North Central Illinois Laborers' Health and Welfare Fund

6714 N. Frostwood Parkway
Peoria, IL 61615
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Suite 402
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Peoria, IL 61604

Third Party Administrators

Benefits Administrative Services
1040 N. Second Street, P.O. Box 4509
Rockford, IL 61110-4509

Health Alliance Medical Plan, Inc.
102 E. Main Street
Urbana, IL 61801-2744

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NOTE

All of the benefits of this Plan, including retiree benefits, are made available to you and your eligible Dependents by the Trustees as a privilege and not as a right. You and your eligible Dependents do not acquire any vested right to Plan benefits either before or after your retirement. The Trustees may, and they reserve the right to:

- Amend or terminate the Plan;
- Expand, reduce or cancel coverage for active Participants, Dependents and Retirees;
- Change eligibility requirements or the hourly contribution and/or self-payment rates; and
- Otherwise exercise their prudent discretion at any time without legal right or recourse by you or your Dependents, retirees or any other person.

For Eligibility Information contact:
North Central Illinois Laborers' Health and Welfare Fund
6714 N. Frostwood Parkway
Peoria, IL 61615
Telephone: 309-692-0860
866-692-0860
Facsimile: 309-692-0862
Electronic Mail Address: ncilhwf@ameritech.net

For Information and Claim Forms regarding medical benefits from Blue Cross Blue Shield of Illinois and HFN and dental, vision and hearing benefits, contact:
Benefits Administrative Services
1040 N. Second Street, P.O. Box 4509
Rockford, IL 61110-4509
Telephone: 815-969-9663
Toll free: 800-249-7947
Facsimile: 815-969-9770

For Information and Claim Forms regarding medical benefits from Health Alliance, contact:
Health Alliance Medical Plan, Inc.
102 E. Main Street
Urbana, IL 61801-2744
Telephone: 217-337-8400
Toll free: 800-322-7451
Facsimile: 217-337-8008

For preauthorization of:
Inpatient hospitalization, outpatient surgeries and rehabilitation services:
Under Blue Cross/Blue Shield and HFN, call:
American Health Holding, Inc. 800-892-1893
Under Health Alliance Benefit Plans, call:
The Health Alliance Medical Plan at: 800-322-7451

Mental Health and Substance Abuse call:
Member Assistance Program (MAP) at: 800-472-4992

Transplant benefits, call:
American Health Holding, Inc. 800-892-1893
Health Alliance plan participants call 800-332-7451

Your failure to have these benefits preauthorized may result in a reduction of your benefits.

LIFE EVENTS

At some point in your life, you will experience a life event that impacts health care coverage for you and your Dependents. You may have experienced some of these life events already. Life events such as those below can affect your benefits coverage:

- Marriage
- Birth of a child
- Adoption of a child
- Divorce or legal separation
- Your child reaches the maximum age for coverage
- Your spouse loses a job or takes a new job
- End of work
- Medical leave
- Military duty
- You become disabled
- Your death
- Death of a Dependent
- Retirement

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when these different events occur.

NOTE

Marriage. If you get married you should provide the following information to the Fund Office, to ensure your spouse is covered:

- Enrollment/Change Form
- Copy of your marriage certificate;
- Spouse's date of birth;
- Name of your spouse's employer; and
- Spouse's health insurance information if your spouse is covered under another group health insurance plan.

Getting Married

When you get married, your spouse is eligible for medical, dental, prescription drug, hearing care and vision care benefits. However, if your spouse is employed and your spouse's employer offers health coverage and subsidizes 75% or more of the cost of your spouse's single coverage, your spouse must enroll in that single coverage. If that coverage is offered and your spouse does not enroll in that coverage, your spouse will not be covered by this Plan. If your spouse does enroll in the coverage offered by your spouse's employer, then this Plan will cover your spouse's health expenses as the secondary plan under the coordination of benefits provisions. This Plan will also cover your dependents. Your spouse is not required to enroll for dependent coverage in your spouse's employer's plan in order to have secondary coverage under this Plan. The Plan has adopted this requirement to keep the Plan solvent and to keep your contributions lower.

Once you provide the required information about your spouse and your spouse's health benefits from your spouse's employer, coverage for your spouse begins on the date of your marriage, provided you are eligible for benefits. If your spouse does not have an employer that subsidizes 75% of the cost of your spouse's single coverage under that employer's group health plan, this Plan will provide primary coverage for your spouse. If your spouse is covered under another group health plan, you must report that other coverage to the Fund Office so that benefits may be coordinated with your spouse's other coverage.

You need to notify the Fund Office of your marriage and provide the necessary documentation within 31 days of your wedding in order to have your spouse covered from the date of marriage. If you notify the Fund Office after 31 days, your spouse will be covered by the first day of the month following receipt of the documentation by Fund Office

Adding a Child by Birth or Adoption

Your natural born child will be eligible for coverage on the date of birth. If you adopt a child or have a child placed with you for legal guardianship or adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage and your child meets the Plan's definition of a Dependent child. Stepchildren who live in your home are eligible for coverage on the date of your marriage, provided that they are living in your home and your spouse is required to maintain medical and/or dental coverage.

You need to notify the Fund Office of the birth, adoption, placement for adoption or legal guardianship or addition of stepchildren within 31 days in order to have your Dependents covered from the date of birth, adoption or placement. If you notify the Fund Office later than 31 days, your Dependents will be covered on the first day of the month following receipt of the documentation by the Fund Office.

Adding a child. If you need to add a child to your coverage, you should provide the following information to the Fund Office within 31 days to secure coverage:

- Enrollment/Change Form
- Birth date, effective date of adoption or placement, or marriage date for purposes of adding stepchildren;
- Copy of the birth certificate or adoption papers
- Copy of the birth certificate, marriage certificate, dependent confirmation forms and legal documents (for stepchildren); and
- Copy of your child's other medical insurance information, if covered under another group health insurance plan.

NOTE

Divorce or Legal Separation

If you and your spouse obtain a legal separation or divorce, your spouse will no longer be eligible for coverage as a Dependent under the Plan. However, your spouse may elect to continue coverage under COBRA for up to 36 months. See page 13 for additional information and the requirements for electing COBRA Continuation Coverage.

You should contact the Fund Office if a Qualified Medical Child Support Order (QMCSO) has been issued as a result of your divorce or legal separation. A QMCSO may affect benefit coverage for your dependents. Therefore, it is important to notify the Fund Office immediately to avoid unnecessary delays in claim payments or denial of benefits.

Divorce or legal separation.
If you become legally separated or divorced, you should provide the following information to the Fund Office:

- Enrollment/Change Form
- Copy of your separation or divorce decree; and
- Copy of any QMCSO, if applicable. If your spouse wants to continue coverage, he or she should:
- Contact the Fund Office within 60 days of the divorce or legal separation; and
- Enroll for COBRA Continuation Coverage.

NOTE

Child Losing Eligibility

In general, your child is no longer eligible for coverage when he/she is no longer dependent on you for support or reaches age 19 (age 23 if a full-time student). However, if your child is determined to be mentally or physically disabled before reaching age 19 and continues to be mentally or physically disabled and dependent on you for at least half of the child's support, that child will continue to be covered as your dependent. You should notify the Fund Office immediately when your child is no longer eligible for coverage.

Child's loss of Dependent status.
If your child becomes ineligible for benefits because he/she has reached the maximum age and wants to continue coverage, he or she should:

- Contact the Fund Office within 60 days of losing eligibility; and
- Enroll for COBRA Continuation Coverage.

NOTE

Your Dependent child may consider applying for COBRA coverage as your child nears the age of 19 or 23 (if a full-time student). Your Dependent child may, if eligible, elect to continue coverage under COBRA for up to 36 months. However, if you do not notify the Fund Office that your child is no longer a Dependent within 60 days of the time your child loses dependent status, your child will not be eligible to elect COBRA Continuation Coverage. See page 71 for a definition of Dependent and full-time student.

NOTE

When your spouse or dependent loses a job, you may:

- Add your spouse to your coverage; and
- Add your Dependent children to your coverage.

When your spouse or dependent takes a new job, you:

- Should provide information about the new employer's plan to the Fund Office.

Your Spouse or Dependent Loses a Job or takes a New Job

When your spouse or dependent loses employer-provided insurance due to the loss of his or her job, you should contact the Fund Office to let them know that this Plan's coverage may be primary..

If your spouse takes a new job and your spouse's employer offers health coverage and subsidizes 75% or more of the cost of your spouse's single coverage, your spouse must enroll in that single coverage. If that coverage is offered and your spouse does not enroll in that coverage, your spouse will not be covered by this Plan. If your spouse does enroll in the coverage offered by your spouse's employer, then this Plan will cover your spouse's health expenses as the secondary plan under the coordination of benefits provisions. This Plan will also cover your dependents. Your spouse is not required to enroll for dependent coverage in your spouse's employer's plan in order for them to have coverage under this Plan. The Plan has adopted this requirement to keep the Plan solvent and to keep your contributions lower.

When your spouse obtains new health insurance coverage you must provide the Fund Office with information about the new health plan so benefits can be coordinated between the two plans. If your dependent obtains new health coverage, you will also need to provide the Fund Office with information about the new benefit plan. Coordination of coverage is not an option for dependents when they have primary insurance coverage with a group plan through employment or independent purchase.

Leave of Absence

If you take a leave of absence under the Family and Medical Leave Act (FMLA) or if you take military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), your eligibility under this Plan may be affected. You should refer to the explanation of these types of leave in the eligibility section on page 9 and 10.

In the Event of Your Disability

If you become Totally and Permanently Disabled, your attending physician will need to submit proof of your disability to the Fund Office. When you are disabled, you may receive a maximum of 12 months' coverage without charge for your disabling condition only. For example, if you lose a limb in an accident, the Plan will cover your expenses related to that loss of limb for a period of 12 months without charge, but will not cover unrelated conditions or illnesses.

However, if you wish to continue full coverage under the Plan, you may self-pay for coverage (see page 10) or you may elect COBRA coverage. The 12-month continuation of coverage for a disabling condition is not automatic. You must submit proof of your disability to the Fund Office and inform them of your election for this coverage option.

In the Event of Your Death

At the time of your death, your spouse or beneficiary should notify the Fund Office and provide a copy of your death certificate. Your spouse or beneficiary should complete a Death Benefit application from the Plan (see page 41). If your spouse and Dependents are covered under the Plan on the date of your death, they may continue health care coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary self-payments. If you are retired at the time of your death, you will not be eligible for a Death Benefit; however, your spouse and Dependents may be eligible for continuation of your Retiree coverage. To determine if your spouse and/or Dependents are eligible to continue coverage under the Retiree health plan, please review the information on page 45 or contact the Fund Office.

NOTE

At your death,
your spouse or beneficiary should notify the Fund Office and:

- Provide an Enrollment/Change Form;
- Provide a copy of your death certificate;
- Apply for Death Benefit, if eligible; and
- Enroll and pay for COBRA to continue Plan coverage, or
- Enroll and pay for Retiree Health coverage, if eligible.

In the Event of Your Dependent's Death

If your spouse or child dies, you should notify the Fund Office within 31 days and provide a copy of your Dependent's death certificate.

When You Stop Working

If you are eligible for benefits under Eligibility A, coverage for you and your Dependents will end on the last day of any three-month period for which the required hours of contributions were not made on your behalf. You may then elect to continue coverage under the North Central Illinois Laborers' Health and Welfare Fund's self-payment option or COBRA Continuation Coverage.

NOTE

When you stop working,
you may continue coverage under COBRA. You should:

- Notify the Fund Office; and
- Enroll for COBRA coverage.

If you are eligible for benefits under Eligibility B, your coverage will end on the last day of the month for which contributions have been made on your behalf. You may then elect to continue coverage under the COBRA Continuation Coverage only. You would only be eligible for the COBRA coverage after you make the necessary self-payments for the coverage.

When You Retire

If you are an Eligibility A employee in this Plan, initially retire on or after age 53 or retire because of disability at any age, and you have at least 10 consecutive years of active participation under either or both consecutively the Central Laborers' Health and Welfare Fund (only years prior to July 1, 2003 will be credited for this purpose) and the North Central Laborers' Health and Welfare Fund immediately before your retirement, you may elect to participate in the Retiree Plan until you reach age 65 or become eligible for Medicare. You will be required to make self-payments for your coverage after your retirement. See page 44 for additional information about Retiree benefits provided by this Plan.

NOTE

When you retire,
you may elect retiree coverage. Be sure to complete any forms necessary to secure continuing coverage.

NOTE

Contribution hours are your hours of work for which your employer contributes to this Fund under the terms of a Collective Bargaining Agreement.

Eligibility for Bargained Employees

The Eligibility Rules described in this booklet are effective as of July 1, 2002. You become eligible for coverage when:

- you perform work that is under the jurisdiction of any local union participating in this Health and Welfare Fund; and
- sufficient contributions are made on your behalf by Contributing Employers.

Seasonal bad weather or temporary work shortage will not necessarily cause you to lose eligibility because all contribution hours over a 12-month period are counted in determining your eligibility.

Initial Eligibility for Eligibility A Employees

You first become eligible for Welfare Plan benefits when you have completed 500 hours of work for which contributions or contribution hours have been made on your behalf to the Welfare Plan within a six consecutive month period. When you have met this requirement, your eligibility for Welfare Plan benefits begins on the first day of the second calendar month following the 500th contribution hour.

Once you become eligible for Welfare Plan benefits, your eligibility will continue for at least three months.

If, however, you have completed 500 contribution hours before the completion of a six consecutive month period, your eligibility will begin on the first day of the second month that follows the month you completed your 500th contribution hour. Your eligibility for Welfare Plan Benefits will continue for at least three months.

EXAMPLE

For Example:

Ryan begins working on March 1. He works 85 hours in each month March, April, May, June, July, and August and his employer reports and pays contributions to the Plan for all hours worked. Because Ryan has worked 510 contribution hours by the end of August, he becomes eligible for benefits on October 1, which is the first day of the second month following his completion of 500 or more contribution hours.

If Ryan worked 160 hours per month beginning in March, he would complete 500 contribution hours by the end of June. Ryan's eligibility would begin on August 1.

Initial Eligibility for Eligibility B Employees

If you are eligible for Plan benefits under Eligibility B, your coverage begins on the first day of the month following the date you begin working for an employer that contributes to the Plan on your behalf. If you are already working for an employer that later begins participating in the Plan, your coverage begins on the first day of the month following the date that your employer makes contributions on your behalf. To be eligible for Eligibility B coverage under this Plan, your employer must be making contributions to the Plan on your behalf and you must be working full-time, which is 40 hours per week (total contributions of 2,080 hours per year).

For Example:
You begin working full-time for your employer on August 15, 2002 and your employer begins making contributions to the Plan on your behalf for your hours worked. Your coverage begins on September 1, 2002. Coverage continues as long as your employer continues to pay contributions on your behalf on the 15th of the month before the month that your coverage is to continue.

EXAMPLE

As an Eligibility B employee, you are not eligible for an extension of eligibility after coverage terminates, except through COBRA (see page 13).

Dependents' Eligibility

Your Dependents are eligible for coverage when you are eligible if they meet the definition of Dependent on page 71, if you have identified them on an enrollment form and have provided the required eligibility documentation. If you marry and/or acquire a child while you are eligible, your Dependent becomes eligible on the date you marry or the date a child is born to you, adopted or placed with you for adoption or legal guardianship. You must complete an enrollment form and provide required eligibility documentation for your Dependent within 31 days of the event. However, if you do not enroll your Dependent within 31 days of marriage, birth, adoption, legal guardianship, etc., your dependent's coverage effective date will be postponed until the first day of the month following the date you apply to cover your Dependent.

Continued Eligibility and Termination of Eligibility A

After you satisfy the Initial Eligibility rules, your eligibility will continue for each succeeding three-month period if contributions are made on your behalf that satisfy one of the requirements for that three-month eligibility period according to the following schedule:

If You Work	*You Will Continue to Be Eligible for Plan Benefits During:*
250 contribution hours in September, October, November; or ***500*** contribution hours in June through November; or ***750*** contribution hours in March through November; or ***1,000*** contribution hours in December through November.	January, February and March
250 contribution hours in December, January, February; or ***500*** contribution hours in September through February; or ***750*** contribution hours in June through February; or ***1,000*** contribution hours in March through February.	April, May and June
250 contribution hours in March, April, May; or ***500*** contribution hours in December through May; or ***750*** contribution hours in September through May; or ***1,000*** contribution hours in June through May.	July, August and September
250 contribution hours in June, July, August; or ***500*** contribution hours in March through August; or ***750*** contribution hours in December through August; or ***1,000*** contribution hours in September through August.	October, November and December

ELIGIBILITY

Your eligibility is terminated at the end of the last day of any of the above three-month eligibility periods if the required contributions have not been made on your behalf for the 250, 500, 750 or 1,000-hour work requirement.

The rules that cover your continuing eligibility have been designed to enable you to "look-back" during designated 12-month periods to take advantage of the hours of contributions you earned during periods of high employment. This helps you to avoid losing coverage during seasonal work slowdowns or periods of low employment.

EXAMPLE

For Example:

Angelo becomes eligible for Plan benefits on July 1, 2001. Angelo's benefits continue for the three months of July, August and September. To determine his eligibility for October through December, Angelo looks back to his hours of work during the previous June, July and August. If his hours for that period total 250, then he continues to be covered during October through December. If his hours do not total at least 250 for that period, Angelo looks back to the 6-, 9- or 12-month period to see if he meets the hours requirement for that period.

To determine whether he is eligible for coverage during January, February and March 2003, Angelo looks back to September, October and November 2002. If his hours for that period total 250, then he continues to be covered during January, February and March 2003. If his hours do not total 250 for that period, Angelo looks back to the 6-, 9- or 12-month period shown in the table on page 7 for the January, February, March coverage period. If Angelo does not meet the hours requirement for the January, February and March 2003 period, his coverage ends at the end of the day on December 31, 2002.

Contributing Employers are required to report and remit the contributions required by the collective bargaining agreement to the Health and Welfare Fund on a monthly basis. Some Contributing Employers submit their monthly reports based on actual hours worked during the full calendar month. Other Contributing Employers submit their monthly report based on their payroll periods for the reported month. The Health and Welfare Fund's records used to determine eligibility are based on the monthly hours reported on each Contributing Employer's monthly remittance report.

NOTE

Fund Office records.
Your contribution hours are posted in accordance with your employer's normal reporting procedure.

Contribution hours from all of your Contributing Employers are counted. So if you move from one Contributing Employer to another, your eligibility will continue if the combined contribution hours received on your behalf from all Contributing Employers meets one of the continued eligibility rules.

In addition, if a Local Union or District Council stops participating in the North Central Illinois Laborers' Health and Welfare Fund with respect to one or more bargaining units, continued eligibility of employees in that bargaining unit or units will be determined by the Board of Trustees. For this purpose, coverage for a bargaining unit will be considered terminated as of the last day the collective bargaining agreement requires employer contributions to be paid to the North Central Illinois Laborers' Health and Welfare Fund.

Continued Eligibility and Termination of Eligibility B

After you satisfy the Initial Eligibility rules for Eligibility B, your eligibility will continue for each succeeding month if contributions are made on your behalf for those months.

When you stop working, your eligibility ends on the last day of the month for which contributions are received on your behalf. You will have the option of continuing coverage only through COBRA (see page 13).

> ***For Example:***
> You stop working full-time for your employer on August 15, 2003. Your coverage ends on August 31, 2003, the last day of the month in which you stop working and the last day of the month for which your employer has made contributions to the Fund for your coverage. You will be sent a notice detailing how you can elect to continue coverage through COBRA.
>
> EXAMPLE

Certification of Coverage

When your coverage ends, or when your Dependent's coverage ends, you (or your Dependent) will be provided with certification of the length of coverage under this Plan. This may help reduce or eliminate any pre-existing limitations under a new group medical plan. The Fund Office will automatically provide this certification when coverage ends for you or your dependent.

