARE			
• **Foreign Travel** Medically necessary Emergency Services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum
The above listed Medicare payments, limits, deductibles and coinsurance are based on 2018 costs and are used for illustration purposes only.			
There may be limits on physical therapy, occupational therapy, and speech language pathology services. If so there may be exceptions to these limits.			

PRESCRIPTION DRUG BENEFITS
Class C Members

Prescription drug coverage for Class C Members is available through the Prescription Drug Vendor and participating pharmacies only. The co-payments listed below are for illustrative purposes only and may change based on your personal situation. Please show your identification card at participating pharmacies.

CO-PAYMENTS, PER PRESCRIPTION

Description of Benefit	Retail (30-day)	Retail (60-day)	Retail (90-day)	Mail Order (30-day)	Mail Order (60-day)	Mail Order (90-day)
Part D Phase: Deductible	$0 deductible					
Part D Phase: Initial Coverage Limit (ICL) – The following copays below will apply up to the ICL amount of $3,700.						
Tier 1 – Preferred Generic	$0/$5	$0/$10	$0/$10	$0	$10	$10
Tier 2 – Non-Preferred Generic	$0/$5	$0/$10	$0/$10	$0	$10	$10
Tier 3 – Preferred Brand	$30/$35	$60/$70	$90/$105	$35	$70	$70
Tier 4 – Non-Preferred Brand	$60/$65	$120/$130	$180/$195	$65	$130	$130
Tier 5 – Specialty	33%	33%	33%	33%	33%	33%
Part D Phase: Coverage Gap – The following copays will apply for the Coverage Gap until member reaches the Troop amount of $4,950.						
Part D Phase: Coverage Gap	Tiers 1-5					
Tier 1 – Preferred Generic	$0/$5	$0/$10	$0/$10	$0	$10	$10
Tier 2 – Non-Preferred Generic	$0/$5	$0/$10	$0/$10	$0	$10	$10
Tier 3 – Preferred Brand	$30/$35	$60/$70	$90/$105	$35	$70	$70
Tier 4 – Non-Preferred Brand	$60/$65	$120/$130	$180/$195	$65	$130	$130
Tier 5 – Specialty	31%	31%	31%	31%	31%	31%
Troop amount that begins Catastrophic Phase	$4,950					

Catastrophic Phase Cost-Sharing Amounts	Catastrophic Phase Cost-Sharing Amounts
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: • **5% of the cost, or** • **$3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs**

DENTAL BENEFITS
Class C Members

Dental benefits are not offered to Class C Members

VISION BENEFITS
Class C Members

CALENDAR YEAR MAXIMUM		
Per Covered Person To be used for Exam, Frames, Lenses	The Plan pays up to $125.00	

Vision Benefits are provided to subsidized Retiree-Members only.

Schedule of Benefits – Life Insurance

Life and AD&D benefits are available to Class A, B and C Members as follows:		
CLASS MEMBERSHIP	**DEATH BENEFIT**	**AD&D DEATH BENEFIT**
Class A and Class B Members only	**$40,000**	**$40,000**
Class C Retirees with 30+ years of service as a bargaining unit Employee.*,**	**$10,000**	**$10,000**
Class C Retirees with 15-29 years of service as a bargaining unit Employee.*,**	**$5,000**	**$5,000**

*** For purposes of these rules, the years of service as a bargaining unit Employee are determined by the Trustees or their delegate.**

****Rock Island Class C Retirees are not eligible for death benefits.**

DEPENDENT DEATH BENEFIT

Benefits are available to Dependents and spouses of Class A and B Members only. If a Member is in Class C then his/her Dependents and spouses are not covered, no matter what group they are in.

Spouse	$5,000
Child	$2,000

The terms and conditions for payment of death benefits are governed by the terms of the group term life insurance contract(s) issued to the Welfare Fund by Reliance Standard Life Insurance Company. These contract(s) define the terms under which a beneficiary is entitled to benefits.

The insurance contract(s) are available for your review in the Fund Office. No benefits are provided under this Plan except as may be paid by the insurance company under the terms of the applicable insurance contract.

Schedule of Benefits – Loss of Time

Loss of time benefits are payable to Class A/bargaining unit Employees only.
Loss of time benefits are <u>not</u> payable to non-collectively bargained Employees.

Weekly benefit

Non-occupational	$350 (less FICA/MEDC)
Occupational	$350 (less FICA/MEDC)

Benefits are payable based on a seven (7) day week.
Maximum benefit period

Non-occupational	26 weeks
Occupational	1 week

Waiting Period	
Non-occupational accident	1st day
Non-occupational Illness	8th day
Occupational accident/Illness	1st day

Bargaining unit Employees on Loss of Time benefits are credited with 5 Hours per day, with a maximum of 100 Hours per month and subject to the following lifetime maximums.

Lifetime maximums based on years of service as a bargaining unit Employee:

(For purposes of this rule, the number of years of service as a bargaining unit Employee is determined by the Trustees or their delegate.)

0 – 15 years of service = lifetime maximum of twelve (12) months.

16 – 30+ years of service = lifetime maximum of twenty-four (24) months.

Each occurrence is subject to the maximum benefit period stated above.

A physician's report establishing proof of continuing disability must be submitted every six (6) months and more frequently if and as required by the Trustees or their delegate.

All loss of time benefits terminate if the Employee's Union or Employer withdraws from participation in the Fund, on the effective date of withdrawal.

MEDICAL BENEFITS

Medical benefits may be available when you Incur Covered Charges for care of an Injury or Sickness while you are covered for these benefits under the Plan. The Plan Administrator has the discretionary authority to make factual and all other determinations as to whether you are entitled to receive any benefits under the Plan.

Deductible

Deductible Amount – A deductible is an amount of money that is paid once each Calendar Year per Covered Person and per Family Unit. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges.

Deductible Three-Month Carryover – Covered Charges Incurred in, and applied toward the deductible in October, November and December will also be applied toward the deductible in the next Calendar Year.

Family Unit Limit – When the amount shown in the Schedule of Benefits has been Incurred by members of a Family Unit toward their Calendar Year Deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Benefit Payment

For Class A and B Members, each Calendar Year, benefits will be paid for your Covered Charges that are in excess of the deductibles and any co-payments, subject to all other Plan provisions, exclusions and limitations. Payment will be made at the percentage shown in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any limit listed in the Plan.

For Class C Members, benefits will be paid based on coordination of benefits, with Medicare as the primary payer.

Out-of-Pocket Limit

Covered Charges are payable at the percentages shown each Calendar Year until you reach the out-of-pocket limit shown in the Schedule of Benefits. Then, Covered Charges you Incur will be payable at 100% (except for excluded charges) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for excluded charges) for the rest of the Calendar Year.

Maximum Annual Benefit Amount

The Maximum Annual Benefit Amount for specific services is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all of those specific Covered Charges during the Plan Year for a Covered Person.

Covered Charges

"Covered Charges" are the Reasonable and Customary Charges that are Incurred for the following services and supplies. These charges are subject to the benefit limits, exclusions and other provisions of this Plan.

1. **Hospital Care:** the medical services and supplies furnished by a Hospital, Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

   Charges for Outpatient Hospital Care will be payable as shown in the Schedule of Benefits.

   Charges for Emergency Room Care will be payable as shown in the Schedule of Benefits.

   Charges for an Intensive Care Unit Stay are payable as shown in the Schedule of Benefits.

2. **Coverage of Pregnancy:** the Reasonable and Customary Charges for the care and treatment of Pregnancy are covered the same as any other Sickness and will be payable as shown in the Schedule of Benefits.

   Group health plans generally may not, under Federal law, restrict 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 cesarean section; however, Federal law 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

3. **Skilled Nursing Facility Care:** the room and board, nursing care and other services and supplies furnished by a Skilled Nursing Facility will be payable if and when:

   a) The patient is confined as a bed patient in the facility, and

   b) The attending Physician completes a treatment plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

   Covered Charges for a Covered Person's care in these facilities is shown in the Schedule of Benefits.

4. **Physician Care:** the professional services of a Physician for surgical or medical services. These services will be payable as shown in the Schedule of Benefits.

   a) Charges for **multiple surgical procedures** will be a Covered Charge, subject to the following provisions:

   (i) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Reasonable and Customary Charge that is allowed for the primary procedure; 50% of the Reasonable and Customary Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If two or more surgeons on separate operative fields perform multiple unrelated surgical procedures, benefits will be based on the Reasonable and Customary Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Reasonable and Customary Charge percentage allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Reasonable and Customary Charge allowance.

5. **Private Duty Nursing Care:** the private duty nursing care by a licensed nurse (R.N., L.P.N., or L.V.N.). These benefits will be payable as shown in the Schedule of Benefits. Covered Charges for this service will be included to this extent:

   a) **Inpatient Nursing Care:** charges are covered only when care is Medically Necessary or not Custodial Care and the Hospital Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

   b) **Outpatient Nursing Care:** charges are covered only when care is Medically Necessary and not Custodial Care. The only charges covered for Outpatient Nursing Care are those shown below, under "Home Health Care Services and Supplies".

6. **Home Health Care Services and Supplies:** charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Skilled Nursing Facility confinement would otherwise be required. These benefits will be payable as shown in the Schedule of Benefits. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care plan.

   Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

   A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

7. **Hospice Care Services and Supplies:** charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care plan.

   Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

8. **Other Medical Services and Supplies:** the services and supplies listed below, not otherwise included in the items above, will be payable as any other Illness or as shown in the Schedule of Benefits:

   a) Local Medically Necessary professional land or air **Ambulance Service**.

   b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

   c) **Cardiac Rehabilitation** as deemed Medically Necessary, provided services are rendered: (i) under the supervision of a Physician; (ii) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (iii) initiated

within 12 weeks after other treatment for the medical condition ends; and (iv) in a Medical Care Facility.

d) **Radiation** or **Chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

e) **Chiropractic Services** by a licensed M.D., D.O. or D.C. All services rendered by a chiropractor are subject to the maximum shown in the Schedule of Benefits.

f) Initial **Contact Lenses** or glasses required following cataract surgery.

g) Charges for the rental or purchase of **Durable Medical Equipment**, whichever is economically justified. Repair or replacement of purchased Durable Medical Equipment which is due to the growth and development of the participant and/or when Medically Necessary and not as the result of loss, theft or damage will be considered an eligible expense. Replacement of purchased Durable Medical Equipment due to equipment failure will be covered only once in a five-year period. Routine maintenance of the equipment is not an eligible expense.

h) **Laboratory Studies**.

i) Treatment of **Mental Disorders** and **Substance Abuse**. Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

   (i) All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

   (ii) Psychiatrists (M.D.), Psychologists (Ph.D.), Licensed Clinical Social Workers (LCSW) or Counselors may bill the Plan directly. Other licensed Mental Health Practitioners must be under the direction of and must bill the Plan through these professionals.

j) **Injury to or care of Mouth, Teeth and Gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

   (i) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;

   (ii) Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident;

   (iii) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;

   (iv) Excision of benign bony growths of the jaw and hard palate;

   (v) External incision and drainage of cellulitis;

   (vi) Incision of sensory sinuses, salivary glands or ducts; and/or

   (vii) Reduction of dislocations and excision of Temporomandibular Joints (TMJ's).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

k) **Occupational Therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function, subject to any limits as shown in the Schedule of Benefits. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

l) **Organ Transplant** charges covered under the Plan that are Incurred for care and treatment due to an organ or tissue transplant are subject to these limits:

   (i) The transplant must be performed to replace an organ or tissue.

   (ii) As shown in the Schedule of Benefits.

   Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. Donor charges will be paid under the plan of the recipient. Donor charges include those for:

   (i) Search, procurement and evaluation of the organ or tissue;

   (ii) Removing the organ or tissue from the donor; and

   (iii) Transportation of the organ or tissue within the United States, Canada or approved medical tourism site as approved by the Case Management firm, to the place where the transplant is to take place.

m) The initial purchase, fitting and repair of **Orthotic Appliances** such as braces, splints or other appliances that are required for support after an open-cutting operation only, subject to any limits as shown in the Schedule of Benefits.

n) **Physical Therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function, subject to any limits as shown in the Schedule of Benefits.

o) **Prescription Drugs,** subject to any limits as shown in the Schedule of Benefits.

p) **Preventative Services:**

   This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (PPACA). Preventive Services are paid for based on the Plan's payment schedules for the individual services. Coverage is provided on a PPO Network basis with no cost-sharing (for example, no deductibles, coinsurance, or copayments), and is not provided on an out-of-network basis as reflected in the Schedule of Benefits. The Preventive Services covered by the Plan include the following:

   (i) Items or services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);

   (ii) Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention;

(iii) Preventive care and screenings for newborns, infants and children as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, including the American Academy of Pediatrics Bright Futures guidelines; and

(iv) Preventive care and screenings as provided for women as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, to the extent not included in certain recommendations of the USPSTF, as outlined in the Women's Preventive Services Subsection that follows. including the following services:

WOMEN'S PREVENTIVE SERVICES

a. Well-woman visits, including preconception and prenatal care;

b. Screening for gestational diabetes;

c. Human papillomavirus testing for women age 30 or over;

d. Counseling for sexually transmitted infections;

e. Counseling and screening for human immune-deficiency virus;

f. Breastfeeding support, supplies and counseling;

g. Screening and counseling for interpersonal and domestic violence; and

h. The following Contraceptive methods and related clinical services, including patient education and counseling, in each of the following eighteen categories of contraceptive methods are covered by the Plan, as long as the generic or least expensive option within a category is selected.

