North Central Illinois Laborers' Health and Welfare Fund

Summary Plan Description and Plan Document 2025 Edition

North Central Illinois Laborers' Health and Welfare Fund

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This Summary Plan Description/Plan Document has been prepared for active and retired Participants of the North Central Illinois Laborers' Health and Welfare Fund. This Summary Plan Description also serves as the official Plan rules and regulations that establish the Plan. The Trustees reserve the right to interpret, amend, or terminate the Plan at any time. The Trustees have not empowered anyone else to speak for them regarding the Health and Welfare Fund. No Employer, union representative, supervisor, or shop steward is in the position to discuss your rights under this Fund with authority. No benefits in this booklet are vested.

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Introduction

The Board of Trustees of the North Central Illinois Laborers' Health and Welfare Fund is pleased to provide you with this updated Summary Plan Description (SPD), which also serves as the Plan Document. This SPD/Plan Document contains current health and welfare benefits information for active and retired Participants. The benefits described in this booklet are effective **July 1, 2025**. This SPD/Plan Document replaces and supersedes prior versions. The Plan offers:

- Medical benefits through the:
  - Blue Cross and Blue Shield of Illinois Preferred Provider Organization (PPO); and
  - Cigna;
- A Member Assistance Program (MAP);
- Telehealth Services;
- Prescription drug benefits;
- Dental benefits;
- Vision benefits;
- Hearing benefits;
- Loss of Time benefits (for eligible Eligibility A and C employees only);
- Life Insurance benefits (for eligible Eligibility A and C employees only); and
- Accidental Death and Dismemberment Insurance benefits (for eligible Eligibility A and C employees only).

If you have questions about how the Plan works, please call or write the Fund Office at:

North Central Illinois Laborers' Health and Welfare Fund
4208 W. Partridge Way, Unit 3
Peoria, Illinois 61615

866-692-0860 [toll-free]
309-692-0860 [phone]
309-692-0862 [fax]
ncil@ncil.us [e-mail]

This booklet describes all the benefits that are provided under two different *Schedules of Benefits* included under the Plan. Your eligibility for each program is based on your eligibility class: A, B or C. Y***ou should rely on your particular Schedule of Benefits to determine the specific benefits and amount of coverage provided to you by the Plan. The Schedule of Benefits are available free of charge to any Participant or beneficiary who so requests.***

You may not assume you are covered by a benefit because it is described in this booklet. Call the Fund Office if you have questions about your benefits.

This booklet contains a summary in English of your plan rights and benefits under North Central Illinois Laborers' Health and Welfare Fund. If you have difficulty understanding any part of this booklet, contact Professional Benefit Administrators (PBA) at 800-435-5694 or 630-655-3755.

It is the Trustees' goal to maintain a financially stable Fund while providing adequate health care coverage to you and your family. The Fund has implemented some cost-control methods such as medical deductibles and out-of-pocket maximums to ensure that the Fund can meet your current and future health care needs. You can help manage health care costs for you and the Fund by:

- **Visiting network providers** – Network providers, which include Hospitals, Physicians, and other health care providers, charge negotiated, reduced rates. In addition, the Plan pays a higher percentage when you use a network provider.
- **Examining emergency treatment alternatives** – In the event of an Emergency Medical Condition, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can obtain the same level of care at a Physician's office or an urgent care facility as in

a Hospital emergency room. Keep your Physician's telephone number accessible and locate the nearest facility so you will be prepared in case of an Emergency Medical Condition.

- **Preauthorizing services** (under both the Cigna and Blue Cross and Blue Shield of Illinois plans) – Certain services under the Plan require Preauthorization.
- **Requesting generic medications** – Often medications come in two forms: generic and brand-name. Generic medications have to meet the same quality standards for pureness and effectiveness, but can cost much less than their brand-name equivalents. Check with your Physician to see if a generic medication is appropriate for you.
- **Using the mail-order program –** The mail-order program is a convenient way to have maintenance medications delivered to your home. When you use the mail-order program, you generally pay less for a larger supply of medication.
- **Enrolling your spouse in employer-sponsored coverage (this does not apply to retired Participants)** – If your spouse's employer offers health coverage, and the employer subsidizes 75% or more of the cost, your spouse **must** enroll in that coverage. If that coverage is offered and your spouse does **not** enroll, your spouse will **not** be covered by this Plan. If your spouse enrolls 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 (see page 107).

  Subject to a hardship exception, your Dependent spouse cannot be covered under this Plan, if he or she has or has available, medical coverage from your Dependent spouse's employer and that employer subsidizes at least 75% of the cost of single coverage, unless your Dependent spouse's employer provides the same maximum benefits to all its employees, without regard to the coverage the Dependent spouse may have in another plan. For example, if the plan of your Dependent spouse's employer automatically enrolls an individual in a wrap-around plan due to other coverage, that plan will not offer the same maximum benefits as this Plan. For additional information about this provision, see page 109.

All the benefits of this Plan are made available to you and your eligible Dependents by the Fund 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 and their eligible Dependents;
- Change eligibility requirements or the hourly contribution and/or self-payment rates; and
- Otherwise, exercise prudent discretion at any time without legal right or recourse by you, your Dependents, or any other person.

We urge you to read this information and, if you are married, share it with your spouse. Also, please keep this SPD/Plan Document with your important papers so you can refer to it when needed.

Sincerely,

Board of Trustees

Contact Information

If You Need Information About …	Contact …	Contact Information …
Eligibility, Life Insurance Benefits, and Accidental Death and Dismemberment Insurance Benefits	North Central Illinois Laborers' Health and Welfare Fund 4208 W. Partridge Way, Unit 3 Peoria, Illinois 61615	309-692-0860 or 866-692-0860 [phone] 309-692-0862 [fax] Ncilhwf.com [website] ncil@ncil.us [e-mail]
Vision, Hearing, and Loss of Time Benefits	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oak Brook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax] pbaclaims.com/ [website]
BCBSIL PPO		
Preauthorization of Medical Claims	Valenz Health Five Radnor Corporate Center 100 Matsonford Road, #5-444 Wayne, PA 19087	800-367-9938 [phone] valenzhealth.com [website]
Medical Benefits and Claim forms	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oak Brook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax] pbaclaims.com/ [website]
For a list of BCBSIL Participating Doctors and Hospitals	Blue Cross and Blue Shield of Illinois 300 E. Randolph St., 22-102 A Chicago, IL 60601	800-810-2583 [phone] bcbsil.com [website]
Cigna PPO		
Preauthorization of Medical Claims, Medical Benefits and Claim forms	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oak Brook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax] pbaclaims.com/ [website]
For a list of Cigna PPO Participating Doctors and Hospitals	Cigna PO Box 188061 Chattanooga, TN 37422-8061	800-435-5694 [phone] mycigna.com [website]
Member Assistance Program (MAP)	AllOne Health Code: ncilmap	800-292-2780 [phone] ers-eap.com [website]
Prescription Drug Benefits	Sav-Rx Mail Order: P.O. Box 8 Fremont, NE 68026	800-228-3108 [phone] SavRx.com [website]
Dental Benefits	Delta Dental of Illinois Group No. 20141	800-323-1743 [phone] deltadentalil.com [website]
Telehealth Services	RelyMd Employer Code: MYIDR1289	855-879-4332 [phone] Patient.relymd.app [website]

Life Events

At some point in your life, you will experience a life event that impacts health care coverage for you and your Dependents. 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.

Getting Married

When you get married, your spouse is eligible for medical, dental, prescription drug, vision and hearing benefits.

You must notify the Fund Office of your marriage and provide the necessary documentation within **31 days** of the date of your marriage to have your spouse covered from the date of marriage. If you notify the Fund Office after 31 days, your spouse will be covered the first day of the month following receipt of the documentation by the Fund Office. You should use the Fund's Enrollment/Change Form for these notices.

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 must provide this information to the Fund Office each year.

If Your Spouse Has Other Coverage Available

This provision does not apply to spouses of retired Participants. If your spouse is employed, your spouse's employer offers health coverage, and the employer 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, your spouse will **not** be covered by this Plan. If your spouse enrolls 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 (see page 107). The Plan has adopted this requirement to help keep your contributions lower.

This Plan also covers your Dependents. Your spouse does not have to enroll for Dependent coverage under his or her employer's plan to have coverage under this Plan for your Dependent children.

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 is employed, your spouse and his or her employer must complete the Fund's Spousal Health Care Information form.

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 and the Spousal Health Care Information form if your spouse is covered under or has coverage available under another group health insurance plan, such as an employer plan.

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:

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

Failure to disclose and enroll in spousal coverage will result in the loss of benefits. If your spouse does not have an employer who subsidizes 75% of the cost of his or her single coverage under that employer's group health plan, this Plan will provide primary coverage for your spouse.

Adding a Child

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 adoption, coverage will become effective on the date of placement for adoption, as long as you are responsible for health care coverage and your child meets the Plan's definition of a Dependent child. You must notify the Fund Office of the birth, adoption, placement for adoption, legal guardianship, or addition of stepchildren within **31 days** to have your Dependents covered from the date of birth, adoption, legal guardianship, or placement for adoption. 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. You should use the Fund's Enrollment/Change Form for these notices.

Divorce or Legal Separation

If you and your spouse obtains 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. You or your spouse must notify the Fund Office within **60 days** of the divorce or legal separation for your spouse to obtain COBRA continuation coverage. See page 25 for additional information and the requirements for electing COBRA continuation coverage.

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 QMCSOs, 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.

Qualified Medical Child Support Orders (QMCSOs)

The Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and National Medical Support Notices that meet the QMCSO requirements. A Qualified Medical Child Support Order (QMCSO) is a court order or administrative order relating to child support that provides for a child's coverage under the Plan. A copy of the Plan's QMCSO qualification procedures and a sample order are available, free of charge, upon request from the Fund Office.

You should contact the Fund Office if a Qualified Medical Child Support Order (QMCSO) has been issued due to 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.

Child Losing Eligibility

In general, your child is no longer eligible for coverage at the end of the month in which he or she reaches age 26. However, if your child is determined to be mentally or physically disabled before reaching age 26 and continues to be mentally or physically disabled and dependent on you for at least half of his or her support, your 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.

Your Dependent child may consider applying for COBRA continuation coverage as your child nears the age of 26. If eligible, your Dependent child may 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 date your child loses Dependent status, your child will not be eligible to elect COBRA continuation coverage.

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

- ☐ Contact the Fund Office within 60 days of losing eligibility; and
- ☐ Enroll for COBRA continuation coverage.

Change in Your Dependent's Employment Status

When your spouse or Dependent loses employer-provided healthcare coverage due to the loss of his or her job, you should contact the Fund Office to let them know the date of the loss of the other coverage. You must present proof sufficient to the Trustees when your spouse or Dependent loses employer-provided health insurance.

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 at the earliest opportunity. If that coverage is offered and your spouse does **not** enroll, your spouse will **not** be covered by this Plan. This provision does not apply to spouses of retired Participants. If your spouse enrolls in the coverage offered by his or her employer, this Plan will cover your spouse's health expenses as the secondary plan under the Coordination of Benefits provisions (see page 107). If your spouse is employed, your spouse and his or her employer must complete the Fund's Spousal Health Care Information form. This Plan will also cover your Dependent children. Your spouse does not have to enroll for Dependent coverage under his or her employer's plan to have coverage under this Plan for your Dependent children.

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.

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 child obtains new health coverage, you will also need to provide the Fund Office with information about the new benefit plan.

Leaves of Absence

Parental Leave (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 who is subject to the FMLA and required to grant you leave under the FMLA; and
- You arrange with your Employer and the Fund to make the required contributions to the Health and Welfare Fund during your leave.

In addition, the FMLA allows you to take up to 26 weeks to care for a service member who must be your son, daughter, parent or next of kin, who is undergoing medical treatment, recuperation, or therapy for a serious Illness or Injury incurred in the line of duty while in the armed services, and who is an outpatient or on the temporary disability retired list of the armed services.

12 weeks of ***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.

Generally, Employers that employ at least 50 employees within a 75-mile radius during a calendar year are subject to the FMLA rules.

Twenty-six weeks of ***FMLA*** leave is generally granted to care for a service member, as noted in this section.

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 Fund Office to prevent you from losing eligibility. You should also notify the Fund Office. 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 during 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 an FMLA leave is determined by your Employer. The Fund will not intervene in any Employer-employee disputes.

Leave Entitlement

An Employer covered under FMLA may grant you up to a total of 12 weeks (or 26 weeks, if applicable) of unpaid leave during any 12-month period for one or more of the following reasons:

- For the birth or placement of a child for adoption or foster care;
- To care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- To take medical leave when you are unable to work because of a serious health condition.

Leave for birth or adoption (including foster care placement) must conclude within 12 months of the birth or placement.

Spouses employed by the same Employer are entitled to a *combined* total of 12 weeks (or 26 weeks, if applicable) of family leave for the birth, placement of a child for adoption, foster care, or to care for a child or parent (but not parent-in-law) who has a serious health condition.

Under some circumstances, you may take FMLA leave intermittently, which means taking leave in blocks of time, or by reducing your normal weekly or daily work schedule. Intermittent FMLA leave for birth or adoption or foster care placement requires your Employer's approval. FMLA leave may be taken intermittently whenever it is necessary to care for a family member's serious health condition, or because you have a serious health condition and are unable to work.

Maintenance of Health Benefits

An Employer is required to maintain the same health coverage for you on FMLA leave as the coverage that was provided before the leave was taken and under the same terms as if you had continued work. Therefore, an Employer covered under the FMLA must continue to contribute on your behalf while you are on FMLA leave as though you had been continuously employed.

Returning to Work

Upon return from FMLA leave, you must be restored to your original job, or to an equivalent job with equivalent pay, benefits, and other employment terms and conditions. In addition, your use of FMLA leave cannot result in the loss of benefits that you earned or were entitled to before using FMLA leave.

Termination of FMLA Coverage

Health care coverage during FMLA leave ends on the earliest of the following dates:

- When you return to work;
- When timely payments for coverage are not made;
- When you inform your Employer that you will not be returning to work;
- When the Plan is terminated; or
- When 12 weeks (or 26 weeks, if applicable) of leave end.