Reserve Bank for Eligibility A Employees

If you are eligible under Eligibility A, contributions paid to the Health and Welfare Fund on your behalf for hours of work beyond 1,875 per calendar year will be credited to your Eligibility Reserve Bank. These hours are multiplied by the current contribution rate to determine a dollar amount that may be used only for continued Plan coverage.

> You earn a dollar amount in an ***Eligibility Reserve Bank*** when your contribution hours exceed 1,875 in a calendar year. The balance in your Eligibility Reserve Bank may be used for self-payments or to offset self-payments under the Active coverage plan.
>
> NOTE

You may accumulate a maximum of one quarterly self-payment in this Bank and use the money in your Eligibility Reserve Bank when you have insufficient hours to continue your eligibility. This money can only be used as a credit to offset or reduce the self-payment you must make to continue coverage. Your coverage will terminate as explained in the Continued Eligibility and Termination of Eligibility A section if the amount in your Reserve Bank is not sufficient to cover the self-payment and you do not pay the difference.

Continued Eligibility for Eligibility A Employees During Disability Periods

If you become ill or injured and are unable to work because of a certified disability, you will be credited with 20 disability hours for each full week of the disability for the purpose of maintaining eligibility. Your credit may not exceed 260 hours during any continuous 12-month period or period of disability due to the same or related causes.

A certified disability is one in which you are totally disabled as a result of a non-occupational or occupational Injury or Illness or by which you are drawing the Loss of Time Benefit from this Health and Welfare Fund that is described on page 40. Sufficient proof of the certified disability must be provided to the Fund Office in order for disability hours to be credited.

Family and Medical Leave Act

Under the Family and Medical Leave Act of 1993 (FMLA), eligibility for benefits must be extended to you and your Dependents if:

- you are an active Participant;

- you have been granted leave by your employer under FMLA; and
- your employer makes the required contributions to the Health and Welfare Fund during your leave.

NOTE

FMLA leave is generally granted only for the following reasons:

- Birth, adoption, or placement of a child with you for adoption;
- Care of a seriously ill spouse, parent or child; or
- Your serious Illness.

The FMLA requires your employer to inform you of your rights and obligations under this law. You should ask your employer if you have any questions.

If you have been granted FMLA leave, your employer must notify the Health and Welfare Fund Office to prevent you from losing eligibility. You may wish to notify the Fund Office yourself, but you are not required to do so. Your employer must verify your eligibility for benefits while on leave, and your employer must pay for your extended eligibility before the Health and Welfare Fund will provide benefits.

To be eligible for FMLA leave, you must:

- Have worked for one Contributing Employer for at least 12 months; and
- Have worked for one Contributing Employer for at least 1,250 hours over the previous 12 months; and
- Work at a location where your employer employs at least 50 employees within a 75-mile radius.

Your eligibility for a FMLA leave is determined by your employer. The Fund will not intervene in any employer-employee disputes

NOTE

Military leave.

If you enter military service, you should:

- Notify your Contributing Employer and the Fund Office; and
- Make any required self-payments to the Fund Office to continue your coverage if you wish to continue your health coverage with the Plan in addition to your military health coverage.

Service in the Armed Forces.

Your health care coverage will continue if you serve in the Uniformed Services of the United States (active or inactive duty training) for up to 31 days. If you serve for more than 31 days, you may continue your coverage at your own expense for up to 18 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you continue your coverage at your own expense, it will stop at the *earliest* of the following:

- The date you or your Dependents do not make the required payments within 30 days of the due date;
- The date the Fund no longer provides any group health benefits;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- The last day of the month after 18 consecutive months.

For more information about self-payments under USERRA, contact the Welfare Fund Office at 309-692-0860 or toll free at 866-692-0860.

Self-Payment Rules for Eligibility A Employees

ACTIVE PARTICIPANTS

Under certain circumstances when your coverage would otherwise end, you may be eligible to make self-payments to continue eligibility and coverage under the Plan. To participate under the self-payment provision, you must have become eligible for coverage as required under the Initial Eligibility for Eligibility A section of these eligibility rules. Once you become eligible and your coverage later terminates, you can self-pay for the benefits

that are outlined in the Schedule of Benefits located in the back pocket of this booklet, as explained in the following rules, or you can choose to self-pay for COBRA Continuation Coverage as described on page 13.

Notice. The Health and Welfare Fund Office will send a letter to those employees who have lost their eligibility showing the date of eligibility termination and the amount that must be paid to continue eligibility under the self-payment rules.

The letter will be sent to the employee's most current address on file at the Health and Welfare Fund Office. Therefore, it is important – and your responsibility – to maintain a current mailing address on file with the Fund Office at all times and to notify the Fund Office of any change of address. Participating Local Unions and District Councils are not responsible to keep your address current.

You are responsible to make self-payments if you wish to continue eligibility. The self-payment for the specified three-month period must be postmarked no later than 25 days from the date of the letter of termination mailed by the Health and Welfare Fund Office.

For Example:
Jim's eligibility terminates on December 31, 2002. Jim's termination notice is dated January 5, 2003. Jim wishes to continue his eligibility for the three-month period beginning January 1, 2003, so his self-payment must be postmarked no later than January 30, 2003.

EXAMPLE

If you self-pay for three months of eligibility and reinstate your eligibility during that period, as a result of working the required hours for reinstatement, you will receive a refund for any months covered by the self-payment during which your eligibility reinstated.

Each subsequent self-payment must be postmarked no later than 25 days after the date of the termination letter mailed by the Health and Welfare Fund Office. You may continue to make self-payments for up to four consecutive three-month periods beyond the time your coverage would have ended under the Health and Welfare Fund's regular termination rules.

All checks or money orders should be made payable to "North Central Illinois Laborers' Health and Welfare Fund" and sent to the following address:

North Central Illinois Laborers' Health and Welfare Fund
6714 N. Frostwood Parkway
Peoria, IL 61615

The Trustees will determine, from time to time, the dollar amount of self-payment that participants will be required to make to continue eligibility. You will not be allowed to make self-payments to qualify under a Plan of benefits that is no longer in effect.

Your self-payment will not be accepted (and no further self-payments will be accepted) and you must re-qualify for coverage based on employer contributions as described in these eligibility rules if:

- you fail to make the required self-payment within the specified time;
- your self-payment check received by the Health and Welfare Fund Office is returned because of insufficient funds in the account to cover the amount of the check; or

- the self-payment is less than the required amount specified in the termination letter, in which case it will be considered the same as failure to have made the required self-payment.

DISABLED EMPLOYEES

If you are a Totally and Permanently Disabled Participant who makes self-payments under these rules, you may continue to make self-payments until the date you become eligible for Medicare. When you become eligible for Medicare, your family will continue to be able to pay for coverage by making the required self-payments. You will be considered Totally and Permanently Disabled if you are receiving a Disability Pension from the Central Laborers' Pension Plan.

The Trustees may require medical evidence of Total and Permanent Disability and reserve the right to require a medical examination by a Physician of their choice. If you are a disabled Participant and fail to make the required self-payment within the specified time, you will not be allowed to make any further self-payments. The benefits you qualify for as a disabled Participant will be the same as for active Participants, excluding the Death Benefit, Accidental Death and Dismemberment and Loss of Time Benefits, except as provided under the Medical Expense Benefit. The self-payment amount will be a fixed dollar amount that is determined from time to time by the Trustees.

Reinstatement of Eligibility for Eligibility A Employees

If your eligibility ends because the necessary contributions were not made on your behalf, you may re-qualify for coverage if 250 or more hours of contributions are received on your behalf in a three consecutive month period within the six-month reinstatement period as described below. Eligibility will be reinstated on the first day of the second calendar month that follows the date you meet the 250-hour requirement.

After reinstatement, you will remain eligible for at least three consecutive calendar months. You must meet the requirements for continued eligibility as explained in the *Continued Eligibility and Termination of Eligibility A* section.

If you retire, this reinstatement rule is valid only for your initial termination of coverage for retirement. It is not intended to apply to each subsequent self-payment period.

If 250 hours of contributions are received on your behalf in less than three consecutive calendar months, your eligibility will reinstate on the first day of the second calendar month that follows the month that 250 hours of contributions are received on your behalf.

Six-Month Reinstatement Period. For purposes of this reinstatement rule, hours will be counted for work you performed in the month immediately before the month your coverage terminated and the next five months. This is your six consecutive month reinstatement period. Suppose, for example, that your eligibility terminates as of January 1, 2002 because you do not have the required contribution hours through November 30, 2001. You must reinstate eligibility no later than July 1, 2002 based on 250 hours or more of work performed in a three- (or less)-consecutive-month period between December 1, 2001and May 31, 2002. If you do not meet the requirements of this reinstatement rule, you must again meet the 500-hour requirements in the *Initial Eligibility for Eligibility A Employees* section on page 6.

For Example:
Harry's coverage terminates on March 31, 2002. Harry did not work during March, April or May 2002. Harry works 85 hours each month during June, July and August 2002 and his employer contributes to the Plan on his behalf. Because Harry has worked more than 250 hours by the end of a six-month period (February through August 2002) his coverage is reinstated on October 1, 2002, which is the first day of the second month following his completion of 250 hours of work.

If Harry worked 140 hours per month during May and June 2002, he would complete more than 250 hours of work by the end of June 2002. Harry's eligibility reinstatement would begin on August 1, 2002, the first day of the second month following his completion of at least 250 hours of work within a six-month reinstatement period.

EXAMPLE

If your eligibility ends and a period of six consecutive months elapses, you must again satisfy the 500-hour requirements in the *Initial Eligibility for Eligibility A Employees* section.

Reinstatement of Eligibility for Eligibility B Employees

If your eligibility ends because you stop working for your employer, your coverage may be reinstated on the date you again begin working for an Eligibility B employer that contributes to the Plan on your behalf.

Delinquent Contributions

To be considered eligible for benefits, the required contributions must be received by the Health and Welfare Fund Office. If your Contributing Employer does not pay the required contributions and as a result, your eligibility does not become effective or is terminated, the Trustees will make every effort to collect the required contributions from that Contributing Employer.

However, you will be required to make a self-payment if you wish to continue your eligibility due to termination as the result of delinquent hours. If the contributions are collected, you will be credited with the appropriate hours for the period that you actually worked and you will be notified of any change in your eligibility that may result. Any self-payments that you have made will be reviewed and you may receive a full or partial refund of your self-payment.

Continuation Coverage (COBRA)

A federal law requires Health and Welfare Funds, like North Central Illinois Laborers' to offer a temporary extension of health coverage (called "COBRA continuation coverage") at group rates in certain instances when you and/or your Dependents' coverage under the plan would otherwise end. Following are your rights and obligations under the COBRA continuation coverage provisions.

If you are covered by the North Central Illinois Laborers' Health and Welfare Fund you have a right to choose COBRA continuation coverage if you lose your health coverage because:

- you have insufficient banked hours;
- your employment is terminated (unless you are terminated for gross misconduct, such as theft); or
- you have a reduction in hours so that you have insufficient hours of work to qualify for benefits.

When you or your Dependents lose coverage, the Health and Welfare Fund Office will notify you of your COBRA rights and the cost to continue coverage under this option versus the self-payment coverage described previously.

Your spouse has the right to choose COBRA continuation coverage if they lose health coverage for any of the following reasons:

- your death;
- a termination of your eligibility because of insufficient hours of employment and not enough Reserve Bank hours; or
- divorce or legal separation.

In the case of your Dependent child, he or she has the right to COBRA continuation coverage if health coverage under the Health and Welfare Fund is lost for any of the following reasons:

- your death;
- a termination of your eligibility because of insufficient hours of employment or not enough Reserve Bank hours;
- divorce or legal separation from your spouse; or
- the Dependent stops meeting the definition of a "Dependent" under this Plan.

NOTE

Children born, adopted or placed with you for adoption or legal guardianship during your COBRA continuation period ***may be added*** to your COBRA coverage.

If you have a newborn child, adopt a child or have a child placed with you for adoption or legal guardianship (for whom you have financial responsibility) while COBRA continuation coverage is in effect, you may add the child to your coverage. You must notify the Health and Welfare Fund Office in writing of the birth or placement and provide a completed enrollment form and other necessary documentation. (i.e. – birth certificates, legal documents) in order to have this child added to your coverage

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

If you and your Dependents lose eligibility for Plan benefits for one of the reasons noted above within 18 months before or after your entitlement to Medicare, your Dependents have the right to continue health coverage on a self-pay basis under the COBRA rules for up to 36 months from your entitlement to Medicare. If your eligibility under this Plan ends more than 18 months after your entitlement to Medicare, your Dependents have the right to continue health care coverage under the COBRA rules on a self-pay basis for up to 18 months from the time your coverage terminated.

You or your eligible Dependents must inform the Health and Welfare Fund Office (at the address listed in this booklet) of a divorce, legal separation or a child losing Dependent status. Your surviving spouse or dependent child must notify the Health and Welfare Fund Office of your death.

When the Health and Welfare Fund Office is notified that one of these events has occurred, the Health and Welfare Fund Office will notify the appropriate persons of their right to choose COBRA continuation coverage. Under the law, eligible persons have at least 60 days from the date coverage would be lost to inform the Health and Welfare Fund Office that they want COBRA continuation coverage, due to one of the events described above.

If COBRA continuation coverage is not elected, health coverage will end unless you or an eligible Dependent elects to continue coverage under the preceding rules regarding Self-Payments outlined on page 10.

If you or your Dependents choose COBRA continuation coverage, the Health and Welfare Fund is required to provide medical coverage that is substantially similar to the coverage provided to you and your Dependents under the Plan. However, COBRA continuation coverage does not include the Death Benefit, Accidental Death and Dismemberment or Loss of Time Benefits

> ***COBRA does not include***
> Death, Accidental Death and Dismemberment or Loss of Time Benefits.
>
> NOTE

Your coverage (or your eligible Dependent's coverage) may continue for a total of 29 months (an additional 11 months) after your employment is terminated or you have a reduction in your hours. To qualify for this extension, the Social Security Administration must determine that you or your Dependents were totally disabled either:

- at the time of your termination or reduction in hours; or
- within the first 60 days of your COBRA continuation period.

You must notify the Fund Office of your Determination of Disability by the Social Security Administration within the 18-month COBRA continuation period.

You will have the opportunity to maintain COBRA continuation coverage for as long as 36 months after you use your Reserve Bank coverage unless you lost group health coverage due to termination of employment or insufficient hours of work. In that case, the required COBRA continuation period is 18 months or 29 months if you are disabled, as noted above. However, the law also provides that COBRA continuation coverage may be cut short for any of the following reasons:

- the Health and Welfare Fund no longer provides group health coverage;
- the self-payment for your COBRA continuation coverage is not paid, or is not paid on time;
- you become eligible for Medicare;
- you become covered under a new group health plan; or
- your self-payment check received by the Health and Welfare Fund Office is returned because insufficient funds in the account to cover the amount of the check.

If you or one of your eligible Dependent(s) has a health problem that is excluded from or limited under a new group health plan, you or your eligible Dependent will be allowed to maintain COBRA continuation coverage under North Central Illinois Laborers' until you or your eligible Dependent has been covered for a total of 18, 29 or 36 months of coverage, whichever is applicable.

When your coverage ends, you will be provided with certification of your length of coverage under this Plan. This may help reduce or eliminate any pre-existing condition limitations under a new group medical plan.

Change in Eligibility Rules or Plan

The Board of Trustees, in their discretion, are empowered to change or amend the preceding eligibility rules or the Plan of benefits described in this booklet or any other provision of the Plan in accordance with the Trust Agreement, as they, in their sole discretion, determine to be necessary. You will be notified in writing of any changes to the Plan.

NOTE

For Hospitalization, surgery or rehabilitation, remember to:

- Have your Hospital stay or treatment preauthorized by calling the number for your specific plan that is listed on the *Schedule of Benefits* and on page 1;
- Have your mental health treatment preauthorized by the Member Assistance Program (MAP) at 800-472-4992;
- Have your substance abuse treatment preauthorized by the MAP at 800-472-4992; or
- Check to see if you need to get a second surgical opinion if your Physician recommends surgery.

When you or your eligible Dependents incur expenses as a result of a non-occupational Illness or Injury, the Medical Expense Benefit Plan reimburses you or your provider for a portion of the Covered Charges. You or your eligible Dependent must first satisfy the deductible or make a required co-payment as shown in the *Schedule of Benefits* in the back pocket of this booklet. After the deductible is met, the Plan pays the percentage of the Usual and Customary Charges shown in the *Schedule of Benefits*. Once you have met the out-of-pocket limit, the Plan may pay up to 100% of Covered Charges incurred for the remainder of the calendar year up to the calendar year maximum.

At the end of each calendar year during the Open Enrollment Period, you will have the opportunity to choose your benefit coverage for the upcoming year through:

- A Preferred Provider Option (PPO) Plan,
- A Three-Tiered Plan (one that contains an exclusive provider (EPO) network, PPO network and out-of-network benefits), or
- In the case of Retirees, a Preferred Provider Organization (PPO) Plan or a Three-Tiered Plan.

The benefit design of each of the Plans offered by the Health and Welfare Fund are outlined in the *Schedule of Benefits* located in the back pocket of this booklet. Please call the Fund Office if you have questions about the coverage offered under any of the options. Health care coverage is a very personal decision, so you must decide which option is right for you and your eligible Dependents.

It is important to remember that the medical program is not designed to cover every health care expense. The Plan pays Covered Charges for services and treatments that are allowed under this Plan, up to the limits and under the conditions established under the rules of the Plan. The decisions about how and when you receive medical care are up to you and your Physician – not the Plan. The Plan determines how much it will pay. You and your Physician must decide what medical care is best for you.

NOTE

Save money.
You save money by using a network provider:
First, you save money because the cost of the services provided is discounted; and
Second, the Plan pays a greater percentage of the cost of the discounted PPO network services.

Preferred Provider Organization

The Health and Welfare Fund has joined with several health care networks that provide benefits for you made up of physicians, hospitals and medical professionals that have agreed to provide discounted rates for some services that you or your eligible Dependents receive from them. After your deductible or a specified co-payment is satisfied, the Plan pays a higher percentage of Covered Charges when you receive services from a network Hospital or Physician. Contact the Fund Office or the Plan network administrator to determine if your provider participates in the network.

Deductible

The deductible is the dollar amount shown in the *Schedule of Benefits* that you and your eligible Dependents are responsible to pay before the Medical Expense Benefit is payable. Only Covered Charges may be used to satisfy the deductible. The deductible as shown in the *Schedule of Benefits* is applied each calendar year.

If Covered Charges used to satisfy the deductible, in part or in full, are incurred during the last three months of a calendar year, then those charges will be used to satisfy the deductible for the following year as well.

You do not need to satisfy the deductible and it does not apply to:

- Outpatient surgical procedures performed on the day of surgery (see page 18);
- The Second Surgical Opinion Expense Benefit (see page 24);
- Wellness, preventive, well-child or well-baby care services, provided that the services are obtained at an in-network provider.

Family Deductible

After eligible family members have collectively satisfied the family deductible shown in the *Schedule of Benefits* within a calendar year no further deductible will be required for them for the remainder of that calendar year.

Service Co-Payment

The Three-Tiered Plan design (one that contains an exclusive provider (EPO) network, PPO network and out-of-network benefits) requires a co-payment to be made to a provider at the time services are rendered. Once the co-payment is made, as long as the clinician or facility participates with your health care network, the remainder of the expense for the service will be covered at 100%.

Out of Pocket Co-Payment

Each plan has a designated out-of-pocket expense that represents the maximum amount an individual or family will pay in co-payment, either as a percentage of benefits or as a service co-payment. Please refer to the *Schedule of Benefits* for specific amounts.

Please remember that an individual's satisfaction of his/her out of pocket co-payments only occurs from allowable expenses. Expenses incurred that exceed a maximum benefit as defined by a plan will be the member's responsibility, regardless of whether the co-payment requirement has been previously satisfied..

For Example:
John is covered under the PPO plan. His annual out of pocket co-payment is $2,100. In June, John meets his out-of-pocket maximum co-payment obligation and he knows that all expenses he now incurs at any in-network providers will be covered at 100%; however, in July, John exhausts his physical therapy benefits by attending more than 60 visits in a year. Since John has met a maximum under his physical therapy benefits, any expenses John incurs for physical therapy, from that point forward, will be his responsibility, even though he has satisfied his annual out-of-pocket co-payment. This is because the Plan does not cover expenses beyond the allowable maximum for physical therapy benefits.