(1) Sterilization surgery for women;

(2) Surgical sterilization implant for women;

(3) Implantable rod;

(4) IUD copper;

(5) IUD with progestin;

(6) Shot/injection;

(7) Oral contraceptives (combined pill);

(8) Oral contraceptives (progestin only);

(9) Oral contraceptives extended/continuous use;

(10) Patch;

(11) Vaginal contraceptive ring;

(12) Diaphragm;

(13) Sponge;

(14) Cervical cap;

(15) Female condom;

(16) Spermicide;

(17) Emergency contraception (Plan B/Plan B One Step/Next Choice); and

(18) Emergency contraception (Ella).

In addition, a specific FDA-approved item will be provided without cost-sharing if your health care provider certifies that it is Medically Necessary for you. Medical Necessity may be based on the severity of actual side effects, differences in permanence and reversibility of contraceptives, and the provider's determination of your ability to adhere to the appropriate use of the item or service. In the event that there is a dispute about whether the requested method of contraception is Medically Necessary, you may file a claim for benefits (medical or prescription drug, as appropriate) following the process set forth in the Processing Claims for Benefits Section of the SPD. Any claim relating to emergency contraception will be decided and communicated to you within 72 hours.

The Plan covers oral contraceptives for Plan participants through the Plan's prescription drug program, subject to the applicable coinsurance or copayment provided in the Schedule of Benefits.

PPO Network Preventive Services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant or Eligible Dependent for PPO Network services. This means that the service will be covered at 100% of the Plan's Allowable Charge, with no coinsurance, copay or deductible when you use PPO Network providers.

If Preventive Services are received from a non-network provider, they will not be eligible for coverage under this Preventive Services benefit.

Federal guidelines are unclear in some cases about which preventive care must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

In certain circumstances, as determined by the Fund, the Preventive Services benefit is only payable with an appropriate diagnosis.

ROUTINE PHYSICAL AND GYNECOLOGICAL EXAM COVERAGE

PPO Network Routine Physicals and Gynecological Exams are not subject to the office visit copayment. There is a limit of one Routine Physical and one Gynecological Exam per Calendar Year. To avoid any possible office visit charges for Preventive Services during the Calendar Year, you should have all Preventive Services performed during your PPO Network Routine Physical or Gynecological Exam.

Out-of-network Routine Physicals and Gynecological Exams are not covered.

WELL CHILD CARE EXAM COVERAGE

Well Child Care physical exams recommended in the American Academy of Pediatrics Bright Futures guidelines are treated as Preventive Services and paid at 100% if they are received from a PPO Network provider.

Out-of-network Well Child Care physical exams are not covered.

PREVENTIVE SERVICES OFFICE VISIT COVERAGE

For office visits other than office visits in connection with a Routine Physical or Gynecological Exam, the following applies:

PPO Network office visits for Preventive Services may be subject to cost-sharing, depending on the circumstances of the office visit, as discussed below.

(i) If a Preventive Services item or service is billed separately from the office visit, then the Plan will impose cost-sharing with respect to the office visit.

(ii) If the Preventive Services item or service is not billed separately from the office visit, and the primary purpose of the office visit:

  (a) Is the delivery of such Preventive Services item or service, then the Plan will pay 100% for the PPO Network office visit.

  (b) Is not the delivery of such Preventive Services item or service, then the Plan will impose cost-sharing with respect to the PPO Network office visit.

For example: If you have a cholesterol screening test during a PPO Network office visit, and the Physician bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge a copayment for the office visit but not for the lab work. If you see your Physician to discuss recurring abdominal pain and you have a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit. Keep in mind that if you receive your Preventive Services during your PPO Network Routine Physical or Gynecological Exam, you will not be charged an office visit copay. See Routine Physical and Gynecological Exam Coverage above.

Out-of-network office visits are covered in the manner described in the Schedule of Benefits.

To avoid any possible office visit charges for Preventive Services you receive during the Calendar Year, you should have all Preventive Services performed during your Routine Physical or Gynecological Exam. See Routine Physical and Gynecological Exam Coverage above.

WOMEN'S PREVENTIVE SERVICES

Women's Preventive Services in accordance with Health Resources and Services Administration are paid at 100% if they are provided by a PPO Network provider. Out-of-network services are not covered.

PREVENTIVE SERVICES COVERAGE LIMITATIONS AND EXCLUSIONS

(i) Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate Preventive Services codes. Services covered for diagnostic reasons are covered under the applicable Plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if you or your Dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.

(ii) Services covered under the Preventive Services benefit are not also payable under other portions of the Plan.

(iii) The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.

(iv) Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered. However, travel immunizations are covered under the medical benefits after you pay the required deductible and copayment.

(v) Examinations, screenings, tests, items, or services are not covered when they are Experimental or Investigative, as determined by the Plan.

(vi) Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

- When required for education, sports, camp, travel, insurance, marriage, adoption or other non-medical purposes;
- When related to judicial or administrative proceedings;
- When related to medical research or trials; or
- When required to maintain employment or a license of any kind.

vii. Over-the-counter drugs, medicines, vitamins, and/or supplements are covered only when required under the Preventive Services benefit, and only when prescribed by a Physician. Other prescription medications are covered under the Plan's prescription drug benefit, as required under the ACA.

q) The initial purchase, fitting and repair of fitted **Prosthetic Devices** that replace body parts, subject to any limits as shown in the Schedule of Benefits.

r) **Reconstructive Surgery:** correction of abnormal congenital conditions and reconstructive mammaplasties will be considered Covered Charges. This mammoplasty coverage will include reimbursement for:

(i) Reconstruction of the breast on which a mastectomy has been performed;

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(iii) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient.

s) **Speech Therapy** by a licensed speech therapist, subject to any limits as shown in the Schedule of Benefits. Therapy must be ordered by a Physician and follow either:

(i) Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person;

(ii) An Injury; or

(iii) A Sickness that is other than a learning or Mental Disorder.

t) **Sterilization Procedures,** subject to any limits as shown in the Schedule of Benefits.

u) **Surgical Dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

v) Coverage of **Well Newborn Nursery/Physician Care**.

Routine Well Newborn Nursery Care is room, board and other normal care for which a Hospital makes a charge. These benefits will be payable as shown in the Schedule of Benefits.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Reasonable and Customary Charges for nursery care for the first five days after birth while the newborn child is Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

Group health plans generally may not, under Federal law, restrict 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 cesarean section. Federal law 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Routine Physician Care is limited to Reasonable and Customary Charges made by a Physician for routine pediatric care while the newborn child is Hospital confined.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

w) Charges associated with the initial purchase of a **Wig after Chemotherapy,** subject to any limits as shown in the Schedule of Benefits.

x) Diagnostic **X-rays,** subject to any limits as shown in the Schedule of Benefits.

Y) **CLINICAL TRIALS**

The Plan covers charges for your participation in a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are those that are:

- Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if you were not participating in the Approved Clinical Trial; and

- Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

You are eligible for payment of charges related to participation in an Approved Clinical Trial if you:

- Satisfy the protocol prescribed by the Approved Clinical Trial provider; and

- Either:

  - Your network participating provider determines that your participation in the Approved Clinical Trial would be medically appropriate; or

  - You provide the Plan with medical and scientific information establishing that your participation in the Approved Clinical Trial would be medically appropriate.

For the purposes of this provision, an Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be

- Approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA), (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE), if the study has been reviewed and approved through a system of peer review that the Secretary of HHS

determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

- A study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

- A drug trial that is exempt from investigational new drug application requirements.

The following expenses are not covered by the Clinical Trials benefits:

- Expenses Incurred due to participation in an Approved Clinical Trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

- Expenses Incurred at a non-network provider if a network participating provider will accept you in an Approved Clinical Trial.

COST MANAGEMENT SERVICES

Utilization Review

Cost Management Services Phone Number

Please refer to your Employee ID Card for the Cost Management Services telephone number.

You, the patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after an emergency.

Note: *Any reduced reimbursement due to failure to follow Cost Management procedures will not accrue toward the maximum out-of-pocket limit.*

Utilization review is required to pre-certify inpatient hospitalization days and certain medical procedures. The program consists of:

1. Pre-certification for the following non-emergency services before medical and/or surgical services are provided:

   Hospitalizations
   Out Patient Surgery

2. Retrospective review of emergency inpatient admissions;

3. Concurrent review, based on the admitting diagnosis, when an extension of the pre-certified inpatient days is requested by the attending Physician; and

4. Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Utilization Review is required for non-emergency and emergency Hospital admissions. The utilization review administrator does not approve Employee or Dependent eligibility for Plan benefits. All claims must be submitted to the Plan for processing to determine the amount of benefits, if any, to be paid under the terms of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider. If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

You are free to choose any Physician or surgeon, and the Physician-patient relationship will be maintained. You, together with your treating Physician, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's How the Program Works

Pre-Certification – Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the number of inpatient Hospital days that are approved. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from you or your Provider. Contact the utilization review administrator at the telephone number on your ID card **at least 48 hours before** services are scheduled to be rendered with the following information:

- ❑ The name of the patient and relationship to the covered Employee,
- ❑ The name, identification number and address of the covered Employee,
- ❑ The name of the Fund,
- ❑ The name and telephone number of the attending Physician,
- ❑ The name of the Medical Care Facility, proposed date of admission, and proposed length of stay,
- ❑ The diagnosis and/or type of surgery, and
- ❑ The proposed list of medical services to be provided.

If there is an **emergency admission** to a Medical Care Facility, you, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the emergency inpatient admission.

The utilization review administrator will authorize the number of days of confinement in the Medical Care Facility. **Failure to follow this procedure may reduce the reimbursement received from the Plan. If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced as shown in the Schedule of Benefits.**

Concurrent Review/Discharge Planning

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and will coordinate with the attending Physician, Medical Care Facilities and Covered Person either a scheduled release date or an extension of the Medical Care Facility stay.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days no later than 24 hours before the end of the original pre-certified number of days or services.

REMEMBER:

1. Call the utilization review administrator before all non-emergency inpatient Hospital stays or outpatient surgery and within 48 hours of the first business day after an emergency inpatient admission.

2. The utilization review administrator reviews and approves hospitalization days based on the Physician's diagnosis and treatment plan. It does not approve Employee or Dependent eligibility, and it does not approve charges as covered charges under the Plan. All claims must be submitted to the Plan for processing under Plan terms.

3. If you do not follow the utilization review procedures, payment for covered charges under the Plan will be reduced.

Case Management

When a catastrophic condition, such as a spinal cord Injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime, care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting – even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician. This plan of care may include some or all of the following:

- Personal support to the patient;
- Contacting the family to offer assistance and support;
- Monitoring Hospital or Skilled Nursing Facility;
- Determining alternative care options; and
- Assisting in obtaining necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: *Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.*

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who meets the requirements as stated in the Eligibility Section of this Plan Document.

Adverse Benefit Determination means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Baseline means the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office or institution, which is not a Hospital or in a Hospital, where birth occurs in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Child and/or Children means, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible Foster Child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

CHIP refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

Chiropractic Services relates to all care rendered in a chiropractor's office, and includes but is not limited to skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

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

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis, cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions are **not** included: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning Sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Cosmetic means any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

Covered Expense(s) means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions.

Covered Person means an Employee, Retired Employee or Dependent who is covered under this Plan. Please refer to the Eligibility Section.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual insurance policy, Medicaid, Medicare, and a State Children's Health Insurance Program (SCHIP). Creditable Coverage also includes coverage under a public health plan of a State, city, county or other government subdivision, or of the U.S. or of any foreign country. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care, or long-term care, means care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding or supervision over medication that could normally be self-administered.

Dentist means a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent – A Dependent is:

1. The covered Employee's legally married Spouse;

2. The covered Employee's Child until the end of the month in which the Child reaches age 26;

3. A "Special Dependent". A Special Dependent is a Child of a covered Employee or retiree who had but lost coverage under the Plan due to reaching the upper age limit, but who is incapable of working or being gainfully employed because of a permanent physical or mental disability.

