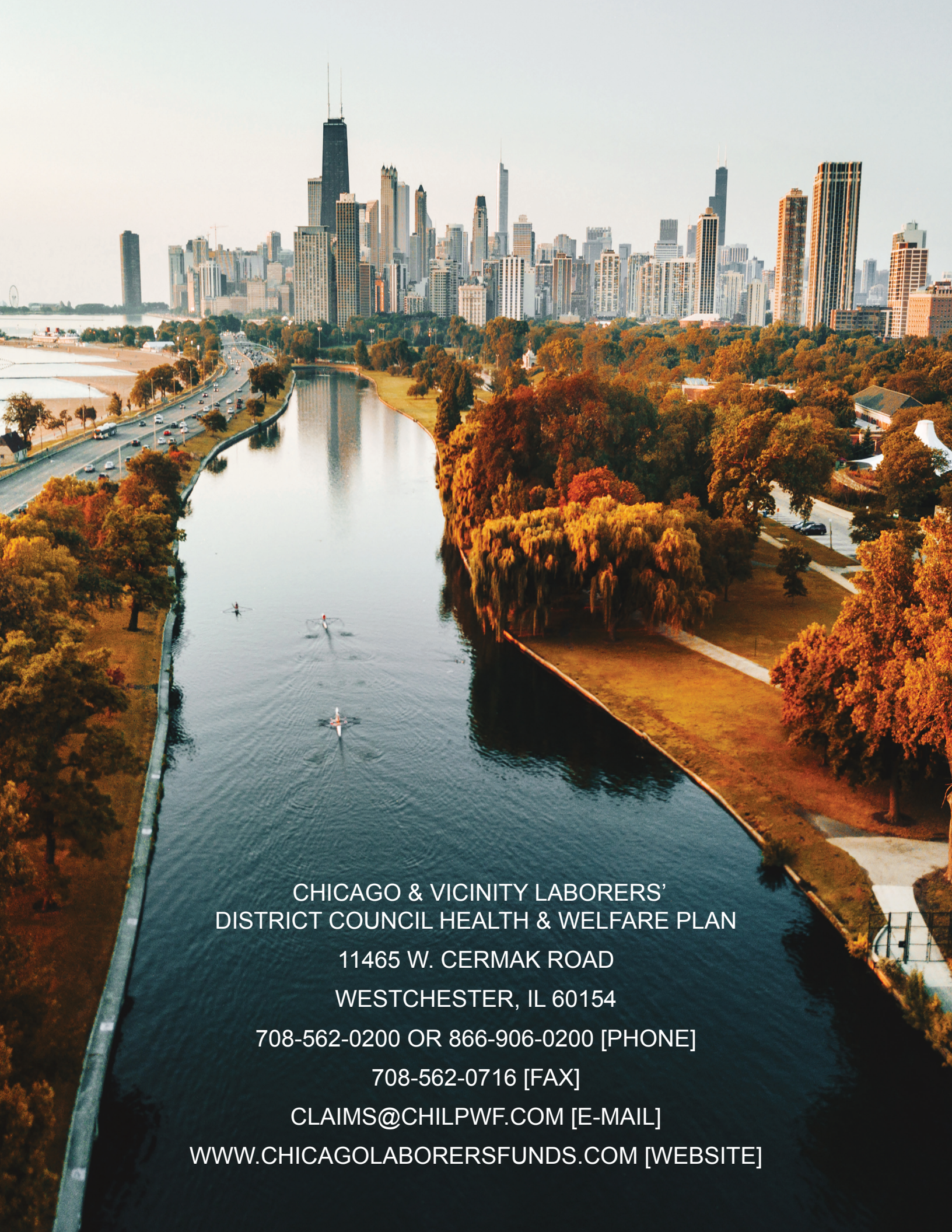
2020 EDITION

CHICAGO & VICINITY LABORERS' DISTRICT COUNCIL

HEALTH & WELFARE PLAN

COMBINED PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

ACTIVE PLAN I



CHICAGO & VICINITY LABORERS'
DISTRICT COUNCIL HEALTH & WELFARE PLAN

11465 W. CERMAK ROAD

WESTCHESTER, IL 60154

708-562-0200 OR 866-906-0200 [PHONE]

708-562-0716 [FAX]

CLAIMS@CHILPWF.COM [E-MAIL]

WWW.CHICAGOLABORERSFUNDS.COM [WEBSITE]

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Segal

Only the Board of Trustees is authorized to interpret this combined Plan Document and Summary Plan Description ("Plan/SPD"). No Employer, Union, or any representative of any Employer or Union, is authorized to interpret this Plan/SPD nor can any such person act as agent of the Trustees. You may only rely on information regarding the Plan that is communicated to you in writing and signed on behalf of the Board of Trustees either by the Trustees, or, if authorized by the Trustees, signed by the Administrator.

Benefits under the Plan will only be paid when the Trustees or persons delegated by them decide, in their discretion, that the participant or beneficiary is entitled to benefits in accordance with terms of the Plan.

The Trustees reserve the right and have been given the sole and unrestricted discretion to amend, modify, or discontinue all or part of the Plan whenever, in their sole judgment, conditions so warrant. If all or a part of the Plan is terminated, the Trustees would provide for payment of expenses incurred up to the date of termination, arrange for a final accounting of the Plan and distribute the balance of the assets in a manner consistent with the terms and conditions of the Trust Agreement establishing the Plan under the Fund.

IMPORTANT IMPORTANTE WAŻNE

This Plan/SPD contains a summary in English of your rights and benefits under the Plan. If you have difficulty understanding any part of this Plan/SPD, contact the Chicago & Vicinity Laborers' District Council Health & Welfare Plan, 11465 West Cermak Road, Westchester, IL 60154. Office hours are from 8:30 a.m. to 4:00 p.m., Monday through Friday. For assistance, you can call the Fund Office at 708-562-0200.

Este folleto contiene un sumario en Ingles de sus derechos y beneficios bajo el Plan. Si tiene dificultad en entender cualquier parte de este folleto póngase en contacto con el Chicago & Vicinity Laborers' District Council Health & Welfare Plan, 11465 West Cermak Road, Westchester, IL 60154. Las horas de oficina son de 8:30 a.m. a 4:00 p.m., de Lunes a Viernes. Para obtener asistencia también puede llamar a las oficinas al 708-562-0200.

Questo opuscolo contiene un sommario in lingua inglese dei vostri diritti e delle vostre indennità secondo questo Piano. Se avete difficoltà a capire qualsiasi parte di questo opuscolo, contattate il Chicago & Vicinity Laborers' District Council Health & Welfare Plan, 11465 West Cermak Road, Westchester, IL 60154, USA. L'orario d'ufficio è dalle 8.30 alle 16.00, dal lunedì al venerdì. Per ottenere assistenza, potete telefonare all'ufficio, al numero 708-562-0200.

Ta broszura zawiera streszczenie w języku angielskim Państwa praw i korzyści wynikających z tego Planu. W przypadku trudności ze zrozumieniem jakiejkolwiek części tej broszury prosimy o kontakt z Chicago & Vicinity Laborers' District Council Health & Welfare Plan, 11465 West Cermak Road, Westchester, IL 60154. Biuro czynne codziennie od poniedziałku do piątku od 8:30 do 4:00. Pomoc można uzyskać telefonicznie pod numerem 708-562-0200

Chicago & Vicinity Laborers' District Council Health & Welfare Plan

11465 West Cermak Road
Westchester, IL 60154
Telephone: **708-562-0200** or **866-906-0200**
Fax: **708-562-0716**
Email: **Claims@chilpwf.com**
Website: **www.chicagolaborersfunds.com**

To Active Plan 1 Participants:

We are pleased to provide you with this Plan/SPD, which sets forth the Plan of Benefits for Active Plan 1 of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan.

To comply with the Employee Retirement Income Security Act of 1974, as amended (ERISA), this Plan/SPD sets out the information that must be given to participants, including a statement of your rights and protections under that law. In addition, this Plan/SPD provides you with the eligibility rules that apply for you to obtain and continue your benefits coverage, the conditions governing the payment of benefits, and an explanation of the procedures you must follow when filing an out-of-network Claim or appealing a Claim that has been denied.

The benefits described in this Plan/SPD are in effect as of January 1, 2020. Note that the benefits described in this Plan/SPD are **not guaranteed** (meaning they are not legally "vested"). All benefits may be changed, reduced or eliminated at any time by the Fund's Board of Trustees.

We have organized the information within this Plan/SPD in an easy-to-find format. You can also recognize specific terms, defined at the end of the Plan/SPD, because the first letter of the term is capitalized.

We urge you to read this Plan/SPD carefully so that you may fully understand the benefits available to you and your family. If you are married, share this Plan/SPD with your spouse. We also suggest that you keep this Plan/SPD with your important papers so it will be readily available for future reference.

This Plan/SPD replaces and supersedes all other Plan Documents and Summary Plan Descriptions previously adopted by the Fund. If any changes are made to the Plan's benefit provisions, they will be communicated to you via a notice that will be sent to the last known mailing address the Fund Office has on file for you. **Therefore, it is extremely important that you notify the Fund Office if you change your mailing address.**

As the Fund's Board of Trustees, we recognize how important it is to have comprehensive healthcare benefits. We encourage you and your eligible dependents to take full advantage of the benefits and services offered by the Fund.

If you have questions about the information in this Plan/SPD, please contact the Fund Office. If you would like, you may request to speak to someone in the Claims Department who speaks Spanish, Polish or Italian.

Sincerely,

The Board of Trustees

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THE PLAN'S "GRANDFATHERED" STATUS

The Trustees of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan believe that this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Fund Office at 1-708-562-0200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

INTRODUCTION

This Plan/SPD describes the health and welfare benefits available to you and your eligible dependents as of January 1, 2020.

YOUR BENEFITS

The Chicago & Vicinity Laborers' District Council Health & Welfare Plan offers comprehensive healthcare coverage to help you and your dependents stay healthy. This coverage can also help provide financial protection against catastrophic healthcare expenses. The Plan provides:

- Medical Benefits;
- Prescription Drug Benefits;
- Vision Benefits;
- Dental Benefits;
- Weekly Income Benefits (for Eligible Members only); and
- Death and Accidental Dismemberment Benefits.

The Plan also includes a Health Reimbursement Arrangement (HRA), which is designed to provide reimbursement of certain healthcare out-of-pocket expenses on a tax-free basis.

The benefits described in this Plan/SPD, which are effective as of January 1, 2020, are for Active Plan 1 participants.

These are some of the life events that may affect your benefits:

- Beginning a new job;
- Birth, adoption, or placement for adoption of a child;
- Major illness;
- Military duty;
- Marriage or divorce;
- Retirement; and/or
- Death of a dependent.

Information in this Plan/SPD shows how your benefits fit into the different stages of your life.

WAYS YOU CAN BE A WISE HEALTHCARE CONSUMER

It is the Trustees' goal to maintain a financially stable Fund while providing comprehensive healthcare coverage to you and your family. This becomes more challenging as healthcare costs continue to rise. The Fund has implemented some cost-saving measures such as medical deductibles and a medical Preferred Provider Organization (PPO) to ensure that the Fund can continue to meet a majority of your current and future healthcare needs.

To help save money for you and the Fund, use your healthcare benefits wisely. You can do so by taking advantage of cost-saving features built into the Plan. Whenever possible:

- **Visit PPO providers**—PPO providers, including Hospitals, Physicians and other healthcare providers, charge negotiated rates that are often less than those of non-PPO providers. In addition, the Plan pays a higher percentage of your healthcare costs when you use PPO providers.
- **Get regular physical exams**—Getting physicals regularly can help you live a healthier life by identifying potential health risks earlier, which could mean less healthcare problems overall.
- Have your prescriptions filled at preferred retail pharmacies and/or through the contracted mail-order facility. Using a preferred network retail Pharmacy and/or the mail-order facility will save you and the Fund money.
- **Take generic equivalents**—If you are prescribed a brand name medication, ask your Physician if a generic equivalent is available. The cost of a generic medication can be significantly less than the cost of a brand name medication and, as required by law, generic medications are medically equivalent to brand name medications – meaning they are just as effective.
- **Consider emergency treatment alternatives**—In the event of an emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can receive the same level of care at a Physician's office or at a convenience care clinic that you can receive in an emergency room. Keep your Physician's telephone number handy and find an urgent care facility near your home so you will be prepared in case of an emergency.
- **Review receipts and explanations of benefits (EOBs) carefully**—Sometimes, providers incorrectly bill for their services. It is important to review all receipts and EOBs to ensure that charges are correct and that you are receiving PPO or preferred rates when appropriate.

CONTRACTED NETWORK PROVIDERS

- *Medical Care.* The Plan offers you medical benefits through the **Blue Cross Blue Shield of Illinois (BCBSIL) BlueCard Preferred Provider Organization (PPO)**. With the PPO network, you have access to many participating Physicians and Hospitals throughout the area where you live. By using the services of network providers—Physicians and Hospitals that participate in the BCBSIL network—you receive services at pre-negotiated discounted rates and you receive the higher network level of benefits. To find an up-to-date list of PPO network providers, visit www.bcbsil.com or call 800-810-2583
- *Smoking Cessation.* The Plan offers Smoking Cessation Benefits, including laser treatments through **Laser Concepts of Chicago**. To utilize the services of Laser Concepts of Chicago, call 630-916-8280 or visit www.laserconceptschicago.com.
- *Prescription Drugs.* The Plan offers Prescription Drug Benefits through **CVS/Caremark**, a Pharmacy Benefit Manager (PBM). There are more than 50,000 Pharmacies participating in the CVS/Caremark network nationwide, including almost all of the major drug chains. Visit the CVS/Caremark website at www.caremark.com for a list of participating Pharmacies. You must show your prescription drug program ID card when you fill your prescription at a CVS/Caremark Pharmacy to receive your prescription drug medications at discounted prices. If you do not use a participating Pharmacy or do not show your ID card when you fill your prescription, you will be responsible for 100% of the cost of the prescription medication and you will need to file the prescription as a paper claim through CVS/Caremark.
- *Dental Care.* Dental Benefits are provided through Delta Dental of Illinois, a dental Preferred Provider Organization. Your level of coverage will depend on whether or not your Dentist or orthodontist is a Delta Dental network provider. To receive the most benefits and the highest level of discounts, your provider must participate in the **Delta Dental PPO** Network. You should contact Delta Dental at 800-323-1743 before seeking dental care. Delta Dental can help you select a network Dentist or orthodontist and answer specific questions relating to your Dental Benefits. You may also use Delta Dental's website at www.deltadentalil.com to find a network provider.
- *Routine Vision Care.* The Plan has contracted with **Vision Service Plan (VSP)** to provide discounted vision care such as annual eye exams, glasses, and contact lenses. To locate a VSP network provider near you, call toll-free 800-877-7195 or you may also use VSP's website at www.vsp.com to find a network provider.
- *Vision Correction Surgery.* The Plan has contracted with **QualSight, Inc**. to provide discounted vision correction surgery. To find out if you may be a candidate for vision correction surgery, contact QualSight at 877-718-7676.

CONTACT INFORMATION

For information about…	Contact
Eligibility, Benefits, Claims	**Fund Office** Chicago & Vicinity Laborers' District Council Health & Welfare Plan 11465 W. Cermak Road Westchester, IL 60154 708-562-0200 or 866-906-0200 708-562-0716 [fax] Claims@chilpwf.com [e-mail] www.chicagolaborersfunds.com
Medical PPO Network/Providers—BlueCard PPO	**Blue Cross Blue Shield of Illinois** 800-810-2583 www.bcbsil.com Group No.: P15412
Smoking Cessation Program	**Laser Concepts of Chicago** 630-916-8280 www.laserconceptschicago.com
Prescription Drug Program	**CVS/Caremark Inc.** www.caremark.com **Retail Drug Program** 888-727-5574 Group No.: RX6597 **Specialty Drug Program** 866-387-2573 Group No.: RX6597
Dental Program	**Delta Dental of Illinois** 800-323-1743 8:30 AM—5 PM Monday–Friday www.deltadentalil.com Group No.: 1133
Vision Programs	**Vision Service Plan (VSP)** (Routine Vision) 800-877-7195 7 AM—10 PM Monday–Friday 9 AM—10 PM Saturday and Sunday www.vsp.com Group ID#30028671 **QualSight, Inc.** (Vision Correction Surgery) 877-718-7676 www.qualsight.com

NONDISCRIMINATION NOTICE UNDER SECTION 1557 OF THE AFFORDABLE CARE ACT

DISCRIMINATION IS AGAINST THE LAW

The Chicago & Vicinity Laborers' District Council Health & Welfare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Chicago & Vicinity Laborers' District Council Health & Welfare Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Note that effective August 18, 2020, the Chicago & Vicinity Laborers' District Council Health & Welfare Plan is not obligated to comply with Section 1557 of the Affordable Care Act, and this notice is no longer applicable thereafter.

The Chicago & Vicinity Laborers' District Council Health & Welfare Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ms. Catherine Wenskus, the Civil Rights Coordinator.

If you believe that the Chicago & Vicinity Laborers' District Council Health & Welfare Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ms. Catherine Wenskus, Civil Rights Coordinator, The Chicago & Vicinity Laborers' District Council Health & Welfare Plan, 11465 West Cermak Road, Westchester, Illinois 60154-5768, Telephone: 708-562-0200, Fax: 708-947-7297, E-Mail: cathyw@chilpwf.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ms. Catherine Wenskus is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ILLINOIS TOP 15 LANGUAGES

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-708-562-0200.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-708-562-0200.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-708-562-0200.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-708-562-0200. 번으로 전화해 주십시오.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-708-562-0200.
Arabic	مقر) 1-708-562-0200. مقرب لصتا .نامجلاب كل رفاوتت ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا رذكا ثدحتت تنك إذا :ةظوحلم .
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-708-562-0200.
Gujarati	ध्यान द: यद आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-708-562-0200. पर कॉल कर।
Urdu	لاک - ںیہ پاےتسد ںیم تفم اتمدخ یک ددم یک ناںز وک آپ وت ،ںیہ ےتلوب ودرا آپ رگا :رادرخ ںیرک 1-708-562-0200.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-708-562-0200.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-708-562-0200.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-708-562-0200. पर कॉल करें।
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-708-562-0200.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-708-562-0200.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-708-562-0200.

ELIGIBILITY

PARTICIPANT ELIGIBILITY

You first become eligible for benefits under the Plan after you have worked the required minimum number of hours in Covered Employment either within a 6- or 12-consecutive month period. Your coverage becomes effective on the first day of the month following your completion of the required hours.

The chart below outlines the Plan's requirements for your initial eligibility.

COVERED EMPLOYMENT

Work for an Employer that is required to contribute to the Fund on your behalf.

Minimum Covered Employment Hours Required*		
Age Group	Hours During 6 Consecutive Months	Hours During 12 Consecutive Months
Under Age 50	500	800
Ages 50 to 54	400	700
Ages 55 and over	200	300

*If you are covered by a collective bargaining agreement that includes an early eligibility provision, you will be provided with an addendum that may modify these initial eligibility rules.

EXAMPLE: INITIAL ELIGIBILITY

Jake, who is age 30, begins working in Covered Employment on February 1st. He works 90 hours each month, for six consecutive months. By the end of July, he has worked 540 hours during the six-consecutive month period (90 x 6 = 540). As a result, Jake becomes initially eligible for coverage on August 1, the first day of the month following his completion of the required 500 hours.

CONTINUING ELIGIBILITY

Once you become eligible under the Plan, you continue to be eligible on a month-to-month basis. Your coverage continues as long as you work 500 hours in Covered Employment during the preceding 6 months or 800 hours in Covered Employment during the preceding 12 months (or the appropriate minimum hours for your age group, as indicated in the above chart).

When you consider retiring from Covered Employment, contact the Fund Office's Pension Department at 708-562-0200. A representative will advise you of your pension benefit options and discuss available welfare benefit options.

EXAMPLE: CONTINUING ELIGIBILITY

Jake (from the prior example) became initially eligible for coverage on August 1. He continued to work in Covered Employment and worked 70 hours in August. Therefore, he continued to be eligible for coverage in September since he worked at least 500 hours during the preceding six-month period (90 hours during the months of March, April, May, June and July plus 70 hours in August: 90 x five, plus 70 = 520).

The Fund Office sends you statements every other month that list the number of hours reported by your Employer. If you have questions or concerns regarding your hours and eligibility, please contact the Fund Office.

You can check your eligibility 24 hours a day by calling 708-947-7260. Be sure to have your Social Security Number handy and follow the instructions given in the telephone prompts (available in English or Spanish).

MILITARY SERVICE

Healthcare coverage under the Plan will continue for you (or your dependents) if you serve in the uniformed services of the United States (active duty or inactive duty training) for up to 31 days, provided you were eligible for benefits at the time of your deployment. If you serve in military service for more than 31 days, you may continue your coverage for your dependents at your own expense for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) subject to the same rates and timeframes as COBRA. Coverage continued under the provisions of USERRA runs concurrently with the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage. COBRA is explained in more detail on page 14. In the event of a conflict between the Plan's provisions governing military leave and the provisions of USERRA, the provisions of USERRA will apply.

If you continue coverage at your own expense, the coverage will end at the earliest of the:

- Date you or your dependents do not make the required payments within 30 days of the due date;
- Date the Fund no longer provides any group health benefits;
- Date you reinstate your eligibility for Plan coverage;
- End of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- Last day of the month after 24 consecutive months of coverage.

While you are deployed for military service, your eligibility will be "frozen." Once your military service ends, your eligibility will be reinstated upon your return to covered work as a laborer, provided you meet USERRA reemployment provisions. For more information about self-payments under USERRA, contact the Fund Office.

REEMPLOYMENT

Following your discharge from military service, you may be eligible to apply for reemployment with your former Employer in accordance with USERRA. Such reemployment includes your right to elect reinstatement in any existing healthcare coverage provided by your Employer.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth, adoption, or placement with you for adoption of a child;
- The care of a seriously ill spouse, parent, or child;
- Your own serious illness; or
- Certain exigencies or urgent needs for leave that arise because your spouse, parent or child is on active military duty or notified of an impending order to active duty.

In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member. The service member must be:

- Your spouse, son, daughter, parent, or next of kin;
- Undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in the armed forces; and
- An outpatient or on the temporary disability retired list of the armed services.

Generally, you are eligible for a leave under the FMLA if you:

- Have worked for a covered Employer for at least 12 months Birth, adoption, or placement for adoption of a child;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 employees are employed by your Employer within 75 miles.

Your eligibility for FMLA leave and benefits will be determined by your Employer. You are eligible for a leave under FMLA if you:

- Have worked for an Employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the Employer within a 75-mile radius.

The Fund will maintain your prior eligibility status until the end of the leave, provided your Employer properly grants the leave under federal law and makes the required notification and payment to the Fund.

If you and your Employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute, in the absence of the required contribution. The Board of Trustees will have no direct role in resolving the dispute. Coverage under this Plan will continue during FMLA leave on the same basis as other similarly situated Employees.

Contact your Employer to determine if you are eligible for FMLA leave.

CHANGING EMPLOYERS

Benefits described in this Plan/SPD are for Active Plan 1 participants who perform work in the jurisdiction of the Chicago & Vicinity Laborers' District Council for Employers who are engaged in the construction industry. The Fund has alternate plans that cover employees who perform work in the jurisdiction of the Chicago & Vicinity Laborers' District Council, but work for Employers who are not engaged in the construction industry or who contribute at different hourly rates. Your Employer's contribution rate determines in which of the plans you and your dependents may participate. In the future, if you change Employers, you may participate in a different plan

AFTER RETIREMENT

Your coverage under the Plan will continue after you retire from Covered Employment as long as you maintain a sufficient number of hours during the preceding 6- or 12-consecutive month period. When your hours eligibility expires and you no longer qualify for benefit coverage under the Plan, you will be offered the chance to elect COBRA continuation coverage. In addition, if you meet certain retiree eligibility requirements, you may be offered coverage under the Retiree Medical Plan 1 or the Retiree Basic Medical Coverage Plan.

If you are a retiree considering a return to active employment, contact the Fund Office to obtain the most current eligibility requirements and restrictions.

If you engage in disqualifying employment (as defined by the Chicago & Vicinity Laborers' District Council Pension Plan after you retire, your pension benefits will be suspended. In addition, your coverage under the Retiree Medical Plan 1 or Retiree Basic Medical Coverage Plan will end on the day that you begin working in disqualifying employment. You will not be eligible for COBRA continuation coverage when your coverage under the Retiree Medical Plan 1 or Retiree Basic Medical Coverage Plan ceases. You will regain eligibility for coverage under Active Plan 1 (or another Active Plan) on the first day of the month following the completion of the required number of hours if you return to work in Covered Employment. When returning to work in Covered Employment after receiving a pension benefit, you will regain eligibility following the completion of 500 hours in a six-consecutive month period or 800 hours in a 12-consecutive month period. These requirements apply regardless of your age.

Current provisions allow a retired participant to return to disqualifying employment twice. The third time you return to disqualifying employment, you will not be eligible to participate in any retiree welfare benefit plan.

If you retire and return to disqualifying employment three times, you will no longer be eligible to obtain Retiree Medical Plan 1 or Retiree Basic Medical Coverage Plan coverage. Your only option to continue medical coverage, when your eligibility under one of these Plans ends, will be to elect COBRA continuation coverage under Active Plan 1.

Refer to the Retiree Medical Plan Document and Summary Plan Description for more information.

WHEN YOUR COVERAGE ENDS

Your coverage ends on the earliest of:

- The first day of the month following the date you fail to meet the required Covered Employment hours;
- 31 days after your eligibility ends and Death and/or Accidental Dismemberment Benefit coverage ends;
- The first day of the month that you do not meet the requirements for continued eligibility for medical benefits and Weekly Income Benefits (more information about Weekly Income Benefits eligibility can be found on page 53);

- Certain exigencies or urgent needs for leave that arise because your spouse, parent or child is on active military duty or notified of an impending order to active duty;
- The date you become eligible for other coverage due to other employment; or
- The date the Plan is terminated.

When coverage ends, you and your dependents may be eligible to continue your coverage under the federal law known as COBRA. See page 14 for more information.

DEPENDENT ELIGIBILITY

If you are eligible for benefits under the Plan, then your dependents, if any, may be eligible for dependent benefits under the Plan at the same time.

You are required to provide documentation to the Fund Office that verifies your dependent's status. Documentation may include a certified birth certificate, adoption papers, court orders, affidavits, tax returns, or other proof of financial support.

If your child works in Covered Employment and is covered for benefits under the Plan on that basis, he or she will be treated as the Eligible Member under the Plan rather than as a dependent.

If your Spouse works in Covered Employment and is covered for the benefits under the Plan on that basis, he or she will be treated as the Eligible Member under the Plan and as your dependent Spouse.

If your dependent has coverage under another medical plan, Coordination of Benefits will apply. See page 64 for more information.

DEPENDENT DEFINED

Your dependents are:

- Your Spouse (including a same-sex Spouse) if you are not divorced; and
- Your child(ren) until the end of the month in which he/she turns age 26.