FMLA and Other Benefits

You will not accrue additional benefits during an unpaid FMLA leave, but you cannot lose benefits you had accrued before your leave. Your benefits coverage will continue when you return to work without any new conditions or the need to meet eligibility requirements.

How FMLA Works With COBRA

Taking a family or medical leave is not itself considered a COBRA qualifying event. If you return from leave within 12 weeks (or 26 weeks, if applicable), there will not be a loss of coverage.

If you do not return from leave at the end of 12 weeks (or 26 weeks, if applicable), that is considered a COBRA qualifying event (a reduction in hours causing a loss of coverage). You will have up to 12 weeks (or 26 weeks, if applicable) of health care coverage maintained during FMLA leave, and, if you elect and pay for COBRA continuation coverage, you will have an additional 18 months (or 36 months, if applicable) of continued coverage under COBRA.

Taking an FMLA Leave

If you need to take an FMLA leave, your Employer may require you to provide:

- 30-day advance notice of the need to take the FMLA leave, if the need is foreseeable;
- Medical certifications supporting the need for leave due to a serious health condition affecting you or an immediate family member;
- Second or third medical opinions and periodic recertifications (at your Employer's expense); and
- Periodic reports during FMLA leave regarding your status and intent to return to work.

When leave is needed to care for an immediate family member or your own Illness, and is for planned medical treatment, you must schedule treatment so that it will not unnecessarily disrupt your Employer's operation. You and your Employer must certify to the Trustees that you have been granted leave under the Family and Medical Leave Act.

Service in the Uniformed Services

If you serve in the uniformed services (active duty or inactive duty training), you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Health coverage includes medical, prescription drug, dental, vision, and hearing benefits provided under the Plan.

Military leave. If you enter military service, you should:

- ☐ Notify your Contributing Employer and the Fund Office; and
- ☐ Make any required 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.

If you serve for 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you serve for more than 31 days, you can continue coverage for you and your Dependents at your own expense for up to 24 months. In addition, your Dependent(s) may be eligible for health care coverage under the TRICARE Military Health System. This Plan will coordinate coverage with TRICARE.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in one of the uniformed services and includes:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Inactive duty training;
- Full-time national guard duty; and
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

Uniformed services means the:

- ☐ United States armed forces;
- ☐ Army National Guard;
- ☐ Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty;
- ☐ Commissioned Corps of the Public Health Service; and
- ☐ Any other category of persons designated by the President in time of war or emergency.

Your eligible Dependents may continue coverage under the Plan by electing and making payments for COBRA continuation coverage. Note that your Dependents cannot

independently elect USERRA coverage.

If you continue your coverage at your own expense, coverage will end on 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 date you lose eligibility for coverage under USERRA, for example, due to a dishonorable discharge;
- 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 you have had the maximum coverage under USERRA (generally 24 months).

You must notify the Fund Office when you enter the military (or as soon as possible if you are called to active service or an emergency service) and when you return to covered employment. For more information about continuing coverage under USERRA, contact the Fund Office.

Reinstating Your Coverage

Following discharge from military service, you may apply for reemployment with your former Employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your Employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

Reemployment

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

When you are discharged or released from military service that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a Contributing Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a Contributing Employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for a Contributing Employer.

When you are discharged, if you are Hospitalized or recovering from an Illness or Injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to or make yourself available for work for a Contributing Employer, up to a maximum of five years. The Fund will maintain your prior eligibility status until the end of the leave, provided your Employer properly grants the leave under the federal law and you make the required notification and payment to the Fund. If you do not return to work within the required timeframes, you must again meet the initial eligibility requirements to be eligible for coverage.

If you have any questions about taking a leave, please speak directly with your Employer. If you have any questions about how a leave of absence affects your benefits, please contact the Fund Office.

If You Are Out of Work Due to Disability

Loss of Time Benefits. If you are out of work due to a non-work related disability, you may receive weekly Loss of Time benefits until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first. If you become totally and permanently disabled, your attending Physician will need to submit proof of your disability to the Fund Office. For more information about Loss of Time benefits, see page 70.

Extension of Coverage for Disability Conditions. In addition to Loss of Time benefits, you may receive a maximum of 12 months of 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. 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.

Self-Payment for Coverage While Disabled. If you wish to continue full coverage under the Plan while you are disabled, you may make self-payments for coverage or you may elect COBRA continuation coverage.

Disability. When you are out of work due to a non-work related disability:

- ☐ Notify your Employer and the Fund Office.
- ☐ Provide the Fund Office with proof of your disability.
- ☐ Apply for Loss of Time benefits.

When you are out of work due to a work-related disability:

- ☐ Notify your Employer and the Fund Office.
- ☐ Contact your local workers' compensation office and apply for workers' compensation benefits.

Workers' Compensation. If you are out of work due to a work-related disability, you may be eligible for workers' compensation benefits. Contact your local or state workers' compensation office. The Fund does not provide coverage for work-related disabilities.

Life Insurance Continuation During Disability. If you become totally and permanently disabled before age 60 while you are an Eligibility A or C Employee, your Life Insurance benefit coverage will continue for a maximum of nine months if premiums are continued on your behalf and you have applied for the waiver of premium benefit. At the end of the 9-month continuation period, your waiver of premium benefit may be approved for a maximum of 12 months if you continue to be totally and permanently disabled and you provide satisfactory proof of your disability to the Trustees.

You must notify the Fund Office when your disability ends.

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. 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. In addition, if you are an active Eligibility A Employee at the time of your death, your surviving spouse may choose to either (1) exhaust your current eligibility hours, and then make up to four quarterly self-payments at the active rate, waiving any right to COBRA continuation coverage, or (2) may elect COBRA continuation coverage for 36 months, waiving any right to choose self-payment coverage. If your surviving spouse chooses to make self-payments, your surviving spouse may use any balance in your Reserve Bank toward the first quarterly self-payment or toward the first COBRA payment. In making the self-payments, your surviving spouse will be subject to the rules governing self-payments for Eligibility A Employees outlined in the section entitled *Self-Payment for Active Eligibility A Employees* on page 16.

If you are retired at the time of your death, you will not be eligible for a Life Insurance 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 retiree benefits, see page 32 or contact the Fund Office.

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. In addition, you may need to update your beneficiary information.

When You Retire

When you retire, you will have access to a Health Reimbursement Arrangement (HRA) account that is your Retiree Pre-Funded Subsidy allowance balance. (See page 32 for information on the Retiree Pre-Funded Subsidy Allowance.) The Plan does not provide coverage for retirees. However, you can use the HRA to offset the cost of coverage that you buy through the Midwest Laborers' Private Health Insurance Exchange. For more information on the HRA, please see the North Central Illinois Laborers' Health and Welfare Fund Retiree-Only Health Reimbursement Account SPD and Plan Document.

When You Leave Employment

If you are eligible for benefits as an Eligibility A Employee, 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. See page 25 for more information.

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

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

If you are eligible for benefits as an Eligibility B or C Employee, coverage for you and your Dependents 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 for yourself and your Dependents under COBRA continuation coverage only. You would only be eligible for the COBRA continuation coverage after you make the necessary payments for COBRA continuation coverage.

Returning to Work

Active Participants

If your eligibility ended and you start working again for a Contributing Employer, your coverage will be reinstated as described on page 18, as applicable. If you return to work following a military leave of absence, your coverage will be reinstated as described on page 10.

Retirees

You can return to employment and become eligible for active coverage if you meet the Plan's initial eligibility requirements (see page 13). See page 32 regarding the rules governing return to work by retirees and re-retirement.

Keep Plan Informed of Address Changes

To protect your family's rights, you should keep the Plan's Administrative Manager informed of any changes in the addresses of family members. When your coverage ends, you will be provided with certification of your length of coverage under this Plan.

Eligibility

For information about eligibility for retiree benefits, see page 32.

Eligibility A Employees

Eligibility A Employees include active, bargained employees.

Contribution hours are hours of work for which a Contributing Employer contributes to this Fund under the terms of a collective bargaining agreement.

Initial Eligibility for Eligibility A Employees

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
- Have completed 500 hours of work for which contributions or contribution hours have been made on your behalf to the Plan within a six-consecutive month period.

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.

Benefits available to Eligibility A Employees include:

- Medical benefits;
- Member Assistance Program (MAP);
- Telehealth Services;
- Prescription drug benefits;
- Dental benefits;
- Vision benefits;
- Hearing benefits;
- Loss of Time benefits;
- Life Insurance benefits; and
- Accidental Death and Dismemberment (AD&D) Insurance benefits.

When Coverage Begins

When you have met the initial eligibility requirements, Plan coverage begins on the first day of the second calendar month following the 500th contribution hour. 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.

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

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.

Continued Eligibility for Eligibility A Employees

After you satisfy the initial eligibility requirements, 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 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

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

Angelo became eligible for Plan benefits on July 1, 2024. Angelo's benefits continued for the three months of July, August, and September. To determine his eligibility for October through December, Angelo looked back to his hours of work during the previous June, July, and August. If his hours for that period totaled 250, then he will continue to be covered during October, November, and December. If his hours did not total at least 250 for that period, Angelo looked back to the 6-, 9- or 12-month period to see if he met the hour requirement for that period.

To determine whether he is eligible for coverage during January, February, and March 2025, Angelo will look back to September, October, and November 2024. If his hours for that period totaled 250, then he will continue to be covered during January, February, and March 2025. If his hours did not total 250 for that period, Angelo will look back to the 6-, 9- or 12-month period shown in the table above for the January, February, and March coverage period. If Angelo does not meet the hours requirement for the January, February, and March 2025 period, his coverage will end at the end of the day on December 31, 2024.

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 monthly reports based on actual hours worked during the full calendar month or 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.

Contribution hours from all your Contributing Employers are counted. Therefore, 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 meet one of the continuing eligibility requirements.

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

When Coverage Ends for Eligibility A Employees

Your eligibility will end:

- On the last day of any of the 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;
- When the Plan ends;
- When you die;
- When you retire; or
- When a required self-payment or COBRA payment for coverage is not received by the due date.

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 end 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.

Reserve Bank for Eligibility A Employees

If you are eligible as an Eligibility A Employee, contributions paid to the Health and Welfare Fund on your behalf for hours of work over 1,875 per calendar year are credited to your Reserve Bank.

Your ***Reserve Bank*** is credited with your contribution hours that you work in excess of 1,875 in a calendar year if you are an Eligibility A Employee. The balance in your Reserve Bank may be used for self-payments under the active coverage, retiree coverage, or COBRA continuation coverage payments.

You may accumulate a maximum of 250 hours in your Reserve Bank and use the hours in the Reserve Bank to pay for continuing coverage when you would otherwise lose coverage under the Plan. These hours can only be used as a credit to offset or reduce the self-payment you must make to continue coverage through self-payment for Eligibility A Employees, through COBRA continuation coverage, or through retiree coverage. The Reserve Bank will be used first to pay for your self-payments, COBRA continuation coverage payments, or retiree coverage self-payments, depending on which continuation option you choose. You will then be required to make self-payments directly to the Fund to continue your coverage under the option you have chosen.

Self-Payment for Active Eligibility A Employees

If your coverage ends, you may be eligible to make self-payments to continue coverage under the Plan. To make self-payments, you must have met the initial eligibility requirements for Eligibility A Employees as described on page 13. If your coverage ends, you can make self-payments for active benefits or for COBRA continuation coverage as described on page 25.

You may elect to make self-payments for a maximum of 12 months (four quarters), unless this period is temporarily extended by resolution of the Board of Trustees due to work conditions. Once you elect continuing coverage through self-payments, you may not elect COBRA continuation coverage and you will not be eligible for any extended coverage period because of a second qualifying event, as explained in the *Continuing Coverage* section beginning on page 25. COBRA continuation coverage will not be offered to you at the end of your self-payment period.

It is important to notify the Fund Office *in writing* of any change of address. Participating local unions and district councils are not responsible for keeping your address current.

You may use your Reserve Bank to pay for up to one quarter of your self-payments. The use of your Reserve Bank is considered your first self-payment. After your Reserve Bank is exhausted, you must make continuing self-payments directly to the Fund.

The Fund Office will send a letter (to your current address on file) if you lose eligibility. The letter shows the date your eligibility ends and the amount due to continue eligibility through self-payment. It is important – and your responsibility – to always maintain a current mailing address on file with the Fund Office and to notify the Fund Office *in writing* of any change of address. Participating local unions and district councils are not responsible for keeping your address current.

You are responsible for making self-payments 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 mailed by the Fund Office.

Example

Jim's eligibility ended on December 31, 2024. Jim's self-payment Notice was dated January 5, 2025. Jim wished to continue his eligibility for the three-month period beginning January 1, 2025, so his self-payment had to be postmarked no later than January 30, 2025.

If contributions hours are paid late and you were eligible for coverage, you will receive a refund of your self-payment for any months during which you were eligible for coverage. 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. The Trustees will determine the self-payment amount, which is subject to change.

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

North Central Illinois Laborers' Health and Welfare Fund
4208 W. Partridge Way, Unit 3
Peoria, IL 61615

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 for coverage 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 self-payment notice, in which case it will be considered the same as failure to have made the required self-payment.

Self-Payment for Disabled Eligibility A Employees

You may make self-payments if you are totally and permanently disabled. 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 they reserve the right to require a medical examination by a Physician of their choice.

Please note that if you are awarded a Disability Pension, you must apply for Medicare benefits and send proof to the Fund Office that you have made such application.

Your benefits as a disabled Participant will be the same as for active Participants, excluding the Loss of Time benefit, Life Insurance benefit, and Accidental Death and Dismemberment Insurance benefit. The self-payment amount is determined by the Trustees and is subject to change from time to time.

If you are totally and permanently disabled, you may make self-payments until the earlier of:

- The date you become enrolled in Medicare;
- The end of four quarters of self-payments;
- The date you do not make a timely self-payment for coverage; or
- The date you are no longer disabled.

When you become eligible for Medicare while continuing coverage under this provision, your family will continue to be able to pay for coverage by making the required self-payments for coverage. If you do not make the required self-payment within the specified time, you will not be allowed to make any further self-payments.

Extension of Benefits

If you or your eligible Dependent is totally disabled at the time your coverage under this Plan ends, 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 ended.

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 the normal activities of a person of like age and gender who is in good health due solely to an Injury or Illness that is not employment-related.

Please note that this 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 your Physician.