Under this Plan, "Spouse" has the meaning given on page 68, and "Child" has the meaning given for "Child(ren)" on page 59.

Durable Medical Equipment means equipment which a) can withstand repeated use, b) is primarily and customarily used to serve a medical purpose, c) generally is not useful to a person in the absence of an Illness or Injury and d) is appropriate for use in the home.

Emergency Services means with respect to an Emergency Medical Condition (defined below), a medical screening examination **within the emergency department of a Hospital,** including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

- The term **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

- The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Employee means a person who is an active, regular Employee of the Employer regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer means a contributing Employer to the Construction Industry Welfare Fund of Rockford, Illinois Group Health Benefit Plan.

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

Experimental and/or Investigational means any drugs, devices, procedures or treatments such that:

1. Its use requires approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to, the Federal Drug Administration (FDA); or

2. Its use is not yet recognized as acceptable medical practice throughout the United States to treat that Illness or Injury; or is subject to:

a. A written investigational or research protocol; or

b. A written informed consent or protocol used by the treating facility in which reference is made to the drug, device, procedure or treatment as being Experimental, Investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or

c. A written protocol, protocols or informed consent used by any other facility studying substantially the same drug, device, procedure or treatment which states it is Experimental, Investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or

d. An ongoing review by an Institutional Review Board (IRB); or

3. It does not have:

a. The positive endorsement of national medical bodies or panels, such as the American Cancer Society, the Agency for Health Care Policy and Research, or the National Cancer Institute; or

b. Multiple published peer review articles, in a recognized professional medical journal, concerning such drug, device, procedure or treatment and reflecting its reproducibility by non-affiliated sources which the Company determines to be authoritative; or

c. Trial results which indicate the drug, device, procedure or treatment are at least as effective as the current standard therapy.

Any drug, device, procedure or treatment which is deemed to be Experimental or Investigational in nature by an appropriate technological body established by state or federal government is considered an Experimental procedure.

Routine patient costs associated with an Approved Clinical Trial are deemed not to be Experimental or Investigational.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

Family Unit means the covered Employee or Retired Employee and the family members who are covered as Dependents under the Plan.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Fund means the Construction Industry Welfare Fund of Rockford, Illinois.

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration.

Genetic Information means information about genes, gene products and inherited characteristics that may be derived from an individual or a family member. This includes

information regarding an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and Genetic Information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency is an organization that meets all of these tests: a) its main function is to provide Home Health Care Services and Supplies; b) it is federally certified as a Home Health Care Agency; and c) it is licensed by the state in which it is located, if licensing is required.

Home Health Care Services and Supplies include: a) part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); b) part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); c) physical, occupational and speech therapy; d) medical supplies; and e) laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization whose main function is to provide Hospice Care Services and Supplies and is licensed by the state in which it is located, if licensing is required.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital unit that provides treatment under a Hospice Care Plan and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital is an institution, which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: a) it is accredited as a Hospital by The Joint Commission; b) it is approved by Medicare as a Hospital; c) it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; d) it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of register nurses (R.N.s); and e) it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" is expanded to include the following.

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: a) maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; b) has a Physician in regular attendance; c) continuously provides 24-hour-a-day nursing service by a registered nurse (R.N.); d) has a full-time psychiatrist or psychologist on the staff; e) is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse; and f) is licensed by the state in which it is located, if licensing is required.

Hours for purposes of determining eligibility, are those hours as reported for an Employee by an Employer. To be credited by the Fund as an "Hour" for purposes of determining eligibility,

the Fund must receive the full amount of the Employer contribution due for each hour. Hourly contribution rates are determined by the Trustees.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Incurred means that Covered Charges are Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Charges are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Charges for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury means any damage to a body part resulting from trauma from an external source.

Intensive Care Unit is defined as a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has facilities for special nursing care not available in regular rooms and wards of the Hospital, special lifesaving equipment which is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one registered nurse (R.N.) in continuous and constant attendance 24-hours a day.

Late Enrollee means an eligible Employee who does not enroll under the Plan when first eligible, or within 31 days of loss of other coverage that qualifies as a Special Enrollment event under the Plan. The term Late Enrollee includes those eligible Dependents who are not enrolled by the eligible Employee within 31 days of a Special Enrollment event, as required under Plan terms.

Maximum Annual Benefit Amount or Annual Maximum Benefit Amount are terms that appear in this Plan in reference to the aggregate benefit maximum for specific benefits listed in the Plan Section called "Schedule of Benefits". "Annual" is understood to mean January 1 through December 31. The specific Maximum Annual Benefit Amounts are shown on the Schedule of Benefits.

Medical Care Facility means a Hospital or a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medically Necessary care and treatment a) is recommended or approved by a Physician or Dentist; b) is consistent with the patient's condition or accepted standards of good medical and dental practice; c) is medically proven to be an effective treatment of the condition; d) is not performed mainly for the convenience of the patient or provider; e) is not conducted for research purposes; and f) is the most appropriate level of services which can be safely provided to the patient.

The fact that any particular provider may prescribe, order, recommend, or approve a service, supply or level of care does not, of itself, make such treatment Medically Necessary or make the charge a covered charge.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member means an individual who is a participant in the Plan as an Active Employee, Disabled Employee, Class B Early Retiree or Class C Retiree.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA means in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and

2. the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most current actuarial tables for a person of the same height, age and mobility as the Covered Person.

Naprapathic Care Services relates to all care and treatment rendered by a Doctor of Naprapathy*; Naprapathy is a branch of medicine (manual medicine) that focuses on the evaluation and treatment of neuro-musculoskeletal conditions. Naprapathic treatment consists of naprapathic manipulative techniques, adjunctive (additional) treatments, and nutritional counseling. **Doctors of Naprapathy (D.N.) (naprapathic Physicians) are not Doctors of Medicine (M.D.) (allopathic Physicians), an important distinction.*

No-Fault Auto Insurance is the basic reparation provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program will be administered in a psychiatric facility which is accredited by The Joint Commission will be licensed to provide Partial Hospitalization services, if required

by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours a day and no charge is made for room and board.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws for the state where he or she practices.

Physician means Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Licensed Clinical Social Worker (LCSW), Speech Language Pathologist and any other practitioner of the Healing Arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license. To the extent required by the Patient Protection and Affordable Care Act of 2010 (PPACA), if a service is covered under the Plan, the Plan will not discriminate based on the license or certification of the individual providing the service, if the individual is licensed to provide such services in the state in which the services are performed and the individual is acting within the scope of that license.

Plan means **Construction Industry Welfare Fund of Rockford, Illinois Group Health Benefit Plan**, which is a benefit Plan for eligible Employees and Retired Employees of **Construction Industry Welfare Fund of Rockford, Illinois** and is described in this Plan Document.

Plan Year is the 12-month period beginning on November 1st of each year and ending on October 31st.

Pre-Admission Testing Services cover diagnostic lab tests and x-ray exams when:

1. Performed on an outpatient basis within seven (7) days before a Hospital confinement;

2. Related to the condition which causes the confinement; and

3. Performed in place of tests while Hospital confined.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a) a Food and Drug Administration approved drug or medicine which, under federal law, is required to bear the legend, “Caution: federal law prohibits dispensing without prescription”; b) injectable insulin; and/or c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such a drug must be Medically Necessary in the treatment of a Sickness or Injury.

Preventive Care means certain Preventive Care services. This Plan intends to comply with the Patient Protection and Affordable Care Act’s (PPACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;

2. recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;

3. comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and

4. comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm or at https://www.healthcare.gov/prevention.

Qualified Medical Child Support Order is a judgment or decree by a court of "competent jurisdiction" that requires a group health plan to provide coverage to the Dependent Children of a Covered Employee pursuant to a state domestic relations law, or an administrative order in the form of a National Medical Child Support Order issued by a State agency. A person who is an alternate recipient under a Qualified Medical Child Support Order will be considered a beneficiary under the Plan for purposes of the Act. "Alternate Recipient" means any Child of a Covered Employee who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. A Covered Employee may obtain without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

Reasonable means in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Retired Employee or Retiree, where a Plan specifically provides for retiree coverage, is a former Active Employee of an Employer who meets the definition of a Retiree adopted by the Fund as set forth under the Plan Document, and who elects coverage subject to payment of the required retiree contribution.

Sickness is: Illness, disease or Pregnancy.

Skilled Nursing Facility is a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided;

2. Its services are provided for compensation and under the full-time supervision of a Physician;

3. It provides 24-hour per day nursing services by a licensed nurse, under the direction of a full-time registered nurse (R.N.);

4. It maintains a complete medical record on each patient;

5. It has an effective utilization review plan;

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental ill persons, Custodial or educational care or care of Mental Disorders; and

7. It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital or any other similar nomenclature.

Spouse is a person to whom a Member is legally married, including a marriage that was validly entered into in a state or country whose laws authorize the marriage of two individuals of the same sex. The term does not apply to persons (whether the same or opposite sex) who have entered into a domestic partnership, civil union or other similar formal relationship recognized under State or foreign law that is not denominated as a “marriage” under the laws of that State or country. The term excludes a person from whom the Member is divorced or legally separated.

Substance Abuse/Chemical Dependency is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that result in chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint. Care and treatment will include but is not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means:

- In the case of an Active Employee:

  The complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. The Plan Administrator has the discretionary authority to determine Total Disability.

- In the case of a Dependent:

The complete inability to perform the normal activities of a person of like age and sex in good health as a result of Injury or Sickness. The Plan Administrator has the discretionary authority to determine Total Disability.

Trust Agreement means the Agreement and Declaration of Trust establishing the Construction Industry Welfare Fund of Rockford, Illinois, as that instrument as may be amended from time to time.

Trust Fund or Fund means the Construction Industry Welfare Fund of Rockford, Illinois.

Trustees means the Employer Trustees and Union Trustees, collectively, as selected under the Trust Agreement, and as constituted from time to time in accordance with the provision of the Trust Agreement. Where this Plan Document / Summary Plan Description allows or requires action by the "Trustees", such action will be taken by and in accordance with the requirements of the Trust Agreement.

Usual and Customary means Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Women's Health and Cancer Rights Act of 1998 provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedemas).

PLAN EXCLUSIONS

Note: *Exclusions related to Prescription Drugs are on file with the Pharmacy Benefit Manager (PBM).*

Note: *Exclusions related to Dental benefits are shown in the Dental Benefits Section.*

For all medical benefits shown in the Schedule of Benefits, a charge for the following is **not** covered:

1. **Abortion** – Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest; however, complications of abortion are covered by the Plan.

2. **Claim Forms** – Fees incurred for completing claims forms.

3. **Cosmetic Procedures** – Charges incurred in connection with the care or treatment of, or operations that are performed for Cosmetic purposes, except to correct a congenital anomaly, reconstructive breast surgery if a mastectomy has been performed, or for Injuries sustained in an accident.

4. **Custodial Care** – Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except as shown in the Schedule of Benefits.

5. **Dental** – Oral surgery or dental treatment, except as specifically provided in the Plan.

6. **Educational or Training Programs** – Services performed by a Physician or other provider enrolled in an educational or training program when such services are related to that program, except as specifically provided in the Plan.

7. **Educational or Vocational Testing** – Services for educational or vocational testing or training, except as shown in the Schedule of Benefits.

8. **Excess Charges** – The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Reasonable and Customary Charge.

9. **Exercise Programs** – Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, and occupational or physical therapy covered by this Plan.

10. **Experimental, Investigational or Not Medically Necessary** – Care and treatment that is either Experimental/Investigational or not Medically Necessary.

11. **Eye Care** – Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, except as shown in the Schedule of Benefits.

12. **Foot Care** – All treatment of the feet (except open cutting operations and treatment required due to metabolic or peripheral vascular disease), except as shown in the Schedule of Benefits.

13. **Foreign Travel** – Care, treatment or supplies obtained outside of the U.S. if travel is for the sole purpose of obtaining medical services, unless approved by utilization management.

14. **Genetic Testing and Counseling** – Charges related to genetic testing or counseling, except as shown in the Schedule of Benefits.

15. **Government Coverage** – Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

16. **Hair Loss** – Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

17. **Hearing Aids and Exams** – Charges for services or supplies in connection with hearing aids or exams for their fitting, except as shown in the Schedule of Benefits.

18. **Home Birth –** Charges incurred in a non-Hospital or Birthing Center environment.

19. **Hospital Employees** – Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

20. **Hygiene** – Services, supplies, care or treatment to a Covered Person for hygienic purposes, except as shown in the Schedule of Benefits.