Common law spouses, domestic partners and civil unions (regardless of sex) are not eligible dependents under the Plan. Under the Plan, your child is defined as:

- Your natural child;
- Your stepchild;
- Your adopted child or child placed with you, the Eligible Member, for adoption;
- Your child who is entitled to coverage pursuant to a Qualified Medical Child Support Order (QMCSO);
- Your child for whom you have legal guardianship, provided:
  - You, the Member, are named legal guardian;
  - The child resides in your home in a parent-child relationship;
  - The child depends on you for more than half of his or her financial support;
  - You have taken full parental responsibility and control for the child;
  - The child is not living in your home temporarily;
  - The child is not still under the control of the social service agency that placed the child with you; and
  - The natural parents do not share parental responsibility and control of the child with you. Parental responsibility includes monetary support of any kind, maintenance of health coverage, and other supportive functions.
- Your unmarried child who is age 26 or older, if the child becomes physically or mentally disabled before reaching age 26. The disabled child must depend on you for more than half of his or her financial support and maintain a principal residence with you for more than one-half of the calendar year. If the disabled child does not live with you after a divorce or separation, the child will be a dependent child, provided that:
  - You and the other parent are: 1) divorced or legally separated under a decree of divorce or separate maintenance; 2) separated under a written separation agreement; or 3) live apart at all times;
  - You and the other parent provide over one-half of the child's support; and
  - The child is in the custody of one or both of his or her parents for more than one-half of the calendar year.

The disabled child must not be a "qualifying child" of any other taxpayer as defined in Internal Revenue Code Section 152(c).

Physically or mentally disabled means that the child is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more. You must give the Fund Trustees written proof of your child's disability. Please contact the Fund Office three to six months **before** your child's coverage would otherwise end to request a Proof of Incapacitated Child Form for completion. You must provide the Fund Office with the completed form and a copy of your child's medical records for review before your child's coverage would otherwise end. When the Trustees receive proof of your child's disability, they have the right to have a physician of the Trustees' choice examine the child. The Trustees may require such an examination as often as they believe is reasonable. The Trustees may request continuing proof of your child's disability and will notify you when this proof is required.

For purposes of a disabled, unmarried child over age 26, the term, child, **does not** include:

- A child who is living in your household if you are not the legal custodian, unless your divorce or separation decree requires that you provide benefit coverage for the child;
- A child who is in full-time armed forces service; or
- A child who is not otherwise defined as your child, except for a child who is the subject of a paternity order that calls for health insurance coverage, limited as follows:
  - » If the paternity order is entered into by consent or without contest, the Plan is entitled to and may require verification of paternity through a DNA test or by receipt of a birth certificate.
  - » If your child works in Covered Employment and is covered for benefits under the Plan on that basis, he or she will be treated as the Eligible Member under the Plan rather than as a dependent.

All mid-year changes to existing elections must comply with the HIPAA special enrollment requirements.

IF YOUR SPOUSE HAS GROUP EMPLOYER-SPONSORED BENEFITS

If your Spouse is provided an incentive to opt-out of other coverage and your Spouse is covered under this Plan, your Spouse's coverage will be limited as if your Spouse had enrolled in the other group coverage. Any benefits payable to your Spouse under any portion of the Plan will be reduced by the amount of any benefits available in the other group coverage, even if your Spouse does not enroll or participate in the other group coverage.

WHEN DEPENDENT COVERAGE ENDS

Your dependent's eligibility for benefits under the Plan will end on the same day that your coverage ends. Your dependent's coverage under the Plan also ends:

- When your dependent no longer meets the Plan's definition of an eligible dependent (e.g., due to divorce or a child reaching age 26);
- The date the Plan is terminated; or
- When your Spouse or dependent enters the armed forces.

If you die while you are eligible for benefits, your dependents are eligible to continue coverage by electing COBRA continuation coverage for up to 36 months (see page 14). If your dependents elect COBRA continuation coverage, the first 18 months are free; that is the Fund pays for the first 18 months of COBRA continuation coverage. After that, if your dependents elect to continue coverage for up to an additional 18 months, they will be required to pay for this coverage at the COBRA rates in effect at that time.

SPECIAL ENROLLMENT

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents.

You must request enrollment within the specified time periods provided below and satisfy all documentation requirements as follows:

- You must request enrollment of a newborn child in the Plan within 31 days of birth. You must provide the Plan with a certified copy of the newborn's birth certificate, listing you as a parent, within 90 days of the date of birth to continue your dependent's coverage under the Plan. If you do not provide a copy of your newborn's birth certificate within 90 days of the date of birth, benefit coverage will be suspended.
- You must request enrollment of an adopted child, including a child placed for adoption, in the Plan within 31 days of the adoption or placement for adoption. You must provide the Plan with a copy of an Order of Adoption and/or Adoption Agreement, along with any other documentation requested by the Fund within 90 days of the adoption or placement for adoption. If you do not provide a copy of the Order of Adoption and/or Adoption Agreement, or other appropriate documentation within 90 days of the date of adoption or placement of adoption, benefit coverage will be suspended.
- You must request enrollment for a newly eligible dependent (such as a spouse or stepchild) in the Plan within 31 days of marriage. You must provide appropriate documentation as requested by the Fund Office, such as a marriage license, within 90 days of the marriage to continue your newly eligible dependent's coverage under the Plan. If you do not provide a copy of the marriage license within 90 days of the date of the marriage, benefit coverage will be suspended. If you or your dependent's coverage under a Medicaid plan or state CHIP plan is lost, as a result of the loss of eligibility, you may request coverage no later than 60 days after the date coverage terminates. You must provide proof of loss of eligibility, within 90 days of the loss to continue coverage under the Plan. If you do not provide a proof of loss within 90 days of the loss, benefit coverage will be suspended.
- If you or your dependent becomes eligible for assistance under a Medicaid plan or state CHIP plan, you may request coverage no later than 60 days after the date you become eligible for assistance. You must provide proof of eligibility for assistance within 90 days of becoming eligible for assistance to continue coverage under the Plan. If you do not provide proof of eligibility for assistance within 90 days of eligibility, benefit coverage will be suspended.

In all cases, if the documents aren't submitted within a year of the date the dependent was first eligible, the effective date of coverage will be the date the documents are received. If appropriate documentation is received within one year, the effective date will be the date the dependent was first eligible.

REINSTATEMENT OF ELIGIBILITY

If your coverage ends, you can reinstate your eligibility by satisfying the Plan's initial eligibility requirements again (see page 6). For information regarding your eligibility during and after your return from a leave of absence for military service or family and medical leave (see page 7).

EXTENSION OF BENEFITS

If you are an Inpatient at the time your coverage under the Plan ends, the Plan will provide an extension of benefits limited to the Covered Services of this Plan that are rendered by and regularly charged by the Inpatient Facility in which you are an Inpatient. Benefits will be provided under the terms of the Plan until you are discharged. No benefits are payable following discharge.

RESCISSION OF COVERAGE

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days' advance written notice of that Rescission of Coverage. 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 will be effective back to the time that you should not have been covered by the Plan.

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 record keeping 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 pay required premiums or contributions for your coverage in a timely manner.
- 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 Spouse and children 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.

CHANGES IN ELIGIBILITY RULES

The Trustees reserve the right, at their sole and unrestricted discretion, to change, modify, or discontinue all or part of the eligibility rules or the benefits provided under the Plan at any time. The Trustees have the authority to establish contribution rates and self-payment rules and they reserve the right to change them at any time in their sole and unrestricted discretion.

CHANGES IN SOCIAL SECURITY NUMBERS

If you change your Social Security Number (SSN) for any reason, you are required to submit written verification to the Fund Office from your local Social Security Administration (SSA) office. Your local SSA office will also provide you with documentation that your prior work history under an old or temporary SSN has been moved to your new SSN.

If you do not have a valid SSN, the Internal Revenue Service (IRS) can provide you with a Tax Identification Number (TIN). If you are assigned a TIN, you may be asked to provide documentation from the IRS or the SSA to register the new TIN with the Fund Office.

In addition, you **must** submit your prior work history documentation to the Fund Office when your SSN is changed so we may correct your work history records in the Plan's data processing system. Failure to submit the appropriate documentation may affect your eligibility for benefits. You must provide your SSN upon the Plan's request due to federal requirements on the Plan to report coverage. The Fund Office will also require that you complete a new enrollment card and *Annual Claim Form.*

CONTINUATION OF COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, you or your dependents may continue healthcare coverage past the date coverage would normally end. Under certain circumstances, by making the required COBRA payments, you or your dependents may continue coverage under the:

- ***COBRA Core Plan,*** which includes Medical, Prescription Drug, and Death Benefits as described in this Plan/SPD; or
- ***COBRA Full Plan,*** which includes Medical, Prescription Drug, Dental, Vision, and Death Benefits as described in this Plan/SPD.

The COBRA continuation coverage will be identical to the coverage you had under the Plan on the day before your qualifying event. You will not be eligible to continue coverage for Weekly Income or Accidental Dismemberment Benefits.

If you have a new child that meets the Plan's definition of an eligible dependent (e.g., if you have a newborn child, adopt a child, or have a child placed with you for adoption for whom you have financial responsibility) while your COBRA continuation coverage is in effect, you may add that child to your coverage. You must give the Fund Office written notice of the birth, adoption, or placement of a child with you for adoption to have the child added to your coverage under the Plan.

Children born, adopted, or placed for adoption as described above, have the same COBRA rights as a Spouse or dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA continuation coverage, these children's continued coverage depends on timely and uninterrupted COBRA payments on their behalf.

For COBRA continuation coverage, you must notify the Fund Office within 60 days of a:

- Divorce; or
- Child losing dependent status.

If you do not notify the Fund Office, you will lose your right to continue coverage under COBRA.

QUALIFYING EVENTS

Federal law requires that the Plan provide you with an opportunity to continue coverage upon a loss of coverage, because of a qualifying event. Qualifying events include:

Qualifying events include:

- Termination of your Covered Employment (for causes other than gross misconduct);
- Reduction in your hours reported for Covered Employment;
- Your death;
- You become entitled to (i.e., enrolled in) Medicare Benefits (under Part A, Part B, or both);
- Your divorce; or
- Your child's loss of dependent status under the Plan.

PARTICIPATION AGREEMENT AND INDEPENDENT SELF-CONTRIBUTORS

If you are receiving benefits under a Participation Agreement for Independent Self-Contributors, you are remitting contributions for yourself and possibly other non-bargaining unit employees who are performing collective bargaining work. You are not entitled to COBRA continuation coverage if you cease to remit contributions on your behalf. If you do not submit contributions on behalf of your employees covered under a collective bargaining agreement, your benefits will be suspended until such time that all contributions, penalties, interest, and any costs of collection are paid in full. The Trustees reserve the right to terminate a Participation Agreement for Independent Self-Contributors for failure to remit contributions required under that Participation Agreement as well as for failure to remit contributions required under the terms of the related collective bargaining agreement.

NOTIFYING THE FUND OFFICE

You or your beneficiary must inform the Fund Office of a divorce or child losing dependent status under the Plan within 60 days of the event. If you or your dependents do not notify the Fund Office within 60 days of such an event, you lose your right to elect COBRA continuation coverage.

Your Employer may notify the Fund Office of your termination of employment, reduction in hours, death, or entitlement to Medicare coverage. However, because Employers contributing to multiemployer funds may not be aware of these events, the Fund Office will rely on its records for determining when eligibility is lost under these circumstances. To ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Fund Office of any qualifying events as soon as they occur.

ELECTING COBRA CONTINUATION COVERAGE

When the Fund Office is notified that a COBRA-qualifying event has occurred, you and your dependents will be notified of your right to elect COBRA continuation coverage. To elect continuation coverage, you must complete the election form and submit it according to the directions on the form. You then have 60 days from the later of the date the election notice was provided or the date coverage ended due to the qualifying event to return the election form to the Fund Office.

Whether or not you elect coverage for yourself, your dependents have the opportunity to elect coverage independently from you. For example, in the event of your death, your child may elect continuation coverage, even if your Spouse does not. A parent may elect to continue coverage on behalf of any dependent child(ren). Your Spouse can elect continuation coverage on behalf of all qualified beneficiaries.

In determining whether to elect continuation coverage, your dependents should consider the following consequences if they fail to continue their group health coverage through COBRA:

- They should take into account that they have special enrollment rights under federal law. They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your Spouse's Employer) within 30 days after their group health coverage ends because of the qualifying event. They will also have the same special enrollment rights at the end of continuation coverage if they elect COBRA continuation coverage for the maximum time available to them.

The Plan currently offers two levels of COBRA continuation coverage, the COBRA Core Plan and the COBRA Full Plan. Once you elect a level of coverage, you may change your election to a different level of coverage only if the 60-day election period has not expired. Once the 60-day election period ends, you are no longer eligible to change coverage level.

PAYING FOR COBRA CONTINUATION COVERAGE

The Fund Office will notify you of the cost of your COBRA continuation coverage when it notifies you of your right to elect such coverage. The Trustees determine the cost for COBRA continuation coverage each year. It will not exceed 102% of the cost to provide this coverage. If you qualify for extended disability coverage under COBRA, the cost for the 19th through the 29th month is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Payment of premiums provide coverage for you and your covered dependents and is the same amount of money each month for both you and covered dependents, if any. You must remember to remit your premiums each month. Simply electing COBRA continuation coverage does not make you eligible.

Your *first* payment for COBRA continuation coverage must include payments for any months retroactive to the day coverage under the Plan terminated. This payment is due no later than 45 days after the date you or your dependent signed the election form and returned it to the Fund Office.

Subsequent payments are due on the first business day of each month for which coverage is provided, with a grace period of 30 days. If payment is not received by the due date, all benefits will terminate immediately. Once your COBRA continuation coverage is terminated, it cannot be reinstated.

COBRA PAYMENTS

You must pay your COBRA payments on time. Your coverage will be cancelled and cannot be reinstated if your payments are not received by the due date.

No payments will be made on Claims presented to the Fund Office and eligibility cannot be updated until a timely COBRA premium payment is received.

COVERAGE PERIOD

- *Coverage Continues for 18 Months.* You may elect to purchase COBRA continuation coverage for yourself and your dependents for up to 18 months if coverage ends due to your termination of Covered Employment (except for gross misconduct) or your reduction in hours
- *Coverage Continues for 29 Months (Extended Disability Coverage).* Your coverage or your dependent's coverage may continue for a total of 29 months (an additional 11 months) after your Covered Employment is terminated or you have a reduction in your hours if you or one of your dependents is totally disabled, as determined by the Social Security Administration. The determination must be made either:
  - At the time of your termination from Covered Employment or reduction in hours; or
  - Within the next 60 days after your termination from Covered Employment or reduction in hours.

You must notify the Fund Office of your determination of disability by the Social Security Administration before the end of the 18-month period of COBRA continuation coverage. *In addition, if, at a later date, you become employed or are no longer considered totally disabled by the Social Security Administration, you must notify the Fund Office.*

- *Coverage Continues for 36 Months.* Your dependents may elect to continue coverage for up to 36 months if coverage ends due to your:
  - Death;
  - Attainment of Medicare healthcare coverage entitlement during the first 18 months of COBRA continuation coverage;
  - Divorce; or
  - Dependent child no longer meeting the definition of child and not qualifying for dependent coverage under the terms of the Plan. See page 9 for the definition of dependent under the Plan.

LOSS OF CONTINUED COVERAGE

The period of COBRA continuation coverage for you or your dependents may be cut short for any of the following reasons:

- You or your dependents do not make the required COBRA payments within 30 days of the due date;
- The Plan stops providing any group health benefits;
- After the qualifying event, you or your dependents become covered under another group healthcare plan; or
- You or your eligible Spouse becomes entitled to Medicare.

OTHER OPTIONS

You may also be eligible for other coverage options, such as coverage through the Health Insurance Marketplace, Medicaid, or other group health plan options (such as through a spouse's plan). More information is available about the Health Insurance Marketplace at www.healthcare.gov.

CHANGES IN FAMILY STATUS

At some point in our lives, each of us will experience—if we have not already—a life event that affects our healthcare coverage. Beginning a new job, having a child or adopting one, getting married or divorced, having a major illness, performing military duty, retiring from employment as a laborer, and losing a loved one, are all examples of life events. This Plan/SPD not only sets forth the Chicago & Vicinity Laborers' District Council Health & Welfare Plan but also shows how those benefits fit into the different stages of your life.

Call the Fund Office at 708-562-0200 to notify them of any change in your family status.

When you experience a change in family status, you should contact the Fund Office to report the change. The Fund Office will provide you with any forms you must complete in order to report the change. This helps ensure that the Fund Office has your correct address and family information on file. It also enables the Fund Office to keep updated information about your marital status, your dependents, and whether you or your dependents have other benefit coverage. This information helps in processing your Claims quickly and accurately.

NOTIFY THE FUND OFFICE

You can help avoid delays in benefits payments by notifying the Fund Office:

- Of new dependents; and
- When a dependent is no longer eligible for coverage (you may want to continue their coverage through COBRA).

ADDING A DEPENDENT

Depending on your situation, there will be paperwork that you will need to submit to the Fund Office. For example, if you have a baby, you must submit a certified copy of your newborn child's birth certificate within 90 days of birth. Original documents are required and will be returned to you via certified mail.

Also, if you adopt a child, or have a child placed with you for adoption, you must submit a copy of the adoption papers (or correspondence from your adoption attorney if the adoption is in process) to the Fund Office. When you notify the Fund Office of a change in family status, they will guide you through the process.

GETTING MARRIED

If you get married, you will need to submit a certified copy of your marriage license to the Fund Office. You may obtain a certified copy from the county in which you were married. The church record of your marriage is not sufficient. Original documents are required and will be returned to you via certified mail. Common law spouses, domestic partners and civil unions (regardless of sex) are not eligible dependents under the Plan.

IF YOUR DEPENDENT LOSES ELIGIBILITY FOR COVERAGE

If your dependent child loses eligibility for coverage under the Plan by reaching age 26, your dependent child may continue coverage under COBRA. You or your dependent child must notify the Fund Office of the loss of dependent status within 60 days from the date of loss to be eligible to elect COBRA continuation coverage. See page 14 for more information about COBRA continuation coverage.

IN THE EVENT OF DIVORCE

If you obtain a divorce, you must notify the Fund Office immediately and submit a complete copy of your certified divorce decree. If your ex-Spouse was covered under the Plan on the day before the divorce and wants to continue coverage under COBRA, you or your ex-Spouse has 60 days from the date of the divorce to notify the Fund Office of the divorce and request COBRA information from the Fund Office. See page 14 for more information about COBRA continuation coverage.

The failure to properly notify the Fund Office of your divorce may result in the Rescission of Coverage and the repayment of claims wrongfully paid by the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan recognizes Qualified Medical Child Support Orders (QMCSOs). QMCSOs must be submitted to the Plan Administrator who will determine whether the order is qualified as a QMCSO under federal law. A copy of the procedures that the Plan follows to make this determination is available free of charge at the Fund Office.

QMCSO

An official court order that provides benefits for dependent children, or other qualified beneficiaries, in the event of a divorce or other family law action.

If a child is added to coverage based on a QMCSO, the parent seeking reimbursement for medical expenses must submit proof of payment.

IN THE EVENT OF DEATH

If you die, your surviving Spouse or dependents should contact the Fund Office. The Fund Office will assist them in submitting a Claim for a Death Benefit.

If you are eligible for benefits under the Plan at the time of your death, your dependents are eligible for COBRA continuation coverage for a period of up to 36 months. The Plan provides the first 18 months of COBRA continuation coverage free of charge. After that, if your dependents elect to continue coverage for up to an additional 18 months, they will be required to pay for this coverage at the COBRA rates in effect at that time.

In the event of one of your eligible dependent's death, you should contact the Fund Office to submit a Claim for a Death Benefit for your dependent. If your dependent was covered under the Plan, you will need to submit a certified copy of your dependent's death certificate.

MEDICAL BENEFITS

HOW THE MEDICAL PLAN WORKS

You are covered for expenses you incur for most, but not all, medical services and supplies. Please see page 28 for the list of exclusions. Your expenses must be Medically Necessary to be eligible for coverage. *All charges for your care are subject to Usual and Customary Charges.* Benefits are paid on a calendar year basis. If you or a dependent use a non-network provider, you are responsible for any expenses you incur that exceed Usual and Customary Charges. See page 92 for the definition of Usual and Customary Charges.

The Plan provides:

- Medical benefits that pay 100% of the first $10,000 in covered expenses, per covered person each calendar year.
- After you have accumulated $10,000 in covered medical expenses, you are responsible for payment of your annual $200 individual or $400 family deductible.
- After you have met your deductible, the Plan pays 90% of covered expenses if you use a network provider and 80% if you use a non-network provider for the next $7,500 in covered charges.
- After that, the Plan again pays 100% of eligible covered expenses for the remainder of the calendar year.

MEDICALLY NECESSARY

Services, treatments, or supplies ordered by your Physician that are:

- Required to identify or treat an injury or illness;
- Appropriate and consistent with the symptoms, diagnosis, or treatment of the condition, disease, illness, or injury;
- In keeping with acceptable National Standards of Good Medical Practice; and
- The most appropriate that can be safely provided to you under the circumstances on a cost-effective basis.

ANNUAL DEDUCTIBLE

The Plan has an individual and a family medical annual deductible provision. The annual deductible is the amount of covered medical expenses that you pay after the Plan has paid the first $10,000 in covered medical benefits each calendar year.

The amount of your individual annual deductible is $200. To meet the family deductible, one family member must first meet the $200 deductible. Then, the annual family deductible is satisfied when the combined deductibles of all family members reach $400 in a calendar year. However, no one family member can apply more than his or her individual deductible to the family deductible.

ANNUAL DEDUCTIBLE

The amount of covered medical expenses that you pay after the Plan has paid your first $10,000 in covered expenses and before the Plan pays. The amount of your individual annual deductible is $200.

Any covered expenses that are applied to an individual deductible in the last three months of any calendar year may also be applied to that individual's next calendar year's annual deductible. The family deductible does not carry over to the next calendar year deductible.

COINSURANCE

After the Plan pays the first $10,000 in covered expenses and you or your family have satisfied your annual deductible, the Plan pays a percentage (90% for network providers; 80% for non-network providers) of the next $7,500 in covered expenses (called the "Coinsurance Limit"). After your Coinsurance on the next $7,500 in covered expenses is met, the Plan will pay 100% of any additional covered expenses you incur for the remainder of the calendar year, up to your lifetime maximum for certain benefits and subject to Usual and Customary Charges.

Certain covered expenses that were incurred during the last three months of the preceding calendar year may be counted toward the Coinsurance Limit.

Note: These estimated Coinsurance amounts are applicable to expenses covered by the Plan only. All charges are subject to Usual and Customary Charges and may result in a payment of less than 100% if a non-network provider is used.

AVOID USING NON-NETWORK PROVIDERS

If you consistently use network providers, the amount of covered medical expenses you may be responsible to pay during a calendar year is **$950** (which equates to your $200 annual deductible plus 10% of the $7,500 Coinsurance Limit, which is $750).

EXAMPLE:
YOU AND THE PLAN COVER YOUR ANNUAL MEDICAL COSTS

John, his wife Joan, and their daughter Julia are covered by the Plan. They each had medical expenses that exceeded $10,000 in 2018. John had medical expenses of $12,000, Joan had medical expenses of $11,600 and Julia's medical expenses reached $10,100. The family deductible of $400 was applied to the family's expenses before the Plan paid a percentage of the family's additional medical expenses. Assuming the family used network providers, their expenses for the year were:

Expenses	John's	Joan's	Julia's	Family
Total medical expenses	$12,000	$11,600	$10,100	$33,700
Less first $10,000 (Paid by Plan)	- $10,000	- $10,000	- $10,000	- $30,000
Balance	$2,000	$1,600	$100	$3,700
Less deductible (You Pay)	**- $200**	**- $100**	**- $100**	**- $400**
Balance	$1,800	$1,500	$0	$3,300
Plan pays 90%	- $1,620	- $1,350	- $0	- $2,970
Member pays 10%	**$180**	**$150**	**$0**	**$330**
Total family expenses (deductible and Coinsurance)				**$730**

Out of a total of $33,700 in medical expenses, John and his family paid only $730.

LIFETIME MAXIMUM

The Plan does not have an overall lifetime maximum, but a lifetime maximum may apply to certain benefits (refer to the Schedule of Medical Benefits beginning on page 21).

PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan offers benefits and care from a network of Physicians and Hospitals that participate in the Blue Cross Blue Shield of Illinois (BCBSIL) BlueCard Preferred Provider Organization (PPO). When you use a network provider, you save money for yourself and the Plan because network Physicians and Hospitals have agreed to charge a negotiated price for their services.

You do not receive a PPO discount on medical expenses that are not covered by the Plan. Please see pages 28-30 for Plan exclusions.

PPO

A network of Physicians and Hospitals that have agreed to charge negotiated rates. Since network providers have agreed to these negotiated rates, you help control healthcare costs for yourself and the Plan when you use a network Physician or Hospital.

EXAMPLE:
USING A NETWORK PROVIDER CAN SAVE YOU MONEY

Let's compare what Joe pays when using a network Hospital outpatient surgical facility versus a non-network Hospital outpatient surgical facility.

During the Plan Year, and prior to the following care, Joe received benefits of $10,000 under the Plan and satisfied his $200 per person annual deductible. If Joe receives care at an outpatient surgical facility, his share of the cost will be determined as follows:

	Network Hospital Outpatient Surgical Facility	Non-Network Hospital Outpatient Surgical Facility
Expenses Charged	$3,200	$3,200
Network Discount*	– $1,280	– $0
Remaining (Adjusted) Charges	$1,920	$3,200
Plan Pays	$1,728 (90%)	$2,560 (80%)
Joe Pays	**$192** (10%)	**$640** (20%)

Joe saves $448 by using a network Hospital outpatient surgical facility.

* This example assumes a network savings rate of approximately 40%. The actual savings may vary.

** This example also assumes the non-network facility expenses do not exceed Usual and Customary Charges. If they did, Joe would be responsible for the difference between the expenses charged and the Usual and Customary amount, as well as the 20% ($640).

Understand that it's your decision whether or not to use a network Physician, Hospital or facility. You always have the final say about the providers you and your family use.

To select a network provider in your area you may contact BCBS at 800-810-2583 or visit the BCBS website at www.bcbsil.com for a free listing of network providers.

SCHEDULE OF MEDICAL BENEFITS

The chart below highlights the Plan's medical benefits. Benefits are paid on a calendar year basis. *All covered expenses must be within the guidelines of Usual and Customary Charges*.

Additional limitations apply for certain services. These limitations are explained later in this section.

Medical Benefits	Benefit Amount/Limitations
Annual Deductible	After the Plan pays the first $10,000 of medical expenses, you must pay: • $200 per person per calendar year • $400 per family per calendar year
Medical Coinsurance	After you pay your annual deductible, the Plan pays the applicable Coinsurance rate of the next $7,500 per person of eligible expenses each calendar year; the Plan then pays 100% of additional expenses incurred during the calendar year
Network Provider	Plan pays: 90% of $7,500 of covered expenses, after the deductible; then 100% incurred during the calendar year
Non-Network Provider	Plan pays: 80% of $7,500 of covered expenses, after the deductible; then 100% incurred during the calendar year
Chiropractic Services and Spinal Manipulation Annual Maximum	$4,000 per person per calendar year
Home Healthcare Services and Skilled Nursing Facility Services Annual Maximum	180 days per calendar year
Hospice Care	365-day overall maximum
Infertility Treatment Lifetime Maximum	$12,500 per person per lifetime (Eligible Members and Spouses only)
Speech Therapy for Dependents[1]	• Standard developmental therapy benefits - Benefits for therapy for special diagnoses (subject to review)
Transplant Benefit	Contact Fund Office to determine coverage
Prosthetic Devices[2]	• $25,000 lifetime maximum for each initial or replacement device • Devices covered only when ordered by a Physician and only for the standard models • Replacement devices covered once every five years for adults and every two years for a child under the age of 26
Additional Medical Coverage	The following Additional Medical Coverages are not subject to the Annual Deductible or Coinsurance provisions, except as noted. Benefit Amount/Limitations
Diabetes Education	Plan pays 100% of covered expenses
Hearing Aids	Plan pays 100% of covered expenses, up to $1,500, every three calendar years
Wellness Benefits	Plan pays 100% of covered expenses
Screening Colonoscopy or Flexible Sigmoidoscopy (Eligible Members and Spouses only)	Plan pays 100% of covered expenses per person once every five years
Smoking Cessation (Eligible Members and Spouses only)	Plan pays 100% of covered expenses up to $1,000 per lifetime
Nebulizers	Plan pays 100% of covered expenses per person once every three years

[1]See explanation on page 27.