EXAMPLE

Maximum Benefits

The maximum amount payable with respect to all Illnesses or Injuries of any one individual during any calendar year will be the amount shown in the *Schedule of Benefits* or specific areas within this guide that describe particular benefits

Preauthorization

You must have your non-emergency Hospitalization, outpatient surgery, rehabilitation and mental health and substance abuse treatment authorized in advance. Your failure to have these benefits preauthorized may result in a reduction of your benefits. To obtain preauthorization, you or your Physician should call the number listed on your Plan ID card or in the *Schedule of Benefits* at least three days before the hospitalization or treatment. If you have an emergency admission or treatment, you or a family member should call the preauthorization number within 48 hours of admission or treatment.

Covered Charges

Benefits are payable for Usual and Customary Charges incurred for Medically Necessary treatment, services, and supplies ordered by a Physician for the following services:

1) ***Hospital services*** from the first day of inpatient treatment. Covered room and board charges may not exceed the Hospital's average rate for semiprivate rooms. If the Physician prescribes a private room, Covered Charges may not exceed the Hospital's average rate for private rooms.

   Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that the provider obtain preauthorization from the plan or the issuer for prescribing a length of stay not in excess of 48 or 96 hours, as applicable.

   Note that: All non-emergency Hospital admissions must be preauthorized in advance of the stay. The utilization review firm (as specified on your insurance card or the Member Assistance Program, in the case of mental health or substance abuse treatment) will evaluate the proposed admission plan and length of stay based on individual treatment needs. The utilization review firm must be contacted within 48 hours of an emergency admission. Your failure to have your hospitalization preauthorized may result in a reduction of your benefits.

2) ***Hospital outpatient treatment***.

3) ***Diagnosis, treatment and surgery**** made by a Physician or surgeon.

   *Charges incurred ***on the day of surgery*** for outpatient surgical procedures performed by a Physician, including both facility charges and Surgeon's charges, will be payable at the amount shown in the *Schedule of Benefits* with no deductible required. Such outpatient surgery can be performed in a Hospital's outpatient department, a freestanding medical care facility or a Physician's office. All other Covered Charges, including any follow-up treatment, are subject to the deductible and will be paid at the percentage shown in the *Schedule of Benefits*.

   NOTE: You are not required to pay a deductible or co-pay for outpatient surgical procedures performed on the day of surgery.

4) ***Physiotherapy*** by a licensed physiotherapist, other than a physiotherapist who normally lives in your home or is a member of your family or your spouse's immediate family.

5) ***Medical and surgical benefits for mastectomies,*** as required by federal law, including the following, when requested by the patient in consultation with her Physician:
   a. reconstruction of the breast on which the mastectomy has been performed;
   b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c. prostheses and physical complications of all stages of mastectomy including lymphedemas.

6) ***Initial trusses, braces or supports, casts, splints, and crutches.***

7) ***Rental of Durable Medical Equipment*** such as wheelchairs and Hospital-type beds. The rental benefit limit will not exceed the purchase cost.

8) ***Oxygen*** and rental of equipment for its administration.

9) ***Local ambulance service to the Hospital***. Transportation by air or rail is considered a Covered Charge in an emergency when treatment is not available locally. Your Physician must order this treatment, and travel will only be covered to the nearest Hospital providing the necessary medical care or treatment.

10) ***X-rays*** and ***laboratory tests***.

11) Treatment by use of ***radium and radioactive isotopes***.

12) ***Anesthesia*** and its administration.

13) ***Blood*** and blood plasma.

14) ***Pregnancy-related expenses, including pre-natal care and delivery,*** on the same basis as any other Injury or Illness.

15) ***Dental work and oral surgery***. Benefits are payable for expenses only if incurred for one of the fol lowing reasons:
   a. the repair of natural teeth or other body tissues, required as a result of a non-occupational Injury occurring while covered, provided treatment is rendered within six months of the accident; or
   b. the excision of partially or completely unerupted impacted teeth.

   Medical benefits are coordinated with your dental benefits when it is required that oral surgery be performed at a hospital facility or under general anesthesia. When this situation arises, benefits are paid as follows:
   - ◊ All Usual & Customary surgeon and anesthesia expenses are paid by your dental benefit and are subject to the annual dental maximum.
   - ◊ All Usual & Customary hospital related expenses are paid by your medical benefit. Medical necessity is required when any dental work is performed at a hospital facility or requires the use of a general anesthetic.

   For the purpose of the dental work or oral surgery recognized by this paragraph, the term Physician includes a duly licensed dentist.

The benefits that are described in the following paragraphs are also Covered Charges under the Medical Benefit Plans and are subject to the calendar year Deductible or co-payments and the rules and limitations explained under each item.

Home Health Care

You and your eligible Dependents are entitled to benefits for Home Health Care services and supplies provided by a Home Health Care Agency up to the maximum of 40 visits per person per calendar year as shown in the *Schedule of Benefits*. This care must be Medically Necessary and ordered in writing by your Physician.

NOTE

One Home Health Care Visit
is either:
- Four hours of home health aide services; or
- Each visit by a member of a Home Health Care Agency team.

Covered Home Health Care includes charges for the following services:

- part-time or intermittent home nursing care by or under the supervision of a registered graduate nurse;
- part-time or intermittent home health aide services that consist primarily of caring for the patient;
- physical, occupational or speech therapy if provided by the Home Health Care Agency; (Speech therapy is only covered if it is required as the result of a head injury, disease or stroke. The speech therapy would only be covered up to the restoration of the normal functions that were present prior to the Injury, disease or stroke.)
- medical supplies and laboratory services used in the treatment of the patient that are prescribed by a Physician; and
- allowable drugs and medications prescribed by a Physician if not provided under the Plan's prescription drug program.

Benefits are not payable for any expense incurred for:

1) Services or supplies not specified in the Home Health Care Plan;
2) Services of any individual who normally lives in your home or is a member of your family or your Dependent's family;
3) Services of any social workers; or
4) Transportation services.

Organ Transplants

You and your eligible Dependents are entitled to benefits for Transplant Surgery. The Plan pays the Usual and Customary Charges you incur for Transplant Surgery in the same way it covers hospitalization, surgery and doctor's visits, up to the maximum calendar benefit shown in your *Schedule of Benefits* located in the back pocket of this booklet.

NOTE

If you are in the Blue Cross Blue Shield Plan or the HFN Plan, you must notify American Health Holding, Inc. for preauthorization of transplant services at least 7 working days before the scheduled date of any transplant services or as soon as reasonably possible. You may reach American Health Holding, Inc. at 800-892-1893. American Health Holding, Inc. will review your treatment options and preauthorize your transplant services.

If you are in the Health Alliance Plan, you must contact Health Alliance and work with the Health Alliance Transplant Coordinator for preauthorization of transplant services at least 7 working days before the scheduled date of any transplant services or as soon as reasonably possible. You may reach Health Alliance at 217-337-8400 or toll free at 800-322-7451. Health Alliance will review your treatment options and preauthorize you transplant services.

Covered transplant services include:

- The evaluation,
- The donor search,
- The organ procurement/tissue harvest, and
- The transplant procedure.

Services and supplies for Medically Necessary and Medicare-approved organ or tissue transplants are payable under this Plan, subject to plan provisions and limitations. Other transplant procedures are covered when the Plan determines that it is Medically Necessary to perform the procedure at a preauthorized transplant facility.

Donor charges for covered organ and tissue transplants are also covered by the Plan as follows.

- In the case of an organ or tissue transplant, donor charges are considered Covered Expenses ONLY if the recipient is a covered person under this Plan. If the recipient is not a covered person, no benefits are payable for donor charges.
- The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a covered expense unless the search is made in connection with a transplant procedure arranged by a preauthorized transplant facility.

If a covered transplant is Medically Necessary and preformed at a preauthorized transplant facility, the medical care and treatment and transportation and lodging provisions described below apply.

Covered expenses for medical care and treatment services provided in connection with the transplant procedure include:

- Pre-transplant evaluation for one of the preauthorized procedures,
- Organ acquisition and procurement,
- Hospital and physician fees,
- Transplant procedures,
- Follow-up care for a period up to one year after the transplant, and
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient if the search is made in connection with a transplant procedure arranged by a preauthorized transplant facility. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

American Health Holding, Inc. or Health Alliance will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging, and meals for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of $50 per day for one person or $100 per day for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the preauthorized transplant facility.
- If the patient is a covered Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed at the $100 per diem rate.
- There is a combined overall lifetime maximum of $10,000 per Covered Person for all transportation, lodging, and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures..

Hospice Care

You or your eligible Dependents are entitled to Hospice Care benefits if you are Terminally Ill. The Plan pays the Usual and Customary Charges, as shown below and at levels defined by each plan in the *Schedule of Benefits*.

Covered Hospice Care includes charges for the following services:

- Hospice Care facility, Hospital, or convalescent facility inpatient charges for room and board, up to the facility's most common semi-private charges;
- services and supplies for pain control and other acute and chronic symptom management;
- part-time or intermittent nursing care by a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.) for up to eight hours per day;
- medical supplies, drugs and medicines prescribed by a Physician;
- medical social services under the direction of a Physician;

- part-time or intermittent home health aid services for up to eight hours per day; and
- services performed by other providers of care who are not part of or employed by a Hospice Care Agency or Home Health Care Agency, when that agency keeps responsibility for patient care, such as a physical or occupational therapist or a Physician for consultation or case management services

NOTE

Respite care is care furnished by a provider or facility during a period of time when the family or usual caretaker cannot, or chooses not to, attend to the covered family member's needs for any reason.

Benefits are *not*-payable for the following services:

1) Bereavement counseling, pastoral counseling, financial or legal counseling, such as estate planning or drafting of a will and funeral arrangements;
2) Homemaker or caretaker services that are not solely related to the care of the patient such as sitter or companion services for the patient or other family members, transportation, house cleaning and house maintenance;
3) Respite care; or
4) Services of any individual who normally lives in your home or is a member of your family or your Dependent's family.

Alcohol and Drug Abuse Treatment

NOTE

Preauthorization of alcohol and drug abuse treatment. All expenses for substance abuse treatment must be preauthorized by the Member Assistance Program (MAP). Your treatment is not covered if it is not preauthorized. Call 800-472-4992.

Benefits for Alcohol and Drug Abuse Treatment must be preauthorized by the Member Assistance Program (MAP). Your treatment is not covered if it is not preauthorized. You may contact the (MAP) by calling 800-472-4992. If preauthorized, the following inpatient and outpatient treatment will be covered for you and your eligible Dependents:

- ***Inpatient*** treatment for confinement in a licensed drug and alcohol residential treatment facility or Hospital for care up to the calendar year maximum shown in the *Schedule of Benefits*.
- ***Outpatient*** treatment for the treatment and care of alcohol and drug abuse in a licensed drug and alcohol non-residential treatment facility, a certified non-residential treatment program or Hospital up to the calendar year maximum shown in the *Schedule of Benefits*.

A Doctor of Medicine (MD), psychiatrist, psychologist, or certified addictions counselor must recommend the course of treatment. You may receive Alcohol and Drug Abuse Treatment on an inpatient, outpatient or a combination of inpatient and outpatient basis. Covered Charges for Alcohol and Drug Abuse Treatment do not count toward the out-of-pocket maximum shown in the *Schedule of Benefits*.

Benefits are *not* payable for the following services:

1) Treatment that is not preauthorized;
2) Treatment and services received from anyone other than the attending Physician, psychiatrist, psychologist or certified addictions counselor;
3) An admitting fee or deposit;
4) Treatment that is payable under any other benefit from the Plan;
5) Treatment involving the family of the person for whom a claim is submitted when they are part of the therapy;
6) Treatment received for the satisfaction of a court order or DUI conviction; or
7) Any inpatient or outpatient treatment, strictly for detoxification regardless of receipt of a preauthorization by the MAP (Member Assistance Program).

Mental and Nervous Disorders

You and your eligible Dependents are entitled to benefits for Covered Charges incurred for treatment of Mental and Nervous Disorders. Benefits for inpatient and outpatient treatment are paid at the levels shown in the *Schedule of Benefits*. Benefits are limited to 30 days of inpatient treatment and 30 outpatient visits annually. These Covered Charges do not count towards the out-of-pocket maximum also shown in the *Schedule of Benefits*. All treatment for mental and nervous disorders must be preauthorized by the Member Assistance Program (MAP). Your treatment is not covered if it is not preauthorized. You may call 800-472-4992 during regular business hours (8 a.m. to 6 p.m. Monday through Thursday and 8 a.m. to 5 p.m. on Friday) for preauthorization.

NOTE

Preauthorization of mental health treatment.
All expenses for treatment of mental and nervous disorders must be preauthorized by the Member Assistance Program (MAP). Your treatment is not covered if it is not preauthorized. Call 800-472-4992.

Covered Mental and Nervous Disorder services include the following:

- services furnished by a licensed or accredited Hospital, subject to the requirements of the MAP; and
- outpatient services approved by the MAP.

Spinal Manipulation – Medical or Chiropractic

If you or your eligible Dependents incur expenses for detection, treatment or correction of a structural imbalance, subluxation or misalignment of your vertebral column, benefits are payable up to the maximum dollar amount and maximum number of treatments shown in the *Schedule of Benefits* under the Spinal Manipulation benefit. Covered services must be for the purpose of alleviating pressure on spinal nerves and its associated effects related to such structural imbalance, misalignment or distortion by physical or mechanical means.

Covered Charges include expenses for office visits to a Physician or a licensed chiropractor. Acupuncture must be prescribed by a Physician and is covered under the Spinal Manipulation benefit. Both Spinal Manipulation and acupuncture are subject to the calendar year maximum benefit amount and maximum number of treatments shown in the *Schedule of Benefits*.

Therapy provided with spinal manipulations is limited to the calendar year maximum benefit amount and number of treatments year shown in the *Schedule of Benefits*.

Rehabilitation Services

You and your eligible Dependents are entitled to benefits for Covered Charges incurred for medically necessary inpatient and outpatient Rehabilitation Services. Inpatient Rehabilitation Services in a Skilled Nursing Facility is limited to 60 days of treatment per calendar year. Outpatient Rehabilitation Services are limited to 60 visits per calendar year. This includes physical, occupational therapy and cardiac rehabilitation. Benefits must be preauthorized and are payable up to the maximum amount shown in the *Schedule of Benefits*. Speech therapy is only covered if it is required as the result of a head injury, disease or stroke. The speech therapy is only covered up to the restoration of the normal functions that were present prior to the injury, disease or stroke. If your benefits are not preauthorized, you will be subject to the Hospital/Rehabilitation Non-authorization Benefit Reduction shown in the Schedule of Benefits

Prosthetic Appliances

You and your eligible Dependents are entitled to benefits for prosthetic appliances (artificial limbs or eyes) for the initial replacement of natural limbs or eyes. Subsequent expenses for such artificial limbs or eyes are subject to the following guidelines:

NOTE

The ***lifetime maximum*** for prosthetic appliances is $25,000.

- Coverage is provided for a replacement prosthetic device for children up to age 18 when replacement is necessary due to growth of the child and is Medically Necessary as determined by the Physician.
- Coverage is provided for a total replacement of such prosthetic device for adults, provided that five years have elapsed since the previous device was purchased. This replacement also must be Medically Necessary as determined by the Physician.
- Replacement because of damage, as might occur in an accident, is covered when Medically Necessary as determined by the Physician (Payment for repair or replacement may be contingent upon any third-party insurance that is liable for payments.)
- A lifetime maximum of $25,000 for the initial placement, subsequent repairs and replacement of all prosthetic devices will apply per individual.

Well-Child Care

Your eligible Dependents who are under the age of 18 are entitled to coverage for well-child care benefits when an in-network provider renders services. Well-child care benefits include:

- Physical examinations, and
- Required immunizations, as recommended by the American Academy of Pediatrics.

The percentage the Plan pays is shown in the *Schedule of Benefits*. (Exception – Required Immunization charges will be reimbursed when the service is rendered by a local Public Health Department and only after proof of payment is submitted to the Fund Office).

Temporomandibular Joint (TMJ) Treatment

You or your eligible Dependents are entitled to treatment of jaw problems including temporomandibular joint (TMJ) dysfunction, disorder or syndrome and any other craniomandibular disorder, or other conditions of the joint linking the jawbone and skull and muscles, and nerves and tissues relating to that joint. The TMJ benefit does not include orthodontic treatment. The percentage the Plan pays after the deductible is satisfied and the calendar year maximum is met are shown in the *Schedule of Benefits*.

Podiatry Services

You and your eligible Dependents are entitled to services provided by a podiatrist for foot care. The percentage the Plan pays, after the deductible/co-payment is satisfied, is shown in the *Schedule of Benefits*.

Orthotics expenses are covered up to the calendar year maximum. Certain limitations apply to the reimbursement for orthotic expenses.

- Medical necessity must be presented by the ordering Physician.
- The orthotic must be specially molded for the recipient.

Second Surgical Opinion Benefit

You and your eligible Dependents are entitled to receive a second surgical opinion if your Physician recommends surgery while you are eligible for benefits under this Plan. The surgery must not be emergency in nature or caused by a job-related medical condition.

Benefits are payable for the Usual and Customary Charges for consultation fees and any necessary laboratory tests or x-rays up to the maximum percentage shown in the *Schedule of Benefits*.

If the second opinion does not confirm the need for surgery, you may consult another legally qualified Physician for a third opinion. Benefits for the third opinion are payable for the Usual and Customary Charges mentioned above up to the maximum percentage payable shown in the *Schedule of Benefits*. You do not need to pay a deductible toward the expenses for a second (or third) surgical opinion.

Legally Qualified Physician. For the purpose of this benefit, a legally qualified Physician is one who is board certified in the field of the proposed surgery, or a specialist in the field of medicine concerned with the condition involved.

NOTE

The Plan pays the expense of a second (and third) surgical opinion. You do not pay a deductible for this benefit.

Exclusions. No benefits are payable under the Second Surgical Opinion Expense Benefit for any of the following:

1) A consultation by a Physician who is not a legally qualified Physician as defined above;
2) X-rays and tests not related to the proposed surgery;
3) An examination not made in person by the Physician rendering the opinion;
4) An examination where no written report is submitted by the examining Physician;
5) An examination by the same consulting Physician who also performs the surgery;
6) An examination by a Physician who has a financial interest in the outcome of his opinion;
7) A consultation regarding dental work or treatment; or
8) A consultation about Illnesses or Injuries arising out of and in the course of your job.

Wellness, Preventive, Well-Child and Well-Baby Care Benefit

If you and your dependents incur covered expenses for routine physical examinations obtained while you are eligible under the Health and Welfare Fund, reimbursement of those expenses will be paid up to the maximum amount per person stated in the *Schedule of Benefits*. These are referred to as wellness, preventive, well-child and well-baby care services. You do not need to pay a deductible before receiving reimbursement for these expenses.

NOTE

The Plan provides wellness, preventive, well-child and well-baby benefits for you and your dependents with no deductible, up to an annual maximum per person defined in the *Schedule of Benefits*.

Covered physical examination expenses for you and your dependents include routine physical examinations performed by a legally qualified in-network Physician, or under an in-network Physician's direct supervision, including the cost of x-ray and laboratory expenses connected with the examination. Mammograms, pap smears and prostate examinations are included as covered Wellness expenses.

Testing for asbestos/spirometry on Participants will only be covered under the annual physical examination benefit charges, for respiratory clearance or as required by federal law. The asbestos/spirometry tests must be performed in conjunction with an annual physical.