21. **Illegal Acts** – Charges for services received as a result of Injuries sustained, or Sickness contracted, while the Covered Person a) was engaged in an illegal felonious act or occupation; b) committed or attempted to commit any crime, criminal act, assault constituting a felony or other felonious behavior; or c) participated in a riot or public disturbance. This exclusion does not apply to alcohol or drug use. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

22. **Infertility, Reproductive Enhancement, Genetic Manipulation** – Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, in-vitro fertilization and other related procedures, except as shown in the Schedule of Benefits.

23. **Missed Appointments** – Charges incurred in the event of a missed appointment.

24. **No Charge** – Care and treatment for which there would not have been a charge if no coverage had been in force.

25. **No Obligation to Pay** – Charges Incurred for which the Plan has no legal obligation to pay.

26. **No Physician Recommendation** – Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the Regular Care of a Physician. "Regular Care" means ongoing medical supervision or treatment that is appropriate care for the Injury or Sickness.

27. **Obesity** – Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered.

28. **Occupational** – Care and treatment of an Injury or Sickness that is occupational; that arises from work for wage or profit including self-employment.

29. **Personal Comfort Items** – Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-Prescription Drugs and medicines, first-aid supplies and non-Hospital adjustable beds.

30. **Plan Design Excludes** – Charges excluded by the Plan as set forth in this Plan Document.

31. **Pregnancy of Children** – See the Schedule of Benefits for limitations (if any).

32. **Prescription Drugs** – Charges for outpatient drugs not purchased through the Prescription Drug card vendor (if applicable) or coordinated by Case Management.

33. **Replacement of Braces** – Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

34. **Sales Tax** – Charges for sales tax.

35. **Self-Inflicted** – Any loss due to an intentionally self-inflicted Injury, while sane or insane. This exclusion does not apply if the Injury resulted from an act of domestic violence or an underlying medical (including both physical and mental health) condition.

36. **Services Before or After Coverage** – Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

37. **Sex Changes** – Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery and medical or psychiatric treatment.

38. **Shipping and Handling** – Charges for shipping and handling.

39. **Sleep Disorders** – Care and treatment for sleep disorders unless deemed Medically Necessary.

40. **Surgical Sterilization Reversal** – Care and treatment for reversal of surgical sterilization.

41. **Telephone Consultations** – Charges incurred for consultations by telephone.

42. **Temporomandibular Joint Syndrome (TMJ)**. Please refer to the Dental Benefits Section.

43. **Travel or Accommodations** – Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as Covered Charges.

44. **Vitamins** – Charges for vitamins and nutritional supplements whether or not a Physician's Prescription is required.

45. **War** – Any loss that is due to a declared or undeclared act of war. This exclusion does not apply to any Covered Person who is not a member of the armed forces.

46. **Self-Injected or Self-Administered Drugs** – Drugs that are self-injected or self-administered are not covered. Such drugs may be covered under the Prescription Drug benefit.

LOSS OF TIME BENEFIT RULES

Class A Members Only

THIS BENEFIT IS NOT PAYABLE TO INDIVIDUALS PARTICIPATING AS NON-BARGAINING UNIT EMPLOYEES

This benefit applies when an Employee has a Total Disability that meets all of these tests:

1. Total Disability starts while the Employee is covered for this benefit;
2. Total Disability is being continuously treated by a Physician; and
3. Total Disability is due to an Injury or Sickness.

Failure to provide requested Physicians' statements will result in termination of benefits. Employees are responsible for providing the following information in a clearly understandable format:

- History regarding when symptoms first appeared or accident happened;
- Diagnosis;
- Dates of treatment;
- Nature of treatment;
- Progress;
- Prognosis;
- Suitability for rehabilitation; and
- Physician's signature and tax I.D. number.

Additional information may be required based upon the individual Illness or Injury

Benefit Payment

Benefits will be paid, as described in the Schedule of Benefits, for a Total Disability, up to a weekly benefit limit, as described in the Schedule of Benefits. An Employee's minimum weekly benefit payment is described in the Schedule of Benefits.

Period of Total Disability

A period of Total Disability is the period of time that an Employee is Totally Disabled.

A physician's report establishing proof of continuing disability must be submitted every six (6) months and more frequently if and as required by the Trustees or their delegate.

Bargaining unit Employees will have allocated to their eligibility, 5 Hours per day, up to a maximum of 100 Hours per month, when they are receiving Loss of Time benefits.

Disability Claim Procedures

You must follow the procedures outlined below to obtain disability benefits as a covered Employee under this Plan.

Disability Claims

You should direct all claims and questions regarding your disability claims to the Claims Administrator. The Plan Administrator will, ultimately and finally, be responsible for adjudicating such claims and for providing a full and fair review of the decision on such claims in accordance with the following provisions and with ERISA.

The Plan Administrator has discretionary authority to interpret the Plan in order to make disability claim determinations as the Plan Administrator may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any disability benefits under the Plan. Disability benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Employee is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Employee claiming benefits under the Plan will be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the disability is covered under the Plan. If the Plan Administrator determines that the disability is not covered under the Plan, or if the Employee fails to furnish such proof, as is requested, no benefit or no further benefits, as the case may be, will be payable to such Employee under the Plan.

The Plan will ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

- **When Disability Claims Must Be Filed**

Disability claims must be filed with the Claims Administrator within *six (6) months* of the date of the onset of the Total Disability. Benefits are based on the Plan's provisions in effect at the time of the onset of the Total Disability. **Claims filed later than the above-referenced date will be denied.**

A claim is considered to be filed when an appropriate claim form, completed and signed by the Employee and his Physician, setting forth the following information, is received by the Claims Administrator:

1. The date of the onset of the Total Disability;

2. The cause of the Total Disability;

3. The prognosis of the Total Disability; and

4. The extent of the Total Disability, including restrictions and limitations preventing the Employee from performing his or her regular occupation.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The following additional information must be provided to the Claims Administrator, although providing this information is not a requirement for the claim to be deemed to be filed:

1. Proof that the Employee is receiving appropriate and regular care for the disabling condition from a Physician who is someone other than the Employee or a member of the Employee's immediate family, and whose specialty or expertise is the most appropriate for the disabling condition(s) according to generally accepted medical practice; and

2. Objective medical findings that support the Total Disability, including but not limited to tests, procedures or clinical examinations standardly accepted in the practice of medicine for the condition(s).

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, the Claims Administrator may request more information, as provided herein. This additional information must be received by the Claims Administrator within 45 days from the date it is requested. **Failure to provide the additional information requested may result in claims being declined or reduced.**

- **Timing of Claim Decisions**

The Plan Administrator will notify the Employee, in accordance with the provisions set forth below, of any adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan.

Extensions: This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Employee prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the

Employee, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

Calculating Time Periods: The period of time within which a benefit determination is required to be made will begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Requests for Additional Information: In the event the circumstances requiring an extension include the need for more information, the Employee must be allowed at least 45 days after receipt of the notice to provide this information. If the additional information is requested during the initial 45-day processing period, then the remainder of time left in the initial processing period is lost, and, upon receipt of the information, the first 30-day extension period begins to run. Similarly, if the additional information is requested during the first extension period, then the remainder of time left in the first extension period is lost, and, upon receipt of the information, the second 30-day extension period begins to run. If the additional information is requested during the second extension period, then the remainder of time left in the second extension period is lost, and the Plan must obtain the Employee's consent to additional time for processing the information provided.

- **Notification of an Adverse Benefit Determination**

The Plan Administrator will provide an Employee with written or electronic notification that a claim is denied, in whole or in part, which will advise the Employee of the following:

1. The specific reason or reasons for the denial, including a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

   (a) The views presented by the Employee of health care professionals treating the Employee and vocational professionals who evaluated the Employee;

   (b) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Employee's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

   (c) A disability determination regarding the Employee presented by the Employee made by the Social Security Administration.

2. Reference to the portion(s) of the Plan Document on which the denial is based

3. A description of any additional material or information necessary for the Employee to perfect the claim and an explanation of why such material or information is necessary;

4. A description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of the Employee’s right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination following a final appeal;

5. A statement that the Employee is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Employee's claim for benefits;

6. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

7. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination (and a statement that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Employee upon request or), alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not; and

8. If the adverse benefit determination is based upon a medical judgment, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

- **REVIEW PROCEDURE**

If the claim requires an independent determination by the Plan Administrator of the disability status of an Employee, spouse, or dependent, and the Plan Administrator denies the claim, in whole or in part, the Employee shall have the opportunity for a full and fair review by the Plan Administrator of the denial, as follows:

1. Prior to such review of the denied claim, the Employee shall be given, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim, or any new or additional rationale, as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give the Employee a reasonable opportunity to respond prior to that date.

2. The Plan Administrator shall respond in writing to such Employee within forty-five (45) days after receiving the request for review. If the Plan Administrator determines that special circumstances require additional time for processing the claim, the Plan Administrator can extend the response period by an additional forty-five (45) days by notifying the Employee in writing, prior to the end of the initial 45-day period that an additional period is required. The notice of extension must set forth the special circumstances and the date by which the Plan Administrator expects to render its decision.

3. The Employee shall be given the opportunity to submit issues and written comments to the Plan Administrator, as well as to review and receive, without charge, all relevant (as defined in applicable ERISA regulations) documents, records and other information relating to the claim. The reviewer shall take into account all comments, documents, records and other information submitted by the Employee relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

4. In considering the review, the Plan Administrator shall take into account all comments, documents, records and other information submitted by the Employee relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Additional considerations shall be required in the case of a claim for disability benefits. For example, the claim will be reviewed by an individual or committee who did not make the initial determination that is subject of the appeal, nor by a subordinate of the individual who made the determination, and the review shall be made without deference to the initial adverse benefit determination. If the initial adverse benefit determination was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional with appropriate training and experience in the field of medicine involving the medical judgment. The health care professional who is consulted on appeal will not be the

same individual who was consulted during the initial determination or the subordinate of such individual.

- **Notice of Decision after Review**

In the case of an adverse benefit determination with respect to disability benefits, on the basis of the Plan Administrator's independent determination of the Participant's disability status, the Plan Administrator will provide a notification in a culturally and linguistically appropriate manner (as described in Department of Labor Regulation Section 2560.503-1(o)) that includes each of the elements described above in "Notice of Adverse Benefits Determination" (other than item #3) and the following additional items:

9. A statement describing any voluntary appeal procedures offered by the Plan and the Employee's right to obtain the information about such procedures;

10. With the statement of the Employee's right to bring a civil action under ERISA Section 502(a) and description of any applicable contractual limitations period that applies to the Employee's right to bring such an action, the calendar date on which the contractual limitations period expires for the claim;

11. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

- **Language Requirements**

All Notices (initial Notice of Adverse Determination and Notice of Decision After review) will be written in a culturally and linguistically appropriate manner when the Employee's address is in a county where 10 percent or more of the population is literate only in the same non-English language.

- **Exhaustion of Remedies**

An Employee must follow the claims review procedures under this Plan and exhaust his or her administrative remedies before taking any further action with respect to a claim for benefits.

- **Failure of Plan to Follow Procedures**

In the case of a claim for disability benefits, if the Plan fails to strictly adhere to all the requirements of this claims procedure with respect to a disability claim, the Employee shall be deemed to have exhausted the administrative remedies available under the Plan, and shall be entitled to pursue any available remedies under ERISA Section 502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim, except where the violation was: (a) de minimis; (b) non-prejudicial; (c) attributable to good cause or matters beyond the Plan's control; (d) in the context of an ongoing good-faith exchange of information; and (e) not reflective of a pattern or practice of noncompliance. The Employee may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies to be deemed exhausted. If a court rejects the Employee's request for immediate review on the basis that the Plan met the standards for the exception, the claim

shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the Employee with notice of the resubmission.

PRESCRIPTION DRUG COVERAGE

How Prescription Drugs Are Covered

Prescription Drugs may be covered under this Plan in two ways:

1. Under the prescription drug card benefit; or

2. Under the medical provisions of the Plan; as authorized.

Pharmacy Drug Charge

Participating Pharmacies have contracted with the Plan to charge you reduced fees for covered Prescription Drugs. Please refer to your Employee ID card for information about the prescription drug card vendor.

Co-Payment

The co-payment is applied to each covered Pharmacy drug charge and is shown in the Schedule of Benefits. The co-payment amount is not a covered charge under the Medical Plan.

If you purchase Prescription Drugs from a non-participating Pharmacy, or from a participating Pharmacy without using your ID card, the amount payable in excess of the co-payment will be the ingredient cost and dispensing fee.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those prescriptions that you take for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). The mail order Pharmacy is able to offer you significant savings on your prescriptions due to the volume.

Specialty Drug Benefit Option

The specialty drug benefit option is mandatory for the dispensing of specialty drugs as determined by the Pharmacy Benefit Manager (PBM). Your failure to use the specialty drug benefit program may reduce the benefits available to you under the Plan.