[2]See explanation on page 26.

MEDICAL COVERED EXPENSES

The Plan covers the actual Usual and Customary Charges for the following listed Medically Necessary services and supplies. Limitations on the number of treatments and the dollar amount for such treatments are contained in this section and on the *Schedule of Medical Benefits* on page 21.

- *Acupuncture,* if treatment is by a licensed acupuncturist for the treatment of pain management only.
- *Alcoholism and/or Substance Abuse treatments* are covered in the same manner as other medical illnesses. Any inpatient treatment must be provided at an Inpatient Facility as defined under the Plan.
- *Ambulance Service* deemed Medically Necessary and not for patient convenience. The Fund may request additional information on your medical condition to evaluate Medical Necessity for transport via ambulance.
- *Ambulatory Surgical Centers,* including supplies and facility charges, are covered based on Medical Necessity for surgical procedures performed on an Outpatient basis.
- *Anesthetic and Oxygen,* including the purchase of or the rental cost up to the amount of the purchase price.
- *Anesthesia Services.* For charges from both an anesthesiologist and a Certified Registered Nurse Anesthetist (CRNA) for services provided on the same day, the Plan will only pay for services performed by one provider. Payment will be made in the order in which the charges are received.
- *Assistant Surgeon charges* by Physicians, Physician Assistants or Certified Surgical Assistants may be covered. However, the Plan may review the Medical Necessity of the assistance for the surgery performed. The Plan does not cover charges for Nurse Practitioner assistance during surgery. Please contact the Fund Office for more information.
- *Breast Reduction Surgery* that is not cosmetic in nature, but is deemed Medically Necessary by the Fund's Medical Consultant(s). Please contact the Fund Office before surgery.
- *Certified Surgical Assistants (CSA).* The Plan pays 85% of the 20% allowed amount of the surgeon's charges for Covered Services provided by Certified Surgical Assistants (CSA).
- *Chemotherapy* for cancer treatment, including Chemotherapy dispensed as a prescription drug.
- *Chiropractic Services & Spinal Manipulation,* if treatment is for back-related care only up to $4,000 per calendar year. No other payment from any other portion of the Plan will be made for such services.
- *Cochlear Implants* are covered as follows:
  - Surgeon's fee and device charges are covered the same as other Prosthetic Devices (see page 26);
  - Other expenses (such as Hospital, pathology, radiology, and anesthesia) are covered the same as other medical benefits; and
  - Associated Speech Therapy may be covered (see page 27 for more information about Speech Therapy coverage).
- *Colonoscopy or Flexible Sigmoidoscopy* (for Eligible Member and Spouse) is covered for routine screening purposes once every five years, which includes all associated charges. Colonoscopy and flexible sigmoidoscopy for a medical diagnosis are covered the same as any other treatment.
- *Contraception* is covered for prescriptions and devices such as Norplant implants, Intrauterine Devices (IUDs), and diaphragms, including all medical charges associated with the devices for you or your Spouse.

USUAL AND CUSTOMARY CHARGE:

- The charge that is no higher than the 95th percentile of the Plan's most currently available healthcare charge data, or where there is insufficient data, a value or amount uniformly established by the Plan for that charge;
- For multiple or bilateral surgeries performed at the same time, 100% for the primary procedure and, for the secondary procedures, an amount determined after medical review;
- For surgical assistance by a Physician, 20% of the charge allowed for the surgery; and
- For PPO providers, Usual and Customary Charges are amounts that do not exceed the negotiated rate.

TO FIND A NETWORK PROVIDER, CONTACT:

BCBSIL
800-810-2583
www.bcbsil.com

- *Convenient Care Clinic (CCC) services.* CCCs are most often staffed by Nurse Practitioners (NPs) or Physician Assistants (PAs). While most CCCs treat people for common illnesses such as colds, the flu, sprains, ear infections, and pink eye, many also provide preventive care including health screenings, vaccinations, and physical exams. A list of BCBSIL network CCCs and services can be found at www.bcbsil.com.
- *Cosmetic Surgery* that is necessary to repair damage caused by an accident if performed within two years of that accident.
- *Dental Services,* if performed within two years of an accident, that are necessary for the repair or alleviation of damage to natural teeth resulting from that accident.
- *Diabetes Education* for participation by you and your family in a diabetes instruction program.
- *Diabetic Supplies,* such as disposable insulin needles/syringes.
- *Diagnostic Service* as ordered by a Physician to determine treatment of a medical or psychological diagnosis. Procedures may include X-rays, blood tests, MRIs, ultrasound, and other laboratory tests.
- *Dialysis Treatment,* which may include hemodialysis or peritoneal dialysis.
- *Doctors' or Physicians' services* may be provided either in or out of a Hospital and include surgical procedures and other Medical Care and treatment. For benefits to be payable, the individual must be legally qualified and acting within the scope of his or her license when services are performed.
- *Durable Medical Equipment* is covered under the Plan and includes equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use at home. Rental of durable medical equipment is only covered up to the purchase price of the same equipment. Medically Necessary replacement, repairs, adjustments and maintenance of durable medical equipment are covered, including replacement of durable medical equipment when a child's growth or a change in the participant's medical condition make replacement Medically Necessary.
- *Erectile Dysfunction Treatment.* Surgeon's fee and device charges are covered the same as other Prosthetic Devices (see page 26).
- *Gardasil Injections* for prevention of cancer are covered under the Plan's wellness benefits (see page 21).
- *Gene Therapy,* when Medically Necessary, may be covered for certain conditions. All Gene Therapy must be approved by the Food and Drug Administration and must not be considered Experimental or Investigational by the Plan.
- *Genetic testing* may be covered for certain conditions; contact the Fund Office for additional information.

DOCTORS, PHYSICIANS, AND OTHER PRACTITIONERS

Benefits may be paid for Medically Necessary services provided by certain legally qualified and licensed practitioners. Such professionals include:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Doctor of Podiatric Medicine;
- Doctor of Optometry;
- Doctor of Ophthalmology;
- Doctor of Chiropractic Medicine;
- Doctor of Naprapathy;
- Licensed Acupuncturist
- Clinical Psychologist;
- Licensed Clinical Social Worker;
- Licensed Marriage and Family Therapists;
- Licensed Clinical Professional Counselor;
- Licensed Physical and Occupational Therapist;
- Certified Registered Nurse Anesthetist;
- Nurse Practitioners;
- Physician Assistants; or
- Doctor of Dental Science and Doctor of Dental Medicine, if the individual provides Medically Necessary medical and/or surgical services or treatment.

- *Hearing Aids* are covered up to a combined maximum of $1,500 every three calendar years. The deductible and Coinsurance provisions do not apply to these expenses.
- *Home Healthcare* following your Hospital stay, up to a maximum of 180 days per calendar year (combined with Skilled Nursing Facility Services). Covered expenses include care by a nurse (RN or LPN), evaluation and development of a plan of home care by a Registered Nurse (RN), Licensed Clinical Social Worker, Physical or Occupational Therapist, and medical supplies, drugs, and medications prescribed by your Physician to the extent they would be covered had you been hospitalized. Covered expenses do not include home health aide services. The program of care should be established by a public or private agency that:
  - Is properly licensed in the state in which the patient is receiving care and where it provides services or is certified under Medicare;
  - Provides therapeutic and Skilled Nursing Services;
  - Has its policies governing services set by a professional group;
  - Provides for supervision of its services by a Physician or registered nurse;
  - Provides mainly therapeutic and Skilled Nursing Services; and
  - Maintains clerical records of all patients.
- *Hospice Care for the Hospice Care* program services described below when rendered by a Hospice Care program provider. To be eligible for Hospice Care benefits, the patient must be diagnosed as terminally ill, as certified by the attending Physician. Terminally ill refers to an individual with a medical prognosis of six months or less to live. Once eligible for Hospice Care benefits, the patient will no longer benefit from standard Medical Care or has chosen to receive Hospice Care rather than standard Medical Care. A family member or friend should be available to provide custodial type care between visits from Hospice Care program providers if Hospice Care is being provided in the home.

  Preparing for a Hospice Care period:
  - Oral or written certification of the terminal illness by the medical director of the hospice or the patient's medical Physician must be submitted to the Fund Office within 13 calendar days after Hospice Care is initiated (that is, by the end of the 14th day). Oral certification can be provided by calling 708-562-0200 and asking to speak with the Fund's Nurse Consultant. If oral or written certification is submitted 15 or more days after Hospice Care is initiated, the hospice benefit will begin on the date the certification is received.
  - The first period of certified Hospice Care will last for 90 calendar days. Oral or written recertification of the patient's status must be provided within the two-week period before the expiration of the 90-day period, but no more than 14 calendar days after the expiration of the 90-day period or benefits will be suspended until recertification is received. Oral or written recertification must be submitted every 90 days thereafter, up to a maximum of one-year of Hospice Care.

WHEN YOU NEED TO SEE A PHYSICIAN

- Call to make an appointment.
- Write down any questions that you want to review with your Physician so you won't forget to ask them during your appointment.
- Make a list of any medications you're taking and how often you take them.
- Show your ID card when you go to your appointment.
- File your Claim with the Blue Cross Blue Shield of Illinois.

It's a good idea to make and keep a copy of your Claim and any supporting materials for your records before you submit it.

HOSPITAL STAYS IN CONNECTION WITH PREGNANCY

The Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section.

Healthcare providers are not required to obtain authorization from the Plan for Hospital stays within these guidelines. Federal law does not prohibit the Physician, after consultation with the mother, from discharging the mother and/or her newborn earlier than 48 (or 96) hours.

The following services are covered under the Hospice Care program:

> A Hospital must meet the requirements of an Inpatient Facility as defined by the Plan.

- Medical appliances, supplies, and dressings;
- Nursing services provided by a registered nurse or licensed practical nurse;
- Home health aide services provided under the general supervision of a registered nurse;
- Occupational, Physical, and Speech Therapy services provided for purposes of symptom control;
- Pain management services;
- Physician visits; and
- Individual and family group counseling by qualified medical practitioners as defined by the Plan.

The following services are not covered under the Plan's Hospice Care benefits:

- Home delivered meals;
- Food in liquid form for the purposes of feeding through a feeding tube to sustain life and prescription drugs, except as covered under the Plan's Prescription Drug Benefits;
- Homemaker or caretaker services and any services or supplies not solely related to the care of the patient, including sitter or companion services for the patient who is ill, house cleaning, and general maintenance of the patient's home;
- Transportation, including, but not limited to, Ambulance Service;
- Traditional medical services provided for the direct care of the terminal illness, disease, or condition;
- Funeral arrangements;
- Pastoral or bereavement counseling;
- Respite Care Services;
- Financial or legal counseling;
- 24-hour Private Duty Nursing Service fees; or
- Hospice Care that extends beyond a one-year period.

Some expenses may be covered by other provisions of the Plan. Contact the Fund Office for more information.

- *Hospital Room and Board* and charges for services and supplies include:
  - Charges for a semi-private room with general nursing services;
  - Charges for a private room if Medically Necessary (such as for contagious or communicable diseases);
  - Intensive care units;
  - Nursery charges for newborns;
  - Emergency room treatment; and
  - Charges made by the Hospital for services and supplies for care received while an Inpatient or Outpatient. These services and supplies do not include room and board, Physicians' fees, or specialized or Private Duty Nursing Service fees.
- *Infertility Treatment,* up to a maximum of $12,500 per covered person per lifetime for combined medical and prescription drug expenses. Covered expenses include expenses relating to the diagnosis of infertility and attempts to cause pregnancy for you or your eligible Spouse only up to the limit listed on the Schedule of Medical Benefits. Treatment may include, but is not limited to, blood tests, medications, lab charges, testing, hormone therapy, artificial insemination, in vitro fertilization, methods and treatments to induce, preserve, or protect the pregnancy, and harvesting of eggs or semen from you or your eligible Spouse. Infertility benefits are not available for dependent children or to individuals who previously had elective sterilization. You have to pay for the entire cost of your infertility prescription medications in advance and then submit a Claim to the Fund Office for reimbursement.
- *Licensed Clinical Social Worker services,* which include specific services provided by a Licensed Clinical Social Worker. Contact the Fund Office for more information.
- *Mastectomy related services,* see reconstructive breast surgery on page 26.
- *Mental Health Treatment (including nervous disorders),* which is covered in the same manner as other medical illnesses. Family counseling may be covered with appropriate diagnosis. Any inpatient treatment must be provided at an Inpatient Facility as defined in the Plan/SPD.

- *Midwife Services* for the delivery of a newborn child only when provided by a Certified Nurse Midwife (CNM). For home deliveries, covered charges are limited to the Usual and Customary Charges for a normal delivery performed in a Hospital.
- *Naprapath services,* only if provided by a licensed Naprapath.
- *Nebulizers,* which are paid at 100%, once every three years.
- *Nurse Practitioners (NP)/Physician Assistants (PA) office services.* A NP or PA is a health professional, qualified by academic and clinical training who performs tasks often reserved for a Physician and who works under the direction, supervision, and responsibility of a Physician. These professionals may take medical histories, examine patients, order and interpret laboratory tests and X-rays, and make diagnoses. They may also treat minor injuries by suturing, splinting, and casting. However, the Plan does not cover NP assistance during surgery, but will pay for a Physician's services if the surgical procedure warrants assistance.
- *Nursery Care* for newborn dependents, including Physician's charges for circumcision or medical treatment, if the newborn dependent is covered under the Plan.
- *Nutritional Counseling,* as a part of diabetes education and for documented cases of anorexia or bulimia.
- *Orthotics,* when Medically Necessary, up to one pair per calendar year. Orthotics must be custom made or custom fit to qualify for reimbursement.
- *Occupational Therapy* as ordered by prescription, by a Physician, to treat a specific covered condition.
- *Physical Therapy* as ordered by prescription, by a Physician, to treat a specific covered condition.
- *Pre-admission Tests for Hospital confinement,* including X-rays, laboratory examinations, tests, or analyses.
- *Pregnancy expenses,* including Physician's fees, Hospital charges, tests, and home birth delivery by a Physician, prenatal office visits, anesthesia, tubal ligations, and other pregnancy-related conditions. For home deliveries, covered charges are limited to the Usual and Customary Charges for a normal delivery performed in a Hospital. You or your Spouse must be covered under the Plan at the time of delivery or at the time of other services for such services and supplies to be covered. The Plan covers charges for pregnancy in the same way it covers any other medical condition.
- *Prosthetic Bras,* which include the initial cost of up to three prosthetic bras following a mastectomy. Replacement bras are not covered.
- *Reconstructive Breast Surgery* and breast prosthesis following a mastectomy.

  Under the federal Women's Health Act and Cancer Rights Act, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. If you or your dependent are receiving benefits under the Plan in connection with a mastectomy and elect breast reconstruction, federal law requires coverage as determined by you and your Physician for:

  - » Reconstruction of the breast on which the mastectomy has been performed;
  - » Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - » Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

  This coverage is subject to the same deductibles and Coinsurance provisions applicable to other physical conditions covered under the Plan.
- *Registered Surgical Assistants (RSA).* The Plan pays the Usual and Customary Charge amount of 85% of the 20% allowed amount of the surgeon's charges for Covered Services.
- *Screening Mammography,* annually covered by the wellness benefit. Diagnostic mammograms performed for a medical diagnosis are covered the same as any other illness. See page 21.
- *Second Surgical Opinion,* including services and supplies necessary to obtain the opinion.

PROSTHETIC DEVICE

A prosthetic appliance (or device) is a type of corrective appliance or device designed to replace all or a part of a missing body part, including but not limited to, artificial limbs and artificial eyes.

Reconstructive surgery may be covered under the Plan only if such procedures or treatment is intended to improve bodily function and/or correct deformity resulting from a congenital anomaly that causes a functional effect or results from a prior covered therapeutic procedure.

- *Skilled Nursing Facility services* based on Medical Necessity, up to a maximum of 180 days per calendar year (combined with Home Healthcare Services). Any inpatient treatment must be provided at an Inpatient Facility as defined in the Plan/SPD.
- *Smoking Cessation* benefits are covered up to a maximum of $1,000 per person (Member and Spouse) per lifetime for medical expenses, which include hypnosis and laser treatments provided through Laser Concepts of Chicago. Smoking cessation prescription medications are covered under the Prescription Drug Program and are not subject to a lifetime maximum. You do not need to meet any deductibles before benefits are paid. The Plan only covers treatment that is prescribed by a Physician, and a prescription is required for all treatment. The Physician's visit is a covered expense under this benefit. To utilize the services of Laser Concepts of Chicago, call 630-916-8280 or visit www.laserconceptschicago.com.
- *Speech Therapy* provided by a licensed Speech Therapist under the supervision of a Physician for treatment of your dependent child from birth up to their fifth birthday. This benefit is provided in conjunction with, and as a supplement to, any state or federally mandated Speech Therapy program. When Claiming Speech Therapy benefits, proof of participation in a state or federally mandated Speech Therapy program must be provided. Benefits for standard developmental therapy are payable only before a child's fifth birthday. Benefits are also available for special diagnoses, payable only before a child's ninth birthday. Special diagnoses include:
  - Vocal nodules;
  - Severe articulation disorder with a history of ear infections;
  - Child psychosis, including non-active/conduct disturbances, speech language disorders, and autism; and
  - Focal dystonia, severe dysarthria, and dysphonia secondary to neurologic impairment.

  To receive benefits for special diagnoses, there must be demonstrable evidence that the dependent has benefited from prior therapy and would benefit from additional therapy.

  Speech Therapy may also be covered for rehabilitation needs resulting from an injury or accident. You may contact the Fund Office for more information.

Laser Concepts of Chicago has four locations in Illinois, as well as locations in Indiana and Wisconsin. For more information about locations and hours, you can call 630-916-8280 or visit www.laserconceptschicago.com.

- *Sterilization Procedures* such as tubal ligation, hysterectomy and vasectomy for the Member and Spouse only. Reversals of such procedures are not covered by the Plan.
- *Suicide attempt.* Medical expenses relating to a suicide attempt are covered like other medical illnesses.
- *Surgery.* If two or more procedures are performed through the same incision, it will be considered one operation and benefits will be payable for the most expensive procedure.
- *Temporomandibular Joint (TMJ) Treatment.* The Plan covers injections and surgery related to TMJ treatment when performed by a licensed Physician, Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD).
- *Transplants.* The Plan provides organ and tissue transplant benefits. If you need information about organ and tissue transplants, you should contact the Fund Office at 708-562-0200 and ask to speak to the Nurse Consultant.
- *Vision Correction Surgery,* including corrective procedures such as LASIK surgery, is covered by the Plan for Eligible Members and eligible Spouses up to one procedure per eye per lifetime. The Plan does not cover re-treatment warranties or enhancements. See page 43 for more information.

The Plan includes a LASIK network, QualSight. When you use a QualSight facility, the Plan pays 100% of LASIK surgery costs, including Intralase. If you do not use a QualSight facility, the Plan will reimburse you for the maximum network amount for your particular surgery. You are responsible for all costs above the maximum PPO allowance.

To find a QualSight facility, call 877-718-7676 or go to www.qualsight.com.

- *Wellness benefits* include blood chemistry profile, complete blood count, urinalysis, blood pressure analysis, electrocardiogram, colorectal screening, prostate (PSA blood test), pap test, Physician's exam, routine mammography, HIV testing, and other preventative exams as ordered by your Physician.
- *Wig,* one after Chemotherapy.

EXPENSES NOT COVERED UNDER MEDICAL BENEFITS

Only expenses related to non-occupational injuries and illnesses are covered.

Expenses that are not covered under the Plan's medical benefits include, but are not limited to, the following:

1. Any expenses incurred during a period in which you or your dependents are not eligible for benefits under the Plan.
2. Any expenses incurred by a dependent who does not meet the Plan's definition of dependent.
3. Services or supplies that are not Medically Necessary or that exceed the Usual and Customary Charge.
4. Personal items received while confined to a Hospital.
5. Services or supplies while you are not under a Physician's care or you are under the care of a person who does not meet the Plan's definition of a doctor or Physician. (See page 91 for the Plan's definition of a Physician or doctor.)
6. Services or supplies that are not recommended or approved by your Physician.
7. Services for conditions other than ones specifically identified as being covered under the Plan.
8. Dental and vision services other than those covered under the dental or vision portion of the Plan. Services that are specifically excluded are:
    a. Dental X-rays.
    b. Dental implants.
    c. Treatment of teeth or gums other than for tumors that need removal by a specialist other than an oral surgeon.
    d. Treatment of other associated structures primarily in connection with treatment or replacement of teeth, unless incurred within two years after an accident that is necessary for the repair or alleviation of damage to natural teeth resulting from that accident.
9. Any expenses relating to appetite control, food addictions, eating disorders, weight reduction, or obesity except for documented cases of bulimia or anorexia that meet standard Diagnostic Service criteria as determined by the Fund Office and the Plan's medical consultants.
10. Nutritional counseling, except for diabetes education and documented cases of anorexia or bulimia.
11. Gastric stapling, gastroplasty, gastric banding, or any other surgeries or procedures related to weight reduction or obesity, including, but not limited to, excess skin removal and any current or future complications resulting from any weight reduction surgery.
12. Hair removal or hair implants.
13. Home health aide, Physical Therapy Assistants and Occupational Therapy Assistants.
14. Infertility expenses beyond the Plan's specific maximum, medical expenses related to the services of a surrogate mother, harvesting of eggs or semen from a donor other than you or your covered Spouse, storage or freezing (Cryotherapy) of eggs or semen for you, your Spouse or a donor and any similar treatments. Infertility benefits are not available for dependent children.
15. Liposuction.
16. All medications, medical supplies, or medical equipment that may be purchased over the counter.
17. Baby formula and breast pumps.
18. Breast reduction surgery that is cosmetic in nature.

EXCLUSIONS

Not all of your medical expenses are covered by the Plan. Please read these items carefully to see what is excluded from or limited in coverage. In rare instances, an item excluded under the Plan may be payable for a specific diagnosis. If you have questions regarding coverage, contact the Fund Office.

19. Expenses of an elective abortion, except when:
    a. The mother's life is in danger; or
    b. There are medical complications from an abortion procedure; or
    c. The abortion is spontaneous; or
    d. There is an objective medical opinion that the unborn child is not expected to live outside the mother's womb if such child was carried to full term.
20. Injuries, illnesses, or diseases you sustained while working and that are covered by any workers' compensation law, Employer liability law, occupational disease law, or similar law.
21. Custodial Care, which includes services or supplies, regardless of where or by whom they are provided, that:
    a. A person without medical skills or background could provide or be trained to provide; or
    b. Are provided mainly to help the patient with daily living activities including walking, getting in or out of bed, exercising or moving the person, bathing, using the toilet, administering enemas, dressing and assisting with hygiene needs, assistance with eating, tube feeding, or gastrostomy feeding, cleaning, preparation of meals, acting as companion or sitter, administering or supervising the administration of medication, or as part of a Maintenance Care treatment plan not reasonably expected to improve the patient's condition, illness, injury, or functional ability.
22. Maintenance or Developmental Care, which includes services or supplies, regardless of where or by whom they are provided, whose primary goal is to maintain the patient's current level of function or further develop the patient's level of function because the patient has not previously reached the level of development expected for the person's age. This includes services and supplies that fall into any of the following categories, except as otherwise noted below:
    a. Learning a skill or function; or
    b. Educational in nature; or
    c. Therapy; or
    d. Durable Medical Equipment (with the exception of wheelchairs).
23. Cosmetic surgery, except when it is performed to:
    a. Correct injuries that occurred as the result of an accident within two years of the accident.
    b. Repair defects that result from a surgery for which the covered individual was paid benefits under the Plan within two years from the date of the surgery that caused the defect.
24. Investigational, Experimental, or Inappropriate Drugs, Devices, Treatment, or Procedures. These include services and treatments that are:
    a. Not yet officially accepted by the medical community.
    b. Not recognized as having proven beneficial outcomes to the patient.
    c. Not yet approved by the Food and Drug Administration.
    d. Still primarily confined to a research setting.
    e. Are not recommended for an advanced state of an illness or disease.
25. Charges incurred by organ donors that are not related to the original donor transplant procedure or complications that result from such surgeries, procedures, or treatment.
26. Services provided by a government Hospital where governmental coverage is primary.
27. Expenses excluded under coordination of benefits clauses.
28. Expenses that may result from failure to use an HMO, PPO, or EPO provider when covered under another plan that so requires.
29. Charges for the reversal of previous elective sterilization, including the use of infertility benefits.
30. Premarital examinations.

31. Marriage counseling.
32. Chelation therapy.
33. Physical Therapy, chiropractic treatment, or Occupational Therapy for developmental delays.
34. Repairs to or replacement of durable medical equipment that are not Medically Necessary.
35. Maintenance charges or batteries for durable medical equipment.
36. Expenses for household equipment and fixtures. This includes, but is not limited to, air purifiers, swimming pools, spas, saunas, escalators, lifts, transportation including ambulance charges for patient convenience, motorized vehicles or scooters, pillows, mattresses, water beds, and air conditioners.
37. Expenses for corrective appliances and durable medical equipment to the extent that they exceed the cost of standard models of such appliances or equipment.
38. Hospital facility and Anesthesia Service charges for dental procedures, except coverage for dependent children age two and younger when documented evidence of uncooperative behavior and extensive dental work is provided. Hospital confinement for dental work performed on children older than two may be covered under the Plan if in compliance with the Claim Department guidelines (contact the Fund Office for more information).
39. Massage therapy.
40. Vision therapy, including orthoptic therapy.
41. Assistant surgeon charges incurred and billed by Nurse Practitioners.
42. Physical examinations required for employment purposes.
43. Multiple charges for office visits by the same Physician on the same date. Only one visit per day is covered.
44. Charges for treatment provided by a patient's family member.
45. LASIK procedures performed on a dependent child.
46. Gym and health club memberships.
47. Services or treatment incurred at a nursing home, convalescent home, rest home or residence for the aged.
48. Services or supplies which are administered via Mobile Health providers are not covered when the alternative, receiving care in a clinical, office or hospital setting is deemed more appropriate by the Fund.
49. Drug testing is covered at the onset of treatment, but claims for excessive or repetitive drug testing performed during maintenance therapy will not be considered. Contact the Fund Office for questions.
50. Home visits being administered to non-homebound patients or patient convenience.
51. Gene therapy services that do not meet the required criteria.

PRESCRIPTION DRUG BENEFITS

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Fund contracts with CVS/Caremark for the provision of its retail/mail order program and its Specialty Drug Program.

To find a participating Pharmacy, contact CVS/Caremark Inc. at www.caremark.com.

HOW THE PRESCRIPTION DRUG PROGRAM WORKS

Your Copay—You are required to pay a copay (the amount shown on the following Schedule of Prescription Drug Benefits) when you have your prescriptions filled at a CVS/Caremark retail Pharmacy or through the CVS/Caremark mail order facility. Upon paying your copay, you are then able to submit a Claim to the Fund Office to have your entire copay reimbursed to you until the initial Basic Prescription Drug Benefit of $5,000 at 100% is exhausted.