Exclusions. No benefits are payable under the wellness, preventive, well-child and well-baby care benefit for any of the following:

1) Charges for services or supplies that are covered in whole or in part under any other portion of the North Central Illinois Laborers' Health and Welfare Fund Plan;
2) Expenses for which benefits are payable under any Workers' Compensation Law;
3) Services received that are not performed by a Physician or under the direct supervision of a Physician;
4) Services received while confined in a Hospital, convalescent or extended care facility, nursing home, night care center or similar institution;
5) Medicines, drugs, appliances, equipment, materials or supplies;
6) Physical examinations to determine the existence or nonexistence of a pregnancy, during the term of the pregnancy, or within 90 days after a pregnancy ends;

7) Psychiatric, psychological and personality or emotional testing or examination;
8) Examinations for the issuance of marriage licenses, employment requirements, insurance policies and maintenance of valid licenses;
9) Full body scans, Ornish program (CHIPS), heart scoring or heart scans;
10) Hepatitis B Immunizations not prescribed or ordered by a Physician during or at the time of the physical examination; or
11) Charges in excess of the specified maximum shown in the *Schedule of Benefits* or as described under a particular benefit in this booklet.

Extension of Benefits

If you or your eligible Dependent is totally disabled at the time your coverage under this Plan terminates, benefits may be extended for Covered Charges incurred for the care and treatment of the condition that caused the disability if:

- the expense would have been covered if the coverage under this Plan had continued;
- you or your Dependent remains totally disabled to the date each such expense is incurred; and
- you or your Dependent is not entitled to similar benefits under any other group plan when such expense is incurred.

Benefits are extended and payable only for the treatment of the Injury or Illness that caused the total disability. The benefits payable will be subject to the same maximums, limitations, and exclusions that were in effect under this Plan at the time coverage terminated.

Benefits will continue until the earliest of:

- the date you or your Dependent is no longer totally disabled;
- the date you or your Dependent becomes covered for benefits under another plan or policy that provides similar benefits; or
- 12 consecutive months following the date that the total disability began.

For this extension, totally disabled means:

- you are prevented from engaging in your regular or customary occupation due solely to an Injury or Illness that is not employment-related; or
- your Dependent is prevented from engaging in substantially all of the normal activities of a person of like age and sex who is in good health due solely to an Injury or Illness that is not employment-related.

Please note: the extension of benefits is not automatic. You must notify the Fund Office of your election of this coverage and submit the necessary proof of disability documented by you Physician.

Medical Benefit Exclusions

The following services are NOT covered and benefits will not be paid for them under the Medical Expense Benefit:

1) Services that are not Medically Necessary as determined by the Plan or are not in accordance with accepted standards of medical practice as determined by the Plan.
2) Eye refractions, eyeglasses, hearing aids or the fitting thereof.
3) Treatment of Injury sustained or Illness contracted resulting from war, declared or undeclared, or any act of war, including accidental Injury or Illness contracted while on duty with any military force of any country or international organization.

4) Treatment of Injuries you received while engaged in a criminal act or acts resulting in a felony conviction or for which felony charges are pending.
5) Treatment of Injuries resulting directly or indirectly from commission of an illegal act, except traffic offenses. However, treatment of Injuries sustained in a motor vehicle accident is excluded where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (B.A.C.) of 0.10 or more. A breathalyzer, blood or urine test result that the claimant had a B.A.C. of 0.10 or more or that the claimant was utilizing an illegal drug at the time of any Injury or Illness, will be considered objective evidence that alcohol or illegal drug use was a contributing cause of the Injury or Illness.
6) Charges for treatment of any intentional act or suicide unless there is an underlying medical condition such as depression.
7) Any Injury, Illness or dental treatment for which the Eligible Person has received, or is reasonably entitled to receive, benefits under a Workers' Compensation or Occupational Diseases Law and/or which arises out of or in the course of any occupation or employment for wage or profit. However, if a case is disallowed by the Industrial Commission, benefits may be payable.
8) Expenses for which you would not have been charged had there been no coverage.
9) Expenses for which there is no legal obligation or financial liability to pay.
10) Hospital charges and confinements not recommended or approved by the Physician.
11) Expenses for educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, auditory aids, speech aids, etc., even if they are required because of your Injury, Illness or disability.
12) Treatment by acupressure, hydrotherapy, massage therapy or biofeedback.
13) Speech therapy unless it is required as the result of a head Injury, disease, or stroke. The speech therapy would only be available up to the restoration of the normal functions that were present prior to the Injury, disease or stroke.
14) Dental implants and/or charges related to orthodontic treatment.
15) Transportation other than local ambulance service. Refer to page 19.
16) Services or supplies that are furnished, paid for or otherwise provided by the U.S. Government or its agencies.
17) Elective abortions unless the life of the mother is endangered if the fetus was carried to term or for any charges for complications resulting from the abortion.
18) Services performed on or to the teeth, nerves of the teeth, gingivae or alveolar processes, except for tumors or cysts or unless resulting from an accidental Injury to sound natural teeth while eligible or covered under another group plan and within six months of the accident; see page 34.
19) Cosmetic surgery unless resulting from accidental Injury or congenital disease or anomaly that results in a functional defect from trauma, infection or other disease of the involved portion of the body.
20) Reversal of voluntarily sterilization.
21) Well-child care and immunizations that are received from an out-of-network provider; except when immunizations are received at a local health department.
22) Any charges that exceed the Usual and Customary Charges.
23) Personal hygiene, comfort or convenience items such as air conditioners, humidifiers, purifiers, dehumidifiers, heating pads, hot water bottles and other non-medical equipment or supplies. Also, personal comfort or convenience items such as radio, television, telephone or guest meals.
24) Services, supplies or surgical procedures for the treatment of a condition of obesity, except that certain services for the treatment of a condition of obesity will be payable if the following criteria are met:
    a. the member is 75% or more over his/her medically desirable weight; and,
    b. the obesity is a threat to the member's life due to other complicating factors; and,
    c. the member has a documented history of unsuccessful attempts to reduce weight by more conservative measures.

25) Expenses related to sexual reassignment.
26) Services for the diagnosis and treatment of infertility.
27) Charges for failure to keep a scheduled visit, completion of claim forms, phone calls, handling fees, personal items, special reports and leaving or signing out against medical advice.
28) Radial keratotomy or any surgical procedure for the improvement of vision when vision can be corrected through the use of glasses or contact lenses.
29) Non-compliance preauthorization penalty and non-approved admission days as determined by the preauthorization firm.
30) Inpatient Rehabilitative Services that can reasonably and appropriately be provided on an outpatient basis.
31) Drugs or medications, cosmetics, dietary supplements, vitamins, nutritional formulas and beauty aids.
32) Expenses related to prevention of pregnancy, including, but not limited to, condoms, drugs or medicines, the Norplant system and other devices. Oral contraceptives that are not purchased through the mail order prescription drug program.
33) Genetically engineered drugs, except those that have been pre-approved by the Board of Trustees or their representative.
34) Charges for infection control and commercial medical waste disposal.
35) Any expenses beyond the maximum amounts listed in the Schedule of Benefits or as described under a particular benefit in this booklet.
36) Orthoptics or vision training.
37) Non-medical services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, psychological counseling or educational therapy for mental retardation.
38) Preparation of reports, evaluations, physical examinations, immunizations, or hospitalizations not required for health reasons such as securing insurance, meeting employment requirements, obtaining government licenses, participating in sports, traveling to foreign countries, or complying with a court order.
39) Private Hospital rooms and/or private duty nursing except when Medically Necessary as determined by the Plan.
40) Custodial Care or assistant care with the activities of daily living including, eating, bathing, dressing, or Custodial Care or self-care activities, homemaker services or services primarily for rest or domiciliary care or any services that do not require skilled care.
41) Experimental medical, surgical, or other Experimental or Investigational health care services that, in the opinion of the Plan are:
    a. not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for proposed use.
    b. Prescription drugs used for certain types of cancer not approved by the FDA or recognized for the treatment of the specific type of cancer for which the drug has been prescribed in the following reference compendia:
        i. The American Medical Association Drug Evaluation,
        ii. The American Hospital Formulary Service Drug Information,
        iii. The United States Pharmacopoeia Drug Information;
    c. subject to federal law requiring internal review, board review, and approval for proposed use;
    d. the subject of on-going FDA Regulated Phase I, II, or III clinical trials;
    e. not demonstrated through a prevailing peer-reviewed medical literature to be safe and effective for proposed use; or
    f. not generally accepted by informed health care professionals in the United States as safe and scientifically effective in treating or diagnosing the condition, sickness or diagnosis for which its use is proposed.
42) Milieu therapy or any confinement in an institution primarily to change or control one's environment.
43) Any services, supplies or treatment not specifically provided as a benefit in this document.
44) Biofeedback for the diagnosis of attention deficit disorder or related disorders.
45) Charges related to orthodontic treatment.

MEMBER ASSISTANCE PROGRAM (MAP)

The Plan provides a Member Assistance Program (MAP) through Health Management Center, a counseling service that provides you with professional and confidential assistance to help you resolve personal and work problems before they get out of control.

MAP Counseling

When you have a question or an issue you would like to discuss, please call the MAP toll-free phone number at 800-472-4992. A MAP representative will arrange an appointment with a MAP counselor in your area at a time convenient for you. During your appointment, the MAP counselor will listen, help you identify the problem and plan a course of action. You and your family members may meet with a MAP counselor for up to five sessions, or you may be referred to other health professionals for further assistance if necessary.

> The MAP provides you with free professional counseling and referral services for many issues that you face in life.
>
> NOTE

Confidentiality is key when you use the MAP. Your privacy is guaranteed; whatever is discussed with the MAP representatives is considered confidential. No information will be given about your use of the MAP or your sessions unless you consent to the release of that information or unless it is given in response to a court order or subpoena.

MAP counseling is available for many issues, including:

- ***Work-related problems*** such as jobsite conflicts, drug testing, sexual harassment and retirement concerns;
- ***Marital problems*** such as separation, divorce, conflicts or domestic violence;
- ***Substance abuse problems*** such as problem drinking, citations for Driving Under the Influence (DUIs), illegal drug use, smoking cessation and misuse of prescription drugs;
- ***Family issues*** such as parent-child conflicts, eldercare, single-parenting and childcare;
- ***Emotional and Mental Health issues*** such as stress and anxiety, depression, anger management and loss of a loved one;
- ***Financial problems*** such as problem gambling, household finances or over-extended credit.

MAP Costs

The counseling services are provided to you free of charge. If you are referred to other mental health or substance abuse services, you may incur a charge for those services that may be payable under other provisions of the Plan. For benefits provided by your health care network plan refer to pages 22 and 23.

Required MAP Preauthorization

You must call the MAP for preauthorization before you begin any mental health or substance abuse treatment. The Plan will pay charges for mental health or substance abuse treatment only when you have preauthorized them through the MAP. For emergency treatment, you must contact the MAP within 48 hours of treatment.

> Call the MAP at 800-472-4992 to have your mental health or substance abuse treatment preauthorized.
>
> NOTE

MAP Contact Information

You may call the MAP at 800-472-4992 at any time of day, seven days per week to request preauthorization of mental health or substance abuse benefits, to report emergency treatment or to make an appointment with a counselor.

PRESCRIPTION DRUG BENEFIT (for Perferred Provider Organization Plans or Three-Tiered Plans)

If you need maintenance medications, you are encouraged to use the mail order program. You will benefit by receiving a larger supply of your prescription medication for the same or a lower co-payment than you would pay at a retail pharmacy.

NOTE

Save money!
You should ask your Physician if a generic or Formulary brand is available to avoid additional prescription drug costs.

If you need maintenance medications, you are encouraged to use the mail order program. You will benefit by receiving a larger supply of your prescription medication for the same or a lower co-payment than you would pay at a retail pharmacy.

You must show your SavRx Identification card to your pharmacist at a participating pharmacy in order to benefit from this Prescription Drug Program when you fill or refill a prescription. The original prescription will be dispensed as written (DAW) by the Physician for the lesser of a 34-day supply or 120 pills. In addition, you may receive up to two refills on the original Physician's prescription provided the prescription allows refills. A new Physician's prescription must be submitted to the SavRx mail order program to obtain any additional refills of maintenance medications after your initial prescription and two refills have been obtained through your local pharmacy.

You can call SavRx at 800-228-3108 or the Fund Office at 309-692-0860 or 866-692-0860:

- To find out if a pharmacy participates in the SavRx program,
- To find the nearest SavRx pharmacy,
- To request quotes or a formulary listing for prescription drugs,
- To find out if a medication is covered by the program, and
- To request mail order envelopes and instructions.

If an FDA approved generic medication is available it MUST be issued in lieu of the brand name or non-formulary prescription. If your Physician has not indicated DAW on your prescription and you choose to receive the brand name medication rather than the available generic medication, you will have to pay the difference in cost between the generic and the brand name or non-formulary medication in addition to your co-payment amount.

If you are on a maintenance medication due to a continuous need for prescriptions throughout the year, you are encouraged to use the mail order service offered by SavRx. The SavRx mail order service can provide you with a three-month supply of your medication delivered directly to your home for the co-payment specified in the *Schedule of Benefits* located in the back pocket of this booklet. Postage costs are absorbed by SavRx. Oral contraceptives must always be purchased through the SavRx mail order program in order to be covered.

The prescription drug co-payment shown in the *Schedule of Benefits* does not apply to the individual/family medical out-of-pocket maximum.

Covered Prescriptions and Supplies

The following items are covered by the Plan:

- Prescription drugs approved by the Food and Drug Administration that are:
  - ◊ purchased from a licensed participating pharmacy;
  - ◊ dispensed in accordance with the prescription of the treating Physician; and,
  - ◊ prescribed for a Medically Necessary and covered treatment of an Illness or an Injury.

- Diabetic supplies. The Plan provides coverage for diabetic supplies such as, insulin syringes and needles, sugar test tablets, sugar test tape, diabetic test strips and acetone test tablets. If insulin and needles/syringes are dispensed at the same time, only one co-payment will be applicable, even if the insulin and needles/syringes are on separate prescriptions.
- Up to twelve (12) pills of Viagra per month by prescription and with prior approval by your Physician. To receive more than twelve (12) pills of Viagra per month, you must obtain prior authorization from the Plan.
- Tobacco cessation products with a Physician's prescription ONCE per lifetime.
- Oral contraceptives ordered through the mail order program.

Prescription Drug Exclusions

Prescription drug benefits are not payable under the Plan for the charges described below:

1) Over-the-counter medications not requiring a prescription;
2) Oral contraceptives purchased without using the SavRx mail order program;
3) Medications lawfully obtainable without a prescription;
4) Devices or appliances, support garments or other non-medicinal substances;
5) Administration fees for drugs or insulin;
6) Investigational or Experimental drugs;
7) Unauthorized refills;
8) Prescription drugs covered under federal, state or local programs for which there is no charge;
9) Medications used for cosmetic purposes, such as Rogaine;
10) Medications when confined to a rest home, nursing home, sanitarium, extended care facility, Hospital, or similar entity;
11) Retin-A except for the treatment of acne vulgaris;
12) Co-payments from other group health insurance drug programs;
13) Charges for Viagra without prior approval of your Physician or for more than twelve (12) pills per month; unless you receive prior authorization from the Plan;
14) Charges for tobacco cessation products obtainable without a Physician's prescription or in excess of ONCE per lifetime;
15) Any injectable medication without prior approval of your Physician;
16) Effective March 1, 2003, the Plan will not cover non-sedating antihistamines. If your doctor writes a letter saying that you cannot tolerate over-the-counter Claritin (Claritin OTC), then SavRX will authorize a substitute.

If you or your eligible Dependents incur covered vision care expenses while you are eligible under the Health and Welfare Fund, you will be reimbursed for those expenses up to the Maximum Benefit specified in the *Schedule of Benefits* located in the back pocket of this booklet.

Covered vision care expenses include charges for:

- an eye examination performed by a legally qualified ophthalmologist or optometrist;
- contact lenses or lenses within frames prescribed by the ophthalmologist or optometrist, including contact lenses obtained through mail order; and
- frames.

NOTE

Vision care
benefits are limited to $200 per person in each 24-consecutive-month period.

Maximum vision care benefits are payable to you and each of your eligible Dependents once every 24 consecutive months. Be careful not to schedule more than one vision examination or order more than one set of lenses and frames within a 24 consecutive month period to keep your out-of-pocket expenses down.

Vision Care Exclusions

No benefits are payable under the Vision Care Benefit for any of the following:

EXAMPLE

For Example:

Joan has an eye examination by an optometrist on January 15, 2002 and the cost of the examination is $65. The Plan pays $65, the cost of the eye examination.

Joan has another examination by an optometrist on January 15, 2003 and the cost of the examination is $65. Joan receives a prescription for lenses from the optometrist at her examination and she purchases lenses and frames on January 15, 2003 at a cost of $150. Because Joan's vision benefits are limited to $200 within a 24-month period, the Plan pays $135 of Joan's additional $215 in covered vision expenses (the $200 maximum minus the $65 vision benefit paid in January 2002).

On February 2, 2004 Joan has another eye examination by an optometrist and the cost is $65. Within the prior 24 months – looking back to February 2, 2002 – the Plan has paid $135 in vision benefits for Joan. Therefore, the Plan will pay the $65 cost of the covered eye examination in February 2004 and Joan will have received the maximum benefit for that 24-month period.

1) Charges for services or supplies that are covered in whole or in part under any other portion of the North Central Illinois Laborers' Health and Welfare Fund;
2) Services and supplies that exceed the maximum shown in the Schedule of Benefits within a 24-consecutive-month period;
3) Expenses for which benefits are payable or reasonably entitled to be paid under any Workers' Compensation law or Occupational Disease Law and/or which arise out of or in the course of any occupation or employment for wage or profit.
4) Special procedures such as orthoptics or vision training and special supplies or non-prescription sunglasses and subnormal vision aids;
5) Visual analysis that does not include refraction;
6) Services or supplies not listed as covered expenses above. (Vision care expenses connected with Illness or Injury are covered under the Medical Expense Benefit of the Health and Welfare Fund.); or
7) Non-prescription safety glasses.

If you or your eligible Dependents incur covered hearing care expenses while eligible for benefits, those expenses will be reimbursed up to the specified Maximum Benefit.

A legally qualified otologist, audiologist or otolaryngologist must perform the hearing examination. The qualified specialist must prescribe the hearing aid instrument. The following Schedule shows the maximum benefits that apply to you and each of your eligible Dependents.

Schedule of Hearing Care Benefits

Hearing Care Exclusions

HEARING CARE BENEFIT	*MAXIMUM BENEFIT PER PERSON*
Hearing Exam	Up to $75 Per 24-Consecutive-Month Period
Hearing Aid	Up to $400 Per 60-Consecutive-Month Period

Benefits will *not* be paid for any of the following:

1) Charges for services or supplies that are covered in whole or in part under any other portion of the North Central Illinois Laborers' Health and Welfare Fund;
2) Expenses for which benefits are payable or reasonably entitled to be paid under any Workers' Compensation law or Occupational Disease Law and/or which arise out of or in the course of any occupation or employment for wage or profit.
3) Examinations that are not made by a licensed otologist, audiologist or otolaryngologist or a hearing aid instrument not specifically prescribed by a licensed otologist, audiologist or otolaryngologist; or
4) Speech therapy related to any hearing disorder.

Most types of dental services are covered under the Dental Plan and are grouped into three categories: Preventative Care, Primary Care and Major Care. Orthodontic benefits provided only for eligible Dependent children who have not yet reached age 19, as explained on page 37.

NOTE

The Plan pays a ***maximum of $1,500 per person*** each year for dental and orthodontic expenses. Orthodontic expenses are further limited to a lifetime maximum of $1500 per eligible Dependent child under age 19.

The Plan pays 80% of covered Dental expenses up to a maximum of $1,500 per person per year. The Plan pays 50% of covered orthodontic expenses up to a maximum of $750 per year and up to a *LIFETIME* maximum of $1,500 per eligible Dependent child who has not yet reached age 19.

Date of Service

The date of service is the date that services are actually rendered. In the case of a prosthesis, the date of service is the date the final impression is performed. The date of service for endodontic treatment is the date the treatment is started.

Preventative Care Dental Services – Coverage A

Preventative Care dental services are designed to help you prevent dental disease or to help you detect it in its early stages.