Covered Prescription Drugs

1. All drugs prescribed by a Physician that require a prescription either by federal or state law, unless otherwise excluded.

2. Certain drugs are covered through the Pharmacy drug plan and others are covered under the Medical Plan.

3. All drugs that are excluded by Medicare Part D are excluded unless mandated by the Affordable Care Act.

Limits to this Benefit

This benefit applies only when you incur a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a Physician; and

2. Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following unless noted otherwise. Please consult with the drug card vendor for a complete listing of Plan limitations.

1. **Administration** – Any charge for the administration of a covered Prescription Drug.

2. **Appetite Suppressants** – A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

3. **Consumed on Premises** – Any drug or medicine that is consumed or administered at the place where it is dispensed.

4. **Devices** – Devices of any type, even though they may require a prescription, including but not limited to therapeutic devices, artificial appliances, braces, support garments or any similar device. However, contraceptive devices are covered, as required by the PPACA.

5. **Experimental Drugs** and medicines, even though you are charged for them.

6. **FDA** – Any drug not approved by the Food and Drug Administration.

7. **Investigational** – A drug or medicine labeled, “Caution – limited by federal law to Investigational use.”

8. **No Charge** – A charge for Prescription Drugs that properly may be received without charge under local, state or federal programs.

9. **No Prescription** – A drug or medicine that legally can be bought without a written prescription. This does not apply to injectable insulin.

10. **Refills** – Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

VISION CARE BENEFITS

Vision care benefits are provided through Spectera as the preferred provider of the Fund.

Benefit Payment

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits, or in the Spectera schedule of benefits.

DENTAL BENEFITS

How Dental Benefits Are Covered

This benefit applies when you incur covered dental charges while you are covered under this Plan.

Dental benefits are provided through Delta Dental.

Deductible

Deductible Amount – This is an amount of covered dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, each Covered Person must meet the deductible shown in the Schedule of Benefits.

Benefit Amount

Each Calendar Year, benefits will be paid for your covered dental charges in excess of the deductible. Payment will be made at the rate shown under "Dental Percentage Payable" in the Schedule of Benefits. No benefits will be paid in excess of the dental Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount for covered dental charges is shown in the Schedule of Benefits.

Dental Charges

Covered Dental charges are the Reasonable and Customary Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is Incurred on the date the service or supply is performed or furnished; however, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Plan will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered Incurred as each visit or treatment is completed.

Covered Dental Services

TYPE I Services: Preventive and Diagnostic Dental Procedures

The limits on Class A Services are for routine services. If dental need is present, this Plan will consider reimbursement of services that are performed more frequently than the limits shown.

1. **Routine Oral Exams,** including the cleaning and scaling of teeth. Limit of two exams per Covered Person each Calendar Year.

2. **X-rays:**

   a) Two bitewing x-ray series every Calendar Year; and

b) One full mouth or panorex x-ray every thirty-six (36) months.

3. Two **Fluoride Treatments** for covered Dependent Children under age 18 each Calendar Year.

4. **Space Maintainers** for covered Dependent Children.

5. **Emergency Palliative Treatment** for pain.

TYPE II Services: Basic Dental Procedures

1. Dental **X-rays** not included in Class A.

2. **Oral Surgery** is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.

3. **Periodontics** (gum treatments).

4. **Endodontics** (root canals).

5. **Extractions** include impacted wisdom teeth, local anesthesia and routine post-operative care.

6. **Re-Cementing** bridges, crowns or inlays.

7. **Repair** of crowns, bridgework and removable dentures.

8. **Rebasing or Relining** of removable dentures.

9. **Fillings**, other than gold.

10. **General Anesthetics**, upon demonstration of Medical Necessity.

11. **Antibiotic Drugs.**

12. **Sealants** on the occlusal surface on a permanent posterior tooth for covered Dependent Children.

TYPE III Services: Major Dental Procedures

1. **Gold Restorations**, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

2. Installation of **Crowns.**

3. Installation of **Precision Attachments** for removable dentures.

4. Installation of partial, full or removable **Dentures**. This service also includes all adjustments made during a six-month period following the installation.

5. Addition of **Clasp or Rest** to existing partial removable dentures.

6. Initial installation of **Fixed Bridgework** to replace one or more natural teeth that were extracted.

7. Installation of **Implants**.

8. **Replacing** an existing removable partial or full denture or fixed bridgework, adding teeth to an existing removable partial denture or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests are met:

    a) The replacement or addition of teeth is required because of one or more natural teeth being extracted;

    b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable; or

    c) The existing denture is of an immediate temporary nature – replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

TYPE IV Services: Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services include the preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and a retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

Predetermination of Benefits

Before starting a dental treatment for which the charge is expected to be **$250.00** or more, you should submit a "Predetermination of Benefits" form.

A regular dental claim form is used for the predetermination of benefits. You complete the Employee section of the form and then give the form to the Dentist to complete.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Delta Dental Plan of Illinois
111 Shuman Blvd.
Naperville, IL 60563
(630) 718-4700

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. You and your Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable, taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

Alternative Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause that governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Reasonable and Customary Charge for an amalgam filling. The patient will pay the difference in cost.

Expenses Not Covered

Charges for the following are **not** covered:

1. **Administrative Costs** of completing claim forms and reports, or for providing dental records.

2. **After Coverage** – The Plan will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for covered dental expenses Incurred for the following procedures will be payable as though the coverage had continued in force:

   A. A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Covered Person and the Dentist delivers and installs the device within two months following termination of coverage;

   B. A crown, if the Dentist prepared the tooth for the crown while the patient was a Covered Person and the Dentist installs the crown within two months following termination of coverage; and

   C. Root canal therapy, if the Dentist opened the tooth while the patient was a Covered Person and the Dentist completes the treatment within two months following termination of coverage.

3. **Broken Appointments** – Charges for broken or missed dental appointments.

4. **Cosmetic Dentistry.**

5. **Crowns** for teeth that are restorable by other means or for the purpose of periodontal splinting.

6. **Excluded Under Medical** – Services that are excluded under the Medical Plan Exclusions.

7. **Experimental** – Charges for services or supplies that are not in keeping with accepted standards of dental practice, including charges for services or supplies that are Experimental.

8. **Hygiene** – Oral hygiene, plaque control programs or dietary instructions.

9. **Medical Services** that, to any extent, are payable under any medical expense benefits of the Plan.

10. **Orthognathic Surgery.**

11. **Personalization** of dentures.

12. **Replacement** of lost or stolen appliances.

13. **Splinting.**

14. **Temporary Full Dentures.**

HEALTH CLAIM PROCEDURES

How to File a Claim

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan. "Health benefits" include *medical, dental, vision and prescription drug claims.*

When a Covered Person has a claim to submit for payment, that person must:

1. Obtain a claim form from the Fund Office or the Claim Administrator.

2. Complete the Employee portion of the form. ***All questions must be answered.***

3. Have the Physician or Dentist complete the provider's portion of the form.

4. For Plan reimbursements, attach bills for services rendered. ***All bills must show the following information:***

    a) Name of Plan;

    b) Employee's name;

    c) Name of patient;

    d) Name, address, telephone number of the provider of care;

    e) Diagnosis;

    f) Type of services rendered, with diagnosis and/or procedure codes;

    g) Date of services; and

    h) Charges.

5. Send the above to the Claims Administrator at this address:

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, IL 60173
847-519-1880

You should direct all claims and questions regarding health claims to the Claims Administrator. The Plan Administrator will be ultimately and finally responsible for adjudicating such claims and for providing a full and fair review of the decision on such claims in accordance with the following provisions and with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with this Plan Document/Summary Plan Description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan will be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the claimant has not Incurred a covered expense or that the benefit is not covered under the Plan, or if the claimant fails to furnish such proof as is requested, no benefits will be payable under the Plan.

Types of Claims

Under the Plan, there are *four* types of healthcare claims: Pre-Service (Urgent and Non-Urgent), Concurrent Care and Post-Service.

Pre-Service Claims:

A "Pre-Service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-Service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize the claimant's life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-Service Claim." The claimant simply follows the Plan's procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-Service Claim.

Concurrent Claims:

A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the claimant requests an extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-Service Claim.

Post-Service Claims:

A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Healthcare claims must be filed with the Claims Administrator within 365 days of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.**

A Pre-Service Claim (including a Concurrent Claim that also is a Pre-Service Claim) is considered to be filed when the request for approval of the treatment or services is made and received by the Claims Administrator, in accordance with the Plan's procedures. However, a Post-Service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (48 hours in the case of Pre-Service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to provide the requested information may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator must notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-Service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-Service Urgent Care Claims:

If the claimant has provided all of the necessary information to process the claim, the claimant will be notified of the decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of

benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-Service Non-Urgent Care Claims:

If the claimant has provided all of the information needed to process the claim, the claimant will be notified of the decision in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim, then not later than 30 days after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 15 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Concurrent Claims:

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), the claimant will be notified of the decision before the end of such period of time or number of treatments. The claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, the claimant will be notified of the decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

Request by Claimant Involving Non-Urgent Care. If the Plan Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-Service Non-Urgent Claim or a Post-Service Claim).

Post-Service Claims:

If the claimant has provided all of the information needed to process the claim, the claimant will be notified of the decision in a reasonable period of time, but not later than 30 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim, then not later than 45 days after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 30 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, but not later

than 15 days after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Extensions – Pre-Service Urgent Care Claims. No extensions are available in connection with Pre-Service Urgent Care Claims.

Extensions – Pre-Service Non-Urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-Service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made will begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that additional information is requested, the period for making the benefit determination is tolled from the date of the request until the claimant responds to the request for additional information.

Notification of an Adverse Benefit Determination

The Plan Administrator will provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-Service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;

2. Specific reason(s) for a denial;

3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;

5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);

8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and

9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

Appeals of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;

2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who will be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

7. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits in the possession of the Plan Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and

8. In an Urgent Care Claim, for an expedited review process pursuant to which:

a) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

b) All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

First Appeal Level

Requirements for First Appeal

The claimant must file the first appeal in writing (although oral appeals are permitted for Pre-Service Urgent Care Claims) within 180 days following receipt of the notice of an adverse benefit determination. For Pre-Service Urgent Care Claims, if the claimant chooses to orally appeal, the claimant may telephone 847-519-1880 and ask for the Claim Manager. To file an appeal in writing, the claimant's appeal must be addressed and mailed (postage prepaid) or faxed to:

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, IL 60173
Attention: Claim Manager
Phone: 847-519-1880
Fax: 847-519-1979

To be considered timely filed, an appeal of an adverse benefit decision must be postmarked or faxed on or before the 180th day following receipt of the notice of the adverse benefit determination. Failure to comply with this important deadline may cause the claimant to forfeit any right to further review on an adverse decision under these procedures or in a court of law.

It will be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/claimant;

2. The Employee/claimant's identification number;

3. The group name or identification number;

4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;

5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Plan Administrator will notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-Service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the appeal.

Pre-Service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-Service Urgent, Pre-Service Non-Urgent or Post-Service.

Post-Service Claims: Within a reasonable period of time, but not later than five (5) days after the date of the second monthly Trustee meeting following the Plan's receipt of the appeal.

Calculating Time Periods: The period of time within which the Plan's determination is required to be made will begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan Administrator will provide a claimant with notification, with respect to Pre-Service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;

2. Reference to the specific portion(s) of the *Plan Document and Summary Plan Description upo*n which the denial is based;

3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of

the Plan to the claimant's medical circumstances, will be provided free of charge upon request;

7. A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information regarding any such procedures;

8. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

9. A description of the Plan's review procedures and the time limits applicable to the procedures;

10. For Pre-Service Urgent Care Claims, a description of the expedited review process applicable to such claims;

11. A statement of the claimant's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator will provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal," as appropriate.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the denial of benefits. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in writing (although oral appeals are permitted for Pre-Service Urgent Care Claims) and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal

The Plan Administrator will notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-Service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.

Pre-Service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-Service Urgent, Pre-Service Non-Urgent or Post-Service.

Post-Service Claims: Within a reasonable period of time, but not later than five (5) days after the date of the second monthly Trustee meeting following the Plan's receipt of the appeal. but not later than 30 days after receipt of the second appeal.

Calculating Time Periods: The period of time within which the Plan's determination is required to be made will begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; (ii) a description of the Plan's review procedures and the time limits applicable to the procedures; and (iii) for Pre-Service Urgent Care Claims, a description of the expedited review process applicable to such claim. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator will provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. Unless the decision is subject to the Plan's external review process and the claimant makes a timely request for external review in accordance with the external review procedures, the decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law, including judicial deference.