To receive reimbursement from the Plan, you must submit your Pharmacy receipt to the Fund Office. A cash register receipt is not sufficient. The Fund Office requires a Pharmacy receipt that indicates the Pharmacy, drug name, national drug code, and total charges for your prescription. Your receipt will also indicate if you filled your prescription at a CVS/Caremark network Pharmacy.

Your Basic Prescription Drug Benefit—The Plan covers 100% of the first $5,000 in expenses associated with your prescription drug medications, which includes the cost of the medications.

Your Coinsurance (In-Network)—Once the Welfare Plan has paid $5,000 toward the cost of your prescription medications, you are required to pay 20% of the cost of your medications at the time of purchase The Plan covers 80% of the remaining eligible expenses. Your coinsurance is your out-of-pocket responsibility and will not be reimbursed to you.

Your Coinsurance (Non-Network)—If your prescriptions are not filled at a CVS/Caremark network Pharmacy or you do not show your medical/prescription drug identification (ID) card when you pick up your prescriptions, you have to pay for 100% of the cost of your medications when you have your prescriptions filled and then request reimbursement by filing a paper claim with CVS/Caremark. For more information, contact the Fund Office. The Plan will only reimburse 50% of the cost to you. The cost of prescription drugs that are filled at non-network pharmacies **will not** count toward your Basic Prescription Drug Benefit.

Specialty Drugs are filled through a separate program with CVS/Caremark (refer to page 33). You will also be responsible for paying 20% of the cost of any specialty medications you take, up to a maximum of $1,000 each calendar year. The specialty drug out-of-pocket maximum is separate from the medical out-of-pocket maximum. Once you have paid $1,000 out of pocket, the Welfare Plan will cover 100% of the cost of such medications for the remainder of the year. Please contact the Fund Office for more information about specialty drugs.

Remember, to receive the negotiated rates with participating CVS/Caremark Pharmacies, you must show your prescription drug ID card at the time you fill your prescription.

Contact the Fund Office for early prescription drug refills. Prescription drug refills are available from your Pharmacy every 30 or 90 days. If you need an early refill of your prescription because you are traveling or are on vacation, you should contact the Fund Office before ordering your refill. The Fund Office will contact you once your early refill is approved through CVS/Caremark.

RETAIL/MAIL ORDER

The CVS/Caremark Pharmacy program provides a network of participating retail pharmacies and a mail order facility where you can have your prescriptions filled. When you have your prescriptions filled at a participating retail Pharmacy or through mail order, you save money for yourself and the Fund.

When you need a medication for a short time—an antibiotic or cold remedy for example—it's best to choose the retail Pharmacy program. If you are taking a medication for 90 days or longer, it's usually best to have it filled through the mail-order prescription drug program.

RETAIL PHARMACIES

The CVS/Caremark retail Pharmacy network includes pharmacies located throughout the United States, including most national and regional chains and most independent pharmacies. CVS/Caremark offers discounted prices on your prescription medications when you go to a participating Pharmacy and present your prescription drug ID card.

You can get a 30-day supply of your medication filled at one time at a network retail Pharmacy.

Also, under CVS/Caremark's **Maintenance Choice program**, you can get up to a 90-day supply of your medication filled at a retail Pharmacy, but the Pharmacy **must** be one that is designated by CVS/Caremark as a 90-day retail network Pharmacy. You can locate a CVS/Caremark Pharmacy at www.cvs.com/StoreLocator.

Maintenance medications are prescription drugs that are used on an ongoing basis. These prescriptions can be used to treat chronic Illnesses like:

- Arthritis
- Diabetes
- Emotional distress
- Heart disorders
- High blood pressure
- Ulcers

THE MAIL-ORDER FACILITY

You can also use the mail order prescription drug program when you need to fill a prescription for a maintenance medication (which are medications that you need to take for three months or more). In addition to being able to get a larger quantity of medication at one time—up to a 90-day supply—your medications will be delivered directly to your home (or to a place of your choosing).

When you need to order medication through the mail order prescription drug program, you should:

- Ask your Physician to prescribe a 90-day supply with refills, if appropriate.
- Mail the original prescription along with the appropriate form to the mail order drug program. You can obtain a form from the Fund Office.
- Allow about 14 days from the time you mail in your order to receive your prescription(s).

If you need to begin taking the medication right away, you may want to ask your Physician for two prescriptions:

- A short-term supply that you can have filled right away at a participating retail Pharmacy; and
- A 90-day, refillable supply that you can have filled through the mail order prescription drug program.

Refills are covered only during the 30 days prior to depletion of your present supply.

GENERIC EQUIVALENTS AND BRAND-NAME MEDICATIONS

Many prescription drugs have more than one name: a generic name and a brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

Generic Medications—A generic medication is a brand-name medication that is no longer protected by a patent and usually serves the same purpose as the original medication. However, the generic costs less than the brand-name medication. Whenever available, you should ask for the generic equivalent.

Brand-Name Medications—While the Plan covers generic and brand-name medications, brand-name medications cost more for both you and the Fund. Therefore, when you and your dependents need a prescription, you may want to ask your Physician whether a generic can be substituted for the brand-name medication. If there is a generic equivalent available

USE OF GENERICS

While the use of generics is not required, you can make your basic $5,000 Prescription Drug Benefits go a long way and help save the Fund money by asking your Physician or Pharmacist for a generic substitute if there is one available. The Food and Drug Administration tests the most commonly prescribed generic medications to ensure that their quality is high. So, the next time you or your family member needs a prescription, ask your Physician if there is a less expensive generic medication available.

Take generics instead of brand-name medications.

Ask your Physician if a generic equivalent is available for the prescriptions you need filled.

and you choose not to use it, you will be responsible for the higher copay amount **and** the difference in the price between the generic equivalent and the brand-name medication. This difference will not apply toward your out-of-pocket maximum.

EXAMPLE:
HOW GENERICS CAN SAVE MONEY

Luke takes a medication on an ongoing basis. The medication is available as a generic and as a brand-name medication. The following information shows how much could be saved in one year by using the generic medication:

	Generic	Brand Name
Cost of a one-month supply of medication	$63	$131
	x 12	x 12
Total yearly cost of medication	**$756**	**$1,572**

If Luke requests the generic, total yearly prescription costs for just this one medication could be $816 less. Since the Fund pays the first $5,000 of covered prescription drug costs, this could be a great source of savings for the Fund. However, if Luke were taking multiple medications, by using brand-name medications he would reach the $5,000 amount a lot quicker than if he chose generic medications.

*This example assumes that Luke has his prescription filled at a participating Pharmacy and receives his prescription at discounted prices.

SPECIALTY DRUG PROGRAM

The Board of Trustees has also implemented a Specialty Drug Program through CVS/Caremark to help save you money.

The Plan covers specialty medications that are used to treat certain complex chronic health conditions. A specialty pharmaceutical or medication is sometimes referred to as a "biotech drug." These medications are designed to treat an ongoing major illness like hemophilia, Hepatitis C, Multiple Sclerosis, osteoarthritis, hypertension, or macular degeneration, to name a few. At times, a specialty medication may be prescribed throughout a patient's lifetime.

Specialty medications are prescription drugs that require special handling and close monitoring. They are often considerably more expensive than traditional prescription drugs, partly due to their specialized use and the manner in which they are administered, manufactured, handled, and distributed:

- Specialty drugs require preauthorization by the prescription drug network provider CVS/Caremark;
- Specialty drugs are primarily self-injectable medications requiring patient training and education; and
- Their unique manufacturing and distribution process limits the number of pharmacies that are capable of effectively purchasing, storing, and distributing the medications.

Before attempting to have your prescription for a specialty medication filled, you or your Physician must call CVS/Caremark at 866-387-2573. If you have not enrolled in the Specialty Drug Program, a one-time fill is allowed at a non-CVS/Caremark retail Pharmacy. A specialty Pharmacy representative will go through the approval process with you or your Physician. Coordination will take place so that your medication can be sent directly to you or your Physician's office, whichever you prefer.

HOW THE SPECIALTY DRUG PROGRAM SAVES YOU MONEY

You and your eligible dependents are required to pay 20% of the cost of the specialty medication, up to a maximum of $1,000 in out-of-pocket expense each calendar year. The Plan pays 80% of the cost of the specialty medication until you reach the out-of-pocket maximum; then the Plan pays 100% of the cost for the remainder of the calendar year.

EXAMPLE:
HOW THE SPECIALTY DRUG PROGRAM SAVES YOU MONEY

Ken must use a specialty medication to treat his rheumatoid arthritis. Here's how the program can save him money.

	Specialty Drug Program	Retail Program*
Annual Cost of Medication	$18,000	$18,000
Plan Pays	- 17,000	- 15,400
Ken's Coinsurance	**$1,000**	**$2,600**

Under the Specialty Drug Program, Ken's Coinsurance is 20% of the cost of the medication, with a maximum out-of-pocket expense of $1,000 per calendar year.

*After your first fill, you must use the Specialty Drug Program.

The standard prescription drug program (also known as the retail program) and the Specialty Drug Program are unique and separate and cannot be combined. At no time will any coinsurance paid under the Retail Program apply to the Specialty Drug Program.

SPECIALTY DRUG PROGRAM ADVANTAGES

When you participate in the Specialty Drug Program and use a CVS/Caremark Specialty Pharmacy, you could take advantage of the following:

- *Excellent Service.* The Program provides:
  - Personal attention from a pharmacist-led CareTeam that provides condition-specific education, instructions on taking medicines properly, and expert advice to help you manage your therapy;
  - Easy access to pharmacists and other health experts 24 hours a day, 7 days a week; and
  - Informative condition-specific materials.
- *Enhanced Convenience.* The Program provides:
  - A single, reliable source for your specialty medication needs;
  - Easy ordering with a dedicated toll-free number;
  - Confidential and convenient delivery to the location of your choice (i.e., home, doctor's office, vacation spot, home of a relative, etc.); and
  - Helpful follow-up care calls to remind you when it's time to refill your prescription, check on your therapy progress, and to answer any questions you may have.

Please note that infertility medications are not covered under the Specialty Drug Program. Contact the Fund Office for more information on infertility benefits offered to eligible participants in certain Plans.

PARTICIPATION IN THE SPECIALTY DRUG PROGRAM IS MANDATORY

With the exception of the one-time fill allowed at a non-CVS/Caremark Pharmacy, if you are an eligible participant presently taking a specialty medication, you are required to enroll in the Specialty Drug Program.

If you are an eligible participant and are prescribed a specialty medication in the future, you will be allowed to fill your prescription at the retail Pharmacy only one time under the current Retail Program benefits. After your initial retail Pharmacy fill, you will be contacted by CVS/Caremark and be sent information on how to enroll in the Specialty Drug Program.

HOW TO ENROLL IN THE SPECIALTY DRUG PROGRAM

To enroll in the Specialty Drug Program, call CVS/Caremark at 866-387-2573 and identify yourself as a participant of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan, Policy RX6597. Remember to request that CVS/Caremark contact your doctor directly to fill your next specialty drug prescription through the CVS/Caremark Specialty Pharmacy and assist you with the enrollment paperwork. All prescriptions are delivered to the location of your choice.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

The chart below highlights the Plan's Prescription Drug Benefits. Benefits are paid on a calendar year basis. *All covered expenses must be within the guidelines of Usual and Customary Charges.*

Additional limitations apply for certain services. These limitations are explained later in this section.

Prescription Drug Benefits (CVS/Caremark Inc.)		
	Benefit Amount/Special Limits	
Basic Prescription Drug Benefit	$5,000 per covered person per calendar year (100% covered for eligible expenses)	
Copays	**Retail Copays[1] 30-day supply**	**Mail Order Copays 90-day supply**
Generic Drug	$5.00	$12.50
Preferred Brand Name Drug	$10.00	$25.00
Non-Preferred Brand Name Drug	$25.00	$62.50
Coinsurance[2]	After the Plan pays the first $5,000 of prescription drug expenses, you have to pay 20% of the cost of the medication for the remainder of the calendar year. The Plan pays the remaining 80% of eligible expenses.	
Coinsurance (Specialty Medications)	You pay 20% of the cost of any specialty medications you take, up to a maximum of $1,000 per covered member each calendar year. Once you have paid $1,000 out of pocket, the Plan covers 100% of the cost of such medications for the remainder of the year.	

[1]You are also able to get a 90-day supply of your prescriptions for maintenance medications (like those used to treat chronic illnesses like arthritis, diabetes, emotional distress, heart disorders, high blood pressure and ulcers) filled at a designated CVS/Caremark 90-day retail network Pharmacy.

[2]If you do not go to a participating Pharmacy or you do not show your ID card when you pick up your prescription, you will pay 100% of the cost for your prescription medication and then request reimbursement by filing a paper claim with CVS/Caremark. The Plan will reimburse only 50% of this cost to you. This amount does not count toward your basic Prescription Drug Benefit.

COVERED EXPENSES

The Plan covers the following under the standard prescription drug program:

- Legend drugs that are not listed as exclusions.
- Insulin.
- Growth hormones, in specific cases only. Coverage does not include anti-aging treatments; contact the Fund Office for more information.
- Immunization agents, blood, or blood plasma.
- Compound medications in which at least one ingredient is a legend drug.
- Levonorgestrel (Norplant) for Eligible Member and Eligible Spouse only.
- Legend contraceptives only if prescribed to treat a medical condition.
- Medications obtained in a foreign country. However, under these circumstances the Plan will reimburse only 50% of the cost of legend prescription medications that are prescribed by a Physician.
- Medications, like those for erectile dysfunction, limited to 10 tablets per month for Eligible Member and eligible Spouse.
- Medications to treat attention deficit disorder and narcolepsy.
- Topical tretinoin, such as Retin-A (restricted to covered individuals age 26 and younger).

- Food in liquid form for purposes of feeding through a gastrointestinal tube to sustain life. This assumes that liquid food is not available as an "over the counter" food supplement in retail Pharmacies. Further, the food will be covered only with a prescription. With the exception of an illness where recovery is not expected, the feeding condition must be expected to improve, otherwise the care will be considered custodial after 12 months. Medical evidence from the patient's Physician must be provided in writing for review by the Fund's medical consultant.

EXPENSES NOT COVERED

Charges for the following drugs and medications are not covered by the Plan:

- Anti-wrinkle agents, such as Renova.
- Dermatologicals, hair growth stimulants.
- Drugs that are considered Experimental or are determined by the Food and Drug Administration as lacking substantial evidence of effectiveness.
- Drugs that require a prescription by state law, but not by federal law.
- Fluoride supplements.
- Infertility medications (however, infertility medications are covered under the Plan's medical benefits for infertility, subject to those exclusions and limitations).
- Non-legend drugs, except those specifically listed as covered.
- Pigmenting/depigmenting agents.
- Vitamins/mineral supplements, except those prescribed as treatment for a diagnosed medical condition resulting from a covered illness or injury, legend pediatric multi-vitamins with fluoride, and pre-natal vitamins.
- Drugs labeled "Caution–limited by federal law to investigational use" or Experimental drugs.
- Medication taken by or administered to a patient in a Hospital, Skilled Nursing Facility, or similar institution that has a facility that dispenses medications operating on its premises.
- Medications to promote weight loss or suppress appetite.
- Medications that can be purchased without a prescription.
- Medications that are covered under any other portion of the Plan.
- Expenses that result from not using a PPO or other prescription drug plan when coverage under another plan is primary to this Plan.

In rare instances, an item excluded under the Plan may be payable for a specific diagnosis. If you have questions regarding coverage, contact the Fund Office.

DENTAL BENEFITS

The Plan offers dental benefits through an arrangement with Delta Dental of Illinois.

HOW THE DENTAL PROGRAM WORKS

Dental benefits help limit the amount you pay for covered dental care services. The Plan covers up to $2,000 per person each calendar year for your eligible dental expenses. Note: This calendar year maximum does not apply for dependent children under age 18.

Coverage is provided through Delta Dental of Illinois, a Preferred Provider Organization (PPO). Dental benefits are also separately administered through Delta Dental.

> To find a network provider, contact Delta Dental of Illinois at 800-323-1743 or www.deltadentalil.com.

Delta Dental has a list of approved amounts for specific procedures. You may contact Delta Dental to:

- Request information about approved costs for specific procedures;
- Find a Delta Dental PPO Dentist;
- Find a Delta Dental Premier Dentist; or
- Check the status of a dental Claim.

You should always contact Delta Dental before seeking dental care. Delta Dental can help you select a network Dentist. There may be a difference in discounts under the Delta Dental program as Delta Dental has multiple networks, the Delta Dental PPO network and the Delta Dental Premier network. The Plan's benefits are greater if your Dentist is a Delta Dental PPO Dentist because these Dentists have agreed to accept the Delta Dental fee schedule as payment in full for certain services. Please note that a Delta Dental Premier Dentist is not a PPO Dentist. So check with your Dentist and with Delta Dental to determine the amount you will be responsible to pay for dental services.

If you do not use a Delta Dental PPO Dentist, the Plan's Dental Benefits may pay only a percentage of your eligible dental expenses.

SCHEDULE OF DENTAL BENEFITS

The chart below highlights the Plan's dental benefits. Benefits are paid on a calendar year basis. *All covered expenses must be within the guidelines of Usual and Customary Charges.*

Additional limitations apply for certain services. These limitations are explained later in this section.

Dental Benefits (Delta Dental)	Delta Dental PPO Preferred Dentist	Delta Dental Premier Dentist and Non-Delta Dental Providers
Non-Orthodontic Benefits Calendar Year Maximum	$2,000 per covered person (adults only)	$2,000 per covered person (adults only)
Basic Care (exams, X-rays, cleaning)	100% Covered	100% Covered[1]
Fillings, Root Canals, Dental Surgery	100% Covered	70% Covered[1]
Dentures[2] (Complete Upper and Lower)	You pay $88; then the Plan pays 100%	You pay 50%[1]
Dental Implants	50% Covered	50% Covered
Orthodontic Benefits	You pay the first $242.11; then Plan pays 100%	Plan pays 100%
Lifetime Maximum	$4,200 per covered person	$1,000 per covered person

[1]For services from non-network providers, the Plan pays this percentage of approved amounts. If your provider charges more than the approved amount, you will have to pay the difference.

[2]The copayments listed are for standard dentures. Partial dentures or special constructions may require a different amount.

DENTAL COVERED EXPENSES

Generally, the Plan's Dental Benefits under the PPO Plan will pay:

- 100% of charges up to approved amounts, which are Usual and Customary Charges for services performed, for your basic care (exams, X-rays, and cleaning) received from a non-network provider.
- 80% of charges of bite guards for bruxism and TMJ only when obtained through a network Dentist, up to $500 per appliance (including the cost of any repairs to the appliance). Replacement of a bite guard is limited to once every three years. The lifetime maximum for bite guard appliances is $1,000.
- 80% of charges of oral appliances for sleep apnea when obtained through a network Dentist, up to $500 per appliance (including the cost of any repairs to the appliance). Replacement of an oral appliance for sleep apnea is limited to once every three years. The lifetime maximum for oral appliances for sleep apnea is $1,000.
- 100% of charges up to approved amounts for fillings, root canals and dental surgery.
- 50% of charges for dental implants.

Delta Dental has a list of approved benefit amounts for specific procedures. If your provider charges more than the approved amount, you will have to pay the difference. You may contact Delta Dental for information about the Plan's approved costs for specific procedures. Before you have any dental services, have your Dentist contact Delta Dental directly for a pre-service inquiry and an estimate of expenses the Plan will cover.

Payment to Delta Dental PPO Dentists is based on preset, reduced fees. Payment to a Delta Dental Premier Dentist is based on Delta Dental's Maximum Plan Allowance (MPA). For both networks, you only have to pay your Coinsurance amount. You are not responsible for charges exceeding the reduced PPO fee, if you receive treatment from a Delta Dental PPO Dentist, or the MPA, if you receive treatment from a Delta Dental Premier Dentist. However, the coinsurance amounts between networks may vary. *To maximize your benefits, use a Delta Dental PPO Dentist.*

Mail dental claims to:
Delta Dental of Illinois
P.O. Box 5402
111 Shuman Blvd.
Naperville, IL 60563

There is a supplement to this Plan/SPD that provides you with specific information about Delta Dental services and covered dental procedures. Contact the Fund Office for a copy of the supplemental booklet.

ORTHODONTIC CARE

Orthodontic care is covered by the Plan up to a lifetime maximum. The lifetime maximum is higher when you use network providers. The *Schedule of Dental Benefits* on page 38 of this section outlines orthodontic benefits and coverage limits.

ROUTINE VISION BENEFITS

To help you manage the cost of routine vision expenses, the Plan provides vision benefits for you and your family through an arrangement with Vision Service Plan (VSP).

HOW THE VISION PROGRAM WORKS

Vision benefits cover expenses such as eye exams, frames, lenses and contacts furnished by a qualified optometrist or ophthalmologist.

The vision program administered by VSP is a preferred provider organization (PPO) with a large national network of participating providers that have agreed to charge discounted rates for most vision services. That means you pay less out of your own pocket when you use a VSP network provider.

You always have the option of using network or non-network providers. However, it's important to remember that when you use a VSP PPO provider, you will pay less out of pocket, have greater coverage and Claims for benefits will be filed for you directly by the VSP network provider. In the event you use a non-network provider for vision services, you will be required to pay for your services at the time you receive them and then submit a Claim reimbursement form to VSP.

It is easy to find a VSP network provider and make the most of your vision benefits under the Plan. Check with your current vision provider to see if they participate in the VSP network. Or, you can find a VSP network provider by visiting the VSP website at www.vsp.com or by calling VSP Member Services at 800-877-7195, Monday–Friday, 8 a.m.–8 p.m.

SCHEDULE OF VISION BENEFITS

The chart below highlights the Plan's Vision Benefits. Benefits are paid on a calendar year basis. *All covered expenses must be within the guidelines of Usual and Customary Charges.*

Additional limitations apply for certain services. These limitations are explained later in this section.

Routine Vision Benefits	VSP Network Provider Plan Pays:	Non-Network Provider Plan Pays Up to the Following Allowances:
Eye exams (includes refraction, limited to one exam per calendar year except for covered persons under age 15)[1]		
Standard Eye Exam	100%	$30 per covered person except for covered persons under age 18
Contact Lens Exam[2]	100%	$95 per covered person except for covered persons under age 18
Lenses[3] (one pair per calendar year) The Plan will provide for one pair of glasses or up to $250 year for Contact Lenses, but not both:		
Single vision	100%	Up to $26
Lined Bifocal	100%	Up to $39
Lined Trifocal	100%	Up to $55

[1]Covered persons under age 15 may also receive an additional set of glasses with a prescription.

[2]Contact lens exams are only covered if contact lenses are purchased during the same visit.

[3]If you go to a VSP provider and select lenses from the network "collection," even if these lenses cost more than the limits specified above, you will not be charged any additional amount. Non-network provider charges will only be reimbursed up to the limits specified.

Routine Vision Benefits	VSP Network Provider Plan Pays:	Non-Network Provider Plan Pays Up to the Following Allowances:
Standard progressive lens (No line Bifocal)	100%	Up to $105
Premium progressive lens (No line Trifocal)	100%	Up to $105
Lenticular	100%	$0
Lens Options		
UV Treatment	100%	$0
Tint	100%	$15
Transition	100%	$40
Standard Plastic Scratch Coating	100%	$25
Standard Polycarbonate	100%	$25
Standard Anti-reflective Coating	100%	$0
Polarized	100%	$40
Oversized	100%	$0
High/Hyper High Index	100%	$0
High Sphere	100%	$0
High Cylinder	100%	$0
Base Curve	100%	$0
Bifocal Add High Power	100%	$0
Prism	100%	$0
Photochromic	100%	$0
Other Add-Ons	No discounts	No discounts
Contact Lenses **The Plan will provide up to $250 for Contact Lenses or one pair of glasses per calendar year, but not both:**		
Contact Lenses (Conventional contact lenses for correction of vision)	100% up to $250; no discount off additional balance over $250	$175
Contact Lenses (Medically Necessary after cataract surgery)	100%	$175
Disposable Lenses	100% up to $250; no discount off additional balance over $250	$175
Frames Maximum	100% up to $75; 20% off balance over	$75
Additional Discounts	In the VSP network, Plan participants also receive a 20% discount on unlimited additional pairs of glasses and sunglasses (i.e., lenses and frames and any additional lens options selected) within 12 months of the last covered eye exam, once the full benefit for services covered by the Plan has been used by the participant.	

EXPENSES NOT COVERED UNDER ROUTINE VISION BENEFITS

Charges for the following vision care expenses are not covered by the Plan.

1. More than one exam, one set of frames, or one pair of lenses per covered person per calendar year unless otherwise provided.
2. Any charges or portion of charge(s) for services or supplies that are covered in whole or in part under any other portion of the Plan or under any other medical or vision benefits plan provided by an Employer.
3. Any charge incurred when you do not use a PPO or other medical or vision plan with vision benefit coverage that is primary to this Plan.
4. Treatment that is solely for cosmetic purposes.
5. Treatment under another benefit provision of the Plan.
6. Treatment covered by workers' compensation benefits.
7. Eye exams required by an Employer as a condition of employment.
8. Special procedures or supplies.
9. Visual analysis that does not include refraction.
10. Medical or surgical treatment of the eyes.
11. Non-prescription eyeglasses of any type.
12. Antireflective coating provided by a non-network optometrist.
13. Claims for expenses that are submitted without a full, itemized receipt.
14. Any vision service not listed on the Schedule of Vision Benefits beginning on page 40.

VISION CORRECTION SURGERY

The Board of Trustees has contracted with QualSight, Inc. to provide Eligible Members and their eligible Spouses with access to discounted vision correction surgery. This program offers **advantages** such as:

- *Access to Quality Physicians.* Independent, NCQA-credentialed, Board Certified ophthalmologists.
- *Experience. QualSight* providers have performed over 1.1 million procedures.
- *Savings.* 40% to 55% off the overall national average cost.
- *Retreatment Warranty.* If your ophthalmologist recommends retreatment within the first year of your procedure, you only have to pay the laser manufacturer's licensing fees of $100 to $300 per eye.

Charges for laser manufacturer's licensing fees and retreatment warranties are not covered under the Plan.

Eligible participants should contact QualSight at 877-718-7676. A QualSight Care Manager will register you and conduct a preliminary screening to ensure that you are a potential candidate for surgery. The Care Manager will explain the Plan and network vision correction surgery benefits available to eligible participants. The Care Manager will also discuss surgical procedures and answer your questions.

Next, you will select a local preferred provider from a nationwide list. The Care Manager will schedule your pre-operative exam with the provider and provide a confirmation to you via first class mail or e-mail. After a successful pre-operative exam, if you are eligible for benefits, you may choose to have the vision correction surgery and follow-up exams with your provider.

VISION CORRECTION BENEFITS

The Plan pays for one vision correction procedure per eye, per lifetime, for Eligible Members and their eligible Spouses. Vision Correction Benefits are not available for dependent children.

While you may choose to use the services of any vision correction provider, your benefits are greater if you use a QualSight preferred provider.

Pre-operative exam, surgery, and post-operative exams are subject to the same coinsurance, deductible, and payment terms as your Medical Benefits.

NON-NETWORK BENEFITS

Non-network benefits are limited and subject to deductible and Coinsurance amounts in accordance with Plan rules. When you receive services from a non-network provider, benefits are limited to the maximum benefit payable to a network provider. You are responsible for any amounts over the network negotiated price per eye for your specific surgery. You should contact the Fund Office to determine the benefits available to you based on the specific vision correction procedure that will be performed.