NOTE

Routine dental exams and cleanings are limited to ***no more than two times per calendar year.***

Coverage includes:

- Oral Examinations. Includes initial oral examination and periodic routine oral examinations. Benefits are payable for no more than two examinations every calendar year.
- Prophylaxis. Includes cleaning, scaling and polishing of your teeth. A dental hygienist may perform this service. Benefits are payable for no more than two cleanings every calendar year.
- Topical Fluoride Application. Benefits for this procedure are available to eligible persons under age 19 and are payable for no more than two applications every calendar year.
- Protective Sealants. Benefits for protective sealants are available to persons under age 17 and are payable for one application during a 36-month period.
- Dental X-rays. Benefits are payable for a set of full mouth x-rays once during a 36-month period, when Medically Necessary as determined by your dentist.Benefits are payable for diagnostic x-rays when Medically Necessary as determined by your dentist. Benefits are payable for bitewing x-rays no more than two times every calendar year.
- Space Maintainers. Benefits for space maintainers are available to eligible persons under age 19 when they are not part of an orthodontic treatment.
- Emergency Treatment. Benefits are payable for emergency oral examinations and treatment for the relief of pain.

Primary Care Dental Services – Coverage B

Primary Care dental services cover a wide range of services for treatment of dental disease, defect or Injury. Coverage includes:

- **Restorative Services**. Treatment requiring use of amalgam, synthetic porcelain and plastic restorations (fillings) or stainless steel crowns.
- **Periodontics**. Treatment for diseases of the gums.
- **Oral Surgery**. Provides benefits for extractions and other types of oral surgery related to the teeth or gums, including pre- and post-operative care.
- **Endodontics**. Includes pulpal therapy and root canal filling.

If you expect that the charges for your Primary Care services may total more than $300, it is wise to ask your dentist to prepare a written report describing the proposed treatment and the cost for the services. This procedure is called "Pre-Estimation of Benefits." See page 35 for more information.

Major Care Dental Services – Coverage C

Major Care dental services cover charges for dental repair on your natural teeth or dentures. Coverage includes:

- ***Gold restorations*** when the teeth cannot be restored with another filling material. (If possible, a synthetic or less expensive filling material should be used. See "Alternate Procedures," page 36).
- ***Inlays, onlays, or crowns*** when the teeth cannot be restored with a filling material.
- ***Repairing or recementing*** of crowns, inlays, bridgework or dentures.
- ***The initial installation of full or partial removable dentures*** or fixed bridge work, provided the Participant's or Dependent's eligibility under this provision was in effect at the time one or more natural teeth, accidentally injured or diseased were removed or extracted and that such denture or bridgework includes the replacement of teeth so removed, extracted or are missing.
- ***The replacement of a crown,*** provided the original crown was installed more than five years prior to the replacement. The Plan treats a temporary crown and permanent crown as a combined benefit, payable up to the Usual and Customary Charges.
- ***Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework*** by a new denture or new bridgework, but only if the existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable.

LIMITATIONS ON FULL AND PARTIAL DENTURES

The Plan will pay benefits toward the replacement for crowns, inlays, bridges, full or partial dentures *only* if five years have elapsed since the prior placement of the crown, inlay, bridge, or denture. The Plan will not pay for the replacement of a bridge or denture that could have been made serviceable or that was lost or stolen.

Also, the Plan will not cover any "personalized restorations" or "specialized techniques" that you and your dentist may agree upon during the construction of a full or partial denture. The Plan's payment of benefits for denture construction is limited to the appropriate amount for a standard denture.

Denture relines are limited to once per Calendar Year.

Pre-Estimation of Benefits

Pre-Estimation of Benefits allows you to know in advance what services are covered and how much will be paid by the Plan for the treatment that your dentist recommends. If you or one of your eligible Dependents know that you will have dental expenses over $300 (such as for Primary Care or Major Care Services), you should ask your Dentist to file a Pre-Estimation of Benefits form.

> ***Avoid surprises***.
> Have your dentist file a Pre-Estimation of benefits form so that you and your dentist will know how much the Plan will pay for the work.
>
> NOTE

Here's how it works:

- Your dentist completes a treatment plan describing the proposed course of treatment by itemizing the services and charges on the claim form that is provided by your dental office.
- You or your dentist submits the written report to Benefits Administrative Services.
- Benefits Administrative Services determines the amount payable under the Plan and informs you and the dentist.
- You and your dentist should discuss the Fund's estimated payment before the work is done.

Pre-Estimation of Benefits will help you avoid surprises and could save you money (see Alternate Procedures). Please note that a Pre-Estimation of Benefits issued by Benefits Administrative Services is valid for a six-month period, provided that you are eligible for Dental Plan benefits at the time the expenses are actually incurred.

NOTE

The Plan covers the ***least costly treatment***. Be sure to choose the most cost-effective treatment to avoid paying the difference from your own pocket.

Alternate Procedures

Often there is more than one way to treat a particular dental problem. For example, either a crown or filling could be used to restore a tooth. You also have choices regarding the materials to be used – for example, precious metal or plastic. Benefits are payable for the least expensive course of treatment. If you and your Dentist decide upon a more costly treatment or your Dentist chooses to bill expenses that are not usual & customary for the service provided, you will be responsible for the additional charges above or the difference in the amount allowable for a service that is approved by Benefits Administrative Services.

Extension of Dental Expense Benefits

If your eligibility for dental benefits terminates, you may continue to receive dental services under the Plan for up to 30 days following termination if you were receiving treatment for Major Care (Coverage C) and your treatment is completed within the 30-day period. Benefits Administrative Services will determine extension of benefits based on the final impression date that is given by your dentist. The final impression date must have occurred while your dental coverage was still active.

Dental Exclusions

Dental benefits are not payable under the Plan for the charges described below. The amount of any charges for the following will be deducted from your dental expenses BEFORE the benefits of the Dental Plan are determined.

1) Charges for services that are more than the calendar year maximum benefit described in the *Schedule of Benefits* (see page 76);
2) Work done for appearance (cosmetic) purposes, except for conditions resulting from accidental Injuries, scars, tumors or diseases;
3) Work done while you are not covered under this Plan, except as provided under the Extension of Dental Expense Benefits provision (see page 36);
4) Charges for mouth rehabilitation will be paid only as related to replacing missing teeth or for necessary treatment of oral disease. The balance of the treatment charges, including charges related to the appliances or restorations intended to increase vertical dimensions or restore the occlusion, will remain your responsibility to pay;
5) Extra sets of dentures or other appliances;
6) Treatment that is otherwise free of charge to you;
7) Treatment that is furnished or payable by the armed forces or any civil unit of any government, that you do not have to pay;
8) Charges for failure to keep a scheduled appointment or charges for completion of the claim form;
9) Charges that are payable or reasonably entitled to be paid under any Workers' Compensation or Occupational Disease Law and/or which arise out of or in the course of any occupation or employment for wage or profit.
10) Charges related to orthodontic treatment regardless of the reason that such treatment is being rendered, including extractions done in conjunction with orthodontic treatment; unless provided to an eligible dependent child as described under the Orthodontic services below and only up to the maximum benefit level allowed by your dental plan.

11) Services or supplies for any condition that was caused by an act of war;
12) Services or supplies that are considered experimental or do not meet the accepted standards of medical or dental practice;
13) Treatment of temporomandibular joint dysfunction with intra-oral prosthetic devices, or any other method to alter vertical dimension;
14) Charges for medications;
15) Charges for denture adjustments for the first six months after the dentures are initially received;
16) Charges for bases, liners and anesthetics used in conjunction with permanent restorations;
17) Charges for treatment by anyone other than a dentist or licensed dental hygienist;
18) Charges for temporary partials, bridges and dentures;
19) Charges for implants and related treatment;
20) Charges for infection control and medical waste disposal;
21) Charges for more than one denture reline per calendar year; or
22) Any services, supplies or treatment not specifically provided as a benefit in this booklet.

Orthodontic Services

Orthodontic treatment received July 1, 2002 and after is covered for eligible Dependent children only and are limited to eligible Dependent children who have not yet reached age 19.

The Plan covers 50% of Orthodontic services up to a Calendar Year Maximum benefit of $750 and a lifetime maximum of $1,500. Orthodontic expenses are also subject to the Calendar Year Maximum of $1,500 for Dental Benefits. This means that if your eligible Dependent child reaches the $1,500 maximum for dental expenses in a calendar year, your Dependent child's orthodontic services will not be covered that year. If your child's Orthodontic services reach the $750 Calendar Year Maximum, then your child's dental expenses will be limited to $750 for that Calendar Year, which represents the balance of the $1,500 Annual Maximum dental benefit.

For Example:
Jim and his dependents are covered by the Plan. Jim's daughter Ann, who is age 15, needs orthodontia treatment and her Orthodontist determines that the cost of her treatment plan will be $3,750 over the two-year period from January 2003 through December 31, 2004. The Plan will pay for 50% of the treatment up to the lifetime maximum of $1,500, paying the Calendar Year Maximum of $750 in 2003 and again in 2004. Jim will pay the balance of the cost of treatment of $2,250.

EXAMPLE

If you have arranged a payment plan with your orthodontist, you will need to provide the Plan with information confirming when orthodontic treatment will begin and whether payments are being made as scheduled. Whenever possible, payments are made directly to the orthodontist, so you should encourage the orthodontist to submit bills directly to Benefits Administrative Services. The orthodontist must submit a detailed billing for services. The Health and Welfare Fund will not make payments on the basis of payment coupons. However, reimbursements for orthodontic expenses may be made directly to you on the basis of the detailed bills submitted by the orthodontist.

Orthodontic benefits are limited by the calendar year and lifetime dollar maximums listed in the *Schedule of Benefits* located in the back pocket of this booklet.

RECOVERY INCENTIVE PROGRAM

NOTE

Your recovery incentive program. If you discover an overcharge for medical services and you arrange for a corrected bill, ***you may receive 25% of the overcharged amount*** from the Plan for your efforts.

This program provides a cash incentive to you and your Dependents if you discover and arrange for recovery of overcharges made on Hospital, Physician and outpatient clinic bills that in turn result in benefit dollars saved for the Health and Welfare Fund. The program rules follow:

- The Health and Welfare Fund will pay you a cash incentive of 25% of the actual amount of an overcharge when the Hospital, Physician or outpatient clinic that made the overcharge agrees that the overcharge is invalid after direct negotiations have taken place between you and the Hospital, Physician or outpatient clinic.
- The maximum paid by the Health and Welfare Fund in any calendar year under this program will not exceed $500 per person. Overcharges totaling less than $25 are not eligible for the Recovery Incentive Program.
- The Health and Welfare Fund will consider only those expenses that the Plan covers in determining the amount payable under this program. Claims involving coordination of benefits will be eligible only if this Plan is primary.
- You must submit proof of eligibility for a cash incentive in the form of a copy of the initial itemized Hospital, Physician or outpatient clinic bill with the overcharges circled, and a copy of the adjusted bill verifying that the overcharges were removed. You must submit this proof to Benefits Administrative Services within 45 days following the date of discharge from the Hospital or the date the charges were incurred. Within 30 days after receipt of proof and verification that the overcharge has been removed, the Health and Welfare Fund will disburse a check to you in the amount of the cash incentive. You should note that these reimbursements are considered income to you and should be reported to the Internal Revenue Service.
- The Trustees and Health and Welfare Fund Staff will not be involved in resolving any conflict between you and the Hospital, Physician, or outpatient clinic with respect to disputed charges. You are solely responsible for handling such disputes.
- The Trustees have the sole right at any time to amend or modify these rules or terminate the Recovery Incentive Program entirely by a majority vote of the Trustees.
- Following are specific suggestions for a careful and complete review of a bill:
  - ◊ List everything that happens while in the Hospital or clinic by reconstructing events daily or immediately upon discharge.
  - ◊ Before leaving the Hospital, clinic or Physician's office, make sure to arrange that an itemized bill is sent to you.
  - ◊ Match your list against bills to detect any discrepancies.
  - ◊ Check the bill carefully for any charges that represent any treatments, services or supplies that were not received. Use the following or similar checklist:
    - Δ Were you billed for the correct number of days that you occupied the room?
    - Δ If intensive care was required, were you billed for the correct number of days that you were confined to an intensive care unit?
    - Δ Were you charged for the day that you were discharged, even though you left before the day's charges began?
    - Δ Were you charged for the correct type of room that you occupied (private, semiprivate, ward, etc.)?
    - Δ Were you billed only for tests or x-rays that you actually received?
    - Δ Were you billed for medication, injections, dressings, supplies, etc. that you did not receive? For quantities in excess of what you remember?
    - Δ Do you recognize medication, injections, dressings, supplies, etc. that you did not receive that may have belonged to a roommate?

- Were medications that your Physician ordered billed throughout your entire stay even though you took them only for a limited period of time?
- Were you billed for the purchase of humidifiers, bedpans, admission kits, etc. that you never received? That you were not allowed to take home?
- If you received physical, radiation, inhalation, and/or occupational therapy, were you charged for the correct type and number of hours of treatment?
- If you received a blood transfusion, were you charged for blood that a donor, blood bank or a Red Cross family or community assurance program replaced?
- If admitted to the maternity wing, were you billed for a labor room that may not have been used because of a swift delivery?
- If permitted to keep your newborn child in your room, were you billed for improper nursery charges?
- Were you billed for miscellaneous charges? Did you ask the Hospital to explain them in specific terms?
- Did a Physician who did not visit you bill you for a visit?

- Circle any overcharges. Report the overcharges to the Hospital billing department and request a corrected bill. If you properly identify the specific discrepancies in the Hospital bill, the Hospital must drop unsubstantiated charges unless there is evidence in the medical file to the contrary. A copy of the adjusted bill will be used as proof that the Hospital removed the overcharges.
- You may receive payment of your cash incentive by sending Benefits Administrative Services a copy of the original bill with the overcharges circled and a copy of the correct bill that the Hospital reissues.
- Once the overcharge amount has been received as a refund from the provider or hospital, a check will be issued to you for your assistance in the recovery of funds.

LOSS OF TIME BENEFIT (For Eligible Active Participants Only)

The Loss of Time Benefit is payable if you are unable to work because of a non-occupational accidental bodily Injury or a non-occupational Illness and you are eligible for benefits as an Eligibility A Employee. The maximum weekly benefit is $250 and the maximum benefit period is 13 weeks, as shown in the *Schedule of Benefits*. The benefit will begin on the first day of a disability due to accidental bodily Injury or on the eighth day of a disability due to Illness. In accordance with federal regulations, Social Security (FICA) and Medicare taxes will be deducted from each payment you receive.

NOTE

Proof of disability. You may be required to periodically submit medical evidence that you are disabled or be examined by a Physician chosen by the Trustees.

The Loss of Time Benefit is only payable for disabilities that occur while you are eligible for benefits under the Health and Welfare Fund as an Eligibility A Employee.

The Trustees may require that you submit, on a periodic basis, medical evidence that you are disabled. You may be required to submit to a physical examination by a Physician selected by the Trustees.

Continuous Periods of Disability

Successive periods of disability due to the same or related causes will be considered as one period of disability unless you:

- have returned to active employment for at least one full working day; or
- are known to be available for active employment.

Loss of Time Benefit Exclusions

NOTE

Occupational Injury or disease means an Injury or disease for which you are entitled to or are pursuing entitlement to benefits under the applicable Workers' Compensation Law, Occupational Disease Law or similar laws.

No benefits will be payable under the Loss of Time Benefit for any:

1) Period of disability during which you are not under the direct care of a Physician;
2) Disability that is due to accidental bodily Injuries arising out of and in the course of your employment;
3) Disability that is due to an occupational Injury or Illness. For this purpose, the Occupational Injury or Illness means an Injury, Illness or disease for which you are entitled to or pursuing entitlement to benefits under the applicable Workers' Compensation Law, Occupational Disease Law or similar laws.
4) Disability that begins while you are not eligible or while the North Central Illinois Laborers' Health and Welfare Fund does not have primary responsibility for your coverage as defined under the Coordination of Benefits section beginning on page 59;
5) Disability that is due to Injuries resulting directly or indirectly from the commission of an illegal act, except traffic offenses. However, treatment of Injuries sustained in a motor vehicle accident is excluded where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (B.A.C.) of 0.10 or more. A breathalyzer, blood or urine test result that the claimant had a B.A.C. of 0.10 or more or that the claimant was utilizing an illegal drug at the time of any Injury, will be considered objective evidence that alcohol or an illegal drug use was a contributing cause of the Injury;
6) Period of disability during which you are considered a Retiree under the North Central Illinois Laborers' Pension Fund and are receiving a monthly pension benefit; or
7) Period of disability during which you are eligible for benefits under this Plan as an Eligibility B Employee.

DEATH BENEFIT (For Eligible Active Participants Only)

If you die while you are eligible for Plan benefits as an Eligibility A Employee, the Death Benefit may be paid to your beneficiary. The amount of the Death Benefit is $10,000 as shown in the *Schedule of Benefits* located in the back pocket of this booklet. This benefit is usually paid to your beneficiary in a lump sum.

Beneficiary

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form and returning it to the Health and Welfare Fund Office. The change will be effective when the Health and Welfare Fund Office receives the completed form.

Continuation of Death Benefit During Total and Permanent Disability

If you become Totally and Permanently Disabled before age 60, your Death Benefit coverage will continue if:

- your physician provides written proof of your disability to the Trustees no later than 12 months after the start of your disability; and
- the proof confirms that you were Totally and Permanently Disabled for at least nine months, and that your disability will continue indefinitely.

In order to have your Death Benefit continue for each 12-month period after initial confirmation of your Total and Permanent disability, you must submit proof of your continuing Total and Permanent disability each year within three months of the anniversary date that your initial proof of disability was submitted. The Board of Trustees reserves the right to have you examined by a Physician of their choosing.

NOTE

Definition of Totally and Permanently Disabled. For the purpose of this benefit, Totally and Permanently Disabled means that you are prevented from engaging in any business, occupation or employment for wages or profit due solely to an Illness or Injury.

EXAMPLE

For Example:

Nick is eligible for benefits under the Plan as an Eligibility A Employee and he becomes Totally and Permanently Disabled on March 1, 2001. Nick sends proof to the Trustees on February 1, 2002 that he has been disabled for at least nine months and that his disability is expected to continue indefinitely. The Trustees accept Nick's proof of disability and Nick's Death Benefit coverage continues for a twelve-month period from February 1, 2002 through January 31, 2003. Nick must submit proof of his continuing disability on or before October 31, 2003 in order to have his Death Benefit coverage continue for the 12-month period from February 1, 2003 through January 31, 2004. Nick must repeat this process each year that he remains disabled in order to keep his Death Benefit coverage in effect.

THE AMOUNT OF COVERAGE THAT IS CONTINUED

The amount of Death Benefit coverage while you are Totally and Permanently Disabled will be the amount that was in force at the time you initially became disabled.

HOW LONG BENEFITS WILL CONTINUE

Benefits will continue under this extension until the earliest of:

- 31 days after the date that you are no longer Totally and Permanently Disabled;
- the date you fail to furnish the Trustees with proof of your continued disability (that must be within three months of the anniversary date the initial proof of disability was submitted); or
- the date you fail to be examined by a Physician designated by the Trustees, if the Trustees request it. Such an examination will not be required more than once a year after your coverage has been continued under this extension for two full years.

Death Benefit Exclusions

No Death Benefit is payable if your death is caused directly or indirectly, wholly or partly, by:

1) Participation in the commission of a felony; or,
2) War or an act of war.
3) Disabilities or Injuries resulting directly or indirectly from the commission of an illegal act, except traffic offenses. However, Injuries sustained in a motor vehicle accident are excluded where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (B.A.C.) of 0.10 or more. A breathalyzer, blood or urine test result that the claimant had a B.A.C. or 0.10 or more or that the claimant was utilizing an illegal drug at the time of the injury, will be considered objective evidence that alcohol or illegal drug use was a contributing cause of the Injury.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (For Eligible A Employees Only)

If you are eligible for benefits under the Plan as an Eligibility A Employee and you suffer any of the losses listed below as the result of an accident, the Accidental Death and Dismemberment (AD&D) Benefit will be paid. Benefits are only payable for losses that occur within 90 days from the date of Injury. This benefit is in addition to any other benefits payable under the Plan.