Eligibility A Employee Reinstatement

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 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 the balance of the quarter in which your coverage is reinstated for up to a maximum of three consecutive calendar months. To continue coverage after reinstatement, you must meet the requirements for continued eligibility explained on page 14.

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

Hours will be counted for work you performed in the month your coverage ended and the next six months. This is your reinstatement period. Suppose, for example, that your eligibility ends on December 31, 2024 because you do not have the required contribution hours through November 30, 2024. You must reinstate eligibility no later than June 30, 2025, based on 250 hours or more of work performed in a three (or less) consecutive-month period between December 1, 2024 and June 30, 2025. If you do not meet the reinstatement requirements, you must again meet the Plan's initial eligibility requirements (see page 13).

Example

Harry's coverage ended on March 31, 2024. Harry did not work during March, April, or May 2024. Harry worked 85 hours each month during June, July, and August 2024 and his Employer contributed to the Plan on his behalf. Because Harry worked more than 250 hours by the end of the reinstatement period (March through September 2024), his coverage was reinstated on November 1, 2024, which was 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 2024, he would have completed more than 250 hours of work by the end of June 2024. Harry's eligibility reinstatement began on August 1, 2024, the first day of the second month following his completion of at least 250 hours of work within the reinstatement period.

If your eligibility ends and a period of six consecutive months elapses, you must meet the Plan's initial eligibility requirements to be covered under the Plan (see page 13).

Eligibility B Employees

Eligibility B Employees include active, non-bargained employees.

Initial Eligibility for Eligibility B Employees

To be eligible as an Eligibility B Employee:

- Your Employer must be making contributions to the Plan on your behalf; and
- You must be working full-time, which is, on average, at least 30 hours of service per week.

Benefits available to Eligibility B Employees include:

- Medical benefits;
- Member Assistance Program (MAP);
- Prescription drug benefits;
- Dental benefits;
- Vision benefits; and
- Hearing benefits.

When Coverage Begins

If you are eligible for Plan benefits as an Eligibility B Employee, 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 begins making contributions on your behalf.

Example

Carl began working full-time for an Employer on August 15, 2024 and his Employer began making contributions to the Plan on his behalf for his hours worked. Carl's coverage began on September 1, 2024. Coverage will continue as long as his Employer continues to pay contributions on his behalf on the 15th of the month before the month that his coverage is to continue.

Continued Eligibility for Eligibility B Employees

Once you satisfy the initial eligibility requirements, your eligibility will continue for each month that contributions are made on your behalf for those months.

When Coverage Ends for Eligibility B Employees

Your eligibility and coverage will end:

- On the last day of the month following the month for which contributions are received on your behalf when you stop working;
- When the Plan ends;
- When you die; or
- On the last day of the month following the month in which you retire.

As an Eligibility B Employee, you are not eligible to continue coverage by making self-payments. However, you can continue coverage through COBRA continuation coverage (see page 25).

Example

Doug stopped working full-time for his Employer on August 15, 2024. His coverage ended on September 30, 2024, the last day of the month in which he stopped working and the last day of the month for which his Employer made contributions to the Fund for his coverage. Doug received a notice detailing how he could elect to continue coverage through COBRA.

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.

Eligibility C Employees

Eligibility C Employees include active employees whose Employer has entered into a written agreement to contribute to the Fund as an Eligibility C Employer subject to the terms set forth herein.

Initial Eligibility for Eligibility C Employees

To be eligible as an Eligibility C Employee:

- Your Employer must be making contributions to the Plan on your behalf; and
- You must be working in a full-time classification or position covered by a written agreement that allows for your participation in the Plan.

When Coverage Begins

If you are eligible for Plan benefits as an Eligibility C Employee, your coverage begins on the first day of the month following the date your Employer first remits premiums to the Plan on your behalf, if you have provided the appropriate enrollment documentation to the Fund Office. You must enroll when you are first eligible or wait until the Fund's next Open Enrollment Period.

Continued Eligibility for Eligibility C Employees

Once you satisfy the initial eligibility requirements, your eligibility will continue each month for which your Employer contributes to the Fund on your behalf.

When Coverage Ends for Eligibility C Employees

Your eligibility and coverage will end:

- On the last day of the month for which contributions are received on your behalf when you stop working;
- When the Plan ends;
- When you die; or
- When you retire.

When your coverage ends, you can continue coverage through COBRA continuation coverage (see page 25).

Reinstatement of Eligibility for Eligibility C Employees

If your eligibility ends because you stop working for your Employer, your coverage may be reinstated on the first of the month following the date you again begin working for an Eligibility C Employer that remits premiums to the Plan on your behalf and you have submitted enrollment documentation to the Fund.

Dependent Eligibility for All Employees

Your Dependents are eligible for coverage when you are eligible if:

- They meet the definition of Dependent on page 123;
- You have identified them on an enrollment form; and
- You 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. 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 the event, 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.

Dependents of Eligibility C Employees who do not enroll within 31 days of an event must wait until the Fund's next Open Enrollment Period.

The Fund Office will accept a copy of any of the following documents as proof of Dependent status:

- Marriage: Copy of the certified marriage certificate.
- Birth: Copy of the certified birth certificate.
- Adoption or Placement for Adoption: Court order signed by a judge.
- Disabled Dependent Child: Complete a Special Dependent Form available from the Claims Administrator.

Spousal Coverage

If your spouse is employed, your spouse's employer offers health coverage, and the employer subsidizes 75% or more of the cost of your spouse's single coverage, your spouse must enroll for single coverage. If that coverage is offered and your spouse does not enroll, your spouse will not be covered by this Plan. This provision does not apply to spouses of retired Participants. If your spouse does enroll in the coverage offered by his or her employer, then this Plan will cover your spouse's health expenses as the secondary plan under the Coordination of Benefits provisions described on page 107. If your spouse is employed, your spouse and his or her employer must complete the Fund's Spousal Health Care Information form.

Other Employer Coverage

Your Dependent spouse cannot be covered under this Plan if he or she has medical coverage available through his or her employer and the employer subsidizes at least 75% of the cost of single coverage, unless that employer provides the same maximum benefits to all its employees without regard to the coverage the Dependent spouse may have in another plan.

The term "same maximum benefits" means that the Dependent spouse's employer's plan must offer the same insurance options to all employees. For example, if the plan of the Dependent spouse's employer automatically enrolls an individual in a wrap-around plan due to other coverage, that plan will not offer the same maximum benefits as this Plan. The term "same maximum benefits" does not require the plan of the Dependent spouse's employer to have the same coverage as this Plan.

If your Dependent spouse is adversely affected by this provision, he or she can file an appeal to the Board of Trustees for determination of hardship exceptions based upon circumstances beyond the control of the Dependent spouse. Your Dependent spouse must assign to the Board of Trustees any available remedies the Dependent spouse has against his or her employer, the plan of the Dependent spouse's employer, and/or the insurer of the Dependent spouse's employer.

When Dependent Coverage Ends

Your eligible Dependent's eligibility will end on the earliest of the following:

- The date your eligibility under the Plan ends;
- The date your Dependent dies;
- The date your Dependent no longer meets the Plan's definition of a Dependent (see page 123 for definition of a Dependent);
- The date the Plan is modified to end Dependent benefits;
- The date the Plan ends;
- For a covered spouse, the day you become legally separated or divorced;
- The date specified in a Qualified Medical Child Support Order; or
- If your Dependent has COBRA continuation coverage, at the end of the last day of the period in which your Dependent's COBRA continuation coverage period ends.

Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days' advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively – going forward – once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 30 days advance written notice.

Special Enrollment

If you or your eligible Dependent declined coverage under this Plan because you have other health coverage, you may be eligible for a special enrollment if:

- You or your Dependents lose eligibility for the other health coverage; or
- The other employer stops contributing toward your or your Dependents' coverage; or
- You acquire a Dependent through marriage, birth, adoption, or placement for adoption.

You must enroll in the Plan within 31 days of losing the other coverage (or the other employer stops contributing toward your or your Dependent's coverage) or of acquiring a Dependent.

If the other health coverage was COBRA continuation coverage, a special enrollment is only available after the COBRA continuation coverage has been exhausted. If the other coverage is not COBRA continuation coverage, a special enrollment is available if you or your Dependent is no longer eligible for coverage or Employer contributions for the other coverage.

If you are declining enrollment for your Dependents (including your spouse) because of other health insurance coverage, you must request enrollment within 31 days after coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your Dependents, provided you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Coverage of a newborn or newly adopted Dependent child who is enrolled within 31 days after birth will become effective as of the date of birth. Coverage of a newly adopted Dependent child who is enrolled more than 31 days after birth, but within 31 days after the child's adoption or placement for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first. All other Dependent additions are effective on the first day of the month following enrollment. To enroll your new Dependent, you will need to complete, sign, and submit an enrollment form to the Fund Office. You will also need to provide proof of Dependent status.

Special enrollments are not available for loss of coverage due to failure to pay premiums, fraud, or misrepresentation. To be eligible for a special enrollment, you must notify the Fund Office within 31 days of the loss of other coverage or the date of marriage, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your Dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) and you request enrollment within 60 days after that coverage ends; or
- If you or your Dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this Plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Delinquent Contributions

To be considered eligible for benefits, required contributions must be received by the 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 take such steps to collect the required contributions from that Contributing Employer as the Trustees determine, in their sole discretion, is prudent.

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 payment for hours worked. 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.

Change in Eligibility Rules or Plan

The Board of Trustees is empowered to change or amend the Plan's eligibility rules or the benefits described in this booklet or any other Plan provision in accordance with the Trust Agreement, as it, in its sole discretion, determines to be necessary. You will be notified in writing of any changes to the Plan.

CONTINUING COVERAGE

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event, known as a qualifying event. Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage is offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

COBRA continuation coverage does not include Loss of Time, Life Insurance, or Accidental Death and Dismemberment Insurance benefits.

Type of coverage. If you or your Dependents choose COBRA continuation coverage, the Health and Welfare Fund is required to provide medical coverage that is the same coverage that you had before the event that triggered COBRA. You will have the choice of electing COBRA continuation coverage for medical and prescription drug benefits only, or of electing COBRA continuation coverage for medical, prescription drug, dental, vision, and hearing benefits. However, COBRA continuation coverage does not include Loss of Time, Life Insurance, or Accidental Death and Dismemberment Insurance benefits.

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

Cost of coverage. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The Fund is permitted to charge the full cost of coverage for similarly situated Participants and Dependents (including both the Fund's share and the Participant's share, if any) plus an additional 2%. If the 18-month period of COBRA continuation is extended because of disability, the Fund is permitted to charge the full cost for similarly situated Participants and Dependents (including both the Fund's share and the Participant's share, if any) plus an additional 50% for members of a COBRA family unit that includes the disabled person for the 11-month disability extension period.

If you are an Eligibility A Participant and have sufficient hours in your Reserve Bank when your coverage under the Plan ends due to a qualifying event, the hours in your Reserve Bank will be used to pay for your COBRA continuation coverage until your Reserve Bank hours are insufficient to pay for your coverage (see page 15). You should contact the Administrative Manager to determine whether you have Reserve Bank hours and to confirm when you must begin making payments for your COBRA continuation coverage.

Qualifying Events

If you are an employee, you become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both). Your spouse's entitlement to Medicare means that your spouse:
  - Was eligible for Medicare benefits; *and*
  - Enrolled in Medicare and the entitlement date is the date of enrollment; or
- You become divorced or legally separated from your spouse.

Your Dependent children become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both). The parent-employee's entitlement to Medicare means that the parent-employee:
  - Was eligible for Medicare benefits; *and*
  - Enrolled in Medicare ,and the entitlement date is the date of enrollment; or
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a Dependent child.

Additional COBRA Qualified Beneficiaries

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 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) 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.

Employer Must Give Notice of Certain Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan's Administrative Manager has been notified that a qualifying event has occurred. The Employer must notify the Plan's Administrative Manager of the qualifying event within 30 days from the date coverage ends when the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's entitlement to Medicare benefits.

You Must Give Notice of Certain Qualifying Events

For other qualifying events (divorce or legal separation of the employee and a spouse or a Dependent child's losing Dependent child status), you must notify the Plan's Administrative Manager within 60 days of the date you would lose coverage due to the qualifying event. You must send this notice to the Plan's Administrative Manager at the Fund Office address listed on page 3.

How COBRA Continuation Coverage Is Provided

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. The cost of COBRA continuation coverage under the Plan is one rate, whether you choose individual coverage or family coverage.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's entitlement to Medicare benefits, divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

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

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as explained in the next two sections.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month continuation period. You must notify the Plan's Administrative Manager of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan's Administrative Manager at the Fund Office address listed on page 3.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in your family can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension is available to the spouse and any Dependent children receiving COBRA continuation coverage if:

- The employee or former employee dies;
- The employee or former employee becomes entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both);

- The employee or former employee gets divorced or legally separated; or
- The Dependent child stops being eligible under the Plan as a Dependent child.

The extension is available only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure to notify the Plan's Administrative Manager at the Fund Office address listed on page 3 within 60 days after the second qualifying event occurs.

Electing COBRA Continuation Coverage

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. For example, both the employee and the employee's spouse may elect COBRA continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their Dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect COBRA continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of COBRA continuation coverage any time until that date. The rate for COBRA continuation coverage is a family rate and is the same amount for individual or for family coverage.

In determining whether to elect COBRA continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you elect this coverage for the maximum time available to you.

To elect COBRA continuation coverage, complete an Election Form provided by the Fund Office. Under federal law, you must have 60 days after the date of the notice to decide whether you want to elect COBRA continuation coverage under the Plan. Send the completed Election Form to the Fund Office.

The Election Form must be completed and returned by mail. If you do not submit a completed Election Form by the date shown on the Form, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Making Payments for COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send any payment for COBRA continuation coverage with the election form. However, you must make your first payment for COBRA continuation coverage within 45 days after the date your election form is returned to the Fund Office. (This is the date the election form is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage within those 45 days, you will lose all COBRA continuation coverage rights under the Plan.

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the Plan would have otherwise ended, up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Fund Office to confirm the correct amount of your first payment.