EXAMPLE:

USING A QUALSIGHT BOARD CERTIFIED OPHTHALMOLOGIST COULD SAVE YOU MONEY

Let's compare what you pay when using a QualSight network provider versus a non-network provider.

	Network Provider	Non-Network Provider
Custom LASIK charges for right eye	$1,300	$2,100
Custom LASIK charges for left eye	$1,300	$2,100
Total charges	$2,600	$4,200
Plan pays	- $2,600	- $2,600
You pay	**$0**	**$1,600**

This example assumes that you are eligible, use a non-network provider, and have no deductible or Coinsurance amounts due. Vision correction surgery pricing varies significantly; your responsibility may be greater.

The Plan does not cover retreatment procedures, insurance, or warranties. However, QualSight offers a retreatment warranty at a discount to Eligible Members and their eligible Spouses who chose this option. Payment for any retreatment warranties or repeat surgical procedures are the participant's sole responsibility.

Contact QualSight at 877-718-7676 to find out more about vision correction surgery and to schedule a consultation and exam with a local provider.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PROGRAM

HIGHLIGHTS

Eligibility

- You become eligible to participate in the HRA Program on the same day you become eligible for the Active Plan 1 except that an Independent Self-Contributor is not eligible for the HRA Program.
- Your eligibility will continue as long as you remain covered under the Active Plan, including periods when your eligibility is maintained through election of the COBRA Full Plan (but not the COBRA Core Plan).
- Your Spouse and dependents are also eligible to participate in the HRA Program if they are enrolled in the Active Plan 1 or in another group sponsored health plan that meets specified criteria.

HRA Account Funding

- $500 will be credited to your HRA Account on the day you become eligible for the HRA Program. On January 1st of each subsequent year that you are eligible for the HRA Program, an additional $500 will be credited to your HRA Account.
  - » Credits will be applied to the HRA Accounts of all Eligible Members, including Members who are active by virtue of electing the COBRA Full Plan (but not the COBRA Core Plan).
  - » All Eligible Members will receive the same credit, regardless of whether they are single or have a family.
- Once the $500 has been credited to your HRA Account, it is immediately available for use.
- Any unused balance in your HRA Account at the end of each year will roll over into the next year for future use. There is no limit on the amount that can be carried forward from year to year.
- Your HRA Account will not be credited with more than $500 in a calendar year.
- No earnings are credited to your HRA Account.
- Once you retire, you will no longer receive the $500 annual credit to your HRA Account.

Using Your HRA Account

- **Save your HRA Account for retirement.** Because the balance in your Account rolls over from year to year, you can potentially accumulate a significant balance between now and when you retire. That balance can then be used to cover some of your healthcare expenses in retirement. Refer to the Retiree Medical Plan Summary Plan Description for more information.
- **Pay for HRA-eligible healthcare expenses.** HRA-eligible healthcare expenses are reimbursed at 100%, with no deductible required, until you exhaust your HRA Account balance. Examples include:
  - » Eligible healthcare expenses not covered by the Active Plan or any other healthcare plan;
  - » Premiums for other group healthcare coverage or insurance;
  - » Medicare premiums; and
  - » Long-term care insurance premiums.
- **Make self-payments.** You can use the balance in your HRA Account to make self-payments for COBRA continuation coverage when you are not working enough hours or for Retiree Plan premiums when you are retired.
- After you/your dependents are no longer eligible to participate in the HRA Program, you can continue to use your HRA Account for up to two years, or until the balance in the Account is zero, whichever is first.

HOW THE HRA PROGRAM WORKS

Health Reimbursement Arrangements (HRAs) are generally designed to enable individuals and their families to receive tax-free reimbursement for certain healthcare expenses that are not covered by their group healthcare plans.

HRAs can also be used like savings accounts, in that the balance can be rolled over from year to year to pay for future healthcare expenses, such as self-payment amounts during retirement.

GENERAL OVERVIEW

You will have an individual HRA Account that the Fund will set up and maintain on your behalf after you are eligible for coverage under the Plan. Your HRA Account will be credited with $500 on the date you become eligible for the HRA Program, and on January 1st of each year that you are eligible to participate in the HRA Program. (Note: your Account will be credited with $500 only once in a calendar year). If a balance remains in your HRA Account at the end of a year, it rolls over into the next year, allowing you to use it for reimbursement of future expenses. There is no limit to the amount that can be carried forward from year to year.

As long as you are eligible to participate in the HRA Program, the balance in your HRA Account is available for you to use as you see fit. You can:

- Save the balance in the Account for your future healthcare needs;
- File Claims against the balance to pay for current healthcare expenses that the Fund has agreed to cover, including premiums you pay for other healthcare coverage or insurance, Medicare, and long-term care insurance (see page 57 for information on filing a Claim); or
- Make self-payments for COBRA continuation coverage, if you are eligible for and elect coverage.

After you are no longer eligible to participate in the HRA Program, your HRA Account will continue to roll forward and may be used for up to two years, or until the balance in the Account is zero, whichever occurs first.

In addition, your HRA Account balance is available to your surviving Spouse and dependent children in the event of your death, for up to two years, or until the balance in the Account is zero. The Account balance may only be used for the reimbursement of qualifying healthcare expenses and is not available in cash. Please see In the Event of Your Death on page 48 for more information.

ELIGIBLE HEALTHCARE EXPENSES

Your HRA Account may only be used to pay for eligible healthcare expenses as defined by Sections 105 and 213(d) of the Internal Revenue Code (IRC) and by HRA rules. See the wide range of eligible expenses on page 50 for more information.

Not all healthcare expenses can be reimbursed through the HRA Program. For example, reimbursements for expenses related to long-term care services and reimbursements for premiums paid through salary reduction contributions to an IRC Section 125 Plan are not allowed. In addition, reimbursements for deductibles and copayments for services received from non-network providers are limited to the amounts that would be reimbursable from your HRA Account if you had gone to an in-network provider.

HRA PROGRAM ADMINISTRATION

The Fund Office will administer the HRA Program. Once you are eligible to participate in the Program and an HRA Account is established in your name, the Fund Office will maintain records of your HRA Account balance by processing the annual credits and requests for reimbursement of eligible healthcare expenses.

Any reimbursements you submit for your Spouse's and/or your dependents' healthcare expenses will be charged against your HRA Account.

If you choose to let your HRA Account balance build to cover your self-payments and/or healthcare expenses in the future, you don't have to do anything until you are ready to draw from the Account. If you choose to use your HRA Account balance to cover current healthcare expenses, including premium self-payments, you will file Claims for reimbursement of eligible expenses throughout the year (see page 57 for information on filing a Claim).

TAX CONSIDERATIONS

Contributions credited to your HRA Account are generally not taxable income when made or when paid out as benefits. However, certain actions may cause your HRA benefits to be taxable, such as if:

- You receive reimbursement from your HRA Account for contributions that are paid through salary reductions under an IRC Section 125 Plan;
- Reimbursements are made for individuals who are not "dependents," as defined under IRC Section 152; and
- Cash payments are made to an individual for any reason other than as reimbursement of an eligible healthcare expense (for example, the HRA Account cannot be used to pay death benefits).

> If you submit an expense for reimbursement under the Plan's HRA Program, you cannot deduct that expense on your tax return.

The HRA Program makes no guarantee that any amounts reimbursed to you, your Spouse, or your dependents under the Program will be excludable from your gross income for federal, state, or local income tax purposes. It is your responsibility to determine whether payments under the HRA Program are excludable, and to notify the Fund Office if you have any reason to believe that any such payment is not excludable.

ELIGIBILITY

You become eligible to participate in the HRA Program on the same day you become eligible for the Active Plan 1 except that an Independent Self-Contributor is not eligible for the HRA Program.

Your eligibility to participate in the HRA Program is based on your continued coverage under the Plan.

> Generally speaking, as long as you are enrolled for coverage under the Plan, you are eligible to participate in the HRA Program.

If you do not work enough hours to continue eligibility for coverage under the Plan, and you elect COBRA continuation coverage under the COBRA Full Plan, your eligibility to participate in the HRA Program will continue. Your eligibility to continue in the HRA Program will not continue, however, if you elect the COBRA Core Plan.

DEPENDENT ELIGIBILITY

As with any Plan coverage, your eligible Spouse and/or your other dependents must either enroll in the Active Plan 1 coverage or must be enrolled in other group health plan coverage to be eligible to participate in the HRA Program.

You cannot obtain reimbursement for expenses incurred by your Spouse or your other dependents if you are enrolled in self-only coverage.

> Your Spouse will be ineligible for a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), due to coverage under your HRA.

OTHER GROUP HEALTH PLAN COVERAGE

If you, your Spouse and/or dependents are enrolled in other group health plan coverage, you, you, Spouse and/or dependent must provide proof of other coverage that provides Minimum Value in order to participate in the HRA Program.

If proof of other coverage that provides Minimum Value is not provided, participation in the HRA Program will be restricted to copayments, coinsurance, premiums, and deductibles under the group health plan, as well as medical care as defined under Internal Revenue Code Section 213(d) that does not constitute essential health benefits.

RELATIONSHIP TO A HEALTH SAVINGS ACCOUNT

Participation in the HRA Program will likely disqualify you or your Spouse from contributing to a Health Savings Account (HSA) if you or your Spouse participate in another plan that is considered a High Deductible Health Plan (HDHP). You should contact the Fund Office to request exclusion from the HRA Program if you desire to maintain your HSA eligibility.

OPT-OUT

Once per year, you may request the Fund to freeze your unused HRA balance. Your election must be made prior to the beginning of the Plan Year. An election to freeze your HRA balance is irrevocable until a reinstatement event occurs.

Your HRA balance may be unfrozen and reinstated upon the earlier of the following events:

- The first day of the Plan Year following the year for which you opted out; or
- Your death.

If you opt-out, you cannot access your HRA contributions and upon reinstatement, you cannot submit for reimbursement any claims incurred after the forfeiture and before the reinstatement. However, after the reinstatement event, access to the HRA balance is available for claims and services incurred after the reinstatement event.

WHEN ELIGIBILITY ENDS

When your eligibility for coverage under the Plan ends, your eligibility to participate in the HRA Program also ends. If you do not work enough hours to continue eligibility for coverage under the Plan, and you elect COBRA continuation coverage under the COBRA Core Plan, your eligibility to participate in the HRA Program will end.

If one of your dependents loses eligibility for coverage under the Plan, he/she also loses eligibility to participate in the HRA Program.

If you terminate employment, you may elect, effective on the date of employment termination, to forfeit your HRA Account balance.

Upon your retirement, your participation in the HRA program ends. Any remaining balance is transferred to the HRA program under the Retiree Medical Plan.

Refer to the Retiree Medical Plan Summary Plan Description for more information.

IN THE EVENT OF YOUR DEATH

If you die while you are an active participant in the HRA Program and you have eligible dependents, your dependents will lose their eligibility to continue participating in the Program.

APPLYING FOR BENEFITS

You can submit Claims for reimbursement of eligible healthcare expenses at any time; however, Claims must be filed within one year of when the expense is incurred (see page 57 for information on filing a Claim).

> Claims for reimbursement from your HRA Account must be filed within one year of when the expense is incurred. Contact the Fund Office and request the required claims form.

EXAMPLE:

Jamal has $800 in his HRA Account on January 1, 2019. He can use his HRA Account to reimburse up to $800 in eligible healthcare expenses incurred in 2019, and he has one year from the date of any service he receives to submit his HRA Request for Reimbursement Form. On December 31, 2019, any unused balance in his HRA Account will roll over into the 2020 calendar year.

You will only be reimbursed for eligible healthcare expenses up to the unused amount in your HRA Account during a given calendar year. You cannot apply for reimbursement of expenses in a subsequent year if the balance in your HRA Account was not sufficient to cover the expense in the year in which the expense was incurred.

> You will only be reimbursed for eligible expenses up to the unused amount in your HRA Account.

EXAMPLE:

Jamal incurs $1,000 in eligible healthcare expenses in 2019. He can only be reimbursed up to the $800 he had in his Account on January 1, 2019. He will not be able to submit the unreimbursed $200 after he receives another $500 credit to his HRA Account on January 1, 2020.

WHILE YOU ARE ELIGIBLE TO PARTICIPATE

If you are eligible to participate in the HRA Program as an Eligible Member, you can use your HRA Account balance to pay for eligible healthcare expenses if you choose not to save the balance for your healthcare expenses in retirement.

If you continue your coverage under the Plan by electing the COBRA Full Plan, self-payments are required to maintain coverage. You may use the balance in your HRA Account toward these self-payments. In addition, you may also use your HRA Account balance to pay for eligible healthcare expenses as long as you continue to be eligible for coverage and a balance remains in your Account.

AFTER ELIGIBILITY ENDS

After your eligibility to participate in the HRA Program ends, the balance in your HRA Account will remain available for up to two years. You may continue to submit eligible healthcare expenses for reimbursement from your HRA Account until the earlier of the date the balance reaches zero or two years from the date eligibility ends.

During this time period, you are entitled to reimbursement of expenses from any unused amounts that were credited during the time period you were enrolled in the Chicago & Vicinity Laborers' District Council Health & Welfare Plan.

If you have not been eligible to participate in the HRA Program for two years, your remaining Account balance will be forfeited and cannot be reinstated. Any forfeited amounts revert to the Plan's general assets. In no event will forfeited amounts be paid in cash to any person.

IN THE EVENT OF YOUR DEATH

Your HRA Account will continue to be available to provide reimbursement for your surviving dependents' eligible healthcare expenses in the event of your death. Your Spouse and/or dependents may use your HRA Account balance to pay for eligible healthcare expenses (including expenses you incurred before your death) or to make self-payments to continue coverage until the earliest of:

- When your HRA Account balance is zero;
- Two years after the date of your death; or
- When your dependent loses dependent status.

If you have no surviving Spouse and/or other eligible dependents at the time of your death, any balance in your HRA Account will be forfeited and become a part of the Plan's general assets.

In no event will amounts be paid in cash to any person other than for reimbursement of an eligible healthcare expense. In other words, there are no lump-sum distributions of the HRA Account balance as a death or termination benefit.

While your surviving Spouse and/or dependents may continue to use your HRA Account for two years after the date of your death, as long as they are eligible for Plan coverage (including COBRA continuation coverage) and the Account balance is greater than zero, no further Employer contributions will be made to the HRA Account on their behalf.

EXAMPLE:

If Jamal died on August 31, 2017, his surviving dependents could use his HRA Account balance (until it was depleted) for the two-year period ending August 31, 2019, as long as they remained eligible for coverage.

EXPENSES ELIGIBLE FOR REIMBURSEMENT

You can use the balance in your HRA Account to pay for eligible healthcare expenses incurred by you, your Spouse, and/or your eligible dependents. Eligible healthcare expenses, as defined by the HRA Program, include (but are not limited to) all of the following:

- Self-payment contributions for COBRA continuation coverage, if you are eligible and elect coverage.
- Amounts you and/or your Spouse pay for other coverage (such as Employer insurance, or Medicare, provided it is not paid with salary reduction contributions to an IRC Section 125 Plan).
- Long-term care insurance premiums.
- Healthcare expenses under the Plan, or any other healthcare plan, including:
  - Out-of-pocket costs, such as deductibles, copayments, and coinsurance; and
  - Expenses not covered, or only partially covered.

See page 57 for information on filing a Claim.

Your HRA Account may only be used to pay for eligible healthcare expenses incurred by you and your eligible family members. However, a range of expenses is eligible.

Healthcare expenses do not include reimbursements for expenses related to long-term care services or for premiums paid through salary reduction contributions to an IRC Section 125 Plan.

Healthcare expenses may include medical, prescription drug, dental, and vision expenses.

EXAMPLE:

The Delta Dental Program covers 50% of the PPO charges for dental implants. Under the HRA Program, you will be able to apply for reimbursement of some or all of the unpaid portion, depending on the balance in your HRA Account.

In general, healthcare expenses eligible for reimbursement only include those that are:

- Incurred for services or supplies provided to you or your eligible dependents under the Plan;
- For services or supplies provided on or after the date your HRA Account became effective;
- Not reimbursed by any other health plan, insurance, or other source or entity;
- Not taken (and will not be taken) as a tax deduction by you, your Spouse, and/or your dependents; and
- Not made through salary reduction contributions under the terms of an IRC Section 125 Plan (if for premium contributions).

If you have any questions about whether an expense is eligible for reimbursement, contact the Fund Office.

Only healthcare expenses that are permitted under the terms of Sections 105 and 213(d) of the Internal Revenue Code (IRC) are eligible for reimbursement from your HRA Account. Please note that federal and state tax regulations are subject to change.

An eligible healthcare expense is defined as an expense incurred by you and/or your dependents for medical care, as defined in IRC Sections 105 and 213(d). For more detailed information on eligible healthcare expenses, please refer to IRS Publication 502 entitled, “Medical and Dental Expenses,” Catalog Number 15002Q. It is available at www.irs.gov/pub/irs-pdf/p502.pdf.

Even if an expense is a medical expense applicable under IRC Sections 105 and 213(d), or listed in IRS Publication 502, it may not necessarily qualify as an eligible healthcare expense under the HRA Program.

For instance, the HRA Program cannot reimburse long-term care expenses or premiums for any type of insurance paid through salary reduction contributions to an IRC Section 125 Plan. Likewise, IRS Publication 502 states that nonprescription drugs are ineligible. In addition, the HRA Program has the right to limit or deny reimbursements for certain expenses even though they may be allowed under federal law. For example, reimbursements for deductibles and copayments for services received from non-network providers are limited to the amounts that would be reimbursable from your HRA Account if you had gone to an in-network provider.

EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

Expenses that are not eligible for reimbursement from your HRA Account (as defined by IRC Sections 105 and 213(d)) include, but are not limited to:

- Individual insurance premiums or insurance plans purchased from a state or federal marketplace
- Automobile insurance premiums
- Bottled water
- Cosmetic surgery and procedures
- Cosmetics, toiletries, toothpaste, etc.
- Custodial care
- Diaper service or diapers
- Domestic help
- Funeral, cremation, or burial expenses
- Health programs offered by resort hotels, health clubs, and gyms
- Home or automobile improvements
- Long-term care services
- Marijuana and other controlled substances that are considered illegal under federal law
- Massage therapy (unless prescribed)
- Maternity clothes
- Nursing services to care for a healthy newborn at home
- Special schools for children
- Social activities
- Transportation expenses
- Uniforms or special clothing
- Vitamins and food supplements
- Over-the-counter (OTC) medications without a prescription

In addition to the above list of IRS-excluded expenses, deductibles and copayments for services received from non-network providers are not eligible for reimbursement from your HRA Account to the extent they exceed the amounts that would be reimbursable from your HRA Account if you had gone to an in-network provider.

IN THE EVENT OF DISABILITY OR DEATH

In the event of your disability or death, the Plan may provide benefits to you or your designated beneficiary. Weekly Income, Extended Weekly Income, Death and Accidental Dismemberment Benefits help provide financial protection to you and/or your family in the event you are injured, become disabled or die. This section describes these benefits.

SCHEDULE OF DISABILITY AND DEATH BENEFITS

The chart below highlights the Plan's disability and death benefits. Additional limitations may apply as explained later in this section.

Weekly Income Benefit	Eligible Member Only
Weekly Income Benefit Maximum	
Non-Occupational Injury or Illness	$450 per week
Occupational Injury or Illness	$25 per week
Benefits Begin	On the first day you are unable to work due to an injury; On the eighth day after you are unable to work due to an illness; or On the eighth day after your Physician's first treatment for an illness.
Weekly Income Benefit Maximum Period	26 weeks
Extended Weekly Income Benefit (Non-Occupational Only)	Up to 26 additional weeks per person per lifetime (certain restrictions apply)

Death Benefits	Benefit Amount
Your Death	$50,000 (payable to your beneficiary)
Death of Your Spouse or Child (6 months old or older)	$10,000 (payable to you)
Death of Your Child (less than 6 months old)	$200 (payable to you)

Accidental Dismemberment Benefits	Eligible Member	Dependent
For one hand, one foot, or sight of one eye	$11,000	$3,750
For one hand and one foot, one hand and sight in one eye, or one foot and sight in one eye	$22,000	$7,500
For both hands, both feet, or sight in both eyes	$22,000	$7,500

WEEKLY INCOME BENEFITS (ELIGIBLE MEMBERS ONLY)

The Plan provides a Weekly Income Benefit, also called loss of time benefits, if you cannot work in your own occupation due to an injury or illness, whether or not it is work-related. Your period of disability must be certified by your Physician. Your Physician must specify any weight restrictions when completing the form. This benefit is not available for Independent Self-Contributors.

You are eligible for Weekly Income Benefits if:

- You are covered by the Plan at the time the injury or illness occurs and on the day your period of disability begins;
- You are under the care of a Physician;
- The injury or illness is not self-inflicted; and
- You do not receive benefits from the Chicago & Vicinity Laborers' District Council Pension Plan or the Laborers' International Union of North America (LIUNA) Pension Fund.

If your disability is a result of an accident, you are required to complete a Participant Loss of Time Accident Claim Form. You, your Employer, and your Physician must complete the form in full. In addition, you will be required to complete Subrogation Forms. The Weekly Income Benefit will not be paid until the Participant Loss of Time Accident Claim Form and Subrogation Forms are returned to the Fund Office (see page 68 for more information on subrogation).

Weekly Income Benefits begin when the Fund Office receives proof of your disability. Partial weeks of disability will be paid at a daily rate of one-seventh of the weekly amount (listed below) provided you are receiving workers' compensation disability benefits. Benefits, which are payable for a maximum of 26 weeks, are:

If You Are Unable to Work Due to:	Weekly Benefit Amount
Non-occupational accident or illness	$450
Occupational accident	$25

Weekly Income Benefits generally begin on the first day of your disability that is due to an accident. If your disability is due to illness, benefits begin on the eighth day after the first day you are unable to work or the eighth day after your Physician first treats you for the illness. Occupational and non-occupational (explained below) Weekly Income Benefits may also be paid if you are released for light duty with weight restrictions up to 50 pounds.

EXTENDED WEEKLY INCOME BENEFITS

Under certain circumstances, the Plan allows you to extend your Weekly Income Benefits for up to an additional 26 weeks. You are eligible for this extension if you meet all of the following:

- Your disability is due to a non-occupational accident or illness; and
- You were an active Eligible Member when the disability began and for at least five years before the disability began, including six out of the 12 consecutive months immediately before your disability began; and
- After 26 weeks of Total Disability and coverage under the Weekly Income Benefit, you continue to be Totally Disabled and unable to perform your normal work as a laborer (or if you are employed in a position other than a laborer, the type of work you normally perform).

You must apply for the Extended Weekly Income Benefit before your Weekly Income Benefits would otherwise end.

You must apply for the Extended Weekly Income Benefit before your Weekly Income Benefits would otherwise end.

You are encouraged to begin the application process for the Extended Weekly Income Benefit a minimum of two months before your initial Weekly Income Benefits end. If you are eligible for an extension of benefits beyond 26 weeks, starting the application process early may mean that you will not experience a delay in weekly benefit payments.

If you are eligible, the Extended Weekly Income Benefit begins after you have been Totally Disabled continuously for 26 weeks (six months). Benefits will continue as long as you remain Totally Disabled, up to a maximum of 52 weeks (26 weeks of Weekly Income Benefits plus an additional 26 weeks of the Extended Weekly Income Benefit). The 26 weeks of the Extended Weekly Income Benefit is a lifetime maximum.

EXAMPLE:
HOW THE EXTENDED WEEKLY INCOME BENEFIT WORKS

After 10 consecutive years of employment covered under the Plan, John becomes disabled due to a non-occupational accident. John is eligible for up to 26 weeks of Weekly Income Benefits. After 26 continuous weeks of disability, John is not able to return to work and is eligible for the Extended Weekly Income Benefit for up to 26 additional weeks. After 52 weeks of continuous disability, John is able to return to work. Unfortunately, two years later, John becomes disabled once again in an unrelated accident. This time, John is still eligible for up to 26 weeks of Weekly Income Benefits. However, since John has already received 26 weeks of the Extended Weekly income Benefit, he is not eligible for any further extension of benefits.

Once you are no longer Totally Disabled or you reach the maximum number of weeks of disability, Weekly Income Benefits will end. If you return to work on a trial basis, Weekly Income Benefits will be suspended for up to four weeks. If you continue to work for more than four weeks, you will no longer be considered disabled and you will no longer receive Weekly Income Benefits. However, if you present medical evidence that you cannot continue to work, Weekly Income Benefits will continue (up to the maximum period).

TOTALLY DISABLED

Due to a disabling condition that is non-occupational, you are (and continue to be) totally disabled from performing the type of work that you are normally assigned as a laborer in accordance with the collective bargaining agreement. If you are employed in a position that does not require work as a laborer, you must be disabled from performing the work that you are normally assigned.

If your Total Disability prevents you from returning to gainful employment, you may be eligible for disability pension benefits from the Chicago & Vicinity Laborers' District Council Pension Plan. Once benefits begin under the Pension Plan, the Extended Weekly Income Benefit will end as of the first day of the month in which the disability pension benefits begin. However, since disability benefits under the Pension Plan may not begin right away, you must sign an agreement to reimburse the Plan in the event benefits are later paid retroactively by the Pension Plan. The amount of the reimbursement is based on the amount of benefits paid by the Pension Plan. If the Pension Plan disability benefits are less than the Weekly Income Benefit amount, you will only need to reimburse the amount you are paid by the Pension Plan.

EXTENSION OF BENEFITS IN EVENT OF TOTAL DISABILITY

If you become Totally Disabled and you remain disabled until you receive these Plan benefits, your benefits may be extended after your coverage would otherwise end. Once your coverage under the Plan ends due to a reduction of hours or termination of Covered Employment, you will be offered COBRA continuation coverage (see page 14). If you elect COBRA continuation coverage, you and your dependents may receive coverage under the Plan. If you do not elect COBRA continuation coverage, you will receive these extended benefits that relate to medical expenses for your disability only. Your dependents will not be covered. If you elect COBRA continuation coverage, you are not entitled to any extension of medical benefits under this Plan provision.

Eligible medical benefits include:

- Hospital confinement;
- Surgical operations and medical treatments; and
- Medical expenses.

On the day your coverage would normally end, you must be completely unable to perform your job as a result of an injury or illness that is not related to your work. Your Total Disability must have occurred while you were covered under the Plan.

The extension of your medical benefits under the Plan is limited to expenses that are incurred as the result of the illness or injury that caused your disability. They must also be incurred before the earliest of:

- The date you are covered by another plan;
- 12 months from the end of your coverage under the Plan; or
- Three months after the Plan ends.

DEATH BENEFITS

In the event of:

- Your death, your beneficiary will receive a Death Benefit of $50,000.
- Your Spouse or dependent child's (age six months or older) death, you will receive a Death Benefit of $10,000.
- Your dependent child's (less than age six months) death, you will receive a Death Benefit of $200.

You may name any person as a beneficiary and may change your beneficiary at any time by filling out and submitting the proper beneficiary designation card to the Fund Office (available from the Fund Office). A beneficiary designation is not effective until the Fund Office receives the completed and signed beneficiary designation card. If you name more than one beneficiary, any Death Benefit payable will be paid in equal shares to each named beneficiary unless you specify a different division of payment.

If you name your Spouse as your beneficiary and subsequently divorce, the designation will be void on the date of your divorce. After the date of divorce, you may rename your former Spouse as the designated beneficiary, if you wish, by filing a new beneficiary designation card.