All internal claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's internal claim review procedures have been exhausted, except that if the claimant makes a timely request for external review in accordance with the Plan's external review procedures, this one-year period is tolled during the time the external review is pending.

External Review Procedure under Patient Protection and Affordable Care Act (PPACA)

If a claim is denied in whole or in part because the information provided does not meet the Plan requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or because the treatment is Experimental the Covered Person may have a right to a review by an Independent Review Organization (IRO). The Covered Person may also request an IRO review if the Plan retroactively rescinds coverage back to his or her enrollment date for a reason other than the person not being eligible for coverage under Plan rules. The Covered Person must first exhaust the Plan's internal appeal requirements. The IRO review request must be in writing and must be filed within 4 months of receiving a final denial of an internal Plan appeal.

External Review of Standard Claims

The Plan will have 5 business days after receiving the written request to review the claim and verify that the Covered Person is eligible for an IRO review. The Plan will verify whether (a) the person was an eligible Covered Person at the time the claim was Incurred; (b) the Plan's internal appeal requirements have been exhausted; and (c) all of the information and forms required to process an external IRO review have been provided.

Within 1 business day after completing its review the Plan will send the Covered Person written notice of eligibility for an IRO review. If the Plan's notice asks for additional information it must be provided within the original 4-month IRO review request period. If the original 4-month IRO review request period ended, the Covered Person must provide the information within 48 hours of receipt of the Plan's notice.

If the Covered Person is eligible for an IRO review, the Plan will assign one of three unrelated IROs to review the claim. The IRO will conduct its review under the requirements of the U.S. Department of Labor Technical Release 2010-01. If the Covered Person receives communications from the IRO during the review, he or she is responsible for responding to the IRO in the time period set by the IRO. The IRO determination will be final and binding on the Plan and may be binding on the claimant. Judicial review may be available to the claimant.

Expedited External Review of Urgent Care Claims

A Covered Person may request an expedited external review if:

1. The Covered Person receives an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the Covered Person’s life or health, or would jeopardize the Covered Person’s ability to regain maximum function, and the Covered Person has filed a request for an expedited internal appeal; or

2. The Covered Person receives an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the Covered Person’s life or health or would jeopardize the Covered Person’s ability to regain maximum function; or the Covered Person receives an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Person received Emergency Services, but the Covered Person has not yet been discharged from a facility.

Preliminary Review

Upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request as soon as possible to determine whether the request meets the reviewability requirements set forth in the *Preliminary Review Procedures* section above. The Plan will send the Covered Person a notice as soon as possible informing the Covered Person as to whether the request for review meets the threshold requirements for external review, along with other information described in the Preliminary Review Procedures section above.

Review By Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth for standard reviews, as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will provide coverage or payment for the reviewed claim as soon as possible in accordance with applicable law. The Plan reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law. The Plan must provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If the Covered Person is dissatisfied with the external review determination, the Covered Person may seek judicial review as permitted under ERISA Section 502(a).

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under state or Federal law.

The IRO will maintain records of all claims and notices associated with the eternal review process for a minimum of six (6) years. An IRO will make such records available for examination by the Covered Person, the Plan, or state or Federal government oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

Assignment

As a courtesy, the Plan Administrator will permit benefits for medical expenses covered under this Plan to be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the Employee, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid.

No Covered Person may at any time, either during the time in which he or she is covered under the Plan, or following termination as a Covered Person, in any manner, have any right to assign his right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he may have against the Plan or its fiduciaries.

Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Balance-Billing

In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan’s position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance-billing is legal in many jurisdictions, and the Plan has no control over non-Network Providers that engage in balance-billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan’s position that the Covered Person should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance-billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance-billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

Medicaid Coverage

A Covered Person's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Non U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non U.S. Provider;

2. The Covered Person is responsible for making all payments to Non U.S. Providers, and submitting receipts to the Plan for reimbursement;

3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;

4. The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and

5. Claims for benefits must be submitted to the Plan in English.

Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person or Dependent on whose behalf such payment was made.

A Covered Person, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Persons and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Covered Persons) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;

2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;

4. With respect to an ineligible person;

5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or

6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person or by any of his covered Dependents if such payment is made with respect to the Covered Person or any person covered or asserting coverage as a Dependent of the Covered Person.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

COORDINATION OF BENEFITS

Coordination of the Benefit Plans – Coordination of benefits sets out rules for the order of payment of Covered Charges when you (or your Spouse or covered children) are covered by this Plan and another Benefit Plan. In that event, the Benefit Plans will coordinate benefits when a claim is received.

The Benefit Plan that pays first according to the rules will pay as if there were no other Benefit Plan involved. The secondary and subsequent Benefit Plan(s) will pay the balance due up to 100% of the total Allowable Charges.

For Class C Retirees, this Plan will pay secondary to Medicare. Class C Retirees are required to be enrolled in Medicare Part A and B. This Plan will reimburse as if Medicare Part A and B are in effect, even if the Class C Retiree has not enrolled in both.

Benefit Plan – This provision will coordinate the medical and dental benefits of Benefit Plans. The term "Benefit Plan" means this Plan and any one of the following plans:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Covered Person;
4. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Allowable Charge – For a charge to be allowable, it must be a Reasonable and Customary Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only Benefit Plans, this Plan will not consider any charges in excess of what an HMO or Network Provider has agreed to accept as payment in full. Also, when an HMO or network Benefit Plan is primary and the Covered Person does not use an HMO or Network Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network Benefit Plan had the Covered Person used the services of an HMO or Network Provider.

In the case of service-type Benefit Plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile Limitations – When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. This

Plan will always be considered the secondary carrier regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

Benefit Plan Payment Order – When two or more Benefit Plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

1. Benefit Plans that do not have a coordination provision, or one like it, will pay first. Benefit Plans with such a provision will be considered after those without one.

2. Benefit Plans with a coordination provision will pay their benefits up to the Allowable Charge.

    a) The benefits of the Benefit Plan that covers a person directly (that is, as an employee, Member or subscriber) ("Plan A") are determined before those of the Benefit Plan that covers that person as a Dependent ("Plan B"). Special Rule, if:

        (i) The person covered directly is a Medicare beneficiary; and

        (ii) Medicare is secondary to Plan B; and

        (iii) Medicare is primary to Plan A (for example, if the person is retired); **then**

        Plan B will pay before Plan A.

    b) The benefits of a Benefit Plan that covers a person as an employee who is neither laid-off nor retired are determined before those of a Benefit Plan that covers that person as a laid-off or retired employee. The benefits of a Benefit Plan that covers a person as a dependent of an employee who is neither laid-off nor retired are determined before those of a Benefit Plan that covers that person as a dependent of a laid-off or retired employee. If the other Benefit Plan does not have this rule, and if, as a result, the Benefit Plans do not agree on the order of benefits, this rule does not apply.

    c) The benefits of a Benefit Plan that covers a person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired are determined before those of a Benefit Plan that covers the person as a COBRA beneficiary.

    d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

        (i) The benefits of the Benefit Plan of the parent whose birthday falls earlier in a year are determined before those of the Benefit Plan of the parent whose birthday falls later in that year; or

        (ii) If both parents have the same birthday, the benefits of the Benefit Plan that has covered the parent for the longer time are determined before those of the Benefit Plan which covers the other parent.

    e) When a child's parents are divorced or legally separated, these rules will apply:

        (i) This rule applies when the parent with custody of the child has not remarried. The Benefit Plan of the parent with custody will be considered before the Benefit Plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The Benefit Plan of the parent with custody will be considered first. The Benefit Plan of the stepparent/spouse of the parent with custody that covers the child as a dependent will be considered next. The Benefit Plan of the parent without custody will be considered last.

(iii) This rule will take the place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the Benefit Plan of that parent will be considered before other Benefit Plans that cover the child as a dependent.

(iv) If the specific items 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 of the child, the Benefit Plans covering the child will follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

f) If a dependent child has coverage under this Plan and also has coverage as a dependent under a spouse's plan, then the plan which has covered that dependent child for the longer time period will be primary and the plan which has covered that dependent for the shorter time period will be secondary.

g) If there is still a conflict after these rules have been applied, the Benefit Plan that has covered the parent for the longer time will be considered first. When there is a conflict in coordination of benefit rules, this Plan will never pay more than 50% of Allowable Charges.

h) If another Benefit Plan covers a person directly and that Benefit Plan reduces the benefits payable because that person is covered by this Plan as a Dependent, this Plan will not pay more than 50% of Allowable Charges.

3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payor, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

4. If a Covered Person is under a disability extension from a previous Benefit Plan, that Benefit Plan will pay first and this Plan will pay second.

Claims Determination Period – Benefits will be coordinated on a Calendar Year basis. This is called the "Claims Determination Period."

Right to Receive or Release Necessary Information – To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person, subject to the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A Covered Person will give this Plan the information it asks for about the other plans and their payment of Allowable Charges.

Facility of Payment – This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right to Recover Overpayments and Other Erroneous Payments – This Plan may pay benefits that should be paid by another Benefit Plan. In this case, this Plan may recover the amount paid from the other Benefit Plan or the Covered Person. That repayment will count as a valid payment under the other Benefit Plan. Further, this Plan may pay benefits that are later found greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment.

THIRD PARTY RECOVER, SUBROGATION AND REIMBURSEMENT

Benefits Subject to This Provision - This provision applies to all benefits provided under any section of this Plan.

When This Provision Applies – You or your Dependents may incur medical or other charges related to Injuries or Illness for which benefits are paid by the Plan. The Injuries or Illness may be caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of any charges Incurred in connection with the Injuries or Illness. If so, the Covered Person, his or her spouse, Dependents, estate and others (collectively referred to as the "Covered Person" in this section) may have a claim against that other person or a third party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the Covered Person may have against that other person or third party and will be entitled to Reimbursement. In addition, the Plan will have a first priority lien against any Recovery to the extent of benefits paid or to be paid and expenses Incurred by the Plan in enforcing this provision. Accepting any benefits or making any claim for benefits under this Plan constitutes constructive notice of agreement with and consent to the subrogation requirements described in this provision.

As a condition to receiving benefits under the Plan, the Covered Person must:

1. Assign and subrogate to the Plan his rights to recovery when this provision applies;

2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount;

3. Immediately reimburse the Plan out of the Recovery made from the other person, the other person's insurer or the third party, 100% of the amount of medical or other benefits paid for the Injuries under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for any attorneys' fees including but not limited to fees claimed pursuant to a common fund doctrine, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, the Covered Person and his or her attorney will execute and deliver all required instruments and papers, including a subrogation agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness.

The Plan has no obligation to pay any medical or other benefits for the Injuries or Illness before these papers are signed and things are done; however, in the event the Plan does so, the Plan will still be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing, and will not permit his or her attorney to do anything, to prejudice the

right of the Plan to subrogate and be reimbursed. The Covered Person acknowledges and agrees that the Plan precludes operation of the made-whole and common-fund doctrines. If the Covered Person retains an attorney, the Covered Person agrees to only retain one who will not assert the common-fund or made-whole doctrines. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator has maximum discretion to: a) construe and interpret the terms and provisions of this provision; b) to make all interpretive and factual determinations regarding issues related to subrogation and reimbursement; and c) to decide disputes that may arise relative to a Covered Person's rights. If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, reference herein to the Plan Administrator will be deemed to include such delegate. The decisions of the Plan Administrator will be final and legally binding on all interested parties.

Amount Subject to Subrogation or Reimbursement - All amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

"Another Party" means any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illness, and includes but is not limited to the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, No-Fault Auto Insurance, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery" means any and all monies paid to the Covered Person by way of judgment, settlement, or otherwise (and no matter how those monies may be characterized or designated) to compensate for all losses caused by, or in connection with, the Injuries or Illness. Any Recovery will be deemed to apply, first, for Reimbursement.

"Subrogation" means the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against the other person, the other person's insurer and the third party.

"Reimbursement" means repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses incurred by the Plan in collecting this benefit amount.

When the Covered Person is a Minor, Disabled or Deceased - These provisions apply to the parents, trustee, guardian or other representative of a minor or disabled Covered Person and to the personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the Covered Person's representative has access or control of the Recovery.

<u>When a Covered Person Does Not Comply</u> - When a Covered Person does not comply with the provisions of this Section, the Plan Administrator has the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to reduce future benefits payable under the Plan by the amount due as Reimbursement to the Plan. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, (including fees and costs incurred prior to the filing of the action) regardless of the action's outcome.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

As a participant in the **Construction Industry Welfare Fund of Rockford, Illinois Group Health Benefit Plan** (the Plan), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to elect to continue Plan coverage for yourself, your enrolled spouse or enrolled Dependents if there is a loss of coverage due to a qualifying event.