After you make your first payment for COBRA continuation coverage, you will be required to pay for COBRA continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA continuation coverage are due on the first day of the month for which payment is made. If you make a periodic payment on or before its due date, your coverage under the Plan will continue

for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods. A COBRA payment will be considered on time if it is received within 30 days of the due date. A COBRA payment is considered made when it is mailed (postmarked) or personally delivered.

Payments for COBRA continuation coverage should be sent to the North Central Illinois Laborers' Health and Welfare Fund at 4208 W. Partridge Way, Unit 3, Peoria, IL 61615.

Grace Periods For COBRA Payments

Although COBRA payments are due on the dates previously noted, you will be given a grace period of 30 days to make each COBRA payment. You should note that the grace period does not apply to the first COBRA payment, which is due within 45 days of election of COBRA continuation coverage, as previously described. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage and you submit a claim within that period, you may receive an explanation of benefits that a benefit determination cannot be made due to a pending COBRA payment.

If you fail to make a COBRA payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the Plan. Also, there is no extension of the grace period for that coverage period, or for lack of premium payments or checks returned for insufficient funds. You will lose all rights to continuation coverage under the Plan.

When COBRA Continuation Coverage Ends

COBRA continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid on time;
- A qualified beneficiary becomes covered under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B or both);
- The Employer ceases to provide any group health plan for its employees; or
- The Social Security Administration determines that you are no longer disabled during the COBRA disability extension period. You or your Dependent must give the Fund Office notice that you are no longer disabled within 30 days of the date that the Social Security Administration has determined that you are no longer disabled.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate any other Participant or beneficiary's coverage (such as fraud).

Health Insurance Marketplace Alternative

As an alternative to COBRA coverage, you may find less expensive coverage in the Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a special enrollment event. **After 60 days, your special enrollment period will end and you may not be able to enroll**.

To find out more about enrolling in the Marketplace, such as when the next Open Enrollment Period will be and what you need to know about qualifying events and special enrollment periods, visit HealthCare.gov.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace Open Enrollment Period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next Open Enrollment Period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Medicare Instead of COBRA Continuation Coverage

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty, and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA continuation coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA continuation coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit medicare.gov/medicare-and-you.

[1] medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If You Have Questions

Questions concerning your COBRA continuation coverage rights should be addressed to the Fund Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit EBSA's website at dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA Offices are available through EBSA's website.)

Continuing Coverage Through Self-Payments or Retiree Benefits

Under the Plan, you have the right to continue coverage by electing to make self-payments instead of electing COBRA continuation coverage.

If you are an Eligibility A Employee, you may elect health coverage through self-payments for up to 12 months (four quarters), unless this period is extended by resolution of the Board of Trustees due to work conditions.

You will lose all rights to the COBRA continuation coverage if you elect the self-payment alternative coverage for a maximum period of 12 months (four quarters). COBRA continuation coverage will not be offered to you at the end of your alternative coverage.

Retiree Benefits

The Plan DOES NOT provide benefits for you and your eligible Dependents after you retire.

You are considered to be retired under the terms of the Plan after you exhaust your Reserve Bank and make your final self-payment as described below.

After you have retired and stopped working, you can continue to use your Reserve Bank as payment or partial payment for the first quarterly self-payments for active coverage. Once your Reserve Bank is depleted, you are eligible to make three additional self-payments at the active rate for active coverage. You may make up to a total of four quarterly self-payments for active coverage. After your four quarterly self-payments (through any combination of your Reserve Bank hours and self-payments), your coverage under the Plan will terminate. If you choose to make self-payments rather than selecting COBRA coverage, you will not have the opportunity to select COBRA again.

Thereafter, you may be eligible for a Retiree Pre-Funded Subsidy Allowance through the Health Reimbursement Arrangement (HRA). You can use the HRA to pay for retiree coverage through the Midwest Laborers' Private Health Insurance Exchange. See the North Central Illinois Laborers' Health and Welfare Fund Retiree Only Health Reimbursement Account SPD and Plan Document for more information on the HRA.

After you have retired, you may choose to return to work. If you do so, your pension benefit may be suspended when you return to work, in accordance with the rules of the Pension Plan. Additionally, you will not be eligible to receive the Retiree Pre-Funded Subsidy Allowance through the North Central Illinois Laborers' Health and Welfare Fund's Retiree Only HRA. However, if you work sufficient hours to qualify for active coverage when you return to work, then you will be covered as an active employee during that period.

When you retire after your initial retirement, you will not be allowed to make payments at the active rate upon your re-retirement as you did upon your initial retirement. Instead, your coverage will terminate on the last day of the applicable eligibility period as described in the Plan. If your coverage ends, you will be offered COBRA continuation coverage. Alternatively, you may enroll in the Midwest Laborers' Private Health Insurance Exchange and receive a Retiree Pre-Funded Subsidy Allowance, if any, that you may be eligible to receive through the North Central Illinois Laborers' Health and Welfare Fund Retiree Only HRA. If you choose not to enroll in the Midwest Laborers' Private Health Insurance Exchange, you may also consider enrolling in the Health Insurance Marketplace.

Medical Benefits

The Plan offers comprehensive health care coverage to help you and your eligible Dependents stay healthy and to provide financial protection against catastrophic health care expenses.

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:

- Blue Cross and Blue Shield Preferred Provider Organization (PPO); or
- Cigna Preferred Provider Organization (PPO).

For hospitalization, outpatient surgery, Rehabilitation Services, transplant services, inpatient mental health and/or substance abuse services, and Gene Therapy, remember to have your Hospital stay or treatment preauthorized by calling the number for your specific Plan that is listed on page 3.

The benefit design of each of the medical programs is outlined on the *Schedule of Benefits* for each medical program. The *Schedule of Benefits* is part of this SPD/Plan Document. 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.

This booklet describes all of the benefits that are provided under several different *Schedules of Benefits* included under the Plan. ***Although all benefits are described in this booklet, not all benefits are provided under all the Schedules of Benefits. Therefore, you should rely on your particular Schedule of Benefits to determine which benefits are provided to you by your Plan. You may not assume you are covered by a benefit because it is described in this booklet. You should consult your Schedule of Benefits for the specific benefits and amount of benefits provided to you by the Plan. You may also call the Fund Office if you have questions about your benefits.***

How Medical Benefits Work

Preferred Provider Organization (PPO)

For active Participants and Dependents, the Plan contains a cost management feature—a Preferred Provider Organization (PPO) network, to help manage certain health care expenses. A PPO is a network of Physicians, Hospitals, and other healthcare providers that have agreed to charge negotiated rates. When you use a network provider (a provider that participates in one of the Fund's networks), you save money for yourself and the Plan because the network provider has agreed to charge a discounted dollar amount.

It is your decision whether or not to use a network provider. You always have the final say about the providers you and your family use. To encourage you to use network providers whenever possible, the Plan pays a higher percentage of Covered Charges when you use a network provider. If you have questions, or need a listing of network providers (provided free of charge), see *Contact Information* on page 3.

The Plan pays different levels of benefits based on whether you use a network or out-of-network provider, as listed on the *Schedule of Benefits*. For a listing of the services and supplies covered under the Plan, see page 33.

When you need to see a Physician:

- ☐ Call to make an appointment.
- ☐ Write down any health-related questions you have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- ☐ Make a list of any medications you are taking. Be sure to note how often you take the medication.
- ☐ Show your ID card when you go to your appointment to ensure your Physician knows where to file your claim.

For most Covered Charges, the annual deductible must be met before the Plan begins to pay benefits. Once your copayment and coinsurance amounts for Covered Charges reach the out-of-pocket maximum during the calendar year, the Plan pays 100% of the maximum allowable amounts for most covered services for the rest of that year up to any specific benefit maximums. **You must show your ID card each time you receive medical care. If you do not, your expenses may be paid as out-of-network expenses, even if you use a network provider.**

Save money. You save money by using network providers because the cost of the services provided is discounted; and the Plan pays a greater percentage of the cost of the discounted network services.

Note that some expenses may be covered differently or be subject to different benefit maximums. See the *Schedule of Benefits* for more information. Here is an example of how using a network provider can save you money.

Example

Let's look at what Charles, an active employee, would pay at a network Hospital compared to an out-of-network Hospital under the Blue Cross and Blue Shield PPO. This assumes that he has satisfied his annual deductible.

	*Network Hospital**	*Out-of-Network Hospital*
Covered Charges	*$1,000*	*$1,000*
*Network Discount**	*- $130*	*- $0*
Covered Charges	*$870*	*$1,000*
Plan Pays	*$870 x 80% = $696*	*$1,000 x 50% = $500*
Charles Pays	*$174 ($870 - $696)*	*$500 ($1,000 - $500)*

In the above example, using a PPO Hospital saves Charles $326.

** This example assumes a PPO savings rate of approximately 13%. The actual savings may vary.*

Out-of-Area Benefit

If your primary care Physician **refers** you to a specific out-of-network Physician specialist and **recommends** that a specific out-of-network Physician specialist perform the surgery, and you use the surgical services of the out-of-network Physician specialist, after complying with the additional terms and conditions set forth below, then:

Please note that when you visit a PPO network Hospital, the Physicians and other health care providers in the Hospital may not belong to the network, and vice versa.

- The Plan will pay benefits (including the charges of the Physician specialist and other necessary providers) at the same coinsurance rate as the network coinsurance rate listed on your *Schedule of Benefits*; and
- Your deductible and out-of-pocket maximum will be the same as the network amounts.

You must satisfy the following additional terms and conditions to be eligible for this out-of-area benefit. First, your primary care Physician's referral and recommendation must be objective and based on expectation and opinion on the basis of a medical judgment that the surgical services provided by the specific out-of-network Physician specialist will substantially increase the quality of care that you are expected to receive than if the same surgical services were provided by a Physician specialist within 35 miles of your residence. Second, you must request, *in writing and in advance of receiving the services,* to have any surgical services performed by an out-of-network Physician specialist under this provision. Any such claims shall otherwise

be subject to the provisions set forth in this summary plan description, and any such claims are considered pre-service claims. The claims procedure applicable to pre-service claims is set forth on page 94. The Board of Trustees may consult with a health care professional who has appropriate training and experience in a relevant field of medicine to verify that the quality of care would be substantially increased as required hereunder.

Extension of Benefits

If you or your eligible Dependent is totally disabled at the time your coverage under this Plan ends, 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 ended.

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 purposes of 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 the normal activities of a person of like age and gender who is in good health due solely to an Injury or Illness that is not employment-related.

Please note that this 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 your Physician.

Deductible

The deductible is the dollar amount (as listed on the *Schedule of Benefits*) that you and your eligible Dependents are responsible to pay before the Plan begins to pay medical benefits. Only Covered Charges may be used to satisfy the deductible. The deductible as listed on 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 40);
- Second surgical opinion benefits (see page 47); or

- Wellness, preventive, well-child, and well-baby care services, provided the services are obtained from a network provider.

After eligible family members have collectively satisfied the family deductible (as listed on the *Schedule of Benefits*) within a calendar year, no further deductibles are required for all covered family members for the remainder of that calendar year.

Coinsurance and Copayment

Once you and/or your family meet the deductible, the Plan pays a percentage of Covered Charges, called coinsurance. The amount the Plan pays depends on whether you use network or out-of-network providers and the type of Covered Charge, as listed on the *Schedule of Benefits*. Your payment is the remaining percentage of Covered Charges. For certain services, you pay a flat dollar amount called a copayment.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you pay out of your pocket in a calendar year for Covered Charges. Once your copayment and coinsurance amounts for Covered Charges reach the out-of-pocket maximum during the calendar year, the Plan pays 100% of the maximum allowable amounts for most covered services for the rest of that year *up to any specific benefit maximums*.

In-network expenses not considered Covered Charges do not apply to the out-of-pocket limit. There is no out-of-pocket limit for out-of-network charges.

Example

John's annual out-of-pocket maximum is $2,500. In June, John meets his out-of-pocket maximum and expenses he incurs at any network providers will be covered at 100%, subject to Plan limits. However, in July, John exhausts his 60 visits per year physical therapy benefits. Since John has met a maximum under his physical therapy benefits, any expenses John incurs for physical therapy, after July, will be his responsibility, even though he has satisfied his annual out-of-pocket maximum. This is because the Plan does not cover expenses beyond the allowable maximum for any specific benefit.

Medically Necessary or Medical Necessity

The Plan pays benefits only for services and supplies that are Medically Necessary or based on Medical Necessity. Medically Necessary means those services required to identify or treat an Illness or Injury, and that are determined by the Plan to be:

- Consistent with the symptoms, diagnosis, and treatment of the covered individual's condition, Illness, or Injury;
- In accordance with recognized standards of care for the covered individual's condition, Illness, or Injury;
- Appropriate with regard to standards of good medical practice;
- Not solely for the convenience of the covered individual, Physician, Hospital, or other health care provider; and
- The most appropriate level of service that can be safely provided to the covered individual.

When specifically applied to inpatient services, it further means that the covered individual's medical symptoms or condition require that the treatment or service cannot be safely provided to the covered individual on an outpatient basis.

Benefit Maximums

Certain medical Covered Charges have separate calendar year or lifetime maximums, as listed on the *Schedule of Benefits*.

In addition, there is a maximum amount payable with respect to all Illnesses or Injuries of any one individual during any calendar year, as listed on the *Schedule of Benefits*.

Preauthorization

You must preauthorize certain services in advance. To obtain Preauthorization, you or your Physician should call the number listed on your Plan ID card or on the Contact Information page 3 at least three days before the Hospitalization or treatment. You do not need to follow Preauthorization procedures for an emergency admission or treatment.

The following services require Preauthorization. Some services that require Preauthorization may not be listed below or may change. Make sure to check with Cigna or Valenz for a current, complete list.

Cigna PPO

If you are under the Cigna PPO plan, the following services require Preauthorization:

- Non-emergency inpatient services for medical/surgical and mental health/substance use disorder, except maternity-related stays less than 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- Cochlear Implants;
- Gene Therapy:
- Long-term acute care;
- Skilled nursing facility;
- Rehabilitation;
- Home Health Care (home nursing care);
- Home infusion therapy;
- Outpatient procedures for facial reconstruction, varicose vein treatment, breast reconstruction or reduction, blepharoplasty, or rhinoplasty;
- Potential Experimental or Investigative procedures;
- Spinal procedures;
- Therapeutic radiology; and
- Transplants, including transplant-related travel and lodging;

In addition, the following services are subject to a Medical Necessity review after the initial 5 visits when received from a PPO network provider:

- Chiropractic Services; and
- Physical Therapy and Occupational Therapy.