If you do not name a beneficiary or if your named beneficiary is deceased, your Death Benefit will be paid:

- To your Spouse; or, if none,
- To your living children in equal shares; or, if none,
- To your parents in equal shares; or
- If no Spouse, children, or parents are living, no Death Benefit will be paid.

Your beneficiary may direct the Welfare Fund to assign up to $10,000 of the Death Benefit to be paid to the person who assumes responsibility for funeral expenses or to the funeral home directly.

In the event of your death before you request an extension of the Death Benefit, or before the Fund Office received your completed forms, benefits are still payable provided:

- You were eligible for benefits under the Plan through hours worked in covered employment at the time of your disability;
- Your death was within 12 months from the day your coverage under the Plan ended; and
- The Fund Office receives proof that your Total Disability was uninterrupted from the date your coverage under the Plan ended until the date of your death.

You may name any person as your beneficiary and may change your beneficiary at any time by filling out and submitting the proper beneficiary designation card to the Fund Office (available from the Fund Office). A beneficiary designation is not effective until the Fund Office receives the completed and signed beneficiary designation card.

A beneficiary designation card will not be accepted after a participant's date of death.

DEATH BENEFITS EXCLUSIONS AND LIMITATIONS

Death Benefits are not paid if the eligible participant's death occurs while the participant is committing a felony.

EXTENSION OF DEATH BENEFITS IN EVENT OF TOTAL DISABILITY

If you become Totally Disabled, you can receive up to a three-year coverage extension of the Plan's Death Benefit, which is payable to your beneficiary in the event of your death, at no cost to you or your family. The extension does not include Death Benefits for your Spouse or other dependents. To qualify for the extension:

- You must be eligible for benefits under the Plan through hours worked in Covered Employment at the time your Total Disability begins;
- Your Total Disability must begin before you reach age 60; and
- You must provide proof of the Total Disability to the Fund Office.

You must notify the Fund Office of your Total Disability no later than 12 months from the initial date of your Total Disability. The Fund Office will provide you with an Application for Total Disability 3-Year Extension of Death Benefit Form and an Estimated Functional Capacities Form to be completed by you and your Physician. If you are collecting Weekly Income Benefits as a result of this disability, the Fund Office will send you the forms following 26 weeks of Weekly Income Benefit payments. In addition to the completed forms, you must supply pertinent medical records supporting your Total Disability.

In the event you name someone as your power of attorney, that person may change a beneficiary on your behalf only if the right to do so is explicitly contained in the executed **Power of Attorney** document.

In determining Total Disability, the Plan has the right to require an examination by a Physician designated by the Plan, Fund Office, or Administrator.

If the Fund Office determines that you are Totally Disabled in accordance with the Plan's definition of Totally Disabled, your Death Benefit will be extended for three years, beginning on the date you lose coverage under the Plan due to a reduction in hours required to maintain coverage, see page 14. (Election of COBRA continuation coverage will not delay the three-year extension of Death Benefits.) To continue the extension of coverage, you must provide the Fund Office with proof of your continued Total Disability once a year. The Fund Office will notify you when the information is due. This coverage will end on the earlier of:

- The date you are no longer Totally Disabled; or
- Three consecutive years following the date you lost coverage under the Plan.

ACCIDENTAL DISMEMBERMENT BENEFITS

Accidental Dismemberment Benefits are available if you or any of your eligible dependents suffers the loss of limbs or eyesight due to an accident. For the Accidental Dismemberment Benefit, your eligible dependents are your Spouse and any children age six months or older. Your dependents must meet the Plan's definition of dependent, as outlined on page 9.

Type of Loss	Your Benefit	Your Dependent's Benefit
Loss of both hands, both feet, or sight in both eyes	$22,000	$7,500
Loss of one hand and one foot, one hand and sight in one eye, or one foot and sight in one eye	$22,000	$7,500
Loss of one hand, one foot, or sight in one eye	$11,000	$3,750

ACCIDENTAL DISMEMBERMENT BENEFITS EXCLUSIONS AND LIMITATIONS

The Plan does not cover losses that:

1. Are not permanent.
2. Occur before coverage under any Chicago & Vicinity Laborers' District Council Health & Welfare Plan.
3. Result from self-inflicted injury, illness, suicide, or suicide attempt.
4. Occur while committing a felony.

CLAIM AND APPEAL INFORMATION

ANNUAL CLAIM FORM

You are required to complete an *Annual Claim* Form, which provides the Fund Office with information about your Spouse, dependents, and other medical insurance coverage. It is very important that you complete and return the *Annual Claim Form* when you are first eligible, regardless of whether or not you are submitting a Claim. If the Fund Office does not have your *Annual Claim* Form on file, processing and payment of any Claims will be delayed.

Please ensure that your information on file with the Fund Office is up-to-date by notifying the Fund Office of a change of address as soon as possible. The Fund Office will mail an *Annual Claim* Form to you each year, or more often as required, to process your Claims.

You must complete your *Annual Claim* Form in full. If you are married, both you and your Spouse must sign and date the form. Failure to complete the *Annual Claim* Form in full will delay processing of your Claim for benefits.

An **Annual Claim Form** is required by the Fund Office each year before benefits are payable to update general information on you, your dependents, and other medical insurance coverage you may have.

In addition, you may be asked to complete a separate Accident Claim Form if your medical claims provide a diagnosis that the Fund Office suspects may be an injury due to an accident (e.g., automobile accident).

FILING CLAIMS

A Claim may be submitted in paper form or through Electronic Data Interchange (EDI). All medical and professional Claims must be submitted to Blue Cross Blue Shield of Illinois (BCBSIL). If your provider and services were obtained outside the BCBSIL network area, your provider must file the Claim with their local Blue Cross Blue Shield Plan.

Be sure that each bill indicates the name of the patient, name of the participant, and participant's Social Security number or other number that may be assigned to you by the Fund Office. Make certain that the date for each service appears on the invoice. The provider's name and tax identification number must be on all Claims (invoices), except Pharmacy receipts. In addition, the Claim should indicate the appropriate ICD-10 code (diagnosis) and specific services provided, as defined by the appropriate CPT, HCPC, NDC, or other nationally recognized codes, including the expense charged for each service.

The Fund Office does not accept handwritten bills.

You are responsible for any amounts not paid by the Fund, with the exception of PPO network discounts or discounts that may be negotiated between the Plan and the provider on non-network Claims. PPO or other negotiated discounts do not apply to medical expenses that are not covered by the Plan.

Submit Claims to:

Medical and professional Claims:
Your provider must file Claims directly with their local BCBS plan.

Dental Claims:
Delta Dental of Illinois
P.O. Box 5402
111 Shuman Boulevard
Naperville, IL 60563

All other Claims:
Laborers' Welfare Fund Claim Department
11465 W. Cermak Road
Westchester, IL 60154

Neither you nor any of your eligible dependents may assign your rights as a participant to a provider or other third party (as described below) or in any way alienate your Claims for benefits. Any attempt to assign your rights or in any way alienate a Claim for benefits will be void and will not be recognized by the Fund for that purpose. The Fund will treat any document attempting to assign rights as a participant or to alienate a Claim for benefits to a provider to be only an authorization for direct payment by the Fund to the provider. For example, the Fund will not allow you to assign to a provider any of your rights as a participant under the Plan, including but not limited to, the right to appeal a Claim denial or the right to receive documentation concerning your Claims. In the event that the Fund does receive a document claiming to be an assignment of benefits, the Fund will send payments for the Claims to the provider, but will send all Claim documentation, such as an Explanation of Benefits, and any procedures for appealing a Claim denial directly to you. If the Fund should deny the Claim, only you will have the right to appeal.

The Fund will pay Claims only when covered under the terms of the Plan under which you are eligible. If the Fund pays Claims that it is not required to pay, it may recover and collect payments from you, your eligible dependents, or any other entity or organization that was required to make the payment or that received an erroneous payment. Recovery of such erroneous payments may be made through, but not limited to, an offset or reduction of any future benefits you or your eligible dependents may be entitled to receive from the Fund.

CLAIM TYPES

There are three basic types of Claims under the Plan:

- Healthcare Claims, which include medical, prescription drug, dental, and vision Claims;
- Disability Claims, which include Weekly Income and Extended Weekly Income Benefits; and
- Other Benefit Claims, which include Death Benefits and Accidental Dismemberment Benefits.

HRA PROCEDURES

You may submit Claims for reimbursement of eligible healthcare expenses at any time. However, Claims must be filed within one year of when the expense is incurred. The amount reimbursed for any eligible healthcare expense will not exceed your HRA balance at the time reimbursement is requested. Reimbursement is paid directly to you; you are responsible for paying any providers.

To receive reimbursement for Plan deductibles and coinsurance amounts, you must file a Claim. The Fund Office will not automatically apply the balance in your HRA Account to those expenses.

> You must file a written Claim for reimbursement with the Fund Office as soon as possible. If your Claim is not filed within 12 months of the date the expense is incurred, your Claim will be denied.

To receive reimbursement for eligible healthcare expenses, you must submit a properly completed HRA Request for Reimbursement Form, with the required supporting documentation, in accordance with the Plan's Claim procedures. The HRA Request for Reimbursement Form can be obtained from the Fund Office. The form will include a statement that you must sign verifying that:

- The eligible expenses were incurred for services or supplies provided to you or your eligible dependents under the Plan;
- The eligible expenses were for services or supplies provided on or after the date your HRA Account became effective;
- You have not been, and will not be, reimbursed for these expenses by any other health plan, insurance, or other source or entity;
- You have not deducted, and will not deduct, any of the expenses reimbursed through the HRA Program on your individual income tax return; and
- Premiums submitted for reimbursement were not made through salary reduction contributions under the terms of an IRC Section 125 Plan.

Along with the form, you must provide any of the following, as applicable:

- An itemized bill from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of provider, and amount of charge.
- An Explanation of Benefits (EOB) when requesting reimbursement of the balance of charges for which coverage is available from either this Plan or another plan, plus original receipts verifying payment. Only eligible expenses that have not been reimbursed, as shown on the EOB, will be eligible for reimbursement.
- Proof of the amount, the name of the covered person, date paid, and coverage period when requesting reimbursement for other insurance premiums, such as a Spouse's group health coverage premiums, and verification that the premium was not paid or eligible for payment under an IRC Section 125 Plan. Additional documentation is also required for reimbursement of premiums under a qualified long-term care contract.
- A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs).

- A copy of the prescription and a copy of receipt on which the name of the product has been imprinted by a cash register for over-the-counter medicines and medical supplies. Unreasonable quantities of such items cannot be reimbursed under IRS rules.
- Any additional documentation requested by the Plan.

HRA Claims will be handled in the same manner as all other healthcare Claims.

BENEFIT PRE-CERTIFICATION

The Plan does not require pre-certification for any type of medical treatment. You and your dependents are encouraged to seek Medical Care whenever necessary. However, if you are not sure whether a particular treatment or service will be covered, you may contact the Fund Office in advance of any non-urgent care.

BENEFIT CLAIMS

Benefit Claims covered by the Plan include requests for benefits accompanied by:

- HCFA, Hospital, prescription, dental or vision bills or other types of invoices that include:
  - Patient name and ID number;
  - Participant name and Social Security number or other ID number assigned by the Fund Office;
  - Date of service or date of fill or refill for prescription drug Claims;
  - Specific services performed and expense charged for each service;
  - Type of device defined by HCPC, CPT code, ICD-10, NDC, or other nationally recognized codes, including individual charges for each;
  - Attending Physician's or care provider's name and federal tax ID number (not required for prescription drug Claims);
  - Place of service;
  - Billing address; and
  - Previous balances paid.
- Weekly Income Benefit/Accident Claim Form completed by you, your Employer, and your Physician.
- Copy of death certificate with a fully completed form for Death Benefits.

If the Plan receives a document or transmission that contains the first six items as stated in Benefit Claims, it will be considered a Claim, even if additional information is required to process the Claim. If additional information is required, the Fund Office may request an extension of the time to make a benefit determination.

What is a Claim?

A Claim is a request for Plan Benefits made by a Claimant according to the Plan's procedures for filing Claims. Claims may be submitted in paper form or through Electronic Data Interchange (EDI). A provider may submit a Claim on behalf of a Claimant when benefits are assigned to the provider.

WHAT IS NOT A CLAIM

Any general inquiry about benefits or the circumstances under which benefits might be paid by the Plan is not a Claim. Also, any document or EDI transmission that is submitted to the Fund Office that does not meet the criteria of a Claim, as described above, is not considered a Claim and is not covered by the Plan's Claim and Appeal procedures. Examples include:

- A cash register receipt;
- An Explanation of Benefits (EOB) form from another plan;
- Handwritten bills (invoices) or handwritten statements of services; or
- A balance due statement;

- An inquiry from a participant, Physician, care provider, other insurance carrier, participant's authorized representative, Hospital, or facility regarding:
  - Plan coverage (e.g., a question about whether the Plan covers Diagnostic Service);
  - Plan benefit amounts (e.g., a question as to whether the Plan would pay 100% of surgery costs if the surgery was tomorrow);
  - Plan eligibility (e.g., if you are scheduled for Physical Therapy at a facility twice a week and your Physician calls to ask if you are eligible for benefits); or
  - Consideration of additional payment on a Claim.

Any of the above offered in paper form, verbal inquiry, or EDI transmission is not considered a Claim. Although the Fund Office may respond to such submissions, the legal requirements for processing Claims do not apply.

If you have questions about filing a Claim, please contact the Fund Office by:

- Calling 708-562-0200;
- Writing to Chicago & Vicinity Laborers' District Council Health & Welfare Plan, 11465 W. Cermak Road, Westchester, IL 60154; or
- Emailing: Claims@chilpwf.com.

Who is a Claimant?

A Claimant is usually the patient. However, a Spouse can file a Claim or Appeal on behalf of the patient. In addition, a participant can file a Claim or Appeal for a legal dependent. A Claimant may authorize a representative to file a Claim or Appeal on their behalf. A Claimant must notify the Fund Office of a designation of representation in writing and must complete and sign the Fund's designation of representation form. A Claimant's representative may present a power of attorney for healthcare. If a representative is designated, all Appeal correspondence will be sent directly to the representative, unless specified otherwise.

CLAIM FILING PROCEDURES

- When you submit a Claim to the Fund Office, the Fund Office will determine if you are eligible for benefits and will calculate the amount of any benefits payable.
- You must file a Claim with the Fund Office within 12 months of the date the service was provided. If you do not file your Claim within 12 months, your Claim will be denied.
- When additional information or documents are requested, you must submit the information and/or documents within 24 months from the date that service was provided. If you do not submit the information or documents within 24 months, the Claim will be denied.

CLAIM PROCESSING DEADLINES

The deadlines for processing Claims vary, as follows:

- *Initial Determination.* An initial determination regarding payment or denial of a Claim will be made for:
  - Healthcare Claims, within 30 days of receipt of the Claim.
  - Disability Claims, within 45 days of receipt of the Claim.
  - Other Benefit Claims, within 90 days of receipt of the Claim.
- *Extension of Initial Determination Period.* In some instances, an extension of the initial determination period may be requested due to matters beyond the Plan's control. If an extension is necessary, you will be notified. The notice will include the special circumstances requiring the extension and the date the Plan expects to render a decision. You (or the Claimant) will be notified, for:
  - Healthcare Claims, within the 30-day initial determination period that one 15-day extension is necessary.
  - Disability Claims, within the 45-day initial determination period that up to an additional 60 days maximum is necessary. However, if a determination is not made within the first 75 days, you will be notified that an additional 30 days is necessary.
  - Other Benefit Claims, within the 90-day initial determination period that up to an additional 90 days may be necessary. The extension cannot be more than 90 days from the end of the initial 90-day period, or 180 days total.

- *Additional Information Needed to Process a Claim.* In some instances, the Plan may need additional information or required information that was not originally provided to process a Claim. If such information is needed, you (or the Claimant) will be notified, for:
  - » Healthcare Claims, within the 30-day initial determination period of the information needed. You (or your provider if your provider is notified) have up to 45 days to provide the requested information. If the Fund Office receives the requested information in the 45-day period, the Claim will be processed within 15 days following the receipt of the additional information.
  - » Disability Claims, within the 45-day initial determination period of the information needed. You have up to 45 days to provide the requested information.
  - » Other Benefit Claims, within the 90-day initial determination period of the information needed. The 90-day extension of initial determination period listed above includes any time needed by the Plan to obtain this information.

INITIAL CLAIM DENIAL

If for any reason your initial Claim is denied, in whole or in part, the Fund Office will send you a written notice. The notice will include:

> In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your Claim reconsidered.

- The date of service, health care provider, claim amount if possible, and the denial code and its corresponding meaning for Healthcare Claims;
- The specific reason(s) your Claim was denied (and for Healthcare Claims – include a statement that the Claimant has a right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal);
- The standard that was used in denying the Claim, a description of such standard if applicable;
- A description of any additional material or information needed to perfect the Claim and an explanation of why such added information is necessary;
- Reference to the specific Plan provisions on which the denial was based;
- A description of any additional information you need to submit in support of your Claim;
- An explanation of why the additional information is needed;
- An explanation of the Plan's Claim review procedures and applicable time limits and information regarding how to initiate an appeal;
- A statement that upon request and without charge, a Claimant may request reasonable access to and copies of all documents, records and other information relevant to an initial claim for Healthcare or Disability benefits;
- A statement of your rights under ERISA to bring a civil action. You must follow and completely exhaust the Plan's Appeal procedures (including time limits) before you file a lawsuit under ERISA, the federal law governing employee benefits, or initiate proceedings before any administrative agency. In the event you submit a denied Claim for review and the Claim Appeal is denied, any legal action must begin within 180 days of the date the Plan provides an adverse Appeal determinations;
- For Healthcare Claims, information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes;
- A statement of your right to request a free copy of the internal rule, guideline, protocol, or other similar criteria on which the denial was based;
- A statement of your right to request a free copy of an explanation of scientific or clinical judgment for the determination if the denial was based on Medical Necessity, Experimental Treatment, or a similar exclusion or limit; or
- For Urgent Healthcare Claims, a description of the expedited internal appeal process. The required determination may be provided orally and followed with written (or electronic, as applicable) notification.

- For Disability Claims, the notice will also include:
  - The basis for disagreeing with any disability determination by the Social Security Administration (SSA);
  - The views of a treating health care professional or vocational expert evaluating the Claimant, to the extent the Plan does not follow such views as presented by the Claimant; or
  - The views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination.

You must follow the Plan's Claim and Appeal procedures completely before you can bring any legal action to obtain benefits. The Trustees, or their designated representative, have sole, discretionary authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Trustees.

CLAIM APPEAL

If your Claim is denied or you disagree with the amount of the benefit, you have the right to have the initial determination reviewed by appealing the denial to the Trustees serving on the Welfare Appeals Committee of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan. Your Appeal must be filed in writing at the Fund Office not more than 180 days (or 60 days for Death and Accidental Dismemberment Benefit Claims) after the date you received the letter denying your Claim.

Send your written Appeal to:

Welfare Appeals Committee
Chicago & Vicinity Laborers' District Council Health & Welfare Plan
11465 W. Cermak Road
Westchester, IL 60154

When filing an Appeal (requesting a review of a denied Claim), note the following:

- Your Appeal must be submitted in writing within the applicable timeframe.
- Your Appeal must state the reasons you disagree with the Claim determination.
- You must attach all copies of evidence supporting your Appeal.
- You, or your designated representative, have the right to receive, upon written request, copies of all documents relevant to your Claim.
- Your designated representative may be an attorney.
- You have the right to challenge the denial of a Claim by filing a lawsuit in court, seeking review of the Fund's decision under section 502(a) of ERISA. Such a lawsuit can only be filed after you have followed the Fund's Appeal procedures.
- If your Claim is denied based on an internal rule, guideline, protocol, or other similar criteria, you have the right to request a free copy of that information.
- If your Claim is denied based on a Medical Necessity, Experimental Treatment, or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.
- You have the right to be advised of the identity of any medical experts and you may:
  - Submit additional materials, including comments, statements, or documents; and
  - Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:
    - Was relied upon by the Plan in making the decision;
    - Was submitted, considered, or generated (regardless of whether it was relied upon); or
    - Demonstrates compliance with Claim processing requirements.

APPEAL REVIEW

Once your Claim is received, if you filed your Appeal on time and followed the required procedures, the Claim Department's management staff reviews it first. If the management staff determines that additional benefits are payable under the terms of the Plan, your Appeal is responded to and payment is made within 30 days of the receipt of your Appeal.

In all other cases, the Welfare Appeals Committee of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan Board of Trustees will review your Appeal. The Committee currently meets on the first Tuesday of every month.

> If an extension is needed, you will be notified in writing. The written notice will include the reason why an extension is needed as well as the date by when a decision will be made.

After the Welfare Appeals Committee receives your written request, a determination on your Appeal for:

- *Healthcare Claims* will generally be made within 30 days of receipt of the Appeal but no later than 60 days after your Appeal is received. If an extension is necessary, the Claimant will be notified within the 60-day Appeal determination period that up to an additional 60 days (no more than 120 days total from receipt of the Appeal) may be necessary. The written decision will be mailed to your last known address within five days after the decision is made.
- *Disability Claims* will generally be made within 45 days of receipt of the Appeal. If special circumstances require an extension of time, you will be notified within the 45-day Appeal determination period that up to an additional 45 days (no more than 90 days total from receipt of the Appeal) may be necessary. Before a decision if made on your Appeal, the Plan will provide you with any new or additional evidence considered, relied upon, or generated by the Plan or at the direction of the Plan and any new or additional rationale that is the basis for a denial. The new evidence or rationale must be provided as soon as possible and sufficiently in advance of the date the denial must be issued so you may respond to the new evidence or rationale. The written decision will be mailed to your last known address within five days after the decision is made.
- *Other Benefit Claims* will generally be made within 60 days of receipt of the Appeal. If an extension is necessary, the Claimant will be notified within the 60-day Appeal determination period that up to an additional 60 days (no more than 120 days total from receipt of the Appeal) may be necessary. The written decision will be mailed to the Claimant's last known address no later than five days after the decision is made.

The Welfare Appeals Committee will issue a written decision reaffirming, modifying, or setting aside the action you are appealing. The decision of the Welfare Appeals Committee will be based on all information used in the initial determination as well as any additional information submitted. If your Claim is not paid in full, the written decision will include:

- The specific reason(s) for the decision including: 1). the denial code (if any) applicable to a healthcare claim; and its corresponding meaning; 2). a description of the Plan's standard (if any) that was used in denying the claim, and 3). a discussion of the decision;
- Reference to the specific Plan provisions on which the decision was based;
- A statement notifying you that you have the right to request a free copy of all documents, records, and relevant information;
- A statement that you may bring a civil action suit under ERISA;
- A statement notifying you that you have the right to request a free copy of the internal rule, guideline, protocol, or other similar criteria on which the denial was based;
- A statement notifying you that you have the right to request a free copy of an explanation of scientific or clinical judgment for the determination if the denial was based on Medical Necessity, Experimental Treatment, or similar exclusion or limit;
- For Healthcare Claims, information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes;
- For Disability Claims, the notice will also include:
- The basis for disagreeing with any disability determination by the Social Security Administration (SSA);
- The views of a treating health care professional or vocational expert evaluating the Claimant, to the extent the Plan does not follow such views as presented by the Claimant; or
- The views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination.

PAYMENT IN EVENT OF INCOMPETENCY

In the event the Fund determines that a Claimant is incompetent or incapable of managing Plan benefits and no guardian has been appointed, the Fund may pay any amount otherwise payable to that Claimant to the Spouse, blood relative, or any other person or institution determined by the Fund to have provided benefits or agreed to provide care to the Claimant. Any payment in accordance with this provision discharges the Fund from any further obligation for such payment.

RIGHTS TO INFORMATION

You have the right to receive, upon written request, copies of all documents relevant to the decision made on your Appeal.

The Plan is also required to provide you with the identification of medical or vocational experts whose advice was obtained for reviewing your Appeal. However, the Plan is not required to supply this information automatically. The names of medical or vocational experts will only be disclosed upon receipt of a written request, signed by the participant, for this specific information.

DISCRETIONARY AUTHORITY

The Trustees have full discretionary authority to:

- Determine eligibility for benefits under the Plan;
- Interpret any facts relevant to the determination;
- Determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan;
- Interpret the terms of the Plan; and
- Interpret all of the documents, rules, procedures, and terms of the Plan.

The Trustees' decisions and interpretations are binding and will be honored by the courts, unless the Trustees acted arbitrarily.

COORDINATION OF BENEFITS

The Plan has been designed to help you meet healthcare costs, such as medical, prescription drug, dental, orthodontic, and vision care. It is not intended, however, that you receive greater benefits than your actual healthcare expenses. The amount of benefits payable under the Plan will take into account any coverage you or a covered dependent has under other plans. Benefits under the Plan will be coordinated with the benefits you or your dependents receive from other plans so that no more than 100% of covered expenses will be paid by the combination of plans.

MEDICAID

The Plan honors any Medicaid assignment of rights made on your behalf.

Specifically, in a calendar year, the Plan will always pay to you either:

- Its regular benefits in full; or
- A reduced amount that, if added to the amount received from another plan, will be equal to the total that the Plan would have paid if you were not covered by the other plan.

If you or your dependents are covered under another plan, you must report that health coverage when you make a Claim.

"Another plan" means any:

- Group, blanket, or franchise insurance coverage;
- Service plan contract, group practice, individual practice, and other prepayment coverage;
- Any coverage under a labor-management trusteed plan, union welfare plan, or Employer or employee benefit organization plan;

- Any coverage under a federal, state, or other governmental plan or program that is largely tax-supported or provided through act of government, including Medicare or Medicaid; or
- Dependent benefits payable under this Plan when a spouse is covered both as an Employee and as a Dependent and when a child is covered as a Dependent of more than one Employee.

Generally, a Plan that does not have Coordination of Benefits rules or a Plan that covers you as an employee pays first.

"Another plan" does not mean any:

- Accidental injury plan provided through a school;
- Hospital indemnity plan;
- Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or
- Individual plan, except one that provides no-fault automobile insurance or that is issued on a franchise basis.

If both you and your Spouse are Eligible Members in this Plan, benefits payable to an Eligible Member or dependent under this Plan will be reduced to the extent necessary so that the sum of the benefits payable under this Plan as both the primary and secondary Plan will not exceed 100% of the total allowable expense.

The expenses that are coordinated are any necessary, Usual and Customary Charges or expenses, at least part of which are covered under one of the plans covering you, your Spouse, or your dependents. If a plan provides benefits in the form of services or supplies instead of cash, such as those provided by an HMO, the reasonable cash value of the service rendered and supplies furnished will be considered when benefits are coordinated.

ORDER OF PAYMENT

If you and/or your dependent are covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its payment so that total benefits do not exceed 100% of the allowable expense incurred.

The following rules determine the order of payment:

- A plan that does not have a coordination of benefits rule is primary.
- A group health plan that covers the participant before and concurrent with coverage under this Plan is primary.
- A plan covering the person as an employee, member, subscriber, policyholder or retiree is primary.

A plan that covers you or your dependents as active employees pays benefits before a plan covering you or your dependents as retired or laid off employees.