Schedule of Accidental Death and Dismemberment Benefits

Loss Suffered	Amount of Benefit
Life	$10,000
Two Hands, Two Feet or Sight of Two Eyes	$10,000
One Hand and One Foot	$10,000
One Hand and Sight of One Eye	$10,000
One Foot and Sight of One Eye	$10,000
One Hand or One Foot or Sight of One Eye	$5,000

BENEFITS

If you suffer more than one of these losses listed above in any one accident, you will be paid only for the loss for which the largest amount is payable.

Beneficiary

Benefits for loss of life are payable to the beneficiary you name. Benefits for any other loss are payable to you. You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form and returning it to the Health and Welfare Fund Office. The change will be effective when the Health and Welfare Fund Office receives the completed form.

AD&D Exclusions

No benefit is payable under this Accidental Death and Dismemberment Benefit if your death or any loss is caused directly or indirectly, wholly or partly, by:

1) Bodily or mental Illness, infirmity or disease of any kind;
2) Ptomaine or bacterial infections (except infections caused by pyogenic organisms that occur with and through an accidental cut or wound) or hernia;
3) Participation in the commission of a felony;
4) War or an act of war;
5) Service in any military, naval or air force of any country while such country is engaged in war; or
6) Police duty as a member of any military, naval or air organization or community work.
7) That occurs from disabilities or Injuries resulting directly or indirectly from the commission of an illegal act, except traffic offenses. However, Injuries sustained in a motor vehicle accident are excluded where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (B.A.C.) of 0.10 or more. A breathalyzer, blood or urine test result that the claimant had a B.A.C. or 0.10 or more or that the claimant was utilizing an illegal drug at the time of the injury, will be considered objective evidence that alcohol or illegal drug use was a contributing cause of the Injury

Special Terms

- Loss of hand or foot means that the limb is severed at or above the wrist or ankle joint, respectively.
- Loss of sight means the total and irrecoverable loss of sight.

NOTE

RETIREE BENEFITS

The Plan provides benefits for you and your eligible Dependents if you retire with a pension or you become disabled and retire with a disability pension from the Central Laborers' Pension Fund or another Fund that has entered into an agreement with the North Central Illinois Laborers' Health and Welfare Fund. Eligibility requirements are shown below. To be eligible for Retiree benefits, you must have been eligible for Plan benefits under Eligibility A. If you were eligible for benefits under Eligibility B, you are not eligible for Retiree benefits under the Plan, but you may elect COBRA continuation coverage (see page 13).

NOTE

Retiree means a person who:
1) Is receiving a pension from:
   (a) The Central Laborers' Pension Fund, or
   (b) Another Fund that has entered into an agreement with the Central Laborers' Pension Fund (and submits proof of the pension), and
2) Meets the other eligibility requirements for Retiree Benefits.

Eligibility for Retiree Benefits

You and your Dependents are eligible for Retiree benefits if you:

- retire after reaching age 53, but before age 65 or at any age if you are disabled;
- have been eligible under Eligibility A for at least 10 consecutive years under either or both consecutively the Central Laborers' Health and Welfare Fund (only years prior to July 1, 2003 will be credited for this purpose) and the North Central Illinois Laborers' Health and Welfare Fund immediately before the effective date of your pension;
- are not eligible for Medicare; and
- make proper and timely self-payments to the Health and Welfare Fund for your coverage.

You will receive notice from the Fund Office of your eligibility for Retiree benefits. The Fund will verify that you were an Eligibility A Plan participant and that you are receiving a pension from the Central Laborers' Pension Fund or another Fund that has entered into an agreement with the Central Laborers' Pension Fund. You must complete an application for Retiree benefits and make the required self-payment for Retiree Benefits before or within the first 10 days of the calendar month that follows the calendar month in which your eligibility under the Plan for Active Participants terminated.

The Trustees determine, from time to time, the amount of self-payments for single/family coverage. You are required to make self-payments on a quarterly basis for Retiree benefits. To maintain coverage, you must make quarterly payments on or before the first day of the quarter (January 1, April 1, July 1 and October 1).

EXAMPLE

For Example:

Bob retires from 20 years of active employment at age 57, and begins receiving his pension from the Central Laborers' Pension Fund. Bob receives notice from the Fund Office that he is eligible for Retiree benefits under the Plan. After using his Eligibility Reserve Bank (see page 9) to maintain coverage, Bob's Eligibility A coverage under the Active Participants' Plan ends on December 31, 2002. Bob must complete his application, submit it to the Fund Office and make his first self-payment for Retiree benefits on or before January 10, 2003.

To maintain his Retiree benefit coverage, Bob must make timely quarterly payments on or before April 1, 2003, July 1, 2003, October 1, 2003, January 1, 2004 and on or before the first day of each following quarter until he is no longer eligible for Retiree benefits.

Your Dependents' Eligibility for Retiree Benefits

Your spouse and your Dependent children are eligible for Retiree benefits if you are no longer eligible for Retiree benefits because you have become eligible for Medicare and if you had Eligibility A coverage as an active employee before you retired. You must continue self-payments for your eligible Dependents. Even if your spouse is not eligible for Retiree Benefits, your eligible Dependent children are eligible for Retiree benefits through self-payments. Your Dependents are no longer eligible for Retiree benefits when they become eligible for Medicare. Your Dependent children will lose coverage when they no longer meet the definition of Dependent; if that occurs, they may continue coverage through COBRA (see page 13).

Benefits Available to Retirees

As an eligible Retiree, during the annual Open Enrollment Period, you and your eligible Dependents will be entitled to elect coverage under:

- a Three-Tiered Plan (one that contains an exclusive provider (EPO) network, PPO network and out-of-network benefits); or
- a Preferred Provider Plan (PPO) offered by the Fund.

In addition to the medical benefits provided by the Three-Tiered Plan or PPO Plans, you will receive:

- Prescription Drug benefits;
- Vision Care benefits;
- Hearing Care benefits; and
- Dental Care benefits.

If you choose a PPO Plan or the Three-Tiered Plan, your prescription drug benefits are the same as those provided for active Participants in the Plan, as described on page 30.

If there are any differences in the amount of benefits provided under the Retiree Plan, you will receive that information during the Open Enrollment Period.

Retiree Benefit Exclusions

The following benefits, available to Active Participants, are not offered under the Retiree Plan:

1) Death Benefit;
2) Accidental Death and Dismemberment; or
3) Loss of Time.

Termination of Retiree Benefits

Your Retiree benefits will terminate when the first of the following occurs:

- you become eligible for Medicare for any reason, including age;
- the Plan is discontinued;
- you are no longer entitled to receive a pension from the Central Laborers' Pension Fund; or
- you do not make the required self-payment.

NOTE

Apply for Medicare as soon as eligible.
You must apply for Medicare benefits as soon as you are eligible. When you are eligible for Medicare and you are retired, you are no longer eligible for Retiree benefits. If you do not enroll in Medicare, the Plan will treat you as though you had enrolled and you will not have Plan coverage. It is important that you enroll in Medicare as soon as possible.

Your Dependents' Retiree benefits end when the first of the following occurs:

- your Dependent no longer meets the definition of Dependent;
- the Plan is discontinued;
- you are no longer entitled to receive a pension from the Central Laborers' Pension Fund;
- the required self-payment is not made; or
- your Dependent becomes eligible for Medicare.

Retiree coverage for your Dependent children ends when your Dependent spouse is no longer eligible for Retiree coverage.

Return to Work by Retiree

NOTE

Return to work. You must continue self-payments for Retiree Benefits when you return to work after receiving a pension in order to maintain the right to Retiree Benefits when you retire again. But you need not continue self-payments when you return to work after receiving a disability pension, once you qualify again for active Participants' benefits.

If you are receiving an early regular, or service pension, and you are making self-payments for Retiree benefits and suspend your pension to return to work, you must continue to make self-payments to the Health and Welfare Fund for Retiree Benefits during the period while you are working. If you do not continue your self-payments, you permanently lose your right to receive Retiree Benefits. When you re-retire you will not be eligible for Retiree Benefits.

If you suspend your disability pension and return to work and were making self-payments for Retiree benefits, you are not required to continue to make self-payments for Retiree benefits after the date you earn regular eligibility under the Plan for active Participants. You will be allowed to make self-payments for Retiree benefits when you retire again.

Retiree Pre-Funded Subsidy Allowance

ELIGIBILITY

You may receive a Retiree Pre-Funded Subsidy Allowance to offset your self-payments for Retiree Benefits if you:

NOTE

A Retiree Pre-Funded Subsidy Allowance is earned during your working years and will help offset the cost of your Retiree benefits when you are retired.

You may receive a Retiree Pre-Funded Subsidy Allowance to offset your self-payments for Retiree Benefits if you:

- initially retire on or after March 1, 2002; and
- are at least 53 years of age at the time of your initial retirement; and
- have at least 10 years of uninterrupted active participation in either or both the Central Laborers' Health and Welfare Fund (only years prior to July 1, 2003 will be credited for this purpose) and the North Central Illinois Laborers' Health and Welfare Fund (with Eligibility A coverage) immediately before the date of your initial retirement.

You are also considered eligible for the Retiree Pre-Funded Subsidy Allowance if you had Eligibility A coverage under the Plan and you:

- retire due to a Total and Permanent Disability (as defined by the Central Laborers' Pension Plan), on or after March 1, 2002 and you are not eligible for Medicare or other government-sponsored insurance;
- are a spouse or Dependent of a Participant who became Totally and Permanently Disabled on or after March 1, 2002 who is eligible for Medicare or other government-sponsored insurance;

- are a spouse or Dependent (at the time of death) of a Plan Participant who dies while eligible for the Retiree Pre-Funded Subsidy Allowance; or
- are a spouse or Dependent (at the time of death) of a Participant who was not retired on or after March 1, 2002, but who died and at the time of his or her death:
  - ◊ was an eligible active Participant of the North Central Illinois Laborers' Health and Welfare Fund covered under Eligibility A;
  - ◊ was at least 53 years of age; and
  - ◊ had at least 10 pension credits at the time of death.

TERMINATION OF ELIGIBILITY

The Retiree Pre-Funded Subsidy Allowance ends on the earliest of the date you:

- reach age 65 and become eligible for Medicare;
- become eligible for Medicare because of a Total and Permanent Disability;
- choose not to make a premium payment for Retiree benefits;
- return to work for a Contributing Employer and become eligible for active Participants' benefits; or
- return to work in disqualifying employment as defined in the Central Laborers' Pension Plan.

If you become eligible for Medicare because of age or a Total and Permanent Disability, your spouse will continue to receive the Retiree Pre-Funded Subsidy Allowance if your spouse is age 53 or older. Your spouse's coverage continues until your spouse:

- remarries;
- becomes eligible for Medicare because of age or Total and Permanent Disability; or
- does not pay the required self-payment.

If you initially retire on or after March 1, 2002, are age 53 or older, and suspend your pension to return to active employment, you must complete three years with active contributions of 1,000 hours each fiscal year to be considered eligible for the North Central Illinois Laborers' Health and Welfare Fund Retiree Pre-Funded Subsidy Allowance.

CALCULATING YOUR RETIREE PRE-FUNDED SUBSIDY ALLOWANCE

If you are eligible for the Retiree Pre-Funded Subsidy Allowance, your Retiree self-payment amount will be automatically reduced by the amount of the subsidy.

You may accumulate a maximum of 30 Retiree Subsidy Credits in your lifetime. You begin earning Retiree Subsidy Credits after 500 hours have been reported on your behalf during a calendar year. You are credited with a maximum of one Retiree Subsidy Credit for 1,000 or more hours for which contributions have been paid on your behalf in a fiscal year. Retiree Subsidy Credits are calculated as shown on the following page:

BENEFITS

If You Work:	Retiree Subsidy Credits You Earn Are:
Less than 500 Contribution Hours	0
500 – 599 Contribution Hours	.5
600 – 699 Contribution Hours	.6
700 – 799 Contribution Hours	.7
800 – 899 Contribution Hours	.8
900 – 999 Contribution Hours	.9
1,000+ Contribution Hours	1

Your Retiree Subsidy Credits are multiplied by the amount of the monthly subsidy to determine the dollar amount that will be subtracted from your quarterly Retiree self-payment amount. If the self-payment amount is lower than the Retiree Pre-Funded Subsidy, you or your spouse will receive the lowest amount as the subsidy.

EXAMPLE

For Example:

Ned's initial retirement began April 1, 2002 and he accumulated 22.8 Retiree Subsidy Credits before he retired. For 2002, the amount of the Retiree Pre-Funded Subsidy is $11.54 per Retiree Subsidy Credit. Ned's monthly Retiree Pre-Funded Subsidy is $263.11 ($11.54 x 22.8 Retiree Subsidy Credits). The monthly Retiree Pre-Funded Subsidy amount is multiplied by 3 months and then subtracted from Ned's quarterly self-payment to determine the amount of his self-payment. If Ned chose a PPO Plan that cost $1,800 per quarter for family coverage, his self-payment would be $1,010.67 each quarter ($1,800 – (3 x $263.11)).

If your surviving spouse is eligible for Retiree benefits and has reached age 53, he or she is eligible for 50% of the Retiree Pre-Funded Subsidy Allowance for which you are eligible at the time you become eligible for Medicare or at your death. If your spouse has not reached age 53 at the time you become eligible for Medicare or at your death, your spouse must pay 100% of the self-payment amount until your spouse reaches age 53, at which time your spouse will be eligible for 50% of the Retiree Pre-Funded Subsidy Allowance. Your spouse may only use the Retiree Pre-Funded Subsidy Allowance against his or her self-payment. If the self-payment amount is lower than the Retiree Pre-Funded Subsidy, your spouse will receive the lowest amount as the subsidy.

HOW TO FILE YOUR CLAIMS

Procedure for Filing a Claim

If you need a dental claim form, please contact:

Benefits Administrative Services
1040 N. Second Street, P.O. Box 4509
Rockford, IL 61110-4509
Telephone: 815-969-9663
Toll free: 800-249-7947
Fax: 815-969-9770

Benefits Administrative Services will check the records of your hours worked and will forward the claim forms to you immediately if you are eligible for benefits under the Plan.

If you need a medical claim form for the Blue Cross Blue Shield of Illinois, please contact:

Blue Cross Blue Shield of Illinois
P.O. Box 1364
Chicago, IL 60690

If you need a medical claim form for the Health Alliance Plan, please contact:

Health Alliance Medical Plan, Inc.
102 E. Main Street
Urbana, IL 61801-2744
Telephone: 217-337-8400
Toll free: 800-322-7451
Facsimile: 217-337-8008

If you need a medical claim form for the HFN Plan, please contact:

HFN, Inc.
P.O. Box 3428
Oak Brook, IL 60522
EDS Payer #36335
Toll free: 800-295-5444
Website: www.hfninc.com

Using the Claim Form

When you receive a ***medical*** claim form, complete the Member Section and Dependent Section, if applicable. In the event of an accident, please complete the accident information section.

When you receive a ***dental*** claim form, called a Dental Service Report, follow the instructions carefully when completing it. You will need to complete and sign Part 1 – Insured Information of Dental Service Report. Be sure you answer all questions. Ask your dentist to complete and sign Parts 2 and 3 when treatment has been completed.

Return your medical or dental claim form to Benefits Administrative Services, Blue Cross Blue Shield of Illinois, Health Alliance Medical Plan or HFN at the above address as soon as possible.

When you enter a Hospital, the Hospital may require you to complete an assignment form that directs the Health and Welfare Fund to pay whatever benefits are available under the Plan to the Hospital to satisfy your bill. The Health and Welfare Fund follows the procedure of automatically paying benefits directly to the Hospital if you have an outstanding bill and have "assigned" benefits to the Hospital. You will receive notification of the payment made to the Hospital on your behalf.

Keep Important Information Current

It is important that you notify the Health and Welfare Fund Office whenever you:

- change your home address;
- wish to change your beneficiary;
- receive Workers' Compensation Benefits;
- return to work after your disability ceases;
- enter the Armed Forces of the United States;
- get married or divorced; or
- gain a Dependent or your Dependent is no longer considered an eligible Dependent.

Time Limit for Submitting a Medical or Dental Claim

NOTE

Claim deadline. You have one year from the date of service to file your claim form.

You should submit your claim forms as soon as possible after you receive the services that are the subject of your claim, but in no event later than a year after you receive the services. Benefits Administrative Services, Blue Cross Blue Shield of Illinois, the Health Alliance Medical Plan or HFN will not accept a claim for reimbursement of medical or dental expenses that is received more than one year from the actual date the expense was incurred. This rule applies to all benefits payable under this Plan. However, Benefits Administrative Services, Blue Cross Blue Shield of Illinois, the Health Alliance Medical Plan and HFN will accept all of the previous year's expenses if you submit them in January or February of the current year.

EXAMPLE

For Example:
If you incur a claim on February 1, 2003, you should submit your claim to Benefits Administrative Services, Blue Cross Blue Shield of Illinois the Health Alliance Medical Plan or HFN by no later than February 1, 2004. However, Benefits Administrative Services, Blue Cross Blue Shield of Illinois the Health Alliance Medical Plan or HFN will accept and process your claim for services on February 1, 2003 if you file it after February 1, 2004, but before the end of February 2004.

Claims received after the one-year grace period will be denied unless you can show that it was not possible to provide such notice of claim within the required time and that the claim was filed as soon as was reasonably possible.

Benefit Claims Procedures

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you or the provider must submit a completed claim form, either on a paper claim form or electronically. Simple inquiries or phone calls about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

If you use the services of a PPO or other network provider, the provider will generally file your claims for you. Also, contact Benefits Administrative Services about how to file a claim for life insurance and accidental death and dismemberment benefits.

The following information must be completed in order for your request for benefits to be a claim, and for Benefits Administrative Services to be able to decide your claim:

- Participant name;
- Patient name;
- Patient Date of Birth;
- Social Security Number of participant or retiree;
- Date of Service;

Generally, your Physician or Hospital will supply the following required information:

- CPT-4 (the code for Physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);
- ICD-9 (the diagnosis code found in the International Classification of Diseases, 9th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
- Billed charge;
- Number of Units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address; and
- If treatment is due to accident, accident details.

Note that you may submit your claims involving Urgent Care (defined on page 54) by telephone to Benefits Administrative Services at 815-969-9663 or toll free at 800-249-7947, to the Health Alliance Medical Plan at 217-337-8400 or toll free at 800-322-7451 or to the MAP at 800-472-4992 and you must follow up your phone call in writing within 24 hours with the information listed above.

When you present a prescription to a pharmacy to be filled under the terms of this Plan, your prescription request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

WHEN CLAIMS MUST BE FILED

You must file your claim for benefits as soon as possible following the date you incurred the charges. If you fail to file your claim within a reasonable time, it will not invalidate or reduce your claim if it was not reasonably possible for you to file the claim on time. However, in that case, you must submit your claim as soon as reasonably possible and in no event later than one year from the date you incurred the charges. The Board of Trustees will determine whether you have proved good cause for filing a late claim.

WHERE CLAIMS MUST BE FILED

Your claim will be considered filed as soon as it is received by American Health Holding, Inc., Benefits Administrative Services, Blue Cross Blue Shield of Illinois, HFN, Inc. or the Health Alliance Medical Plan.

If you are in the Blue Cross Blue Shield Plan, you should file all of your post-service medical claims and all other claim at the following address:

Blue Cross Blue Shield of Illinois
P.O. Box 13641040
Chicago, IL 60690

and you should file all of your pre-service claims with American Health Holding, Inc. by telephoning:

American Health Holding, Inc.
800-892-1893

If you are in the Health Alliance Medical Plan, you should file all of your medical claims with Health Alliance at the following address or telephone numbers:

Health Alliance Medical Plan, Inc.
102 E. Main Street
Urbana, IL 61801-2744
Telephone: 217-337-8400
Toll free: 800-322-7451

and you should file all of your non-medical claims with Benefits Administrative Services at the address listed above.