BCBS PPO

If you are under the BCBS PPO plan, the following services require Preauthorization:

- Non-emergency inpatient services, including acute Hospital care, acute Rehabilitation, chemotherapy, clinical trials, detoxification, inpatient surgery, long-term acute care, routine maternity-related inpatient care longer than 48 hours for a vaginal delivery or 96 hours for a cesarean section, inpatient mental health and substance use disorder treatment, observation stays longer than 23 hours, Residential Treatment, Skilled Nursing Facility treatment, and transplants;
- Elective outpatient surgeries (preauthorization not required for endoscopies or colonoscopies);
- Cardiac rehabilitation;
- Chemotherapy;
- Gene Therapy:
- Outpatient clinical trials;
- Dental general anesthesia if performed in a surgical facility;
- Mental health intensive outpatient;
- Mental health partial hospitalization;
- Occupational, Physical, and Speech therapy;
- Pulmonary rehabilitation; and
- Transplant evaluation/listing.

Your Responsibility

It is important to remember that the Plan is not designed to cover every health care expense. The Plan pays for Covered Charges, up to the limits and under the conditions established under the Plan's rules. 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.

Choosing a Physician

You save money for yourself and the Plan when you use a Physician who participates in the Plan's network. One way to find a Physician is to ask around. Ask a family member, friend, or co-worker if they have the name of a Physician they would recommend. Before visiting a Physician, you should contact your PPO (see page 3 for contact information) to ensure your Physician is in the network. Here are some questions you may want to ask the Physician(s) you're thinking about making an appointment with:

☐ *Are you accepting new patients?*

☐ *What's your treatment style?*

☐ *Are you board certified? If so, in what specialties? (Any Physician with a license can practice in any specialty. Board certification is your assurance that the Physician has appropriate training for the specialty.)*

☐ *At which Hospitals do you admit patients for major health care needs? Does the Hospital belong to the PPO network? Do the Hospital technicians (for example, for laboratory tests and X-rays) belong to the PPO network?*

☐ *What are your office hours?*

☐ *On average, how long do patients have to wait to make an appointment?*

☐ *During an appointment, on average, how long is the wait in your waiting room?*

☐ *Do you offer telemedicine visits as an alternative to an in-office visit?*

Medical Covered Charges

Benefits are payable for Allowable 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 semi-private rooms. If the Physician prescribes a private room, Covered Charges may not exceed the Hospital's average rate for semi-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. However, Preauthorization for maternity admissions is not required. You do not need to follow Preauthorization procedures for an emergency admission or treatment. In addition, the Plan does not require you to obtain Preauthorization for a colonoscopy procedure. The organization responsible for Preauthorization under your medical program (as specified on your medical ID card, or the Member Assistance Program, in the case of inpatient mental health and substance abuse treatment) will evaluate the proposed admission plan and length of stay based on individual treatment needs.

2. Hospital outpatient treatment.

3. Diagnosis, treatment, and surgery made by a Physician or surgeon. However, 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 listed on 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 listed on the *Schedule of Benefits*.

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

4. Physiotherapy by a licensed physiotherapist.

   Physiotherapy must be performed 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. All stages of reconstruction of the breast on which the mastectomy has been performed;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
   c. Prostheses; and
   d. Treatment of physical complications of all stages of mastectomy including lymphedemas.

6. Initial trusses, braces, 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. The Plan will cover the purchase of equipment if the cost is less than the rental of the equipment for the necessary period of use.
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 for an Emergency Medical Condition 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.

   Air ambulance services will be covered at 300% of the Medicare reimbursement rate at the time the services are rendered. Cost sharing and reimbursement rates to providers for air ambulance services shall be determined in accordance with the No Surprises Act.
10. X-rays and laboratory tests.
11. Radium and radioactive isotopes treatment.
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 following:
    a. The repair of natural teeth or other body tissues required as a result of a non-occupational Injury, 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 required oral surgery must be performed at a Hospital facility or under general anesthesia. When this situation arises, benefits are paid as follows:
    a. All surgeon and anesthesia Allowable Charges are paid by dental benefits and are subject to the annual dental maximum.
    b. All Hospital- related Allowable Charges are paid through medical benefits.
    c. 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.
16. Tubal ligations and vasectomies.
17. One smoking cessation program. Benefits include Physician services, counseling (through the MAP), nicotine replacement therapy, laser therapy, acupuncture, hypnosis, and prescription and over-the-counter smoking cessation medications, and products.
18. Speech therapy. The Plan will cover services for speech therapy as Rehabilitation or Habilitative Services, subject to the limits specified in your *Schedule of Benefits*. Charges for these services will be paid at the allowable amount and are subject to the Medical Necessity and the Plan's annual deductible and copayment amounts.
19. Off-label drugs if specified criteria are met. An off-label drug includes a drug or device that is FDA-approved but is being used for an indication or at a dosage that reliable evidence shows is an accepted off-label use.

The off-label use of FDA-approved drugs will be allowable for Medically Necessary medical benefits under the Plan if the use is supported by one or more citations in:

a. The AHFS Drug Information (AHFS DI);

b. The U.S. Pharmacopoeia Drug Information;

c. The Micromedex (also referred to as DrugDex);

d. The Facts & Comparisons Off-Label Database;

e. The NCCN Drugs & Biologics Compendium;

f. The Clinical Pharmacology;

g. The Association of Community Cancer Centers (ACCC); or

h. Any CMS-supported compendia, providing the use is not listed as "not indicated" in any one of the listed compendia.

If the above-stated criteria have been met, the off-label drug will not be considered Experimental or Investigative.

20. The provision of medical benefits for off-label use of FDA-approved drugs, as defined above, under this Plan does not apply to prescription drug benefits, including those provided under the Sav-Rx program. Gene Therapy. Gene Therapy that has been approved by the U.S. Food and Drug Administration (FDA) and is not considered experimental or investigational by the Plan. Preauthorization is required. The Plan will cover Gene Therapy as a Medical Benefit, and not as a prescription drug, regardless of whether or not the Gene Therapy is FDA-approved, prescribed, or medically necessary.

Additional Medical Covered Charges

The benefits that are described in the following paragraphs are also Covered Charges under the Plan's medical benefits and are subject to the calendar year deductible, copayments, coinsurance, and rules and limitations explained under each item.

Home Health Care

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.

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 a maximum of 40 visits per person per calendar year as listed on the *Schedule of Benefits*. This care must be Medically Necessary and ordered in writing by your Physician.

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 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 as covered by the Plan;
- Medical supplies and laboratory services used in the treatment of the covered individual 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.

See page 83 for home health care exclusions and limitations.

Transplant Services

You and your eligible Dependents are entitled to benefits for Transplant Surgery. The Plan pays the Allowable Charges you incur for Transplant Surgery in the same way it covers hospitalization, surgery, and Physician's visits, up to the maximum calendar year benefit listed on your *Schedule of Benefits*.

You must notify Medical Cost Management (Valenz) or Professional Benefit Administrators (PBA), as applicable, for Preauthorization of transplant services at least seven working days before the scheduled date of any transplant services or as soon as reasonably possible. They will review your treatment options and preauthorize your transplant services. Refer to page 3 for contact information.

Covered transplant services include the:

- Evaluation;
- Donor search;
- Organ procurement/tissue harvest; and
- 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 they are Medically Necessary and are performed 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 Charges **only** if the Recipient is a covered individual under this Plan. If the Recipient is not a covered individual, no benefits are payable for Donor charges.
- The search for bone marrow or stem cells from a Donor who is not biologically related to the patient is not considered a Covered Charge 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 performed at a preauthorized transplant facility, the medical care, treatment, transportation, and lodging provisions described below apply.

Covered Charges 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 of up to one year after the transplant; and
- Search for bone marrow or stem cells 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 a bone marrow or stem cell search, a maximum benefit of $100,000 is payable for all charges made in connection with the search.

The utilization review vendor (Valenz or PBA, as applicable) 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, 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 individual 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 Allowable Charges, as described below and at levels listed on the *Schedule of Benefits.*

> ***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.

Covered hospice care includes charges for the following services:

- Hospice Facility, Hospital, or convalescent facility inpatient charges for room and board, up to the facility's most common semi-private rate;
- Services and supplies for pain control and other acute and chronic symptom management;
- Part-time or intermittent nursing care by a registered nurse (RN) or a licensed practical nurse (LPN) 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 aide 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 holds responsibility for patient care, such as a physical or occupational therapist or a Physician for consultation or case management services.

Mental Health Treatment

You and your eligible Dependents are entitled to benefits for Covered Charges incurred for treatment of mental health disorders. Benefits for inpatient and outpatient treatment are paid at the levels, and up to the maximums, listed on your *Schedule of Benefits*.

Preauthorization of inpatient mental health treatment. All expenses for inpatient treatment of mental health disorders must be preauthorized. See the Contact Information for Preauthorization information.

(All Plans):

Covered mental health treatment includes the following:

- Services furnished by a licensed or accredited Hospital, subject to preauthorization requirements; and
- Preauthorized inpatient services.

All inpatient mental health treatment must be preauthorized.

Covered mental health treatment includes services furnished by a licensed or accredited Hospital (subject to Preauthorization requirements) and preauthorized inpatient services.

Substance Abuse Treatment

Benefits for inpatient substance abuse must be Preauthorized.

(All Plans):

Preauthorization of inpatient substance abuse treatment. All expenses for inpatient substance abuse treatment must be preauthorized. See the Contact Information for Preauthorization information.

Covered substance abuse treatment includes the following:

- ***Inpatient*** treatment for confinement in a Treatment Facility for Substance Abuse or Hospital, up to the calendar-year maximum listed on your *Schedule of Benefits*.
- ***Outpatient*** treatment for non-Residential care in a Treatment Facility for Substance Abuse, a certified non-Residential Treatment program, or Hospital, up to the calendar-year maximum listed on your *Schedule of Benefits*.

Check your *Schedule of Benefits* for treatment covered by the Plan. Day treatment combined with partial hospitalization may also be available.

A Doctor of Medicine (MD), psychiatrist, psychologist, or certified addictions counselor must also recommend the course of treatment. You may receive substance abuse treatment on an inpatient, outpatient, or a combination of inpatient and outpatient basis.

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 listed on the *Schedule of Benefits* under the Spinal Manipulation benefit. Covered services must be for the purpose of alleviating pressure on spinal nerves and 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 licensed chiropractor. Acupuncture must be prescribed by a Physician and is covered under the Spinal Manipulation benefit.

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 refer to services performed at an inpatient facility, including a Skilled Nursing Facility or a facility providing Residential Treatment, whose purpose is to provide the services described in this paragraph. Rehabilitation Services include physical therapy, occupational therapy, cardiac Rehabilitation Services, and speech therapy. All therapies are covered for purposes of both medical and mental health conditions equally subject to a combined maximum. Rehabilitation Services are subject to the following:

- Inpatient Rehabilitation Services in a Skilled Nursing Facility are limited to 60 days of treatment per calendar year.
- The Plan covers in-network and out-of-network Rehabilitation Services.
- Outpatient Rehabilitation Services are limited to combined maximum of 60 visits per calendar year.
- Benefits must be Preauthorized and are payable as listed on the Schedule of Benefits.

Habilitative Services

Habilitative Services are covered for both medical and mental health conditions, subject to a combined limit of 60 visits per calendar year. Preauthorization is required.

Habilitative Services also generally include ABA (applied behavioral analysis) services. ABA services include the design, implementation, and evaluation of systematic instructional and environmental modifications using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between the environment and behavior, to produce socially significant improvement in human behavior.

Treatment may include the following care when prescribed, provided or ordered for an individual diagnosed with autism, autism spectrum disorder or other developmental disorder (a) by a Physician or a Psychologist who has determined that such care is Medically Necessary, or (b) by a certified, registered or licensed health care professional with expertise in treating autism, autism spectrum disorder or other development disorder, who has determined that such care is Medically Necessary:

- Psychiatric care, including diagnostic services;
- Psychological care, assessments and treatments;
- Habilitative Services; and
- Prescription drugs.

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:

- Coverage is provided for a replacement prosthetic device for Dependents when replacement is necessary due to growth of the child and is Medically Necessary as determined by the Physician.
- Coverage is provided for 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 under the Plan's Subrogation and Reimbursement provisions.

Temporomandibular Joint (TMJ) Treatment

You or your eligible Dependents are entitled to treatment of jaw problems, including temporomandibular joint (TMJ) dysfunction, disorder, or syndrome, other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, muscles, nerves, and tissues relating to that joint. TMJ benefits do not include orthodontic treatment. The percentage the Plan pays after the deductible is satisfied and the lifetime limits for preparatory work and surgery are listed on 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 and copayment are satisfied, is listed on the *Schedule of Benefits*.

Orthotics

Orthotics expenses are covered up to the calendar year maximum listed on the *Schedule of Benefits*. Certain limitations apply to the reimbursement for orthotic expenses. Medical Necessity must be presented by the ordering Physician, and the orthotic must be specially molded for the covered individual.

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 an emergency in nature or caused by a job-related medical condition.

Benefits are payable for the Allowable Charges for consultation fees and any necessary additional laboratory tests or X-rays up to the maximum listed on the *Schedule of Benefits*.

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

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 Allowable Charges mentioned above up to the maximum payable listed on the *Schedule of Benefits*. You do not need to pay a deductible toward the expense 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.

For a list of expenses not paid under the Plan's second surgical opinion benefits, see page 84.

Preventive Services, Wellness, Well-Child and Well-Baby Care Benefits

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). If preventive services are received from a non-network provider, they will not be eligible for coverage under this Preventive Services benefit.

Coverage is provided on an in-network basis only, with no cost sharing (for example, no deductibles, coinsurance, or copayments), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations;
- Services described in the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC); and
- Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics *Bright Futures* guidelines.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost sharing by the Participant or Dependent. This means that the service will be covered at 100% of the Plan's Allowable Charge, with no coinsurance, copay, or deductible.