If a dependent child is covered under more than one plan, the following rules determine the order of payment:

- If the parents are not divorced or separated:
  - The plan of the parent whose birthday (month and day only) occurs earlier in the calendar year is primary (the birthday rule);
  - If the parents have the same birthday, then the plan covering the parent for the longest time is primary; or
  - If one plan uses a rule other than the birthday rule, the plan using the other rule is primary.
- If the parents are divorced or separated:
  - Where there is a court decree or order that establishes financial responsibility for medical expenses, the plan covering the dependent child(ren) of the parent who has financial responsibility is primary.
  - Where there is no court decree, or the decree does not establish who has responsibility for medical expenses or such responsibility is shared equally between the parents, the plan of the parent whose birthday (month and day only) occurs earlier in the calendar year is primary (the birthday rule).

MEDICARE

The Health Insurance for the Aged Program under Title XVIII of the Social Security Act and the Social Security Amendment of 1965 (Public Law 89-87), as this Program is currently constituted and as it may later be amended.

- Where there is no court decree and the parents have the same birthday, then benefits are coordinated in the following order:
- The plan of the parent with custody; then
- The plan of the custodial stepparent, if remarried; then
- The plan of the non-custodial parent.

If none of the above rules apply, the plan covering the patient the longest period of time will be primary.

As an active Eligible Member or the dependent of an active Eligible Member, you do not need to enroll for Medicare Prescription Drug Coverage as long as the Plan provides creditable prescription drug coverage, which means it pays out as much as standard Medicare Prescription Drug Coverage. However, if you are eligible and choose to enroll, your prescription drug coverage will be coordinated with Medicare.

EXCLUSIONS FROM COVERAGE AND COORDINATION OF BENEFITS WITH OTHER HEALTHCARE PLANS

A number of Employers offer healthcare coverage to their employees and exclude or limit coverage to their employees if that employee has a Spouse covered under another healthcare plan, such as the Chicago & Vicinity Laborers' District Council Health & Welfare Plan.

To prevent cost shifting from another healthcare plan to this Plan, this Plan includes the following provisions:

- Coverage will be excluded, or the amount of benefits your dependent may obtain from this Plan may be limited, if your Spouse elects to opt out of an Employer-sponsored plan.
- No benefits will be paid under the Chicago & Vicinity Laborers' District Council Health & Welfare Plan to a participant's dependent who has health coverage of any kind under another Employer's health plan, unless that plan provides the same maximum level of benefits to the dependent (after taking into account the coverage the dependent would be eligible to receive in that plan) as it does to other participants in that plan, without regard to any benefits the dependent may be eligible to receive from the Chicago & Vicinity Laborers' District Council Health & Welfare Plan.

If Your Dependent Has Employer-Sponsored Coverage

If your dependent is covered under an Employer-sponsored plan that would be primary under this Plan's rules or the Association of Insurance Commissioners COB regulations, and the other plan denies or caps benefits to avoid the usual operation of coordination of benefits rules, this Plan will not provide benefits until the other plan provides the customary benefits of a primary plan.

Benefits will be coordinated as follows:

- If a plan's fee-for-service option is primary (pays first), it will pay its regular benefits.
- If it is secondary (pays after another plan covering the person), it will pay a reduced benefit that, when added to the benefit paid by the other plan, will not exceed the highest amount allowed between two plans for services rendered.
- If an Employer of a participant's dependent has one or more other plan(s) that would be primary under this Plan's rules or the model COB regulations of the Association of Insurance Commissioners, and any such other plan contains a provision denying or capping benefits for the participant's dependents (having the effect of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of coordination of benefit rules), the Plan will not be liable to provide benefits until and unless the other plan(s) provides the customary benefits of a primary plan, as determined without regard to such exclusion or cap.

This provision does affect your dependents' coverage under the Chicago & Vicinity Laborers' District Council Health & Welfare Plan if the coordinating plan does not attempt to reduce or exclude benefits as a result of the dependent's coverage under the Chicago & Vicinity Laborers' District Council Health & Welfare Plan.

COORDINATION OF BENEFITS WITH MEDICARE WHEN MEDICARE IS PRIMARY PAYOR

The Plan will coordinate benefits with Medicare when legally possible. Covered Services include your Medicare Part A and B deductibles and copayments. The Plan pays for Covered Services after Medicare pays benefits.

Medicare is a multi-part program:

- Medicare Part A. Officially called "Hospital Insurance Benefits for the Aged and Disabled," Medicare Part A primarily covers Hospital benefits, although it also provides other benefits.
- Medicare Part B. Officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled," Medicare Part B primarily covers Physician's services, although it also covers a number of other items and services.
- Medicare Part C. Called Medicare Advantage, Medicare Part C is the managed care portion of Medicare; specific choices depend on where you live. If you are covered by an HMO, the Plan will presume that you have complied with the HMO rules necessary for your expenses to be covered by the HMO.
- Medicare Part D. Called "Medicare Prescription Drug Coverage," Medicare Part D is Medicare's prescription drug coverage that is offered through private companies to all Medicare-eligible individuals.

Enroll in Medicare One Month Before You Become Eligible

For all purposes of this provision, if you or your dependents are entitled to benefits or other compensation under Medicare and Medicare is your primary coverage, the Plan will reduce your benefit by the amount Medicare would have paid, even if you are not enrolled or participating in Medicare.

Typically, you become eligible for Medicare when you reach age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, dependent widow, or have chronic End-Stage Renal Disease (ESRD). If you are eligible for Medicare based solely on permanent kidney failure (ESRD), Medicare coverage will not start until the fourth month of Dialysis Treatment. Therefore, the Plan is generally your only coverage for the first three months of Dialysis Treatment. When you obtain Medicare because of ESRD, there is a period of time when the Plan is primary and will pay healthcare bills first. This is called the 30-Month Coordination Period. The 30-Month Coordination Period starts the first of the month you are able to get Medicare because of ESRD, even if you have not enrolled in Medicare yet.

The Plan is primary while you are actively working, even if you are over age 65. The Plan is secondary when you are not actively working.

If Medicare is the primary payor, you should promptly enroll in Medicare. The Fund will treat you as enrolled in both Medicare Part A and B when you are first eligible, and you will not receive benefits from the Fund for benefits you are entitled from Medicare.

While, in general, you are not required to file an application for enrollment in Medicare Part A, you are required to file an application for enrollment in Medicare Part B. To be entitled to receive Medicare Part B benefits in the month in which you first become eligible, you must file an application for Part B in the three-month period before the month in which you first become eligible. For example, if you turn age 65 on April 15, you must file your Part B application during the preceding January, February, or March to become entitled to receive Part B benefits on April 1. If you file your application in April, you would not be entitled to receive Part B benefits until May 1 and you will be responsible for the payment of medical expenses incurred during April that Medicare Part B would have paid had you enrolled. After you have enrolled in Medicare Part B, you must provide the Fund Office with proof of your eligibility.

Any benefits payable to you or your dependents under any portion of the Plan will be reduced by the amount of any benefits or other compensation to which you are entitled under any federal law, rules, or regulations constituting a governmental health plan, such as Medicare. Benefits will similarly be reduced if you or your dependents are above age 65 and Medicare is the primary plan over the Plan for the same injury or illness, regardless of whether or not you have received or made application for such benefits or compensation.

If you or your dependents are entitled to benefits or other compensation under Medicare, the Plans will reduce your benefits by the amount Medicare would have paid, even if you are not enrolled or participating.

SUBROGATION AND REIMBURSEMENT

Subrogation

If another person or entity is responsible for your medical expenses, you must help the Plan recover from that person or entity the benefits that the Plan has paid to you.

If You become ill or are injured by the actions of a Third Party, the Fund is not responsible for paying the claims associated with the injury. Any costs associated with Your illness or injury should be paid by the Responsible Third Party. For example, if You are injured in a vehicle collision caused by another driver, the driver or his or her insurance company may be responsible for payment of Your medical expenses. If You are injured at work, Your employer may be responsible for payment of Your medical expenses. However, the wait for payment in these situations can be long, uncertain, and stressful. As a benefit to You, the Trustees, within their discretionary authority under the terms of the Plan, may agree to advance payment of Benefits for the illness or injury, with the understanding that these Benefits will be repaid in full to the Fund out of any Recovery You receive from the Responsible Third Party. The Trustees may refuse to advance payment of Benefits for an illness or injury if, for example, You or any attorney representing You fail to sign the Subrogation and Reimbursement Agreement or provide any other information or documents required by the Fund.

In addition, the Fund has a right of subrogation, meaning the Fund's right to be substituted in Your place with respect to any lawful claim, demand or right of action against a Responsible Third Party to recover the amount of Benefits advanced to You or advanced on Your behalf.

DEFINITIONS

Throughout this section, these words have the following meaning:

- Accident. An incident or omission that causes You to sustain an Illness or Injury for which a Third Party is or may be responsible.
- Benefit(s). All payments made or advanced (or to be made or advanced) by the Fund related to an Accident as determined by the Fund, including, but not limited to, medical expenses and income replacement or lost time benefits, that are subject to reimbursement under this Section.
- Illness. A disease, disorder or condition that requires treatment by a medical professional and/or provider.
- Injury. Damage to the body that requires treatment by a medical professional and/or provider.
- Plan/SPD. The Plan/SPD in effect at the time of settlement.
- Recovery. Any and all payments from another source You receive or to which You are entitled (including, but not limited to, any amounts allocated to a trust set up by You or on Your behalf) as a result of an Accident, including any judgment, award, or settlement regardless of how the recovery is termed, allocated, or apportioned and regardless of whether any amount is specifically included or excluded as medical expenses.
- Reimbursement Amount. The amount of Benefits advanced by the Fund to You or on Your behalf as the result of an Accident that You are obligated to pay back to the Fund out of any Recovery.
- Responsible Third Party. A Third Party that is or may be legally responsible for reimbursing You for Your Accident.
- Third Party. Any person or entity, including, but not limited to, a corporation, association, government, trust or partnership. Third Party also includes any workers' compensation coverage or other insurance coverage, including the underinsured, uninsured, and medpay provisions of Your own insurance policy.
- You (Your). All Plan participants, including eligible dependents.

FUND'S RIGHTS

The Fund has the following rights:

- The Fund is entitled to reimbursement for any Benefit payments advanced to You or on Your behalf for expenses related to an Accident without regard to any common fund doctrine, make whole doctrine, or any other common law doctrine or state statute that purports to restrict the Fund's right to reimbursement in full. The reimbursement is required to be made directly from the Responsible Third Party, from You, from Your attorney, or from any Third Party who possesses Recovery proceeds.

- The Fund will automatically have a lien against any Recovery to the extent of the Reimbursement Amount. The lien may be enforced against You, Your attorney, the Responsible Third Party or any other Third Party who possess Recovery proceeds.
- The Fund must be reimbursed in full out of any Recovery without any amounts deducted for attorney's fees, costs, or future medical expenses, unless the Trustees, within their discretionary authority under the terms of the Plan, agree to do so in writing prior to the final settlement or resolution of the matter.
- The Fund's right to full reimbursement must be satisfied first before any other claims on the Recovery can be satisfied, and this right applies even if the Recovery is not sufficient to fully compensate You for Your Accident, and even if liability is not admitted or found. Any amount left over, after the Fund has been reimbursed, will be paid to You.
- The Fund may exercise its right of subrogation and pursue a suit or claim against the Responsible Third Party if You do not do so within a reasonable period of time after Your Accident.
- The Fund has the right to join or intervene in any suit or claim against a Responsible Third Party brought by You or on Your behalf. The Fund also has the right to accept a tendered settlement offer directly from the Responsible Third Party (up to the Reimbursement Amount) if You reject or fail to accept such offer.
- The Fund has the right to, and You and/or Your attorney must provide, information requested by the Fund regarding any suit or claims You may be pursuing.

YOUR RESPONSIBILITIES

You have certain responsibilities to the Fund as follows:

- You must notify the Fund of the existence of an Accident within one year of the occurrence of the Accident. If the Accident is work related, however, You must notify the Fund of the Accident no later than one year from the date you receive notice that the employer or its worker's compensation insurance carrier ceases to pay compensation related to the Accident. You must notify the Fund within 30 days of the date when any notice is given to any Third Party or the Third Party's attorney of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury or Illness.
- You must comply with all of the Fund's claim and records procedures and cooperate fully with the Fund in the recovery of the Benefits advanced to You (or advanced on Your behalf) by the Fund and the Fund's exercise of its subrogation and reimbursement rights.
- You will be required to complete and submit an Accident Claim Form, Statement of Injured Party Form, Subrogation and Reimbursement Agreement, and other documents required by the Fund. You and Your attorney must sign and agree to the terms of the Fund's Subrogation and Reimbursement Agreement, confirming, among other things, Your and Your attorney's agreement that the Fund is entitled to full reimbursement from any and all Recovery that You may receive or to which You are entitled.
- If the Accident is work related, You understand that the Fund will only pay Benefits if You filed a claim with the Illinois Workers' Compensation Commission, the employer is disputing that claim, and no benefits are currently being paid to You as a result of the employer disputing coverage under the Workers Compensation Act/Occupational Diseases Act.
- You agree to reimburse the Fund in full, in first priority and on a first dollar basis, from any Recovery You receive or to which You are entitled in an amount equal to the full amount of Benefit payments advanced by the Fund as a result of Your Accident, regardless of whether You are made whole by the Responsible Third Party. You must also agree that the common fund doctrine, make whole doctrine and any other common law doctrine or state statute that restricts the Fund's right to full reimbursement shall not be applicable to the Fund's right to full reimbursement of the amount of Benefits it advances to You.
- You must provide other information about Your Accident, such as the case or claim number, as requested by the Fund.
- You must keep the Fund advised of any changes in the status of Your suit and/or claim against the Responsible Third Party.
- You must refrain from doing anything to impair, prejudice or compromise the Fund's subrogation and reimbursement rights without prior written agreement by the Fund. The Fund must be notified before any settlements are concluded and before any trial or other material hearing is held.
- You are solely responsible for Your attorney's fees; the Fund is not liable for any costs or fees incurred by You in pursuing Your suit or claim, regardless of any common fund, make whole, or any other common law doctrine or state statute that purports to require the Fund to pay a portion of the legal fees incurred in the collection of the Recovery. You must indemnify the Fund for any and all losses it suffers as a result of any claims made against the Fund by

Your attorney for attorney's fees under the common fund doctrine. In other words, if Your attorney sues the Fund for payment of attorney's fees under the common fund doctrine and the court rules that the Fund must pay the attorney a fee for the work he or she performed on the case involving the Accident, You are responsible for repaying the Fund the amount the court awards to the attorney and the amount of the attorney's fees the Fund incurs in defending Your attorney's claim.

- You must inform the Fund as to whether You have received a Recovery related to Your Accident before signing the Subrogation and Reimbursement Agreement. If You receive a Recovery before the Subrogation and Reimbursement Agreement is signed, the Fund will not be responsible for the payment of any further Claims related to the Accident and You will still be obligated to reimburse the Fund for the Benefit payments that it has advanced to the extent of any Recovery.

Any Claims related to Your Accident will not be paid until the Fund has received a completed copy of the Subrogation and Reimbursement Agreement signed by You and Your attorney (if You have retained one). If the Fund inadvertently advances payment for Claims related to Your Accident before receiving the completed and signed Subrogation and Reimbursement Agreement, the Fund is not obligated to advance payment for any further Accident-related Claims until it receives the signed Subrogation and Reimbursement Agreement and the Fund will still be entitled to reimbursement for Claims inadvertently paid regardless of whether the completed and signed Subrogation and Reimbursement Agreement is submitted to the Fund. If You sign the Subrogation and Reimbursement Agreement and do not have an attorney at the time You sign it, any attorney who You later retain must sign a written document provided by the Fund agreeing to abide by the terms of the Subrogation and Reimbursement Agreement in order for further Accident-related Claims to be paid by the Fund. If Your attorney fails to sign this written document, the Fund may recoup the costs of claims already paid for this Accident.

If You fail to satisfy Your responsibilities as listed above, the Fund has the right to deny Accident-related Claims and may recoup the costs of any Accident-related Claims it had already paid.

PROCEDURES

You shall notify the Fund of the existence of an Accident within one year of its occurrence. If You do not meet this responsibility, the Fund may suspend or withhold payment of Claims related to such Injury or Illness. You are also responsible for compliance by Your agents and attorneys with these procedures. If You receive a Recovery from a Third Party, You or Your attorney must hold the Recovery proceeds separately from other assets until the Reimbursement Amount has been repaid to the Fund. The Fund holds a claim, equitable lien, and constructive trust over any Recovery proceeds and those proceeds must remain segregated and under Your control. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Fund. Once the Fund's reimbursement rights have been determined, You or Your attorney must make immediate payment to the Fund out of any Recovery proceeds. If You do not pursue a suit or claim against the Responsible Third Party, and the Fund elects to do so, You must allow the Fund to assert the suit or claim in Your name or on Your behalf in the Fund's name and fully cooperate with the Fund's prosecution of the suit or claim.

NONCOMPLIANCE

If You receive a Recovery from a Third Party but do not promptly segregate the Recovery proceeds or You fail to reimburse the Fund in full from those funds, the Fund is entitled to take action to recover the Benefits paid. Such action includes, but is not limited to:

- Initiating an action against You and/or Your attorneys to compel compliance with these terms, the subrogation and reimbursement provisions of the Plan SPD, and the Subrogation and Reimbursement Agreement;
- Withholding benefits payable to or for You or Your covered family members (regardless of whether the Claims are related to the Accident) until You comply or until the Reimbursement Amount has been fully repaid to the Fund; or
- Initiating other appropriate equitable or legal actions.

If You do not reimburse the Fund within 60 days of the date on which You receive the Recovery, You will be responsible for paying the Fund 1% interest per month on the amounts owed until the Fund receives the Reimbursement Amount. The Fund is also entitled to reimbursement of any costs or fees it incurs in efforts to enforce its rights against You or Your attorney.

Any party filing a legal action in connection with this section must file suit in the United States District Court for the Northern District of Illinois, Eastern Division, located in Chicago, Illinois which is also the jurisdiction in which the Fund headquarters is located.

INTERPRETATION & APPLICATION OF SUBROGATION AND REIMBURSEMENT PROVISIONS

In the event that a dispute arises as to (1) whether any part of this Subrogation and Reimbursement section is ambiguous or questions arise as to the meaning or intent of any of its terms, (2) whether any Claim(s) is related to the Accident (without regard to any gap in treatment for the underlying Injury or Illness) or (3) any other issues regarding the application of this section, the Trustees (or their designee) shall have the sole authority and discretion to resolve all disputes regarding the interpretation and application of this section.

VENUE

Any party filing a legal action in connection with this Section shall be required to file suit in the United States District Court for the Northern District of Illinois, Eastern Division, located in Chicago, Illinois which is also the jurisdiction in which the Fund headquarters is located.

CONCLUSION OF CLAIM

Once You have settled or received an award or judgment or any type of Recovery on Your suit or claim against the Responsible Third Party, (1) You are obligated to hold any Recovery proceeds in trust until the Fund's rights and interests in such Recovery have been resolved and satisfied and (2) no further medical expenses associated with that Accident will be paid by the Fund, unless the Trustees, within their discretionary authority under the terms of the Plan, agree in writing prior to the settlement or resolution of the claim or suit that future medical expenses related to the Accident will be covered. In the absence of an agreement regarding coverage of future medical expenses, the Trustees, in their determination as to whether any of your future medical claims are related to the Accident, may take into account, among other things, the length of time between the termination of treatment related to the Accident and the future claim in question and whether the Recovery was sufficient to cover future medical expenses. Therefore, it is very important that You and Your attorney scrutinize the status of all Accident-related Claims before finalizing Your Third Party claim.

PRIVACY POLICY

The rules described below apply to each individual covered under the Fund; whether the individual is the participant, Spouse, or covered dependent child. The information contained in this section describes how certain health information may be used and disclosed and how you may obtain access to this information.

The Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI);
- Your rights to privacy with respect to your PHI;
- The Fund's duties with respect to your PHI;
- Your right to file a complaint with the Fund and with the Secretary of the Department of Health and Human Services (HHS); and
- The person or office you should contact for further information about the Fund's privacy practices.

To safeguard your health information, we request that all visitors show a photo ID when requesting benefit assistance. Acceptable forms of identification include a:

- Driver's license;
- State issued photo ID;
- Consular ID; or
- Passport.

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act (HIPAA). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Privacy Policy attempts to summarize these regulations. The regulations will supersede any conflicting provisions contained here if there is any discrepancy between the information here and the regulations.

YOUR PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) includes all information maintained by the Fund related to your past, present, or future physical or mental health condition or for payment of healthcare. PHI includes information maintained by the Fund in oral, written, or electronic form.

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

WHEN THE FUND MAY DISCLOSE PHI

Under the law, the Fund may disclose your PHI without your consent, authorization, or opportunity to object:

- At your request. If you make a request under the Fund's procedures, the Fund is required to give you access to certain PHI to allow you to inspect it and/or copy it.
- As required by an agency of the government. The Secretary of the HHS may require the disclosure of your PHI to investigate or determine the Fund's compliance with federal law.
- To the Fund's Sponsor. The Fund may disclose PHI to the Fund's Sponsor, the Board of Trustees of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan, for the purposes related to treatment, payment, and healthcare operations. (For example, the Fund may disclose information to the Fund Sponsor to allow them to decide an Appeal or review a subrogation Claim.)
- For treatment, payment, or healthcare operations. The Fund and its Business Associates will use PHI without your consent, authorization, or opportunity to agree or object to carry out:
  - Treatment, which is healthcare treatment. Treatment is the provision, coordination, or management of healthcare and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

The Fund does not need your consent or authorization to release your PHI when:

- You request it;
- A government agency requires it;
- Fund Sponsor is required to review it; or
- The Fund uses it for treatment, payment, or healthcare operations.

EXAMPLE:

The Fund may disclose to a treating orthodontist the name of your treating Dentist so that the orthodontist may ask for your dental X-rays from the treating Dentist.

- Payment, which is paying Claims for healthcare and related activities. Payment includes, but is not limited to, making coverage determinations and payment. These actions include billing, Claim management, subrogation, Fund reimbursement, reviews for Medical Necessity, and appropriateness of care.

EXAMPLE:

The Fund may tell your Physician whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.

- Healthcare Operations, which is involved with keeping the Fund operating soundly. Healthcare operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse compliance programs, business planning and development, business management, and general administrative activities.

EXAMPLE:

The Fund may use information about your medical Claims to refer you to a disease management program, to project future benefit costs, or to audit the accuracy of its Claims processing functions.

WHEN DISCLOSURE OF PHI REQUIRES WRITTEN AUTHORIZATION

In general, the Fund must obtain your written authorization if it uses or discloses your PHI for purposes other than treatment, payment, or healthcare operations.

Generally, the Fund must obtain your written authorization before the Fund uses or discloses psychotherapy notes about you from your psychotherapist. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you.

In addition, the Fund must obtain your written authorization before it can disclose your PHI to your Employer. In some cases, the Fund will require your written authorization before any disclosure is made to a family member (other than a Spouse) or a close personal friend, as described later.

Psychotherapy Notes

Separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

WHEN USE OR DISCLOSURE OF PHI REQUIRES AN OPPORTUNITY TO AGREE OR DISAGREE

Disclosure of your PHI to family members, other relatives, and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

In general, the Fund does not need your consent to release your PHI if required by law or for public health and safety purposes.

WHEN USE OR DISCLOSURE OF PHI DOES NOT REQUIRE AUTHORIZATION

The Fund is allowed under federal law to use and disclose your PHI without your consent, authorization, or request:

- When required by law.
- *For public health purposes* to an authorized public health official if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- *In domestic violence or abuse situations* when authorized by law, to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect, or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- *For oversight activities* to a public health oversight agency when authorized by law. These activities include civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions (e.g., to investigate complaints against providers), and other activities necessary for appropriate oversight of government benefit programs (e.g., to the Department of Labor).
- *For legal proceedings* when required for judicial or administrative proceedings, provided:
  - The requesting party gives the Fund satisfactory assurances a good faith attempt has been made to provide you with written notice;
  - The notice provided sufficient information about the proceeding to permit you to raise an objection; and
  - No objections were raised or were resolved in favor of disclosure by the court or tribunal.

EXAMPLE:

Your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

- *For law enforcement health purposes* (e.g., to report certain types of wounds).
- *For law enforcement emergency purposes,* including:
  - Identifying or locating a suspect, fugitive, material witness, or missing person; and
  - Disclosing information about an individual who is, or is suspected to be, a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.
- *For determining cause of death and organ donation* when required by law, to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death, or other authorized duties. The Fund also may disclose PHI for cadaveric organ, eye, or tissue donation purposes.
- *For funeral purposes* when required to be given to funeral directors to carry out their duties with respect to the decedent.
- *For research purposes,* subject to certain conditions.
- *For health or safety threats* when, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- *For workers' compensation programs* when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in the Plan's Privacy Policy, uses and disclosures will be made only with written authorization subject to your right to revoke your authorization.

OTHER USES OR DISCLOSURES

The Fund may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Fund may disclose PHI to the Plan Sponsor for reviewing your Appeal of a Claim denial or for other reasons regarding the administration of the Fund.

INDIVIDUAL PRIVACY RIGHTS

RIGHT TO REQUEST RESTRICTIONS ON PHI USES, DISCLOSURES, AND RECEIPT

In writing, you may request the Fund to restrict uses and disclosures of your PHI to:

- Carry out treatment, payment, or healthcare operations; or
- Family members, relatives, friends, or other persons identified by you who are involved in your care.

However, the Fund is not required to agree to your request if the Plan Administrator or Privacy Official determines it to be unreasonable. For example, if your request would interfere with the Fund's ability to pay a Claim, the Fund would consider your request unreasonable.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI or to receive communications of PHI by alternative means or at alternative locations. Requests should be sent to:

Privacy Official
Chicago & Vicinity Laborers' District Council Health & Welfare Plan
11465 W. Cermak Road
Westchester, IL 60154
708-562-0200

Designated Record Set includes your medical records and billing records that are maintained by or for the Fund. Records include enrollment, payment, billing, Claims adjudication, and case or medical management record systems maintained by or for a health fund or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

RIGHT TO INSPECT AND COPY PHI

You have a right to inspect and obtain a copy of your PHI contained in a designated record set for as long as the Fund maintains the PHI.

The Fund must provide the requested information within 30 days if the information is maintained at the Fund Office or within 60 days if the information is not maintained at the Fund Office. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

You or your Personal Representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be sent to:

Privacy Official
Chicago & Vicinity Laborers' District Council Health & Welfare Plan
11465 W. Cermak Road
Westchester, IL 60154
708-562-0200

If you disagree with the record of your PHI, you may amend it.

If the Fund denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI.

Forms are available for these purposes.

If access is denied, you or your Personal Representative (defined below) will be provided with a written denial setting forth the basis for why access was denied, a description of how you may exercise your review rights, and a description of how you may file a complaint with the Fund and the Secretary of the Department of Health and Human Services.

RIGHT TO AMEND PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend PHI Policy for a list of exceptions.

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

Your written request to amend PHI should be sent to:

Privacy Official
Chicago & Vicinity Laborers' District Council Health & Welfare Plan
11465 W. Cermak Road
Westchester, IL 60154
708-562-0200

You or your Personal Representative will be required to complete a form to request amendment of the PHI.

RIGHT TO RECEIVE AN ACCOUNTING OF FUND'S PHI DISCLOSURES

At your request, the Fund will provide you with an accounting of disclosures by the Fund of your PHI made after this Policy became effective. The Fund does not have to provide you with an accounting of disclosures related to treatment, payment, or healthcare operations or disclosures made to you or authorized by you in writing. See the Fund's Right to Accounting of Disclosure of PHI Policy for the complete list of disclosures for which an accounting is not required.