This Plan Section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. COBRA continuation coverage may become available to you and to other members of your family who are covered under the Plan when you or they would otherwise lose Plan coverage due to a qualifying event. You, your enrolled spouse or enrolled Dependents will be required to pay for COBRA continuation coverage. This information is included as part of this Plan Document/Summary Plan Description. For additional information, you should contact the Plan Administrator.

A child who becomes a Dependent Child by birth, adoption or placement for adoption with a COBRA participant during a period of COBRA Continuation Coverage is also eligible for coverage under COBRA. As with other COBRA beneficiaries, payment must be made for such beneficiary's coverage during the period of coverage.

The Plan Administrator is located at 1322 East State Street, Rockford, Illinois 61104. COBRA continuation coverage for the Plan is administered by a COBRA Administrator designated by the Plan Administrator. The name of the COBRA Administrator can be found in the ERISA General Information Section at the end of this Plan Document/Summary Plan Description.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is listed as a "qualified beneficiary" at the time of the qualifying event. A qualified beneficiary is an enrolled individual (you, your spouse, and your Dependent Child) who will lose coverage under the Plan because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage (the full cost means the Employee and Employer cost of coverage).

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your Hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;

2. Your spouse's Hours of employment are reduced;

3. Your spouse's employment ends for any reason other than his or her gross misconduct;

4. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or

5. You become divorced or legally separated from your spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-Employee dies;

2. The parent-Employee's Hours of employment are reduced;

3. The parent-Employee's employment ends for any reason other than his or her gross misconduct;

4. The parent-Employee becomes enrolled in Medicare (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. The child stops being eligible for coverage under the Plan as a "Dependent Child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event, but only if the Plan offers retiree coverage. If a proceeding in bankruptcy is filed with respect to the Plan Administrator, and that bankruptcy results in the loss of retiree coverage, if available under the Plan, the Retired Employee becomes a qualified beneficiary with respect to the bankruptcy. The covered spouse and covered Dependent Children of the covered retiree also will be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of Hours of employment, death of the Employee, or entitlement of the Employee in Medicare (Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and spouse, or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You or your spouse must send this written notice to: Fund Administrator, 1322 East State Street, Rockford, Illinois 61104. Your written notice should include the date of the qualifying event. If you or your spouse is notifying the Plan Administrator of a divorce or legal separation, you or your spouse should provide a copy of the legal separation papers or divorce decree.

If you fail to give written notice within the 60-day time period, the spouse and/or Dependent Child will lose the right to elect COBRA continuation.

Length of COBRA Coverage

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA on behalf of their covered spouses, and parents may elect COBRA on behalf of their covered Children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, entitlement of the Employee to Medicare (Part A, Part B, or both), your divorce or legal separation, or a Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage can last for up to 36 months.

When the qualifying event is the end of employment or reduction of the Employee's Hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months equals 28 months).

When the qualifying event is the end of employment or reduction of the Employee's Hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in writing in a timely manner, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

You must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

If the Social Security Administration determines that you are no longer disabled, you are required to notify the Plan Administrator of the loss of Social Security disability status within 30 days of receipt of the notice from the Social Security Administration that you are no longer disabled.

This written notice should be sent to: Fund Administrator, 1322 East State Street, Rockford, Illinois 61104. You should include a copy of the Social Security Administration's letter which gives the effective date of the disability.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your COBRA covered family members experience another COBRA qualifying event within the first 18 months of COBRA continuation coverage, then COBRA continuation coverage is available for up to an additional 18 months. The total months of COBRA coverage, including the COBRA extension, cannot exceed a maximum of 36 months from the original COBRA qualifying event. A COBRA extension is available to the spouse and Dependent Children if the former Employee dies, or is divorced or legally separated. The COBRA extension is also

available to a Dependent Child when that Child stops being eligible under the Plan as a Dependent Child. In certain limited instances, the extension may be available if the former Employee becomes entitled to Medicare after a loss of coverage due to termination of employment or reduction in hours. **In all cases, the 18-month extension occurs only if the second qualifying event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event never occurred.**

The following example shows how the second qualifying event rule works. Former Employee A elects 18 months of COBRA continuation for the entire family. After the first six months of COBRA continuation, former Employee A becomes entitled to Medicare (Part A, Part B, or both). If former Employee A were still actively employed, entitlement to Medicare would **not** result in a loss of coverage under the Employer's health plan. The additional 18-month extension is not available for the former Employee's spouse and Dependents, because if Medicare entitlement had occurred during active employment there would have been no loss of Employer health plan coverage.

In all of these cases, you must make sure that the Plan Administrator is notified within 60 days of the second qualifying event. This notice must be sent to: Fund Administrator, 1322 East State Street, Rockford, Illinois 61104.

Early Termination of COBRA Continuation Coverage

COBRA continuation will end early if the Fund's group health Plan terminates and the Fund does not provide replacement medical coverage. COBRA continuation will also end on the first to occur of the following events.

- The qualified beneficiary first becomes covered under another group health plan after the date of the COBRA election.
- The qualified beneficiary fails to make required contributions when due.
- The qualified beneficiary becomes entitled to Medicare Part A or Part B (or both) after electing COBRA continuation coverage.
- The qualified beneficiary is extending the 18-month coverage because of Social Security disability and is no longer disabled under the COBRA Disability Extension rules described above. In this case the qualified beneficiary is required to notify the Plan Administrator of the loss of Social Security disability status within 30 days of receipt of notice from the Social Security Administration.
- If the Employee's Employer withdraws from participation in the Fund, and the Employer makes group health plan coverage available to (or starts contributing to another multiemployer plan that is a group health plan with respect to) a class of the Employer's employees formerly covered under the Fund.

Important Considerations for A COBRA Coverage Election

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may

pay more out-of-pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

Cost of COBRA Continuation Coverage

The COBRA beneficiary must pay the entire cost of health coverage (the Employer's contribution portion and the active Employee portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation.

If COBRA benefits are extended under the COBRA SSA Disability Extension Rules described above, the cost of COBRA is 102% for the first 18 months, and 150% from the 19th through the 29th month of coverage.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

LEAVE FOR MILITARY SERVICE / UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the Employee has been called to active duty in the uniformed services. USERRA protects Employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An Employee's coverage under this Plan will terminate when the Employee enters active duty in the uniformed services.

If the Employee elects USERRA temporary continuation coverage, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the Employee stopped working.

If the Employee goes into active military service for up to 31 days, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period.

Duty to Notify the Plan

The Plan will offer the Employee USERRA continuation coverage only after the Plan Administrator has been notified by the Employee in writing that the Employee has been called to active duty in the uniformed services and provides a copy of the orders. The Employee must notify the Plan Administrator as soon as possible but no later than 60 days after the date on which the Employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Once the Plan Administrator receives notice that the Employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the Employee (and any eligible Dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the Employee does not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Additionally, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA; therefore, either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Administrator, 1322 East State Street, Suite 300, Rockford, IL 61104, Telephone: 815-397-4267, to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage

If the Employee goes into active military service for up to 31 days, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the appropriate contributions for that coverage are made during the period of that leave.

If the Employee elects USERRA temporary continuation coverage, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the Employee stopped working.

USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA Section on page 111 for more details.

In addition to USERRA or COBRA coverage, an Employee's eligible Dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces

When the Employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the Employee returns to work, provided the Employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the Employee is hospitalized or convalescing from an Injury caused by active duty, these time limits are extended up to two years.

The Employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the Employee's coverage will not be subject to any waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Fund Administrator, 1322 East State Street, Suite 300, Rockford, IL 61104, Telephone: 815-397-4267.

HIPAA PRIVACY AND SECURITY

Members of the Fund's workforce (the “Fund”) have access to the individually identifiable health information of Plan participants for administration functions of the Plan. When this health information is provided from the Plan to the Fund, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Fund's ability to use and disclose PHI and Electronic PHI. The following HIPAA definitions of PHI and Electronic PHI apply to this Plan amendment:

Protected Health Information (PHI). Protected Health Information (PHI) means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

Electronic Protected Health Information. Electronic Protected Health Information (Electronic PHI) means Protected Health Information that is transmitted by or maintained in electronic media.

The Fund will have access to PHI and Electronic PHI from the Plan only as permitted under this Plan Document or as otherwise required or permitted by HIPAA.

Permitted Disclosure of Enrollment/Disenrollment Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Fund information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

Permitted Uses and Disclosures of Summary Health Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Fund, provided that the Fund requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan. "Summary Health Information" means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a fund or plan sponsor has provided health benefits under the Plan; and from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Permitted and Required Uses and Disclosures of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described below and the requirement to obtain written certification described below, the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI and Electronic PHI to the Fund, provided that the Fund uses or discloses such PHI and Electronic PHI only for Plan administration purposes. "Plan administration purposes" means administrative functions performed by the Fund on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Fund in connection with any other benefit or benefit plan of the Fund or any employment-related actions or decisions.

Notwithstanding any provisions of this Plan to the contrary, in no event will the Fund be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

Conditions of Disclosure for Plan Administration Purposes. Fund agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR § 164.508, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan), the Fund will:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Fund with respect to PHI;

- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or Employee Benefit Plan of the Fund;

- Report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;

- Make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR§ 164.526;

- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

- If feasible, return or destroy all PHI received from the Plan that the Fund still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- Ensure that the adequate separation between Plan and Fund (i.e., the firewall), required by 45 CFR § 504(f)(2)(iii), is established.

The Fund further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR § 164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that the adequate separation between the Plan and Fund (i.e., the firewall), required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

- Ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Plan any security incident of which it becomes aware, as follows: the Fund will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, the Fund will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

Adequate Separation Between the Plan and the Fund. The Fund will allow the Plan Administrator and his or her clerical Employees access to the PHI. No other persons will have access to PHI. These specified Employees (or classes of Employees) will only have access to and use of PHI to the extent necessary to perform the plan administration functions that the Fund performs for the Plan. In the event that any of these specified Employees does not comply with the provisions of this Section, that Employee will be subject to disciplinary action by the Fund for non-compliance pursuant to the Fund's Employee discipline and termination procedures. The Fund will ensure that the provisions of this paragraph are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

Certification of Fund. The Plan (or a health insurance issuer or HMO with respect to the Plan) will disclose PHI to the Fund only upon the receipt of a certification by the Fund that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(H), and that the Fund agrees to the conditions of disclosure set forth herein.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your Employer on behalf of a group health plan, that relates to:

1. Your past, present or future physical or mental health or condition;

2. The provision of health care to you; or

3. The past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Plan Administrator at the Fund Office, 815-397-4267.

Effective Date

This Notice is effective November 1, 2015.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your protected health information;

- Provide you with certain rights with respect to your protected health information;

- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and

- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mail to your last-known address that we have on file.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other Hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is Experimental, Investigational, or Medically Necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is not permitted to use or disclose Genetic Information for underwriting purposes.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a Physician.

To Plan Sponsors. For the purpose of administering the Plan, we may disclose to certain Employees of the Fund protected health information. However, those Employees will only use or disclose that information as necessary to perform plan administrative functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the Armed Forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or Illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

- To prevent or control disease, Injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or
- When required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for

the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- About a death that we believe may be the result of criminal conduct; and
- About criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when the individual identifiers have been removed, or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make:

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required,

when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
- Treating such person as your personal representative could endanger you; and
- In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the Employee. This includes mail relating to the Employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the Employee's spouse and other family members and information on the denial of any Plan benefits to the Employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive 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.

Your Rights. You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to the Plan Administrator. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plan Administrator. You may also file a complaint as described in more detail below under the heading “Complaints.”

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request. We may deny your request for

an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan Administrator. Your request must state a time period of not longer than six years. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

Effective February 17, 2010 (or such other date specified as the effective date under applicable law), we will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health Plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to the Plan Administrator. In your request, you must tell us:

- What information you want to limit;
- Whether you want to limit our use, disclosure, or both; and
- To whom you want the limits to apply (for example, disclosures to your spouse).

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Plan Administrator. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice, which may be requested any time from the Plan Administrator.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Plan Administrator at the Fund Office, 815-397-4267. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator

Construction Industry Welfare Fund of Rockford, Illinois Group Health Benefit Plan is the benefit Plan of **Construction Industry Welfare Fund of Rockford, Illinois**, the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by the Trust to be Plan Administrator and serve at the convenience of the Trust. If the Plan Administrator resigns, dies or is otherwise removed from the position, the Trust will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority administer this Plan and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to: a) construe and interpret the terms and provisions of all Plan documents; b) to make all interpretive and factual determinations regarding issues which related to eligibility for benefits; c) to decide disputes that may arise relative to a Covered Person's rights; and d) to decide all questions of Plan interpretation and those of fact relating to the Plan. If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, reference herein to the Plan Administrator will be deemed to include such delegate.