If you are in the HFN, Inc. Plan, you should file all of your medical claims with HFN, Inc. at the following address or telephone numbers:

HFN, Inc.
P.O. Box 3428
Oak Brook, IL 60522
EDS Payer #36335
Telephone: 800-295-5444
Website: www.hfninc.com

Network Hospital, Medical, Mental Health and Substance Abuse, Prescription Drug and other network claims will be filed for you. No claim form is necessary.

You may submit your Urgent Care claims by telephone to Benefits Administrative Services at 800-249-7947 or to the Health Alliance Medical Plan using the telephone numbers listed above and then follow-up your telephone claim with a written claim.

AUTHORIZED REPRESENTATIVES

An authorized representative, such as your spouse or other individual, may complete the claim form for you if you are unable to complete the form yourself. You can obtain a form from Benefits Administrative Services to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an urgent care claim (defined below) without your having to complete the special authorization form.

ASSIGNMENT OF BENEFITS

You may not anticipate, alienate, sell, transfer, pledge, assign or otherwise encumber any interest in benefits to which you are or may become entitled under the Plan. The Trustees may, however, honor your assignment of benefits to the provider of covered services.

Neither you nor your beneficiary may transfer or assign any death benefit payments in anticipation of receiving them.

BENEFIT PAYMENT TO AN INCOMPETENT PERSON

Benefit payments under the Plan may become payable to a person who is adjudicated incompetent. In that event, the Trustees may make such payments for the benefit of the incompetent person, as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose or purposes for which paid if they are paid:

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

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

CLAIM RULES FOR MEDICAL, DENTAL, HEARING, VISION, PRESCRIPTION DRUG, MENTAL HEALTH AND SUBSTANCE ABUSE AND ORGAN TRANSPLANT BENEFITS

The procedures for medical benefits are different for the following types of claims:

- Pre-service (applicable to Hospital, Outpatient Surgical, Rehabilitation and Mental Health and Substance Abuse claims);
- Urgent care (applicable to Hospital, Outpatient Surgical, Rehabilitation and Mental Health and Substance Abuse claims);
- Concurrent care (applicable to Hospital, Rehabilitation and Mental Health and Substance Abuse claims); or
- Post-service.

Refer to the section that pertains to your type of claim and follow the applicable procedures.

PRE-SERVICE CLAIMS

A pre-service claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before you obtain medical care. The Plan requires you to obtain prior approval of hospitalization, outpatient surgery, rehabilitation and mental health and substance abuse services.

However, the Plan will not deny benefits for these procedures or services if:

- It is not possible for you to obtain pre-approval, or
- The pre-approval process would jeopardize your life or health.

> ***For Example:***
> You request pre-approval of your mental health therapy sessions after your Physician recommends the sessions for the treatment of your Illness.
>
> EXAMPLE

If you improperly file a pre-service claim, American Health Holding, Inc. or the Health Alliance Medical Plan will notify you as soon as possible but not later than 15 days after receiving your claim, of the proper procedures you should follow in filing a claim. You will only receive notice of an improperly filed Pre-service claim if the claim includes:

- Your name;
- Your specific medical condition or symptom; and
- A specific treatment, service or product for which approval is requested.

You must refile the claim properly in order for it to constitute a claim under the Plan.

For properly filed pre-service claims, you will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Plan. You will be notified of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you and/or your Physician will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination.

URGENT CARE CLAIMS

An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making pre-service claim determinations:

- Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied, or
- Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

EXAMPLE

For Example:
You request pre-approval of a diagnostic test for appendicitis.

Whether your claim is an urgent care claim is determined by the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a Physician with knowledge of your medical condition determines is an urgent care claim within the meaning described above, will be treated as an urgent care claim.

If you improperly file an urgent care claim, Benefits Administrative Services or the Health Alliance Medical Plan will notify you as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If you are requesting preauthorization of an urgent care claim, the time deadlines are different. The Plan will respond to you and your Physician with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan. The determination will also be confirmed in writing.

If an urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, Benefits Administrative Services or the Health Alliance Medical Plan will notify you and your Physician as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your Physician must provide the specified information within five days. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after the Plan receives the specified information or the end of the period given for you to provide this information, whichever is earlier.

CONCURRENT CLAIMS

A concurrent claim is a claim that is reconsidered after it is initially approved and the reconsideration results in:

- Reduced benefits;
- Extension of benefits; or

- A termination of benefits.

There is no formal deadline to notify you of the termination or reduction of a previously approved benefit (other than by Plan amendment or termination). However, American Health Holding, Inc. or the Health Alliance Medical Plan must notify you of such a decision:

- As soon as possible, and
- In time to allow you to have an appeal decided before the benefit is reduced or terminated.

> ***For Example:***
> Your inpatient Hospital stay is originally certified for five days and your stay is reviewed at three days to determine if the full five days is appropriate.
>
> EXAMPLE

If you request an extension of approved urgent care treatment, Benefits Administrative Services or the Health Alliance Medical Plan must act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

POST-SERVICE CLAIMS

Post-service claims are any claims for Plan benefits that are not pre-service claims. When you file a post-service claim, you have already received the services in your claim.
The following procedures apply to post-service claims:

> ***For Example:***
> You have diagnostic tests performed and then make your claim for benefits afterwards.
>
> EXAMPLE

- Obtain a claim form (or a claim may be filed for you by a PPO or other network provider).
- Complete your (the employee's) portion of the claim form.
- Have your Physician either complete the Attending Physician's Statement section of the claim form, submit a completed HCFA health insurance claim form, or submit a HIPAA-compliant electronic claims submission.
- Attach all itemized Hospital bills or Physician's statements that describe the services rendered.

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

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. Mail any further bills or statements for any Medical or Hospital services covered by the Plan to Benefits Administrative Services as soon as you receive them.

Ordinarily, you will be notified of the decision on your post-service claim within 30 days from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a post-service claim and notify you of the determination.

LOSS OF TIME BENEFIT CLAIMS

For Loss of Time Benefit claims, the Plan will make a decision on the claim and notify you of the decision within 45 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within 30 days.

For Loss of Time Benefit claims, the Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending. You should file your Loss of Time Benefit Claim with Benefits Administrative Services.

NOTICE OF DENIAL OF CLAIM OR ADVERSE BENEFIT DETERMINATION

The Trustees must provide you with a notice of their initial determination about your claim within certain time-frames after your claim is received by Benefits Administrative Services. The notice must provide you with the following information:

1. The specific reason or reasons for the denial of benefits or other adverse benefit determination;
2. A specific reference to the pertinent provisions of the Plan upon which the decision is based;
3. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
4. A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;
5. A copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request;
6. A copy of the scientific or clinical judgment or statement that it is available to you at no cost upon request for group health Plan and weekly sickness and accident claims that are denied due to:
   a. Medical necessity;
   b. Experimental treatment; or
   c. Similar exclusion or limit; and
7. A description of the expedited review process applicable to urgent care claims if the notice is a denial of an urgent care claim.

For urgent care claims and pre-service claims, you will receive notice of the determination even when your claim is approved.

Your Right to Appeal the Denial of a Claim

You have the right to a full and fair review if your claim for benefits is denied by the Plan or if there is any adverse benefit determination with regard to your claim. You must file your appeal in writing, except for urgent care claims, which may be oral. You must make your request directly to American Health Holding, Inc., Benefits Administrative Services or to the Health Alliance Medical Plan, as appropriate, within 180 days after you receive notice of denial. Appeals involving urgent care claims may be made orally by calling Benefits Administrative Services at 815-969-9663 or toll free at 800-249-7947, or by calling the Health Alliance's direct phone number for Member Relations at 800-500-3373. Your application for appeals of other claims must be in writing and must include the specific reasons you feel denial was improper. You may submit any document you feel appropriate, as well as submitting your written issues and comments. American Health Holding, Inc., Benefits Administrative Services or to the Health Alliance Medical Plan will prepare your appeal file for review by the Executive Board and decision by the full Board of Trustees..

REVIEW PROCESS

The review process works as follows:

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

- It was relied upon by the Plan in making the decision;
- It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);
- It demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or
- It constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

The Executive Board will review and the full Board of Trustees will decide your claim on appeal. This means that your appeal will be reviewed and decided by different persons than those at American Health Holding, Inc., Benefits Administrative Services or the Health Alliance Medical Plan that originally denied your claim. The Board will not give deference to the initial adverse benefit determination by American Health Holding, Inc., Benefits Administrative Services or the Health Alliance Medical Plan. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

TIMING OF NOTICE OF DECISION ON APPEAL

- Pre-Service Claims: You will be sent a notice of decision on review within 30 days of receipt of the appeal by Benefits Administrative Services or the Health Alliance Medical Plan.
- Urgent Care Claims: You will be sent a notice of a decision on review within 72 hours of receipt of the appeal by American Health Holding, Inc., Benefits Administrative Services or the Health Alliance Medical Plan.
- Post-Service Claims: Ordinarily, decisions on appeals involving post-service claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for

review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

- Loss of Time Benefit, Death Benefit or Accidental Death and Dismemberment Claims: The decision will be made in the same manner as for post-service claims.

NOTICE OF DECISION ON REVIEW

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Death Benefit and Accidental Death and Dismemberment Benefit Claims

The death benefit will be paid in full, in accordance with the terms of the Death Benefit or Accidental Death and Dismemberment provisions of the Plan, after Benefits Administrative Services receives a copy of a certified death certificate.

Legal Proceedings

You may not bring any action in court to recover Plan benefits:

- before you have exhausted all of your remedies under the Plan's claims and appeals procedures; or
- after three years from the expiration of the time allowance within which you were required to file your claim with the Plan.

Beneficiary

You may designate anyone as your beneficiary. If you change your beneficiary, your beneficiary does not need to consent to the change. If there are any other changes in the Plan, except as may be specifically provided, the beneficiary's consent to the changes is not necessary. If your beneficiary dies before you, your beneficiary's heirs have no claim to your benefits. If you do not name a beneficiary or there is no beneficiary who survives you at your death, benefits will be paid in a single sum to the first of the following beneficiaries who survive you:

- your widow or widower;
- your surviving children;
- your surviving parents;
- your surviving brothers and sisters; or
- the executor or administrator of your estate.

COORDINATION OF BENEFITS

The Plan has been designed to help you meet the cost of your medical expenses. It is not intended that you receive greater benefits than your actual medical expenses, so the benefits payable under the Plan will be coordinated with the benefits of other health care plans. The amount of benefits payable under this Plan may be affected when you are covered by any other plan (defined below), determined without regard to any Coordination of Benefits (COB) rules.

Specifically, in a calendar year, the Plan will always pay either its regular benefits in full or a reduced amount that, when added to the benefits payable by the other plan or plans, will equal 100% of Allowable Expenses incurred by you or your Dependent. When a plan provides payment in the form of services, such as services received from a Health Maintenance Organization (HMO), rather than cash payments, the reasonable cash value of the services will be considered both an Allowable Expense and a benefit paid.

NOTE

Coordination of Benefits (COB) provision. When you or your Dependents are covered by more than one plan, the COB rules prevent duplicate payments and provide the rules for the order in which the plans pay benefits.

Allowable Expenses are any Medically Necessary, Usual and Customary Charges for medical or dental services, treatment or supplies:

- that you or your Dependent incur during a calendar year and while eligible for Plan benefits; and
- part or all of which are covered under any of the plans covering you or your Dependent; and
- do not include any expenses listed in any of the Exclusions.

Although payments by this Plan cannot be more than would normally be paid if the COB rules did not exist, your combined reimbursement may exceed the maximum under this Plan, but cumulative payments by this Plan will not exceed the Maximum allowed for any benefit defined in this booklet.

"Plan" means any plan providing benefits or services for or by reason of medical, dental or vision care or treatment or healing under:

- group insurance;
- group practice, group Blue Cross, group Blue Shield, individual practice offered on a group basis or other group prepayment coverage;
- labor-management trustee plans, union welfare plans, employer organization plans or employee benefit organization plans; or
- governmental programs or coverage required or provided by any statute.

Keep in mind that if your working spouse has single coverage offered through his or her employer that is at least 75% subsidized by that employer, your spouse must enroll in that single coverage in order to have secondary coverage under this Plan. The COB rules will not apply and your spouse will have no coverage under this Plan if your spouse does not enroll in his or her employer's subsidized single coverage. See page ___ for a more detailed explanation.

To administer the COB rules properly, and to determine whether this Plan will reduce its regular benefits, it is necessary to determine the order in which the various plans will pay benefits. The order in which the plans will be considered to pay benefits is determined by the first of the following rules that apply:

- When another plan does not have Coordination of Benefits rules (COB rules), that plan must pay benefits first.
- When another plan has COB rules, the first of the following rules that apply determine which plan will pay benefits first:
  - ◊ If a plan covers the claimant as an employee, then that plan will pay benefits first.
  - ◊ If a plan covers the claimant as a Dependent child whose parents are not divorced or separated, the plan of the parent whose birthday anniversary is earlier in the calendar year will pay on for Allowable Expenses

incurred first; except if both parents' birthdays are on the same day, the plan covering the parent for the longer period of time will pay first. If a plan does not adhere to the "birthday rule" in determining the order of benefits, then that plan must pay first.

◊ If a plan covers a Dependent child whose parents are divorced or separated, then the following rules apply:

  Δ a plan will pay first if it covers a child as a Dependent of a parent who is ordered by court decree to provide health coverage;

  Δ when there is no court decree requiring a parent to provide health coverage to a Dependent child, the following rules will apply:

  Δ when the parent who has custody of the child has not remarried, that parent's plan will pay first; or

  Δ when the parent who has custody of the child has remarried, benefits will be determined by that parent's plan first, by the stepparent's plan second and by the non-custodial parent's plan third.

Once the order of payment is determined, the Health and Welfare Fund Office will add up the regular benefits under each plan in the order in which the plans are considered to pay their benefits and compare the amount with the total Allowable Expenses under this Plan. If payment of regular benefits by the Health and Welfare Fund would result in payment of benefits that exceed Allowable Expenses, the Health and Welfare Fund will reduce the regular benefit paid to eliminate the excess.

If this Plan is secondary and your primary plan does not pay benefits because you did not comply with that plan's rules, this Plan may deny your benefit claim.

The Health and Welfare Fund has the right and does not need consent by you, your Dependent or any person to:

- release or obtain any information the Health and Welfare Fund determines to be necessary to implement these rules;
- make any payments necessary to satisfy the intent of these rules if payments have been made under any other plan that should have been made under the group policy; or
- recover any excess payments in order to satisfy the intent of these rules.

If a Dependent child is employed and is covered by his or her employer's plan, they are no longer covered by this Plan and their employer's plan is responsible to pay benefits and there will be no coordination of benefits with this Plan.

NOTE

NOTE: It is important to enroll in Medicare Part A and Part B or Medicare Part C (Medicare+ Choice – a Medicare HMO offering where available) when you are eligible. Your benefits will be calculated as though you are enrolled, if you are eligible, but choose not to enroll.

Medicare

Your benefits are also coordinated with Medicare if you are eligible for Medicare benefits, unless federal law requires the Plan to be the primary payer. If you are eligible for Medicare Part A and Part B or Medicare Part C, you are required to enroll in Parts A and B or Medicare Part C. If you do not enroll in Medicare Part A and Part B or Medicare Part C when you are eligible, your benefits will be calculated as if you were covered by Medicare Parts A and B or Medicare Part C.

Claim Savings

Whenever this Plan is considered the secondary plan and a claim payment is reduced because of these Coordination of Benefit rules, the amount of the reduction will be carried for the balance of the calendar year as a claim savings for the person for whom the claim was made. This amount may be used for other claims due to any cause in the same calendar year if the person has an out-of-pocket allowable expense after the normal benefits under both plans have been paid. Charges toward the deductible and charges for prescription drug expenses are not eligible for reimbursement from your claim saving, however. The Plan maintains your claim savings record for only a calendar year.

SUBROGATION

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

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

Definitions

The following definitions apply to the terms used in this section:

- **Another Person** or **Entity** means any individual, corporation, municipality, or other governmental entity, parnership, association, trust, or any other organization, no matter how the person or entity has been identified.
- **Another Source** means someone other than you or the Plan and includes:
  - ◊ an insurance company that must pay the claims that result from the acts of another person, such as accident coverage, "no fault" coverage, uninsured or underinsured motorist coverage, personal Injury protection, homeowners insurance, or school or athletic insurance;
  - ◊ an employee health insurance plan or arrangement;
  - ◊ a medical and Hospital plan; or
  - ◊ another person or any other entity (such as a company, organization or corporation) that is responsible for the acts of the person that caused your expenses, such as a homeowner or other property owner.

  Another Source does not include another employer group health plan that covers you, for example, through your spouse's employer, if that coverage is subject to the Coordination of Benefits provisions of this Plan.

- **Compensable Injury** means any Injury for which you or your Dependent may recover payment from another source.
- **Compensated Injury** means any Injury for which the expenses for you or your eligible Dependent has already been paid by another source before this Plan pays benefits toward the same claim.
- **Injury** means either an Illness or an Injury, if caused by the actions of another person or entity. It also includes conditions that you may develop over time, such as from continued exposure to a harmful agent or a prolonged misdiagnosis of your condition.
- **Recovery** means any payment from another source as a result of an Injury. It includes any judgment, award or settlement, whether or not the judgment, award or settlement specifically includes or excludes medical expenses or payments for disability. This definition applies no matter what the recovery is called. For example, "loss," "punitive damages," "pain and suffering," "medical expenses," "attorney's fees," "costs," etc. will all be defined as recoveries.
- **Subrogation** means that the Plan has the right to take your place to ensure that any person or entity responsible for your Injury pays for the expenses of your Injury or reimburses the Plan for the amount it has paid on your behalf for that Injury.

You Must Agree to Reimburse the Plan for Other Payments

Whenever you or your Dependent has an Injury expense that may be paid for by another person or entity, you (and your Dependent if your Dependent is injured) must complete a Reimbursement Agreement (subrogation

agreement) to receive benefits from the Plan. Signing a Reimbursement Agreement is not a guarantee of payments by the Plan. If your Dependent is a minor or is legally incompetent, you and the person who is legally authorized to act on his or her behalf must complete the Reimbursement Agreement. You and your Dependent must also comply with the following terms:

- You must agree to repay the Plan any benefits the Plan has paid because of your Injury. This provision applies even if the recovery does not fully pay you for the Injury expenses.
- You will only be required to repay the amount of the benefits the Plan paid on the claim, or the amount you have recovered, whichever is less, without regard to attorneys' fees and expenses you paid to obtain the recovery.
- The Reimbursement Agreement gives the Plan a lien – or claim – on the money you recover from another source, both to the full extent of the Plan's subrogation rights and to the full extent of its right to repayment under the Reimbursement Agreement. The lien is valid whether or not the Reimbursement Agreement or the Plan's subrogation rights are enforceable.
- You must protect the Plan's right to reimbursement for benefits paid and do everything necessary for the Plan's recovery of benefits it paid. You must assist and cooperate with Plan representatives and sign all required documents to recover benefits paid by the Plan.
- If you receive a judgment or settlement, you must repay the Plan the lesser of the full amount of benefits paid by the Plan, or the amount of the recovery. This provision applies, whether or not the source of the recovery was legally responsible for paying those expenses. If you do not repay the Plan, the Plan may reduce future benefits for your claims until the Plan has recovered the benefits it paid. The Plan's right to reduce future bene fits is in addition to any other legal rights the Plan may pursue to recover benefits.
- You, your Dependent or your Dependent's representative must:
  - ◊ not assign to any other person or entity your right to recover benefits from another source;
  - ◊ obtain the Plan's consent before releasing another person from liability for any Injury; and
  - ◊ not interfere with the Plan's claim and lien.

If you attempt to assign your right to recovery of benefits, the Plan may pursue legal action against you and the person or entity to which you assigned your rights, to cancel your assignment and recover the benefits paid by the Plan.

- The Plan is subrogated to your right to recover from another source.
- The Plan will not be responsible for legal fees and expenses you pay to obtain a recovery from another source, unless the Plan has previously agreed to that in writing.
- The Plan may require your attorneys to sign an agreement that they will honor and enforce the terms of the Reimbursement Agreement before they disburse any money received as a recovery from a Compensable Injury.