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

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

Preventive services are covered in-network as currently recommended by the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Centers for Disease Control (CDC), and the Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics *Bright Futures* guidelines. **Covered services are subject to change from those listed below.**

Preventive Services Benefit Overview

Physical Examination Benefit: The Plan will cover the expense related to a routine physical examination (including routine OB/GYN exams) by a Physician. Routine physical examinations include baseline examinations, periodic examinations and those examinations performed due to a relevant family history.

Preventive Services Covered With No Cost Sharing: The following benefits are available under the Fund's Preventive Services Benefit with no cost sharing. In certain circumstances, as determined by the Fund, the preventive benefit is only payable with an appropriate diagnosis.

Testing for asbestos and spirometry on Participants and Dependents 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.

Physical examinations that are for purposes of meeting employment requirements will be covered by the Plan, but only if they are performed as part of the in-network annual physical examination. Such examinations will be subject to the benefit limitations listed on the *Schedule of Benefits* for wellness expenses and will be subject to the provisions governing the Plan's use and disclosure of your protected health information on page 114. These examinations must be performed in conjunction with an in-network annual physical examination.

Your eligible Dependents through age 21 are entitled to coverage for well-child care benefits when provided by a network provider. Well-child care benefits include:

- Physical examinations; and
- Well-Child Required Immunizations, as recommended by the American Academy of Pediatrics.

The Plan also covers the immunization of girls and young women, at the recommended ages according to the CDC to prevent the human papillomavirus (HPV), a virus that can cause cervical cancer and other diseases.

Please note that Well-Child Required Immunization charges will be reimbursed when the service is rendered

by a local Public Health Department but only after proof of payment is submitted to the Fund Office.

Covered Preventive Services for Adults

- Abdominal aortic aneurysm one-time screening for men ages 65 to 75 who have ever smoked.
- Unhealthy alcohol use screening and counseling: screening and behavioral counseling interventions to reduce unhealthy alcohol use by adults ages 18 and older, including pregnant women, in primary care settings.
- Statins in adults aged 40-75, with cardiovascular disease risk factors.
- Blood pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a Physician visit.
- Cholesterol screening (lipid disorders screening) for adults ages 40 to 75.
- Colorectal cancer screening using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy, in adults in accordance with medically acceptable guidelines such as the U.S. Preventive Services Task Force. The test methodology must be medically appropriate for the patient. The Plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The Plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: bowel preparation medications, anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.
- Depression screening for adults.
- Screening for Prediabetes and Type 2 diabetes in adults ages 35 to 70 who are overweight or obese, and preventive interventions for Prediabetes.
- Diet counseling for adults at higher risk for chronic disease.
- Screening for hepatitis B virus infection in adults at high risk for infection.
- Screening for hepatitis C virus (HCV) infection in adults ages 18 to 79.
- HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.
- Annual screening for lung cancer with low-dose computed tomography in adults ages 50 to 80 who have a 20—pack per year smoking history and currently smoke or have quit within the past 15 years.
- Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m^2 or higher.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
- Tobacco use screening for all adults and cessation interventions and pharmacotherapy for non-pregnant tobacco users.
- Syphilis screening for all adults at increased risk of infection.
- Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Exercise interventions to prevent falls in community-dwelling adults age 65 or older who are at increased risk for falls.
- Low to moderate dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40 to 75 with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or

smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating Physician.

- Screening for latent tuberculosis infection in populations at increased risk.

Covered Preventive Services for Women, Including Pregnant Women

- Well-woman office visits for women beginning in adolescence and continuing across the lifespan, for the delivery of required preventive services.
- Screening women for urinary incontinence annually.
- Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
- BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal, or peritoneal cancer.
- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every year for women aged 40 to 74.
- Breast cancer chemoprevention counseling for women at higher risk. The Plan will pay for counseling by Physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. The Plan will also pay for risk-reducing medications (such as tamoxifen or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.
- Comprehensive lactation support services (including counseling, education by clinicians, and peer support services and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods. The Breastfeeding equipment and supplies include double electric breast pumps (including parts and maintenance), and breast milk storage supplies.
- Cervical cancer screening for women ages 21 to 29 with Pap smear every three years; for women ages 30 to 65, screening with Pap smear alone every three years, or screening with Pap smear and human papillomavirus testing every five years. Women who are at average risk should not be screened more than once every 3 years.
- Chlamydia infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, chlamydia infection screening is covered as part of the prenatal visit.
- Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.

- Folic acid supplements for women who are planning or capable of pregnancy, at prescription strength only if the woman obtains a prescription. Over-the-counter folic acid supplements are not covered.
- Gonorrhea screening for all sexually active women age 24 and younger and in older women who are at increased risk for infection, provided as part of a well-woman visit. The Plan will pay for the most cost-effective test methodology only.
- Counseling for sexually transmitted infections.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Younger women will be eligible for screening if their risk of fracture is equal to or greater than that of a 65-year-old woman. The Plan will pay for the most cost-effective test methodology only.
- Rh incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
- Screening for diabetes after pregnancy in women with history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes.
- Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.
- Screening for prediabetes and type 2 diabetes who are overweight or obese and are aged 37 to 70.
- Tobacco use screening and interventions for all women, as part of a well-woman visit, and expanded counseling for pregnant tobacco users.
- Syphilis screening for all pregnant women or other women at increased risk, as part of a well-woman visit.
- Screening and counseling for interpersonal and domestic violence, as part of a well-woman visit.
- Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia. A prescription must be submitted in accordance with Plan rules.
- Screening for hypertensive disorders in pregnant women with blood pressure measurements throughout pregnancy. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a Physician visit.
- Depression screening for the adult population including pregnant and postpartum women, and older adults.
- Screening for urinary incontinence annually.
- Screening for anxiety in adolescent and adult women, including those who are pregnant and postpartum women.

Covered Preventive Services for Children

- Well-baby and well-child visits from age newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Well-child annual physical exams recommended in the Bright Futures Recommendations are treated as Preventive Services and paid at 100%.

  Visits will include the following age-appropriate screenings and assessments:

  1. Developmental screening for children under age 3, and surveillance throughout childhood.

2. Behavioral assessments for children of all ages.
3. Vision screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.
4. Hearing screening.
5. Height, weight, and body mass index measurements for children.
6. Autism screening for children at 18 and 24 months.
7. Alcohol and drug use assessments for adolescents.
8. Hematocrit or hemoglobin screening for children.
9. Lead screening for children at risk of exposure.
10. Tuberculin testing for children at higher risk of tuberculosis.
11. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders.
12. Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group.
13. Cervical dysplasia screening at age 21.
14. Oral health risk assessment.
15. Blood pressure screening.
16. Depression screening for adolescents ages 12 to 18.
17. Critical congenital heart defect screening in newborns.
18. Medical history.
19. Iron supplements for children ages 6 to 12 months at risk for anemia.
20. Vision screening at least once in all children 3 to 5 years to detect amblyopia or its risk factors.
21. Counseling for children, adolescents, and young adults to age 24 who have fair skin regarding minimizing their exposure to ultraviolet radiation to reduce their risk for skin cancer. Coverage begins at age 6 months.
22. Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
23. Screening for hepatitis B virus infection in adolescents at high risk for infection.
24. Application of fluoride varnish to the primary teeth of all infants and children through to age 5 starting at the age of primary tooth eruption, in primary care practices.
25. Syphilis screening for adolescents who are at increased risk for infection.
26. For adolescents, screening and counseling for interpersonal and domestic violence.
27. Newborn screenings: Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).
28. Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.

- Screening for oral fluoride supplementation at recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
- Obesity screening for children aged 6 years and older with a high BMI, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
- HIV screening for adolescents at increased risk of infection, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group. HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.

Immunizations

Routine adult immunizations are covered for Participants and Dependents who meet the age and gender requirements and medical criteria recommended by the Centers for Disease Control and Prevention (CDC).

- Immunization vaccines for adults--doses, recommended ages, and recommended populations must be satisfied:
    1. Tetanus, diphtheria, pertussis (Tdap).
    2. Measles, mumps, rubella (MMR).
    3. Poliomyelitis.
    4. Influenza.
    5. Human papillomavirus (HPV).
    6. Pneumococcal (polysaccharide).
    7. Hepatitis A.
    8. Hepatitis B.
    9. Meningococca.
    10. Zoster (shingles).
    11. Varicella.
    12. COVID-19.
- Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied:
    1. Hepatitis B.
    2. Rotavirus.
    3. Diphtheria, tetanus, pertussis.
    4. Haemophilus influenzae type b.
    5. Pneumococcal.
    6. Inactivated poliovirus.
    7. Influenza.
    8. Measles, mumps, rubella.
    9. Varicella.

10. Hepatitis A.
11. Meningococcal.
12. Human papillomavirus (HPV).
13. COVID-19.

Office Visit Coverage

Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for in-network office visits under the Preventive Services benefit. Non-network office visits are not covered under the Preventive Services benefit under any condition.

- If a preventive item or service is billed separately from an office visit that is not part of a physical exam, then the Plan will impose cost sharing with respect to the office visit.
- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100% for the office visit.
- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

For example, if you have a cholesterol screening test during an office visit, and the doctor bills you for the office visit and bills you separately for the lab work associated with the cholesterol screening test, the Plan will charge a copayment for the office visit that is not a physical exam, but not for the lab work. In this case, the lab work will be paid at 100%. If you see a doctor to discuss recurring abdominal pain and have a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

Telehealth Services

The Plan pays benefits toward Telehealth Services if the reason for the Telehealth Service, defined as the use of digital information and virtual technologies, i.e. computer, tablet, mobile device, for remote management of an individual's health, is not otherwise excluded.

Telehealth Services are payable without cost sharing when received from RelyMD, the Plan's Telehealth Service provider. Telehealth Services available through a Physician's office or from any other in-network provider (other than the Fund's Telehealth Service provider) are payable at the Plan's applicable in-network cost sharing based on the Allowable Charge. Telehealth Services received from out-of-network providers are paid in accordance with the Plan's out-of-network benefit provisions.

No Surprises Act Services

The No Surprises Act, signed into law in December 2020, protects patients who receive Emergency Services at a Health Care Facility, at an Independent Freestanding Emergency Department or from Air Ambulances. In addition, the law protects patients who receive non-Emergency Services from an out-of-network provider at an in network Health Care Facility. Effective July 1, 2022, Participants and Dependents receiving these services will only be responsible for paying their network cost sharing and cannot be balance billed by the provider or facility for Emergency Services, non-Emergency Services from an out-of-network provider at an in network Health Care Facility or Air Ambulance services from out-of-network provider, as explained below.

- Air Ambulance Services

  Air ambulance services are medical transport for patients by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605. The No Surprises Act requires Air Ambulance Services, to the extent covered by the Plan, to be covered as follows:

- Air ambulance services from an out-of-network provider are covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider;
- The cost-sharing amount will be calculated as if the total amount that would have been charged for the services by an in-network provider of air ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services;
- Any cost-sharing payments the participant or dependent makes with respect to covered air ambulance services will count toward your in-network deductible and in-network out-of-pocket maximum in the same manner as those received from an in-network provider; and
- In general, a participant or dependent cannot be balance billed for these air ambulance services.

- Continuing Care Patients

  If a participant or dependent is a Continuing Care Patient and the Plan's contract with an in-network provider or an in-network facility or Hospital terminates, or benefits are terminated because of a change in terms of providers' and/or facilities' participation in the Plan, the Plan will do the following:

  - Provide notice of the Plan's termination of its contracts with the in-network provider or facility and inform the patient or their representative of the patient's right to elect continued transitional care from the provider or facility; and
  - Allow the patient (90) days of continued coverage at the in-network cost sharing to allow for a transition of care to an in-network provider or facility.

  A Continuing Care Patient is an individual who is: (a) receiving a course of treatment for a Serious and Complex Condition, (b) scheduled to undergo non-elective surgery (including any post-operative care); (c) pregnant and undergoing a course of treatment for the pregnancy; (d) determined to be terminally ill and receiving treatment for the illness; or (e) is undergoing a course of institutional or inpatient care from the provider or facility.

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

- Emergency Services

  The No Surprises Act requires Emergency Services to be covered as follows:

  - Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis;
  - Without regard to whether the health care provider furnishing the Emergency Services is an in-network provider or an in-network facility, as applicable, with respect to the services;
  - Without imposing any administrative requirement or limitation on non-in-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from in-network providers and in-network facilities;
  - Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by an in-network provider or an in-network facility;

- By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services;
- By counting cost-sharing payments you make with respect to non-in-network Emergency Services toward your in-network provider deductible and in-network provider out-of-pocket maximum in the same manner as those received from an in-network provider; and
- In general, participants and beneficiaries cannot be balance billed for these Emergency Services.

- Non-Emergency Services

  The No Surprises Act requires non-Emergency Services performed by an out-of-network provider at an in-network Health Care Facility to be covered as follows:

  - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider;
  - By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such in-network provider were equal to the Recognized Amount for the items and services; and
  - By counting any cost-sharing payments made toward any in-network provider deductible and in-network provider out-of-pocket maximums applied under the Plan (and the in-network provider deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an in-network provider.
  - In general, participant and beneficiaries cannot be balance billed for these items or services.

- Notice and Consent Exception

  Non-emergency items or services provided or performed by an out-of-network provider at an in-network Health Care Facility will be covered based on the Plan's out-of-network provider benefits and forgo the financial protections of the No Surprises Act if:

  - At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the patient (or their representative) is provided with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on treatment, the names of any in-network providers at the facility who are able to provide treatment, and that the patient may elect to be referred to one of the in-network providers listed; and
  - The patient gives written informed consent to continued treatment by the out-of-network provider acknowledging that the patient understands that continued treatment by the out-of-network provider result in greater expenses.
  - The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the out-of-network provider satisfied the notice and consent criteria and, therefore, these services will be covered as follows:
    - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider;
    - With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services; and

- By counting any in-network provider deductible and in-network provider out-of-pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by an in-network provider.
- In general, participants and beneficiaries cannot be balance billed for these items or services.

- Choice of Health Care Professional

  The Plan does not require the selection or designation of a primary care provider (PCP) or pediatrician. You have the ability to visit any network or out-of-network health care provider; however, payment by the Plan may be less for the use of an out-of-network provider.

- Access to Obstetrical and Gynecological Care

  You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

- External Review Process

  The External Review Procedures set forth on page 102 of this Plan shall apply to No Surprise Act service claims.