The Fund has 60 days from the date it receives your request to provide the accounting. The Fund is allowed an additional 30-day extension if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

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

RIGHT TO RECEIVE A PAPER COPY OF FUND'S PRIVACY NOTICE

To obtain a paper copy of the Fund's Privacy Notice, contact:

Privacy Official
Chicago & Vicinity Laborers' District Council Health & Welfare Plan
11465 W. Cermak Road
Westchester, IL 60154
708-562-0200

PERSONAL REPRESENTATIVE

You may exercise your rights through a Personal Representative. Your Personal Representative will be required to produce evidence of authority to act on your behalf before the Personal Representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed, and approved Appointment of Personal Representative Form. You may obtain this form by calling the Fund Office.

You may designate a Personal Representative by completing a form that is available from the Fund Office.

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

The Fund will recognize certain individuals as Personal Representatives without you having to complete an Appointment of Personal Representative Form.

For example, the Fund will automatically consider a Spouse to be the Personal Representative of an individual covered by the Fund. In addition, the Fund will consider a parent or guardian as the Personal Representative of an unemancipated minor unless applicable law requires otherwise. A Spouse or a parent may act on an individual's behalf, including requesting access to their PHI. However, Spouses, adult children and emancipated minor children may request that the Fund restrict information that goes to family members, as described at the beginning of this section by completing and submitting to the Privacy Official a form to request restrictions on uses and disclosures of your PHI.

You should also review the Fund's Recognition of Personal Representatives Procedures for a more complete description of the circumstances where the Fund will automatically consider an individual to be a Personal Representative.

THE FUND'S DUTIES

MAINTAINING YOUR PRIVACY

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This Privacy Policy is to inform you of the Fund's obligation to maintain the privacy of your PHI.

This Privacy Policy was effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this Policy. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund before that date. If the Fund changes any of its privacy practices, a revised version of this Privacy Policy will be provided, by mail, to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

Any revised version of this Privacy Policy will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI;
- Your individual rights;
- The duties of the Fund; or
- Other privacy practices stated in this Policy

DISCLOSING ONLY THE MINIMUM NECESSARY PHI

When using or disclosing PHI, or when requesting PHI from another covered entity (e.g., a healthcare provider or another health plan), the Fund will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations.

"Summary health information" summarizes the Claim histories, expenses, or types of Claims experienced by individuals for whom the Plan Sponsor has provided health benefits under its Plan.

However, the minimum necessary standard will not apply to:

- Disclosures to or requests by a healthcare provider for treatment;
- Uses or disclosures made by the Fund to you;
- Disclosures made by the Fund to the Secretary of the HHS;
- Uses or disclosures required by law; and
- Uses or disclosures required for the Fund's compliance with federal law.

This Policy does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you; and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose summary health information to the Plan Sponsor to premium bids or modifying, amending, or terminating the Funds' Plan of Benefits. Identifying information and genetic information will be deleted from summary health information, in accordance with HIPAA.

REASONABLE AND APPROPRIATE PROTECTION

The Fund will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.
- Ensure that the adequate separation specific to electronic PHI 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 electronic PHI.
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

BREACH NOTIFICATION RIGHTS FOR UNSECURED PROTECTED HEALTH INFORMATION UNDER HIPAA

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Fund Office to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Fund Office is also required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Fund Office to provide notification to the media.

If your unsecured PHI is breached, the Fund Office will notify you without unreasonable delay and in no case no later than 60 calendar days after discovery of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Plan up-to-date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Fund Office or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Fund Office has improperly followed the breach notification process.

RIGHT TO FILE A COMPLAINT WITH THE FUND OR HHS SECRETARY

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the Fund's Privacy official:

Privacy Official
Chicago & Vicinity Laborers' District Council Health & Welfare Plan
11465 W. Cermak Road
Westchester, IL 60154
708-562-0200

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Fund will not retaliate against you for filing such a complaint.

IF YOU NEED MORE INFORMATION

If you have any questions regarding the Fund's Privacy Policy or the subjects addressed in it, you may contact the Privacy Official at:

Privacy Official
Chicago & Vicinity Laborers' District Council Health & Welfare Plan
11465 W. Cermak Road
Westchester, IL 60154
708-562-0200

You have the right to file a complaint if you feel your privacy rights have been violated.

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

PLAN ADMINISTRATIVE INFORMATION

FUND NAME

The Fund's legal name is the Chicago & Vicinity Laborers' District Council Health & Welfare Plan. It is sometimes commonly referred to as the Laborers' Welfare Fund.

Plan or Benefit Plan

A program of benefits described in this Plan/SPD and any other written documents that the Plan Trustees designate to be part of the program of benefits under the terms of the Trust Agreement.

NAME OF PLAN

The name of the Plan is the Chicago & Vicinity Laborers' District Council Health & Welfare Plan.

PLAN SPONSOR AND PLAN ADMINISTRATOR

A Board of Trustees is responsible for the operation of the Plan. Although the Trustees are legally designated as the Plan Administrator, they have delegated certain administrative responsibilities to an Administrator. The Administrator and the Fund staff, under the Administrator's supervision, maintain eligibility records, account for Employer contributions, answer participant inquiries, process Claims and benefit payments, and handle other routine administrative functions. The Administrator contracts with various providers for services, as indicated on page 3. The Fund's Certified Public Accountant prepares required government reports.

TRUSTEE

A Trustee is an individual, or the individual's successor, who is appointed and designated according to the terms of the Trust Agreement to administer the Fund. Trustees designated by the Employer Associations are Employer Trustees. Trustees designated by the Union are Union Trustees.

Fund, Trust Fund, or Welfare Fund

The entire Trust of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan, established and administered according to the Trust Agreement.

BOARD OF TRUSTEES

The Board of Trustees consists of Employer and Union Trustees selected by the Employer Associations and Unions that have entered into collective bargaining agreements related to the Chicago & Vicinity Laborers' District Council Health & Welfare Plan. You may contact the Board of Trustees by using the following address and phone number:

Chicago & Vicinity Laborers' District Council Health & Welfare Plan
11465 W. Cermak Road
Westchester, IL 60154
708-562-0200

As of June 1, 2020, the Trustees of the Plan are:

Union Trustees	Employer Trustees
James P. Connolly Chicago & Vicinity Laborers' District Council 999 McClintock Drive, Suite 300 Burr Ridge, IL 60527	Julie Chamberlin Berger Excavating Contractors, Inc. 1205 Garland Road Wauconda, IL 60084
Martin T. Flanagan Chicago & Vicinity Laborers' District Council 999 McClintock Drive, Suite 300 Burr Ridge, IL 60527	Charles J. Gallagher Gallagher Asphalt Paving Co. 18100 S. Indiana Avenue Thornton, IL 60476
Richard Kuczkowski Local Union No. 2 8842 W. Ogden Avenue Brookfield, IL 60513	Clifton M. Horn A. Horn, Inc. 125 Harrison Street Barrington, IL 60010

Union Trustees	Employer Trustees
Charles V. LoVerde, III Chicago & Vicinity Laborers' District Council 999 McClintock Drive, Suite 300 Burr Ridge, IL 60527	David H. Lorig Lorig Construction Co. 250 E. Touhy Avenue Des Plaines, IL 60018
William J. Martin Laborers' Local Union No. 75 1923 Donmaur Drive Crest Hill, IL 60403	Dennis P. Martin Martin Cement Company 25 Forestwood Drive Romeoville, IL 60446

PLAN INTERPRETATION AND CONTINUATION

Only the Board of Trustees is authorized and has the sole and unrestricted discretion to:

- Interpret the Plan's rules and procedures;
- Decide all questions about the Plan, including questions about eligibility for benefits and the amount of benefits payable;
- Determine the facts of any Claim for Plan benefits; and
- Change the eligibility rules and other Plan terms to amend, increase, decrease, or eliminate benefits or terminate the Plan, partially or totally.

Benefits under the Plan will only be paid when the Trustees or persons delegated by them decide, in their discretion, that the participant or beneficiary is entitled to benefits in accordance with terms of the Plan.

The Trustees intend to continue the Plan indefinitely for your benefit and the benefit of all Plan participants. However, the Trustees have been given the power to amend or terminate the Plan, as they deem necessary. The Plan may be amended or terminated by majority vote of the Board of Trustees at a meeting of the Trustees. If the Plan is terminated, benefits for Covered Expenses incurred before the termination date fixed by the Trustees will be paid to eligible Participants, as long as the Plan's assets are more than the Plan's liabilities. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

If the Plan is amended or terminated, the Fund Office will send you a written notice explaining the change. Please be sure to read all Fund and Plan communications and keep them with this Plan/SPD.

Benefits under the Plan will only be paid when the Trustees or persons delegated by them decide, in their discretion, that the participant or beneficiary is entitled to benefits in accordance with terms of the Plan. The Trustees decide any factual question related to eligibility for and the type and amount of benefits. The decision of the Trustees is final and binding and will receive judicial deference to the extent that it does not constitute an abuse of discretion. If a decision of the Trustees is challenged in court, the decision will be upheld unless the court finds that it is arbitrary and capricious. Individual Trustees, Employers, or Union representatives do not have the authority to interpret the Plan on behalf of the Board of Trustees or to act as agents of the Board with respect to interpretation of the Plan. You may only rely on information regarding the Plan that is communicated to you in writing and signed on behalf of the full Board of Trustees either by the Trustees, or, if authorized by the Trustees, signed by the Administrator.

You are not vested in any of the benefits described in this Plan/SPD. The Trustees reserve the right to amend, modify, or terminate the Plan or any of its benefits at any time, and from time to time, in their sole and unrestricted discretion.

COLLECTIVE BARGAINING AGREEMENTS

You and your dependents may obtain, upon written request to the Fund Office, information as to the address of a particular Employer and whether that Employer is required to pay contributions to the Plan. You may also request a list (including addresses) of all contributing Employers and unions maintaining the Plans.

Collective Bargaining Agreement

The negotiated Labor Agreement between the Union and your Employer that requires contributions to the Fund.

IDENTIFICATION NUMBER

The identification number assigned to the Board of Trustees by the Internal Revenue Service is 36-2151212. The number assigned to the Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

CONTRIBUTIONS

Employer contributions finance the benefits described in this Plan/SPD. All Employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements between the Union and Employer Associations and those Employers that are not members of, or represented by, such Employer Associations but that enter into an individual collective bargaining agreement with the Union.

The collective bargaining agreements specify the amount of contributions, the due date of Employer contributions, the type of work for which contributions are payable, and the geographic area covered by these agreements. All agreements must be approved and accepted by the Board of Trustees.

The Fund Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Plan on behalf of participants working under the collective bargaining agreements.

TRUST FUND, FUND

The Board of Trustees holds all assets in trust pursuant to the Trust Agreement. All benefits and administrative expenses are paid from the Fund's assets. The Trust Agreement consists of all the documents, including all amendments that establish the Trust Fund and its rules of operation. All benefits provided under this Plan are self-funded.

PLAN YEAR

The accounting records of the Plan are kept on a fiscal plan year basis beginning each June 1 and ending the following May 31.

Plan Year

June 1 through the following May 31.

PURPOSE AND TYPE OF PLAN

This is a group health and welfare plan providing self-funded benefits. The Plan is an employee welfare benefits plan maintained to provide medical, prescription drug, dental, vision, disability, and death benefits for you and your dependents who meet the eligibility requirements described in this Plan/SPD.

Your coverage by the Plan does not constitute a guarantee of your continued employment.

Your coverage by the Plan is not a guarantee of continuing employment.

PLAN INSPECTION

If you wish to inspect or receive copies of additional documents relating to the Plan, contact the Administrator at the Fund Office. You will be charged a reasonable fee to cover the cost of copying any document you request.

LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made on:

Catherine Wenskus
Administrator
Chicago & Vicinity Laborers' District Council Health & Welfare Plan
11465 W. Cermak Road
Westchester, IL 60154
708-562-0200

Service of any legal process may also be made on any individual Trustee at the address for the Fund Office.

YOUR ERISA RIGHTS

As a participant in the Chicago & Vicinity Laborers' District Council Health & Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that you are entitled to the following rights.

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Fund 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 Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Plan/SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to: continue healthcare 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. The Fund Office will provide you with the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a Claim that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's Claim and Appeal procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been 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 the Plan, you should contact the 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) at:

National Office
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
866-444-3272

Nearest Regional Office
Employee Benefits Security Administration
Chicago Regional Office
200 West Adams Street, Suite 1600
Chicago, IL 60606
312-353-0900

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the website of the EBSA at www.dol.gov/ebsa.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

Throughout this Plan/SPD, many words are used that have a specific meaning when applied to your Plan coverage. When you come across these terms while reading this Plan/SPD, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. All definitions have been arranged in alphabetical order and are capitalized when used in this Plan/SPD.

Ambulance Service	Local transportation in a specially equipped certified vehicle from your home, scene of the accident, or medical emergency to a Hospital, between Hospitals, between Hospital and Skilled Nursing Facility, or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Service then means the transportation to the closest facility that can provide the necessary service. Ambulance Service does not include transportation to a medical facility for patient convenience (i.e., transportation from your home to a Physician's appointment or therapy session).
Ambulatory Surgical Center	A facility (other than a Hospital): • Whose primary function is the provision of surgical procedures on an ambulatory basis; and • That is duly licensed by the appropriate state and local authority to provide such services.
Anesthesia Services	The administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist that may be legally rendered by them respectively.
Appeal	A Claimant has filed a written request within the specified timeline to have an initial Claim benefit determination reviewed by the Trustees of the Welfare Appeals Committee of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan.
Certified Nurse Midwife (CNM)	An individual who: • Practices according to the standards of the American College of Nurse-Midwives; • Has an arrangement (or agreement with a Physician) for obtaining medical consultation, collaboration, and Hospital referral; • Is a graduate of an approved school of nursing and holds a current license as a registered nurse; and • Is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.
Certified Registered Nurse Anesthetist (CRNA)	An individual who is: • A graduate of an approved school of nursing; • Duly licensed as a registered nurse; • A graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; • Certified by the Council of Certification of Nurse Anesthetists or its predecessors; and • Recertified every two years by the Council on Recertification of Nurse Anesthetists.

Certified Surgical Assistant (CSA)	An individual specializing in surgical assistance who performs functions such as scrubbing for an operative session, assisting in the positioning of a patient, draping the operative site, retracting and exposing the operative site during a surgical procedure, and, providing homeostasis (clamping or tying off bleeders) and suture. A CSA must: • Have completed a specialized course of training, including classroom instruction and clinical application regarding the skills and requirements of a surgical assistant; • Bill for services as a CSA; • Be licensed if such licensure is required by the state in which he or she practices; • Practice under the direct supervision of a Physician or surgeon who is working within the scope of his or her own license; and • Have a Physician or surgeon physically present while the CSA is providing billed services. A bachelor's degree from an accredited college or university is not required to be a CSA. A CSA does not include an individual who is a Surgical Technician (ST), Certified Surgical Technician (CST), Physician Assistant (PA), or Nurse Practitioner (NP).
Chemotherapy	The treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.
Chiropractor	An individual who is licensed to practice as a chiropractor in the state in which services are being provided.
Claim	A request for Plan benefits made by a Claimant according to the Plan's Claim filing procedures. Claims may be submitted in paper form or through Electronic Data Interchange (EDI). A provider may submit a Claim on behalf of a Claimant to receive direct payment, but in no case will the Fund treat the provider as the assignee of such Claim (assignment of Claims is prohibited).
Claimant	A patient, who can be the Member, Spouse, or natural parent of an underage child who files a Claim for benefits.
Clinical Psychologist	A Psychologist who: • Specializes in the evaluation and treatment of mental health; • Has a doctoral degree from a regionally accredited university, college, or professional school; • Has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program or is a registered Clinical Psychologist with a graduate degree from a regionally accredited university or college; and • Has not less than six years as a Psychologist, with at least two years of supervised experience in health services.
COBRA	Those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, that regulate the conditions and manner under which an Employer can offer continuation of group health insurance to eligible persons whose coverage would otherwise terminate.
Coinsurance	A percentage of an eligible expense that an eligible individual is required to pay toward a Covered Service.
Convenience Care Clinic (CCC)	Clinics located in retail stores, supermarkets and Pharmacies. Also referred to as walk-in medical clinics, retail-based clinics or mini-clinics. Convenience Care Clinics provide a cost-effective alternative to treating uncomplicated minor illnesses and for receiving preventive healthcare services instead of visiting a Physician's office or urgent care facility.
Covered Employment	Work for an Employer that is required to contribute to the Fund on your behalf.
Covered Services	Services that are covered by the Plan.
Creditable Coverage	Coverage that equals or exceeds the same actuarial value of defined standard prescription drug coverage as demonstrated through the use of generally accepted actuarial principles in accordance with CMS actuarial guidelines.

Custodial Care	Any services or supplies provided primarily for personal comfort or convenience that provide general maintenance, preventive, and/or protective care without any clinical likelihood of condition improvement. Custodial Care also means those services that do not require the technical skills, professional training, and/or clinical assessment ability of medical and/or nursing personnel to be safely and effectively performed. Custodial Care services: • Can be safely provided by trained or capable non-professional personnel; • Are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.); and • Are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.). Custodial Care also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement.
Dentist (DDS or DMD)	A duly licensed dentist.
Diagnostic Service	Tests rendered for the diagnosis of symptoms and are directed toward evaluation or progress of a condition, disease, or injury. Tests include, but are not limited to, X-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.
Dialysis Facility	A facility (other than a Hospital): • Whose primary function is the treatment and/or provision of maintenance dialysis on an ambulatory basis for hemodialysis or peritoneal dialysis patients; and • Is duly licensed by the appropriate governmental authority to provide such services.
Dialysis Treatment	One unit of service, including the equipment, supplies, and administrative service that are customarily considered as necessary to perform the dialysis process.
Eligible Charge	• In the case of a provider that has a written agreement with the Fund to provide care at the time Covered Services are rendered, the provider's Claim charge for Covered Services. • In the case of a provider that does not have a written agreement with the Fund to provide care at the time Covered Services are rendered, the amount for Covered Services as determined by the Fund Office based on the following order: » The charge that is within the range of charges other similar Hospitals or facilities in similar geographic areas charge patients for the same or similar services, as reasonably determined by the Fund Office, if available; » The amount that the Centers for Medicare & Medicaid Services (CMS) reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to those in the Medicare program; or » The charge that the particular Hospital or facility usually charges its patients for Covered Services.
Eligible Member or Member	An employee of an Employer who meets the eligibility requirements for this Plan's coverage, as described in the eligibility section of this Plan/SPD. In addition to meeting the eligibility requirements set forth in the eligibility section, an owner of an Employer must also sign a Participation Agreement for Independent Self-Contributors and their participation in the Plan must be approved by the Board of Trustees and will be governed by the terms of the Participation Agreement and the Plan.
Employer	The company with which you are employed that has a collective bargaining agreement with the Union or a participation agreement with the Board of Trustees that requires contributions to the Fund.
Gene Therapy	A method of treatment that typically involves replacing a gene that causes a medical problem with a gene that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. Examples of Gene Therapy include, but are not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) Therapies, such as Kymriah and Yescarta, as well as other therapies, such as Luxturna and Zolgensma.

Hospice Care	Palliative and supportive care designed to provide for the physical and psychological well-being of dying persons and their families. The goal of Hospice Care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and quality of life. Hospice Care is available in the home, Skilled Nursing Facility, or special Hospice Care unit.
Hospital	See Inpatient Facility.
Inpatient	A registered bed patient being treated in a Hospital or other healthcare facility.
Inpatient Facility	Any type of medical, health, mental health or substance abuse inpatient setting that provides services or treatment that cannot be effectively provided on an outpatient basis. An Inpatient Facility must be: • accredited by a nationally recognized agency (such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Organization (AOA), Healthcare Facilities Accreditation Program (HFAP), Commission on Accreditation of Rehabilitation Facilities (CARF); • licensed in the State in which it operates; or • approved by Medicare. An Inpatient Facility includes: • a Hospital that provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises; • a Skilled Nursing Facility that provides nursing and related services to individuals who require medical or nursing care and that rehabilitates injured, disabled or sick individuals; or • an intermediate non-hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders. An Inpatient Facility does not include nursing homes, convalescent homes, rest homes or residences for the aged.
Infertility Treatment	Treatment may include, but is not limited to, blood tests, medications, lab charges, testing, hormone therapy, artificial insemination, in vitro fertilization, methods and treatments to induce, preserve, or protect the pregnancy, and harvesting of eggs or semen from you or your eligible Spouse. Infertility means both the inability to conceive and the inability to maintain a pregnancy to full term.
Investigational, Experimental, or Inappropriate Drugs, Devices, Treatment, or Procedures	Procedures, drugs, devices, services, and/or supplies that: • Are provided or performed in special settings for research purposes or under a controlled environment that are being studied for safety, efficiency, and effectiveness; • Are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to the patient; • Specifically with regard to drugs, combination of drugs, and/or devices are not finally approved by the Food and Drug Administration at the time used or administered to the patient; • Are not officially accepted by the medical community; • Are not recognized as having proven beneficial outcomes to the patient; and/or • Are not recommended for an advanced state of an illness or disease.
Licensed Clinical Professional Counselor (LCPC)	A duly licensed clinical professional counselor.
Licensed Clinical Social Worker (LCSW)	A duly licensed clinical social worker.

Maintenance or Developmental Care	Those services that are: • Administered to a patient to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur; • Not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness); or • Educational in nature.
Maintenance Occupational Therapy or Maintenance Physical Therapy	Therapy that is: • Administered to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur; • Not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness); or • Educational in nature.
Marriage and Family Therapist (LMFT)	A duly licensed marriage and family therapist. Marriage counseling is not covered under the Plan.
Medical Care	The ordinary and usual professional services rendered by a Physician or other specified provider during a professional visit for treatment of an illness or injury.
Medically Necessary or Medical Necessity	Services, treatments, or supplies ordered by your Physician that are: • Required to identify or treat an injury or illness; • Appropriate and consistent with the symptoms, diagnosis, or treatment of the condition, disease, illness, or injury; • In keeping with acceptable National Standards of Good Medical Practice; and • The most appropriate that can be safely provided under the circumstances on a cost-effective basis.
Medicare	The program established by Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).
Mental Health Disorder	Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) Manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental health disorders include, among other things, depression, schizophrenia, and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by certified mental health practitioners.
Minimum Value	A group health plan provides Minimum Value if the coverage has an actuarial value of at least 60 percent under the actuarial value of a standard plan as determined by the IRS.
Naprapath	A duly licensed naprapath.
Naprapath Services	The performance of naprapathic practice by a Naprapath that may legally render such services.
Occupational Therapist	A duly licensed occupational therapist.
Occupational Therapy	Constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.
Optometrist	A duly licensed optometrist.
Outpatient	Treatment received while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room, diagnostic laboratory tests and X-rays, medications, and supplies.
Participating Provider Option	A program of healthcare benefits designed to provide economic incentives for using designated providers of healthcare services.
Pharmacy	Any licensed establishment in which the profession of pharmacy is practiced.

Physical Therapist	A duly licensed physical therapist.
Physical Therapy	The treatment of a disease, injury, or condition by physical means by a Physician or registered professional Physical Therapist under the supervision of a Physician that is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.
Physician	A legally qualified physician duly licensed to practice medicine in all of its branches.
Physician Assistant (PA) or Nurse Practitioner (NP)	A duly licensed physician assistant performing under the direct supervision of a Physician, Dentist, or Podiatrist and billing under such provider. An NP or PA is a health professional, qualified by academic and clinical training, who performs tasks often reserved for a Physician and who works under the direction, supervision, and responsibility of a qualified licensed Physician. These professionals may take medical histories, examine patients, order and interpret laboratory tests and X-rays, and make diagnoses. They may also treat minor injuries by suturing, splinting, and casting. However, the Plan does not cover NP or PA assistance during surgery, but will pay for a Physician's services if the surgical procedure warrants assistance.
Plan or Plan of Benefits	The program of benefits described in this Plan/SPD and any other written documents that the Trustees designate to be part of the program of benefits under the terms of the Trust Agreement.
Plan/SPD	The combined Plan Document and Summary Plan Description.
Plan Year	June 1 through the following May 31.
Podiatrist (DPM)	A duly licensed podiatrist.
Private Duty Nursing Service	Skilled Nursing Service provided on a one-to-one basis by an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN). Private Duty Nursing Service is shift nursing of eight hours or greater per day and does not include nursing care of less than eight hours per day. Private Duty Nursing Service is not covered under the Plan except to the extent that it can be covered under the Plan's home healthcare benefits when provided by a home health agency.
Prosthetic Device	A prosthetic appliance or device that is a type of corrective appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs and artificial eyes.
Provider	Any healthcare facility (for example, a Hospital or Skilled Nursing Facility), person (for example, a Physician or Chiropractor), or entity duly licensed to render Covered Services.
Psychologist	A Clinical Psychologist registered in a state where statutory licensure exists. The Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, must meet the qualifications specified in the definition of a Clinical Psychologist.
Reconstructive Surgery	A surgical procedure that is intended to improve bodily function and/or correct deformity resulting from congenital anomaly that causes a functional effect or results from a prior covered therapeutic procedure. Call the Fund Office for further information.
Rescission of Coverage	A cancellation or discontinuance of coverage that has a retroactive effect.
Respite Care Service	Those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services. Respite Care Service is not covered under the Plan.
Skilled Nursing Facility	See Inpatient Facility.
Skilled Nursing Service	Those services provided by a registered nurse (RN) or Licensed Practical Nurse (LPN) that require the clinical skill and professional training of an RN or LPN and that cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care service.

Speech Therapist	A duly licensed speech therapist.
Speech Therapy	The treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes that is designed and adapted to promote the restoration of a useful physical function. Speech Therapy for developmental delay is limited to children under the age of five or children under the age of nine for specific diagnosis. Speech Therapy for older children and adults does not include therapy for developmental delay, educational training, or services designed and adapted to develop a physical function.
Spouse	The person to whom the Eligible Member is legally married under the laws of the state where the marriage occurred (regardless of the laws of the state where the Eligible Member or spouse is domiciled); provided such marriage is evidenced by a certified marriage certificate or other proof acceptable to the Plan Administrator. Common-law spouses, domestic partners, or individuals in civil unions are not eligible Dependents under the Plan.
Substance Abuse	The uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers, and/or hallucinogens, including the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.
Surgery	The performance of any medically recognized, non-Investigational surgical procedure, including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures.
Temporomandibular Joint Dysfunction (TMJ) and Related Disorders	Jaw joint conditions, including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint that link the jawbone, skull and the complex of muscles, nerves, and other tissues relating to that joint.
Totally Disabled or Total Disability	With respect to an Eligible Member, you are (and continue to be) unable to perform the type of work that you are normally assigned as a laborer in accordance with the collective bargaining agreement due to a disabling condition that is non-occupational. If you are employed in a position that does not require work as a laborer, you must be disabled from performing the work that you are normally assigned.
Union	Union means the Chicago & Vicinity Laborers' District Council and all of the local unions affiliated with it.
Usual and Customary (U&C) Charge	The charge that is no higher than the 95th percentile of the Plan's most currently available healthcare charge data: • Where there is insufficient data, a value or amount uniformly established by the Plan for that charge; • For multiple or bilateral surgeries performed at the same time, 100% for the primary procedures and an amount determined after medical review for the secondary procedures; and • For surgical assistance by a Physician, up to a maximum of 20% of the charge allowed for the surgery. For PPO providers, Usual and Customary Charges are amounts that do not exceed the negotiated rate.

JULY 2020