Plan's Right of Subrogation

- Your agreement to repay in the Reimbursement Agreement and the Plan's right of subrogation are separate and distinct rights and obligations. If either the Agreement or the right of subrogation fails or is considered invalid in some way, it will not affect the validity of the other.
- The provisions in the previous section, You Must Agree To Reimburse The Plan For Other Payments also apply to the Plan's Right of Subrogation. If you fail or refuse to sign a Reimbursement Agreement, it does not affect the Plan's subrogation rights or the Plan's right to claim a lien against and collect benefits from any source of possible recovery.
- The Plan has the right to intervene and participate in any legal action you bring against another source.
- If you fail or refuse to take legal action against another source within a reasonable time, the Plan may do so in your name to recover amounts due under the subrogation provision. If the Plan takes legal action, the Plan has the right to deduct its expenses, costs, and attorney's fees out of any recovery or settlement. The Plan is not required, by this provision, to pursue your claim against another person, however.

- If you recover benefits from another source and do not repay the Plan, the Plan may sue you to recover the amount of the benefits paid. The Plan may also reduce any of your future benefits until the Plan is fully repaid, regardless of whether or not the future claim is related to the Compensated Injury.
- If the Trustees determine that recovery from another source is not possible, the Plan will waive its right to subrogation and will pay its normal benefits for your claim.
- The Trustees or their authorized representative have the sole discretion to interpret the Plan's subrogation provisions and to settle any of the Plan's subrogation claims and liens.
- The Trustees have the sole discretion to make a determination regarding questions as to whether any benefit payment is related to a Compensable Injury. You must sign any and all necessary documents, releases and waivers that relate to their determination, upon request.

Compensated Injuries

If another source has already paid you expenses toward treatment of your Injury, the Plan will not begin paying benefits until the total expenses for your Compensable Injury exceed the total amount you have recovered from the other source.

- Any and all monetary recovery you receive will first be applied to benefits payable under this Plan.
- The Plan's subrogation rights are enforceable, regardless of:
  - ◊ who begins the legal action against the person or entity that is responsible for the Injury;
  - ◊ who pays the amount of the recovery;
  - ◊ whether the recovery is in the form of a judgment, settlement or otherwise; or
  - ◊ whether you receive the recovery as an employee, Dependent, legally competent or incompetent person or a representative of any such person.
- Nothing in this section will interfere with or limit the Fund's right to subrogation for medical expenses that were incurred and paid before you recovered the expenses from your Injury.

IMPORTANT INFORMATION ABOUT THE PLAN

Name of Plan. This Plan is known as the North Central Illinois Laborers' Health and Welfare Fund.

Board of Trustees. A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of employer and union representatives, selected by the employers and the unions who have entered into collective bargaining agreements that relate to this Plan. If you wish to contact the Board of Trustees, you may use the address and phone number below:

Board of Trustees
North Central Illinois Laborers' Health and Welfare Fund
6714 N. Frostwood Parkway
Peoria, IL 61615
Telephone: 309-692-0860
Toll free: 866-692-0860
Fax: 309-692-0862
Electronic Mail Address: ncilhwf@ameritech.net

As of July 1, 2002, the Trustees of the Plan are:

Employer Trustees	***Union Trustees***
Glen Turpoff	John Penn
Dennis Dougherty	Mike LaHood
Gary Stewart	Tom DalSanto
Joe Cowan	Michael W. Smith
Mike Cullinan	Duane Demmin
Joe Hart	David Penn

You should send all correspondence to the Board of Trustees or any individual Trustee to the North Central Illinois Laborers' Health and Welfare Fund at the above address.

Plan Sponsor and Administrator. The Board of Trustees is both the Plan Sponsor and Plan Administrator.

Identification Numbers. The Plan number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 300088171.

Agent for Service of Legal Process. The Administrative Manager is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any documents may be served upon the Administrative Manager at the address shown in the front of this booklet. Service of legal process may also be made upon any of the Plan Trustees, individually at the Welfare Fund Office.

Collective Bargaining Agreement. The relevant provisions in the collective bargaining agreement determine the hourly rate at which employers contribute to the Plan and the employees on whose behalf contributions are made. If you request it in writing, you and your Dependents may obtain:

- information about whether an employer is required to pay contributions to the Plan;
- the address of a particular Contributing Employer; and
- copies of the collective bargaining agreement.

You or your Dependents may also examine these documents and information at the Health and Welfare Fund Office or your local union.

Plan Documents. This Summary Plan Description booklet is meant to be an easy-to-understand description of your Plan benefits. This booklet also serves as the Plan Document, which is the Plan's official Rules and Regulations. The Plan is governed by this document and by the Trust Agreement establishing the Plan.

Source of Contribution. The benefits described in the Welfare Plan booklet are provided through employer contributions. The amount of employer contributions is determined by the provisions of the collective bargaining agreement. Self-contributions from employees and surviving spouses are allowed under certain circumstances that are described on page 10 of this booklet.

Trust Fund. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. The Health and Welfare Fund's assets and reserves are invested primarily in short-term money market and government securities.

Type of Plan. This Plan is maintained for the purpose of providing life, disability and medical benefits in the event of death, Illness or Injury. The Plan benefits are shown in the Schedule of Benefits in the back pocket of this booklet.

Plan Year. The Plan Year begins on July 1 and runs through the following June 30.

Eligibility. The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, denial or loss of any benefits are fully described on page 6 - 15 of this booklet.

Claim Procedure. The procedures to follow for filing a claim for benefits are set forth on page 49 of this booklet. If all or any part of your claim is denied, you may appeal that decision, as explained on page 57.

STATEMENT OF EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Security Act of 1974, as amended (ERISA). ERISA provides that all Plan Participants are entitled to the following:

Receive Information about Your Plan and Benefits

You have the right to:

- examine, without charge, at the Health and Welfare Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration (PWBA);
- obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to furnish each Participant.

Continue Group Health Plan Coverage

You also have the right to:

- continue health care coverage for yourself, spouse or other 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 this coverage; review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights); and
- reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - ◊ you lose coverage under the Plan;
  - ◊ you become entitled to elect COBRA continuation coverage; or
  - ◊ your COBRA continuation coverage ceases.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

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

Your Rights Regarding Claim Issues

If your claim 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. The Appeal Procedure and time frame table is located in the back pocket of this booklet.

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 them, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement of your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration (PWBA), U.S. Department of Labor, listed in your telephone directory or at:

NOTE

If you have any questions about the Plan, you should contact the Plan Administrator at the Health and Welfare Fund Office.

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the PWBA Brochure Request Line at (800) 998-7542 or contact the PWBA field office nearest you.

You may also find answers to your questions using the PWBA's website at www.dol.gov/dol/pwba/. A list of PWBA field offices is located at the website..

PRIVACY POLICY

Effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

The Plan will distribute its Privacy Notice:

- Before April 14, 2003 when the privacy rules require distribution,
- Periodically, as required by the rules, and
- When changes are made in policies and procedures.

This Plan and the Plan Sponsor will not use or further disclose your protected health information except as necessary for treatment, payment, health plan operations and Plan administration or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose your protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPAA with respect to your protected health information include the right to:

- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Fund Office.

THE PLAN'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI)

How the Plan Uses and Discloses Your Protected Health Information

The Plan will use your protected health information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Plan will disclose PHI to the Retirement Fund, disability plan, reciprocal benefit plans and workers' compensation insurers for purposes related to administration of these plans.

DEFINITION OF PAYMENT

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant (and their authorized representatives') inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health plan); and
- Reimbursement to the Plan.

DEFINITION OF HEALTH CARE OPERATIONS

Health Care Operations include, but are not limited to, the following activities:

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives; and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;
- Business management and general administrative activities of the entity, including, but not limited to:
  - ◊ Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
  - ◊ Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;
  - ◊ Resolution of internal grievances; and
  - ◊ Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

The Plan's Disclosure of Protected Health Information to the Board of Trustees

For purposes of this section the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan Documents have been amended to incorporate the following provisions:

With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by this Summary Plan Description and Plan Document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
- Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual;
- Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make the information available that is required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the group health Plan with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees will be given access to PHI.

- The Plan Administrator; and
- Staff designated by the Plan Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan sponsor performs for the Plan. If these persons do not comply with this Summary Plan Description and Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

DEFINITION OF TERMS USED IN THIS SUMMARY PLAN DESCRIPTION

Covered Charges means the Usual and Customary Charges for services and treatments that are:

- covered under this Plan;
- for medical conditions covered under this Plan; and
- based on valid medical need according to accepted standards of medical practice.

Contributing Employer means an employer that, pursuant to the terms of a collective bargaining agreement, or other written agreement acceptable to the Trustees, agrees to contribute to the North Central Illinois Laborers' Health and Welfare Fund on behalf of individuals employed by the employer.

Custodial Care means the medical or non-skilled services that:

- do not seek to cure; or
- are provided during periods when the medical condition of the patient is not changing or does not require the continuous administration of medical personnel.

Such services and supplies are Custodial Care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed.

Dependent means:

- your lawful spouse;
- your unmarried child (including stepchild, legally adopted child or child placed with you for adoption, child under your legal guardianship and natural child) who:
  - ◊ is under the age of 19; and
  - ◊ resides with you; and
  - ◊ is chiefly dependent upon you for support;
- an unmarried child who is under the age of 23 and is enrolled as a full-time student in an accredited educational institution, as defined by that institution. Upon request of the Plan, proof of full-time student status is to be furnished from time to time, but in no event more frequently than once per semester. The Participant is responsible for notifying the Plan when a Dependent is no longer a full-time student. If proper notice is not provided, the Plan will have the right to retroactively terminate coverage on the date full-time student status ceased, and recover an amount equal to the Usual and Customary Charge for services provided following such date; and
- your unmarried child who is and continues to be incapable of self-sustaining employment by reason of any handicap condition and is chiefly dependent upon you for lifetime care and supervision, and who was considered to be handicapped upon reaching age 19. Upon request by the Plan, you may be required to furnish proof of such incapacity and dependency from time to time, but in no event more frequently than once a year.
- For purposes of this definition of Dependent, a child includes your unmarried:
  - ◊ newborn child whose coverage becomes effective at birth if you enroll the newborn as a Dependent. If enrollment does not occur within 31 days of birth, the coverage effective date will be postponed until the first day of the month following the date you apply for the newborn's coverage;
  - ◊ child who is placed with you for adoption or legally adopted and resides with you;
  - ◊ child for whom you have been appointed legal guardian, provided the Plan has been presented with the order appointing guardianship, including grandchildren; and
  - ◊ child who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO) approved by the Board of Trustees. Procedures for qualifying Medical Child Support Orders are available from the Health and Welfare Fund Office at no cost.

Donor means a person who undergoes a surgical operation for the purpose of donating a Body Organ(s) for Transplant Surgery.

Durable Medical Equipment means equipment recognized as such by Medicare Part B and that:

- can stand repeated use;
- is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
- is usually not useful to a person in the absence of an Illness or Injury;
- is appropriate for home use;
- is related to the patient's physical disorder; and
- is approved in writing by a Physician as being Medically Necessary.

Experimental or **Investigative** means services or treatment:

- on which the consensus of expert medical opinion, based on reliable evidence (i.e. published reports and/or articles), indicates that further trials or studies are needed to determine the safety, efficiency and outcomes of such treatment or services compared to standard treatment;
- not yet recognized as having proven beneficial outcomes;
- still primarily confined to a research setting;
- not appropriate based on:
  - ◊ medical circumstances; or
  - ◊ the advanced stage of an individual's Illness; or
  - ◊ the likelihood that the service or treatment will measurably improve the individual's Illness or medical condition.

The Trustees, or their designated representatives, have the sole authority to determine whether a treatment, service or supply is Experimental or Investigative.

Home Health Care Agency means an agency or organization that:

- is primarily engaged in providing nursing and other therapeutic services;
- is federally certified and duly licensed, if such licensing is required;
- has policies established by a professional group associated with such agency, including at least one Physician and registered nurse, to govern the services provided;
- provides for full-time supervision of such services by a Physician or by a registered nurse;
- has its own administrator; and
- maintains a complete medical record on each patient.

Home Health Care Plan means a program:

- for you and your Dependent's continued care and treatment;
- established and approved in writing by the attending Physician; and
- certified by the attending Physician that proper treatment would require confinement in a Hospital in the absence of the services and supplies provided by the Home Health Care Plan.

Hospice is an organization licensed as a Hospice by the jurisdiction where it is located that focuses on comfort and pain relief rather than curative treatment for patients who have a prognosis of less than six months to live.

Hospice Care Agency means an agency or organization that provides or otherwise arranges for services to Terminally Ill patients on a 24-hour per day basis and:

- is licensed or certified as a Hospice Care Agency by the jurisdiction where it is located;
- provides skilled nursing services, medical social services, psychological and dietary counseling to the Terminally Ill; and
- provides bereavement counseling for the immediate family.

Hospital means an institution that:

- is primarily engaged in providing, by or under the supervision of Physicians, inpatient diagnostic, surgical and therapeutic services for diagnosis, treatment and rehabilitation of injured, disabled or sick persons;
- maintains clinical records on all patients;
- has by-laws in effect with respect to its staff of Physicians;
- has a requirement that every patient be under the care of a Physician;
- provides 24-hour nursing service rendered or supervised by a registered professional nurse;
- has a Hospital utilization review plan in effect;
- is licensed pursuant to any state or agency of the state responsible for licensing Hospitals; and
- has accreditation under one of the programs of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Unless specifically provided, the term Hospital does not include any institution, or part thereof, that is used principally as a rest facility, nursing facility, convalescent facility, or facility for the aged, inpatient rehabilitation facility or for the care and treatment of alcoholism or drug abuse, except as mandated by state law. It does not mean any institution that makes a charge that you or your Dependent is not required to pay.

Illness means sickness, disorder or disease that is not employment-related. Pregnancy is treated the same as an Illness under this Plan for you or an eligible Dependent.

Injury means physical damage to you or your Dependent's body caused by purely accidental means, independent of all other causes. Injuries that are not employment-related are considered for benefits under this Plan, except under the Life and Accidental Death and Dismemberment Benefits.

Medical Emergency means the sudden and unexpected onset of a traumatic bodily Injury or Illness with severe symptoms and:

- that requires immediate diagnosis or treatment to prevent serious physical impairment or death;
- for which the covered person seeks medical care immediately and in no event more than 24 hours after the onset of the symptoms; and
- in the event of a mental or behavioral health disorder, the lack of the treatment could reasonably be expected to result in the self-harm or harm to others by the covered person.

Medically Necessary means those services required to identify or treat a Member's Illness or Injury, and that are determined by the Plan to be:

- consistent with the symptoms, diagnosis and treatment of the Participant's condition, Illness or Injury;
- in accordance with recognized standards of care for the Participant's condition, Illness or Injury;
- appropriate with regard to standards of good medical practice;
- not solely for the convenience of the participant, Physician, Hospital, or other healthcare provider; and
- the most appropriate level of service that can be safely provided to the participant.

When specifically applied to Inpatient services, it further means that the participant's medical symptoms or condition requires that the treatment of service cannot be safely provided to the participant on an outpatient basis.

Open Enrollment Period means the period of time during which eligible Participants may apply for coverage under any of the various plan options being offered. These periods will be established by the Plan Administrator, but no less frequently than once each calendar year.

Participant means an employee who becomes qualified for coverage upon satisfying the eligibility rules described in this booklet.

Physician means a duly licensed doctor of medicine authorized to perform a particular medical or surgical service within the lawful scope of practice.

Preauthorization means the process adopted by the Plan of prior authorization of all Hospital admissions of 24 hours or more, outpatient surgery, rehabilitation services, transplant benefits and all mental and substance abuse treatment. Preauthorization is performed for the Plan by:

- American Health Holding, Inc. for the Blue Cross Blue Shield of Illinois and HFN medical and transplant benefits,
- Health Alliance Medical Plan for Health Alliance medical and transplant benefits,
- Member Assistance Program (MAP) for mental health and substance abuse benefits.

Preauthorization is not a guarantee of benefits. Please refer to the *Schedule of Benefits* located in the back pocket of this booklet for coverage information.

Recipient means an eligible Participant or Dependent who undergoes Transplant Surgery to receive a Body Organ(s).

Rehabilitation Services means the treatment modalities that are a part of a rehabilitation program that include physical therapy, occupational therapy and cardiac rehabilitation performed on an inpatient basis in a skilled nursing care facility or on an outpatient basis. The Plan covers rehabilitation, subject to co-payments, deductibles, preauthorization requirements and limitations on the number of days of inpatient treatment and the number of outpatient visits.

Terminally Ill means a person who has received a medical prognosis of six months or less to live from a Physician.

Skilled Nursing Facility means an institution or any part of any institution that operates to provide convalescent or nursing care and is primarily engaged in providing inpatients with skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services for the rehabilitation of an injured, disabled or sick person. It is an institution that:

- has policies that are developed with the advice of, and with provisions for review of such policies from time to time by, a group of professional personnel, including one or more Physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides,
- has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies,
- has a requirement that the health care of every patient be under the supervision of a Physician and has a Physician available to furnish necessary medical care in case of an emergency,
- maintains clinical records on all patients,
- provides 24-hour nursing service, which is sufficient to meet nursing needs in accordance with the facility policies, and has at least one registered professional nurse employed full-time,

- provides appropriate methods and procedures for dispensing and administering drugs and biologicals,
- in the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature, is licensed pursuant to such law or is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing, and
- meets any other conditions relating to the health and safety of individuals who receive services in such institutions or relating to the physical facilities thereof.

Transplant Surgery means the transfer of a Body Organ(s) from the Donor to the Recipient.

Treatment Facility for Substance Abuse is a rehabilitation facility for the inpatient or outpatient treatment of individuals suffering from substance abuse. Such a facility may be a freestanding facility or may be a designated portion of a Hospital or other facility, provided such designated portion is solely for the purpose of providing rehabilitative treatment for individuals suffering from alcohol and/or drug abuse (substance abuse). To be considered an approved treatment facility for purposes of this Plan, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and must be approved by the Trustees or their administrative designees.

Usual and Customary Charges means the amount most consistently charged by a licensed Physician or other professional provider for a given service. A customary charge refers to a charge that is within the range of usual charges for a given service billed by most Physicians or other professional providers with similar training and experience in a given geographic area.

Well Child Required Immunization means any immunization that has been recognized and is required for school age and pre-school age children by the Department of Public Health.

Benefits for Eligible Employees and Dependents

Medical Benefits

For specific information describing the benefits available from your Preferred Provider Organization (PPO), three-tiered Plan (one that contains an exclusive provider (EPO) network, PPO network and out-of-network benefits), see the Schedules of Benefits that follow.

For Vision, Hearing, Dental, Death, Accidental Death and Dismemberment and Loss of Time Benefits, you may: **Request claims forms from, and Submit claims to:**	**Benefits Administrative Services** **1040 N. Second Street, P. O. Box 4509** **Rockford, IL 61110-4509** **Telephone: 815-969-9663** **Toll free: 800-249-7947** **Facsimile: 815-969-9770**
Vision Care Benefit	
Covered Services (See Page 32)	Up to $200 per person in each 24-consecutive-month period
Hearing Care Benefit	
Hearing Exam	Up to $75 per person in each 24-consecutive-month period
Hearing Aid	Up to $400 per person in each 60-consecutive-month period
Dental Expense Benefit	
Covered Services	80%
Calendar Year Maximum Benefit	$1,500 (Combined Dental and Orthodontic limit)
Orthodontic Services – Eligible Dependent Children up to age 19 Only	50%
Orthodontic Services – Calendar Year Maximum	$750
Orthodontic Lifetime Maximum	$1,500
Benefits for Eligible Active Employees Only	
Death Benefit	$10,000
Accidental Death and Dismemberment	
Death or Two Dismemberments	$10,000
One Dismemberment:	$5,000
Loss of Time Benefit	
Amount of Weekly Benefit:	$250
Maximum Benefit Period:	13 Weeks
Payment Starts:	1st day after Accident; 8th day after Illnes