- Provider Directory

  The provider directory will be updated at least every ninety (90) days. If a participant or dependent is informed by the Plan through a telephone, electronic, or internet-based inquiry, or receives information from a print or electronic Provider directory that a provider is an in-network provider, but, in fact, the provider is an out-of-network provider and services are furnished by the out-of-network provider, the Plan will:

  - Apply a cost-sharing amount that is no greater than the cost-sharing amount that would have been assessed if the provider was an in-network provider; and
  - Apply the out-of-pocket limit, if any, as if the services were provided by an in-network provider.

For a current provider directory, call your PPO network administrator's phone number or visit your PPO network administrator's website listed on the *Contact Information* page at the beginning of this SPD.

Medical Expenses Not Covered

You should be aware that not every medical expense is covered by the Plan. For expenses not covered by the Plan, see *General Plan Exclusions and Limitations* on page 79.

Member Assistance Program (MAP)

The MAP provides you with free professional counseling and referral services for many issues that you face in life. When you have a question or an issue you would like to discuss, please call the MAP, as listed on page 3. A clinically trained counselor is available on the MAP Help Line 24 hours a day, 7 days a week. The counselor will assist you in getting the care you need. Preauthorizing inpatient mental health or substance abuse treatment, monitoring your care, and helping you with the claims process.

When you call, you may speak to the MAP counselor, or a MAP representative will arrange an appointment with a MAP counselor in your area at a time convenient for you. During your call or 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 six sessions, free of charge, or you may be referred to other network professionals for further assistance if necessary.

Confidentiality is a key component of the services provided by 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 and relationship problems such as separation, divorce, conflicts, or domestic violence;
- Substance abuse problems such as problem drinking, alcohol and drug dependency, illegal drug use, smoking cessation, and misuse of prescription drugs;
- Family issues such as children's behavioral and school issues, parent-child conflicts, elder care, single-parenting, and child care;
- Emotional and mental health issues caused by such things as stress and anxiety, depression, anger management, and loss of a loved one;
- Risk assessment for dangerous behavior; and
- Financial problems such as problem gambling, household finances, or over-extended credit.

However, the Plan does not cover court-ordered DUI (driving under the influence), DWI (driving while intoxicated), and drug abuse programs, except medically necessary treatment otherwise covered by the Plan.

MAP Costs

The MAP counseling services are provided to you free of charge for up to six sessions. 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 Plan provisions. For inpatient and outpatient benefits provided by the Plan for mental health and substance abuse treatment, refer to your *Schedule of Benefits*. Note that your copayment for network services is less than your copayment for out-of-network services.

Case Management

Our Case Management programs through Valenz and Cigna are there for you if you need complex specialty care. Whether it's a high-risk pregnancy, transplant, cancer treatments, multiple trauma or a chronic condition, Case Management will ensure that you receive the right care at the right time in the right setting. They provide access to National Centers of Excellence and transplant networks, patient advocacy through education, support, and alternative funding assistance, and they can provide savings for you and the Fund while getting the best results possible. You will have access to experienced Registered Nurses and Physicians who specialize in case management and specialty care with the Case Management program.

If you have a condition that requires case management services, you will be contacted by Valenz or Cigna. Case management is a voluntary program available for both medical/surgical and mental health/substance use disorder benefits. You are encouraged to take advantage of the free case management services provided by Valenz and Cigna to help reduce costs for you and the Fund. There is no penalty for not accepting case management services. If you think you may need case management services, you can call the number on your medical ID card.

Prescription Drug Benefit

If you or your eligible Dependents incur covered prescription drug expenses while eligible for benefits, the Plan will cover those expenses. The Sav-Rx program was chosen by the Trustees to allow you and your family a more convenient and cost-effective program for prescription services. Please note that prescription drug copayments, as listed on the *Schedule of Benefits,* do not apply to the medical out-of-pocket maximum.

You can contact Sav-Rx as listed on page 3:

- To find out if a pharmacy participates in the Sav-Rx program;
- To find the nearest Sav-Rx pharmacy;
- To request quotes or a formulary (preferred brand) listing for prescription drugs;
- To find out if a medication is covered by the program; and
- To request mail-order envelopes and instructions.

You should ask your Physician if a generic or formulary brand is available to reduce 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 copayment than you would pay at a retail pharmacy.

If an FDA approved generic medication is available, then to receive the greatest cost savings, the prescription **must** be filled with the generic formulary medication instead of the brand-name or non-formulary medication. However, if your Physician indicates that the prescription must be Dispensed As Written (DAW), you will pay the brand-name formulary medication copayment or the non-formulary medication copayment for the 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 formulary medication or non-formulary medication in addition to your copayment amount.

Retail Pharmacy Program

When filling a prescription at a participating pharmacy, simply present your medical ID card and pay the applicable copayment. The amount you pay depends on whether you have your prescription filled with a generic formulary, brand-name formulary, or non-formulary medication. For the Plan's copayments, see the *Schedule of Benefits*.

Through the retail pharmacy program, you may receive 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 Sav-Rx mail-order program to obtain any additional refills of maintenance medications after your initial prescription and two refills have been obtained through a retail pharmacy.

For certain maintenance medications, you can receive up to a 90-day supply at the retail pharmacy. You must show your Sav-Rx identification card to the pharmacist at a participating pharmacy to receive benefits under the Plan's prescription drug benefits. If you use a non-participating pharmacy (out-of-network), your prescription is not covered under the Plan.

Retail Maintenance Program

The Plan also has a retail maintenance program, which allows you to receive a 90-day supply of your medications through a retail pharmacy. You will pay the same copayments as the mail-order program for the 90-day supply, a savings from having to pay three copayments for three 34-day prescriptions. *Please be*

aware that not all pharmacies participate in the retail maintenance medication program. However, currently, Walgreens and CVS are participating pharmacies.

Mail-Order Program

The Plan also offers a mail-order program for your long-term, or maintenance, prescription drug needs. Maintenance medications are often prescribed for heart disease, high blood pressure, asthma, etc. With the mail-order program, you receive a larger supply of medication—up to a 90-day supply at one time—and enjoy the convenience of having the medication sent directly to your home for the copayment specified on the *Schedule of Benefits*. Postage costs are paid by Sav-Rx. Oral contraceptives must always be purchased through the Sav-Rx mail-order program to be covered.

For more information about how to use the mail-order program, see page 3 for Sav-Rx contact information.

Generic and Brand-Name Medications

Almost all prescription drugs have two names: the generic name and the brand-name. By law, both generic and brand-name medications must meet the same standards for safety, purity, and effectiveness.

When you receive a brand-name medication, you generally pay more because they are more expensive. When you or your Dependent needs a prescription, you may want to ask your Physician whether a generic medication can be substituted for a brand-name medication.

Generic or Brand-name

While the Plan covers both generic and brand-name medications, you pay a higher copayment amount when you receive a brand-name formulary medication.

You pay the highest copayment when you have your prescription filled with a non-formulary medication.

In general, using generic medications will help control the cost of health care while providing quality medications—and can be a significant source of savings for you and the Plan. Your Physician or pharmacist can assist you in substituting generic medications when appropriate.

Formulary and Non-Formulary Medications

There are often several types of medications that can be used to treat the same condition. To ensure high-quality care and to help manage costs, the prescription drug program has a formulary that lists preferred drugs. The Plan's formulary includes most generic medications and brand-name medications that are either more effective than others in their class or as effective as and less costly than similar medications. You are responsible for a higher copayment amount for non-formulary medications.

When you or your Dependent needs a prescription, you may want to ask your Physician whether a formulary medication can be substituted for a non-formulary medication. For information about the drug formulary, contact Sav-Rx (see *Contact information* on page 3).

Prescription Drug Covered Charges

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 copayment will be applicable, even if the insulin and needles/syringes are on separate prescriptions.
- Up to 12 Viagra pills per month by prescription and with prior approval by your Physician.
- Tobacco cessation products are covered for both prescription and over-the-counter (OTC) products, with no copayment.
- Up to a 90-day supply of prescription proton pump inhibitors per calendar year. To receive more than a 90-day supply of proton pump inhibitors per calendar year, you must obtain prior authorization from the Plan.
- Preventive services and vaccines.

Prescription Drug Expenses Not Covered

You should be aware that not every prescription drug expense is covered by the Plan. For expenses not covered by the Plan, see *General Plan Exclusions and Limitations* on page 80.

Dental Benefits

The Plan offers a variety of dental services while you or your eligible Dependents are eligible under the Health and Welfare Fund.

The Plan pays a maximum per person each year for dental and orthodontic expenses as listed on the *Schedule of Benefits*. Orthodontic expenses are provided for Dependent children only up to age 19.

Most types of dental services are covered under the Dental Plan and are grouped into three categories: preventive, primary, and major care. In addition, the Plan provides orthodontic benefits only for eligible Dependent children who have not yet reached age 19, as explained on page 67. The deductible is the dollar amount (as listed on the *Schedule of Benefits*) that you and your eligible Dependents are responsible for paying before the Plan begins to pay benefits for preventive care, primary care, or major care. The deductible does not apply to orthodontic services. Only Covered Charges may be used to satisfy the deductible. The deductible as listed on the *Schedule of Benefits* is applied each calendar year.

This deductible is separate from the medical deductible. After you meet the dental deductible, the Plan pays a percentage of covered dental expenses up to a per-person maximum each year as listed on the *Schedule of Benefits*. The Plan pays a percentage of covered orthodontic expenses for each eligible Dependent child under age 19.

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.

After eligible family members have collectively satisfied the family deductible (as listed on the *Schedule of Benefits*) within a calendar year, no further deductibles are required for all covered family members for the remainder of that 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 knows that you will have dental expenses over $300, 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.

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 Delta Dental of Illinois.
- Delta Dental of Illinois 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 Delta Dental of Illinois is valid for a six-month period, provided you are eligible for Dental Plan benefits at the time the expenses are actually incurred.

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 amalgam. 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 the Allowable Charge for the service provided, you will be responsible for the additional charges above the Allowable Charge or the difference in the amount allowable for a service that is approved by Delta Dental of Illinois.

> 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.

Extension of Dental 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 and your treatment is completed within the 30-day period immediately following the termination of your eligibility. Delta Dental of Illinois 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 Covered Charges

Preventive/Diagnostic Care Dental Services

Preventive care dental services are designed to help you prevent dental disease or to help you detect it in its early stages. Coverage includes:

> When you need dental care:
>
> ☐ Schedule an appointment with the dentist of your choice.
>
> ☐ File a completed claim form with the Fund Office.

- **Oral Examinations.** Oral examinations include the initial examination and periodic routine oral examinations. Benefits are payable for no more than two examinations each calendar year.
- **Prophylaxis.** 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 each calendar year.
- **Topical Fluoride Application.** Benefits for this procedure are available to covered individuals under age 19 and are payable for no more than two applications each calendar year.
- **Protective Sealants.** Benefits for protective sealants are available to covered individuals under age 17 and are payable for one application during a 36-month period.
- **Dental X-Rays.** Benefits are payable for:
  - One set of full mouth X-rays during a 36-month period, when Medically Necessary as determined by your dentist;
  - Diagnostic X-rays when Medically Necessary as determined by your dentist; and
  - Bitewing X-rays no more than two times each calendar year.
- **Space Maintainers.** Benefits for space maintainers are available to covered individuals under age 19 when they are not part of orthodontic treatment (see page 67).
- **Emergency Treatment.** Benefits are payable for emergency oral examinations and treatment for the relief of pain.

Primary (Basic) Care Dental Services

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

> **Date of Service**
>
> The date of service is the date that services are actually rendered. In the case of 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.

- **Restorative Services.** Restorative services include treatment requiring use of amalgam, synthetic porcelain, and plastic restorations (fillings) or stainless steel crowns. Restorative services also include posterior composite fillings on your back teeth that match the color of your teeth.
- **Periodontics.** Periodontics include treatment for diseases of the gums.
- **Oral Surgery.** Benefits are payable for extractions and other types of oral surgery related to the teeth or gums, including pre- and post-operative care.
- **Endodontics.** Benefits are payable for pulpal therapy and root canal filling.

If you expect that the charges for primary care dental services may total more than $300, ask your dentist for a proposed treatment cost called pre-estimation of benefits. See page 64 for more information.

Major Care Dental Services

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* on page 65).
- **Inlays, onlays, or crowns** when the teeth cannot be restored with a filling material.
- **Repairing or recementing** of crowns, inlays, bridgework, or dentures.
- **Initial installation of full or partial removable dentures or fixed bridgework**, provided you or your Dependent is covered by the Plan on the date service is rendered, subject to the "Extension of Dental Expense Benefits" provision on page 65.
- **Crown replacement**, provided the original crown was installed more than five years before the replacement. The Plan treats a temporary crown and permanent crown as a combined benefit, payable up to the Allowable 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 before its replacement and the existing denture or bridgework cannot be made serviceable.
- **Dental Implants.** Benefits are payable for artificial tooth root replacements used in prosthetic dentistry. Through dental surgery, these implants are placed below the jaw to replace natural teeth.

Limitations on Full and Partial Dentures

The Plan will pay benefits toward the replacement for crowns, inlays, bridges, and 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.

In addition, 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.

Orthodontic Services

Orthodontic treatment is covered for eligible Dependent children only and is limited to eligible Dependent children under age 19. The Plan covers orthodontic services as listed on the *Schedule of Benefits*. Please note that the Orthodontic Maximums listed in the *Schedule of Benefits* are separate from the overall dental benefits' calendar-year maximum.

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 Delta Dental of Illinois. The orthodontist must submit detailed billing for services. The Plan will not make payments based on payment coupons. However, reimbursements for orthodontic expenses may be made directly to you based on the detailed bills submitted by the orthodontist.

Opt Out of Dental Coverage

If you wish, you may elect to cease coverage for dental benefits under the Plan for yourself or your Dependents at any time by providing written notice to the Fund Office of your intention to cease dental coverage. Cessation of dental coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you.

If you previously elected to cease coverage for dental benefits under the Plan, you may reinstate coverage by providing written notice to the Fund Office. Reinstatement of dental coverage will be effective as of the first day of the month immediately following the date the Fund Office receives such written notice from you.

Dental Expenses Not Covered

You should be aware that not every dental expense is covered by the Plan. For expenses not covered by the Plan, see *General Plan Exclusions and Limitations* on page 80.