Except as is expressly required by law with respect to the Plan's external review process: a) decisions of the Plan Administrator will be final and legally binding on all interested parties; b) any interpretation, determination or other action of the Plan Administrator will be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion, and c) any review of a final decision or action by the Plan Administrator will be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Failing to request external review or comply with the Plan's external review process and related requirements constitutes agreement with and consent of any decision(s) that the Plan Administrator has made, in its sole discretion, and further constitutes agreement to the limited standard or review and scope of review described by this section.

Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator

1. To administer the Plan in light of the reason and purpose for which this Plan is established and maintained.

2. To determine all questions of eligibility, status and coverage under the Plan;

3. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

4. To make factual findings;

5. To decide disputes which may arise relative to a Covered Person's rights.

6. To prescribe procedures for filing a claim for benefits and to review claim denials.

7. To keep and maintain the Plan documents and all other records pertaining to the Plan.

8. To appoint a Claims Administrator to pay claims.

9. To perform all necessary reporting as required by ERISA.

10. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

11. To delegate to any person or entity such powers, duties and responsibilities, as it deems appropriate.

12. To perform each and every function necessary for or related to the Plan's administration.

Plan Administrator Compensation – The Plan Administrator serves without compensation; however all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary – A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties – A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties that must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. By diversifying the investments of the Plan (if any) so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. In accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary – A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Claims Administrator is not a Fiduciary – A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Funding the Plan and Payment of Benefits

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage – Funding is derived from contributions made by Contributing Employers and Self-Payments made by Members.

The Trustees will set, at their discretion, the contribution rate to be paid by Contributing Employers, and the Self-Payment rate to be paid by Members.

Benefits are paid directly from the Plan through the Claims Administrator.

Escheat Laws Do Not Apply – The Plan is maintained under ERISA as a self-funded Plan and is not subject to state escheat and unclaimed property laws. Where a Covered Person or medical provider receives payment by check for Plan benefits, and the check remains outstanding for 180 days after issue, it will be cancelled and the amount credited to the Plan's account. The unclaimed funds so credited will be treated as Plan assets and applied to the payment of current benefits under the Plan. In the event the Covered Person or medical provider to whom the check was originally issued later makes a claim for payment, the Plan will pay said claim under the terms and provisions in effect when the claim was originally Incurred.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Plan is Not an Employment Contract

The Plan is not to be construed as a contract for or of employment.

No Guarantee of Tax Treatment

The Fund does not guarantee the tax treatment of any contributions made or benefits received.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in the Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment will be deducted from future benefits payable.

Amending and Terminating the Plan

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination.

The Construction Industry Welfare Fund of Rockford, Illinois intends to maintain this Plan indefinitely; however, the Trustees of the Fund have the right, at any time, to amend, suspend

or terminate the Plan in whole or in part, in its sole discretion. This includes amending, suspending or terminating the benefits under the Plan.

Any such amendment, suspension or termination will be enacted, by resolution duly adopted by the Trustees or any of their duly appointed delegates in accordance with the requirements of the Trust Agreement. Notice will be provided as required by ERISA. In the event the Trust is a different type of entity, then such amendment, suspension or termination will be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

Summary of Material Reduction (SMR)

A Material Reduction generally means any modification that would be considered by the average Covered Person to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in deductibles or co-payments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Covered Person. The 60-day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Note: *The Patient Protection and Affordable Care Act (PPACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Covered Persons at least 60 days before the effective date of the Material Modification.*

Compliance with Applicable Laws

The Plan will be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Member Responsibilities, Plan's Right to Information

Each Covered Person is responsible for providing the Plan Administrator with his or her current address. If required by the Plan Administrator or its delegate, each Covered Person will be responsible for providing the Plan Administrator with the current address of a covered spouse and each covered Dependent. Each Covered Person is responsible for notifying the Plan Administrator in the event of divorce from a Covered spouse.

Any notices required or permitted to be given to a Covered Person under this Plan Document/Summary Plan Description will be deemed given if directed to the address most recently provided by the Covered Person to the Plan Administrator. The Plan Administrator will have no obligation or duty to locate a Covered Person.

Any person claiming benefits under the Plan must furnish the Plan Administrator or its delegate with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan. Failure to provide information and documentation when and as requested may result in denial of Plan benefits. The Plan Administrator also will have the right to have an autopsy performed in the event of death, where it is not forbidden by law.

Fraud & Rescisson and Other Terminations of Coverage

Rescission of Coverage for Fraud and Intentional Misrepresentation of Material Fact

The following actions by any Covered Person, or with a Covered Person's knowledge of such actions being taken by another, constitute fraud or an intentional misrepresentation of material fact, for which the Plan Administrator may, to the fullest extent permitted by applicable law, rescind and terminate all coverage under this Plan, including retroactively, for the Covered Person and/or the entire Family Unit of which the Covered Person is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who the Covered Person knows or reasonably should know is not a Covered Person under the Plan;

2. Permitting any person who is not a Covered Person of the family unit to use any identification card issued,

3. Attempting to file a claim for a Covered Person for services that the Covered Person knows or reasonably should know were not rendered or Prescription Drugs or other items that were not provided; or

4. Providing false or intentionally misleading information to the Plan.

The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan.

In the event of any such fraud or intentional misrepresentation, the Covered Person will be responsible, to the fullest extent permitted by applicable law, to provide restitution, including monetary payment to the Plan, with respect to any overpayment or ineligible payment of benefits. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs (including fees and costs incurred prior to the filing of the action).

Termination of Coverage upon Divorce

This Plan does not provide coverage to ex-spouses, except as is required by COBRA. A failure to notify the Plan Administrator of a divorce in a timely fashion will not extend the ex-spouse's coverage. The Plan will terminate the ex-spouse's coverage as of the date of divorce, regardless of whether such termination is retroactive. In such situations, the ex-spouse will be allowed an opportunity to elect COBRA coverage for up to 36 months from the date of divorce if the COBRA election is timely and the applicable COBRA premium is paid.

Notice of Intent to Terminate

The Fund will provide at least 30 days' advance notice of a termination of coverage under this section to each Covered Person who may be affected by the termination, so that they may explore their rights to contest the termination or seek other coverage, as appropriate. However, the termination may be made retroactive in the event of fraud, intentional misrepresentation of material fact, or a failure to notify the Plan Administrator of a divorce. In such cases, all outstanding claims will be pended until expiration of the 30-day notice period and then will be rejected unless it is determined that the termination is in error.

The following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days' advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.

- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.

- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively – for the future – once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 30 days' advance written notice.

Limitations on Legal Actions

All claims review procedures provided for in the Plan must be exhausted before any legal action is brought. A request for internal review of an adverse benefit decision must be filed within **180 days** following receipt of the notice of the adverse benefit determination. Any request for external review of an adverse benefit decision must be filed within **four (4) months** following receipt of the notice of the adverse benefit determination. Failure to comply with these deadlines may cause the claimant to forfeit any right to further review of an adverse decision in a court of law.

Any legal action for the recovery of benefits or for a fiduciary's breach of duty must be commenced within **one (1) year** after the Plan's claim review procedures have been exhausted, except that if the claimant makes a timely request for external review in accordance with the Plan's external review procedures, this one (1) year period is tolled during the time the external review is pending.

Certain Employee Rights under ERISA

Covered Persons in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Covered Persons are entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, all Plan documents governing the Plan, including 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 (EBSA).

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

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

Examine without charge at the Plan Administrator's office, or obtain upon written request to the Plan Administrator, a complete list of the Employers and Employee organizations sponsoring the Plan. Participants and beneficiaries also may receive from the Plan Administrator, upon written request, information as to whether a particular Employer or Employee organization is a sponsor of the Plan and, if the Employer or Employee organization is a Plan sponsor, the sponsor's address.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Plan Document/Summary Plan Description and other documents governing the Plan, on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, 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 Covered Persons and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $152 a day (as adjusted for inflation and not to exceed $1,527 per request) 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, which is denied or ignored, in whole or 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 the 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 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 (EBSA) 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 publication hotline of the Employee Benefits Security Administration, 866-275-7922. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded health plan and the administration is provided through a third party claims administrator, Group Administrators, Ltd.

The funding for the benefits is derived from the funds of the **Construction Industry Welfare Fund of Rockford**. The Construction Industry Welfare Fund of Rockford self-funds the medical, dental, vision, and loss of time benefits under the Plan. The funding for the benefits is derived from Employer contributions and self-payments made by covered Employees. These benefits are self-insured by the Plan.

Blue Cross Blue Shield of Illinois (BCBSIL) provides the PPO Network of providers; Delta Dental Plan of Illinois provides the network of dental providers; ESI is the Pharmacy Benefit Manager for covered prescription drugs; and Spectera provides the network of vision providers.

The Union Labor Life Insurance Company (ULLICO), 8403 Colesville Road, Silver Spring, MD 20910, provides stop-loss insurance that will reimburse the Plan for certain losses in excess of amounts described in the stop-loss insurance policy. Under this policy, The Union Labor Life Insurance Company does not insure or guarantee, and has no obligation to pay, any Plan benefits or to make any other payments to any Covered Person. The Fund also purchases Life and Accidental Death and Dismemberment (AD&D) insurance policies to cover the Life and AD&D benefits provided by the Plan.

PLAN NAME	**Construction Industry Welfare Fund of Rockford, Illinois Employee Group Health Benefit Plan**
PLAN NUMBER	501
TAX ID NUMBER	36-2265130
PLAN EFFECTIVE DATE	January 1, 2000. Restated April 1, 2018
PLAN YEAR ENDS	November 1 through October 31
TYPE OF PLAN	This Plan is an Employee Welfare Benefits Plan that provides medical expense benefits, prescription drug benefits, dental expense benefits, vision benefits, life insurance and accidental death and dismemberment benefits, and loss of time benefits.
EMPLOYERS PARTICIPATING IN THE PLAN PURSUANT TO COLLECTIVE BARGAINING AGREEMENT	A complete list of the Employers and Employee organizations sponsoring the Plan may be obtained by participants upon written request to the Plan Administrator, and is available for examination by Plan participants. Participants may receive from the Plan Administrator, upon written request, information as to whether a particular Employer or Employee organization is a Plan Sponsor, and if the Employer or Employee organization is a Plan Sponsor, the Sponsor's address.

PLAN SPONSOR AND PLAN ADMINISTRATOR

The Board of Trustees is the Plan Sponsor and Plan Administrator. The names and addresses of the members of the Board of Trustees are as follows:

LABOR TRUSTEES

Mr. Art Sturms, Co-Chair
Local 11, Area 382
1102 Rail Drive
Woodstock IL 60098

Mr. Richard Boyd
BAC Local 6 (Bricklayers Masonry Contrs.)
251 Circle Shore Drive
Washington, IL 61571

Mr. Sam Giardono
c/o Fund Office
299 Grand Avenue
Loves Park IL 61111

Mr. Dan Jansen
Carpenters Local 792
212 S. First St.
Rockford IL 61104

MANAGEMENT TRUSTEES

Mr. David Anspaugh
NIBCA
1111 S. Alpine Rd. Suite 200
Rockford IL 61108

Mr. Jeff Bockhop
Stenstrom General Contractors
P. O. Box 5866
Rockford, IL 61125

Mr. Glen Turpoff
NIBCA
1111 S. Alpine Rd. Suite 200
Rockford IL 61108

THE ABOVE ARE THE TRUSTEES AT THE TIME OF PUBLICATION. A CURRENT LISTING MAY BE OBTAINED FROM THE FUND OFFICE

FUND OFFICE

Construction Industry Welfare Fund of Rockford, Illinois
1322 East State Street
Rockford, Illinois 61104
815-397-4267

AGENT FOR SERVICE OF LEGAL PROCESS

Construction Industry Welfare Fund of Rockford, Illinois

Plan Administrator
1322 East State Street
Rockford, Illinois 61104
815-397-4267

FUND/PLAN ADMINISTRATOR AND NAMED FIDUCIARY

Construction Industry Welfare Fund of Rockford, Illinois.

Plan Administrator
1322 East State Street
Rockford, Illinois 61104
815-397-4267

COBRA ADMINISTRATOR

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
847-519-1880
www.groupadministrators.com

CLAIMS ADMINISTRATOR

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
847-519-1880
www.groupadministrators.com

Revised Trustees as of _____, 2018

The Trust hereby adopts this Plan Document as the written description of the Plan.

IN WITNESS WHEREOF, this instrument is executed for Construction Industry Welfare Fund of Rockford, Illinois on or as of the day and year first being written.

Dated: _____, 2018

Labor Trustees

_____

Employer Trustees

_____