Vision Benefits

The Plan provides vision benefits for you or your eligible Dependents while you are eligible under the Health and Welfare Fund.

Vision services must be provided by a licensed optical provider to be covered.

Vision Covered Charges

Covered vision care expenses include charges for:

- An eye examination performed by a legally qualified ophthalmologist or optometrist;
- Contact lenses or lenses prescribed by the ophthalmologist or optometrist, including contact lenses obtained through mail-order;
- Frames; and
- Corrective eye surgery, including but not limited to laser surgery, radial keratotomy (RK), automated lamellar keratoplasty (ALK), or laser assisted in-situ keratomileusis (LASIK) surgery.

When you need vision care:

☐ Schedule an appointment with the optician, optometrist, or ophthalmologist of your choice.

☐ File a completed claim form with the Claims Administrator.

Benefits are paid for vision care for you and your family, up the limit shown in the *Schedule of Benefits*.

Maximum benefits are payable for you and each of your eligible Dependents each calendar year, as noted in the following example:

Example

Joan has an eye examination by an optometrist on January 15, 2025, and the cost of the examination is $85. Joan receives a prescription for lenses from the optometrist at her examination, and she purchases lenses and frames on January 15, 2025, at a cost of $225. Because Joan's vision benefits are limited to $250 per calendar year, the Plan pays $250 of Joan's covered vision expenses, and Joan pays the balance of $60 ($85 +$225 = $310 minus the Plan's benefit of $250 = $60). If Joan has additional vision expenses during 2025, they will not be covered by the Plan.

Opt Out of Vision Coverage

If you wish, you may elect to cease coverage for vision benefits under the Plan for yourself or your Dependents at any time by providing written notice to the Fund Office of your intention to cease vision coverage. Cessation of vision coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you.

If you previously elected to cease coverage for vision benefits under the Plan, you may reinstate coverage by providing written notice to the Fund Office. Reinstatement of vision coverage will be effective as of the first day of the month immediately following the date the Fund Office receives such written notice from you.

Vision Expenses Not Covered

You should be aware that not every vision expense is covered by the Plan. For expenses not covered by the Plan, see *General Plan Exclusions and Limitations* on page 80.

Hearing Benefits

The Plan covers hearing expenses, up to the amount listed on the *Schedule of Benefits*.

Hearing Covered Charges

Benefits include charges for medical examinations to determine the need for a hearing aid and for hearing aids. A legally qualified otologist, audiologist, or otolaryngologist must perform the hearing examination. The qualified specialist must prescribe the hearing aid instrument.

The Plan offers two opportunities for you to obtain discounts on hearing aids and supplies:

EPIC Hearing Service Plan (EPIC HSP)

The Fund has made arrangements with EPIC Hearing Service Plan (EPIC HSP), who will assist you in locating quality hearing care professionals and, in most cases, reduce your out-of-pocket expenses for your hearing exams and hearing aid devices. The EPIC HSP maximizes your Hearing Benefit by coordinating referrals through the Plan. To take advantage of this program, call EPIC HSP at its toll-free number, 866-956-5400. Be sure to identify yourself as being covered under the North Central Illinois Laborers' Health and Welfare Fund.

Amplifon Hearing Health Care

The Fund has teamed up with Amplifon to provide you with assistance should you need a hearing aid. The Amplifon hearing program offers:

- A 60-day risk-free hearing aid trial period;
- Follow-up care for one year following purchase, to ensure a smooth a transition to your new hearing aids;
- A two-year supply of batteries or one standard charger to keep you powered; and
- A 3-year coverage warranty for loss, repair, or damage of your hearing aid (exclusions and limitations may apply).

To learn more about the Amplifon hearing aid program, visit amplifonusa.com/ncillaborers or call 833-451-1020.

Hearing Expenses Not Covered

You should be aware that not every hearing expense is covered by the Plan. For expenses not covered by the Plan, see *General Plan Exclusions and Limitations* on page 80.

Loss of Time Benefits

(For Eligibility A and C Employees Only)

The Loss of Time benefit is designed to help provide financial protection if you become injured or Ill and are unable to work because of a non-occupational accidental bodily Injury or a non-occupational Illness. You are eligible for benefits if you are an Eligibility A or C Employee.

If you become totally disabled, you may be eligible for weekly Loss of Time benefits if you:

As an Eligibility C Employee, you are eligible for Loss of Time benefits **only if** your Employer continues to contribute monthly to the Fund during the period that you are totally disabled.

- Were eligible for coverage under the Plan when you become disabled;
- Are unable to work because of a covered non-occupational accident or Sickness;
- Are under the care of a Physician; and
- Are not receiving a pension.

Benefits

The amount of weekly Loss of Time benefits is $400 per week for up to a maximum of 26 weeks. In accordance with federal regulations, Social Security (FICA) and Medicare taxes will be deducted from each payment you receive.

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 or C 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.

You are not eligible for the Loss of Time benefit if you are receiving unemployment compensation. By definition, recipients of unemployment compensation are able-bodied persons who are available for work and are actively seeking employment.

The amount of the weekly Loss of Time benefit is $400 per week for up to a maximum of 26 weeks.

If you can't work because of a non-work-related Injury or Sickness:

- ☐ Call your Employer and the Fund Office.
- ☐ See a Physician as soon as possible.
- ☐ File a claim with the Fund Office.

Your Loss of Time benefits are subject to the Plan's Subrogation and Reimbursement provisions. For accident-related claims, you must sign a Subrogation Reimbursement Agreement. See page 111 for additional information on Subrogation.

When Benefits Begin

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.

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:

- Return to active employment for at least one full working day; or
- Are available for active employment.

Continued Eligibility During Disability Periods (for Eligibility A Employees Only)

Periodically, you may be required to submit medical evidence that you are disabled or be examined by a Physician chosen by the Trustees.

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 to maintain eligibility, up to a maximum of 260 hours. Such hours may be credited to any month in which the Loss of Time benefit is paid, and up to three months after the final month a Loss of Time benefit was paid. 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 separate Illness or Injury will result in a separate disability that starts a separate 12-month period running for that disability.

Occupational Injury or Illness means an Injury or Illness for which you are entitled to or are pursuing entitlement to benefits under the applicable workers' compensation, occupational disease, or similar laws.

A certified disability is one in which you are totally disabled as a result of a non-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 11. Sufficient proof of the certified disability must be provided to the Fund Office for disability hours to be credited.

If you become totally and permanently disabled before age 60 and you are an Eligibility A Employee, your Life Insurance 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. See page 72 for more information.

Loss of Time Benefits Not Covered

Loss of Time benefits are not provided under certain circumstances. See *General Plan Exclusions and Limitations* on page 80.

Life Insurance Benefits

(For Eligibility A and C Employees Only)

Life Insurance benefits provide financial protection to your beneficiary in the event of your death. The benefit is paid if you die while eligible for benefits as an active Participant, even if the cause of death is work-related.

Benefit

The amount of the Life Insurance Benefit is $10,000. For your Life Insurance benefit to be paid to your beneficiary, written proof of your death must be provided. Benefits are paid in one lump sum.

Extension of Life Insurance Benefit After Total and Permanent Disability

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.

If you become totally and permanently disabled before age 60 and you are an Eligibility A or C Employee (and eligible for coverage under the Plan when you became disabled), your basic Life Insurance Benefit coverage may continue for nine months under the Life Insurance continuation provision if premiums are continued on your behalf and you submit proof of your total and permanent disability. If you apply for the waiver of premium benefit after you become totally and permanently disabled, then your insurance will continue without payment of premium for a maximum of an additional 12 months after the 9-month continuation period if you meet certain requirements. You should contact the Fund Office in the event of your disability. Your Physician must provide written proof of your disability.

The amount of Life Insurance Benefit coverage while you are totally and permanently disabled will be the amount that was in force at the time you initially became disabled, less any accelerated death benefit that is paid to you.

Benefits will continue under this waiver of premium extension until the earliest of:

- The date you accept employment (including part-time employment) or are found to be able to accept employment for which you are reasonably fitted by training, education, or experience;
- The date satisfactory proof of total disability is not submitted as required;
- The date you do not furnish the Trustees with proof of your continued disability;
- The date you refuse to submit to a medical examination;
- The date you become a retiree;
- 12 months after the date you are eligible for the waiver of premium benefit; or
- The date the policy terminates.

Accelerated Death Benefit

If you have a Terminal Illness with a life expectancy of 12 months or less, you may be eligible for an accelerated death benefit of 50% of the amount of the Life Insurance benefit. To be eligible for the benefit:

- Your Terminal Illness must result from an Injury or Illness after the policy effective date and while you are eligible for Life Insurance coverage under the Plan;
- You must apply for the accelerated death benefit in writing, providing satisfactory proof of your Illness, while you are eligible for Life Insurance coverage;
- You provide satisfactory certification from a Physician that you are Terminally Ill, and your life expectancy is 24 months or less;
- You provide a second satisfactory certification from a Physician designated by the life insurance company; and
- The life insurance policy must be in force.

Contact the Fund Office or the life insurance company for more information.

Life Insurance Conversion

If your Life Insurance coverage under the Plan ends, you will receive a notice from the Fund Office. You may be eligible within **31 days** after coverage ends to convert your insurance to an individual policy. Written application for the policy must be completed and the first premium must be paid within 31 days after the later of the date your coverage ends or the date you have provided a conversion notification. Accidental Death and Dismemberment, waiver of premiums, and the accelerated death benefit are not available for conversion.

Beneficiary

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

To designate a beneficiary, request a form from the Fund Office. Be sure to review your beneficiary designation from time to time to ensure your Life Insurance benefits are paid as you wish.

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 to one or more of the following, separately, or in combination, as determined by the following order:

- Your surviving spouse;
- Your surviving children in equal shares;
- Your surviving parents in equal shares; or
- The executor or administrator of your estate.

If your beneficiary dies on the same day as you or within 15 days of your death, the benefit will be paid as if your beneficiary died before you, unless a claim has been filed on behalf of the beneficiary before the beneficiary's death.

If the beneficiary is a minor, legally incapacitated, or there is no guardian of your estate, the life insurance company may hold payment or make payment, in its discretion, to a person who satisfies the legal requirements to receive payment, or who is responsible for the beneficiary's care and support.

In no event will your surviving spouse, children, parents, brothers, sisters, or any family member, executor, or administrator of your estate, or other person be entitled to more than the total sum of Life Insurance benefits payable by the life insurance company. Further, the life insurance company will have the sole discretion to determine any Life Insurance benefits due pursuant to the above-stated terms and the manner in which the Life Insurance benefits are allocated and paid.

Life Insurance Exclusions

Life Insurance benefits are not provided in certain circumstances. Gee *General Plan* Exclusions beginning on page 80.

Accidental Death and Dismemberment Insurance Benefits

(For Eligibility A and C Employees Only)

If you are eligible for benefits under the Plan as an Eligibility A or C Employee and you suffer any of the losses listed below as the result of an accident, the Accidental Death and Dismemberment (AD&D) Insurance benefit will be paid.

Benefit

Benefits are paid directly to you for an Injury, or to your beneficiary in the event of your death. The AD&D Insurance benefit is in addition to the Life Insurance benefit.

If you suffer any combination of losses as shown in the following table as the result of one accident, only one amount (the largest) is payable for all losses. The amount paid for all losses resulting from one accident will not exceed the full amount of $10,000. Benefits are payable for the following losses:

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.

Loss Suffered	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
Quadriplegia	$10,000
Paraplegia	$7,500
One hand, one foot, or sight of one eye	$5,000
Hemiplegia	$5,000
Total and permanent loss of speech or hearing	$5,000
Loss of thumb and index finger on same hand	$2,500

Beneficiary

Benefits for loss of life are payable to the beneficiary you name (see page 73). 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 Fund Office. The change will be effective when the Fund Office receives the completed form.

AD&D Insurance Exclusions

You may not obtain a conversion policy for Accidental Death and Dismemberment insurance when your coverage ends. AD&D Insurance benefits are not provided in certain circumstances. See *General Plan Exclusions and Limitations* on page 80.

Recovery Incentive Program

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.

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.

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 valid 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 is $500 per person. Overcharges totaling less than $25 are not eligible under the Recovery Incentive Program.

The Health and Welfare Fund will consider only those expenses that are Covered Charges under this Plan 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 the Claims Administrator 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 for 25% of the overcharge amount. You should note that these reimbursements are considered taxable 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.

Here is what you need to do:

- List everything that happens while in the Hospital, Physician's office, or outpatient clinic by reconstructing events daily or immediately upon discharge.
- Before leaving the Hospital, Physician's office, or outpatient clinic, make sure to arrange that an itemized bill is sent.
- Match your list against the itemized bill you requested to detect any discrepancies. Check the bill carefully for charges that represent any treatments, services, or supplies that were not received (see suggestions below).
- 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 the Claims Administrator a copy of the original bill with the overcharges circled and a copy of the corrected 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.

Use the following or similar checklist for a careful and complete review of a bill:

- Were you billed for the correct number of days that you occupied a room?
- If intensive care was required, were you billed for the correct number of days that you were confined to an intensive care unit?
- Were you charged for the day that you were discharged, even though you left before the day's charges began?
- Were you charged for the correct type of room that you occupied (private, semi-private, ward, etc.)?
- Were you billed only for tests or X-rays that you actually received?
- Were you billed for medication, injections, dressings, supplies, etc. that you did not receive or for quantities in excess of what you remember?
- 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?
- Were you billed for the purchase of humidifiers, bedpans, admission kits, etc. that you never received or 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 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?

At any time, the Trustees have the right to amend or modify these rules or terminate the Recovery Incentive Program entirely by a majority vote of the Trustees.

General Plan Exclusions and Limitations

The exclusions listed in this section are not all-inclusive. Just because a service or supply is not listed as an exclusion does not mean it is a Covered Charge. Only benefits listed as covered are considered Covered Charges under the Plan. In addition, benefits are not payable for amounts in excess of any Plan limitations.

The following expenses are not covered under the Plan.

1. Eye refractions, eyeglasses, hearing aids, or the fitting thereof, except as specifically listed otherwise.
2. 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.
3. Treatment of Injuries received while engaged in a criminal act or acts resulting in a felony conviction or for which felony charges are pending, except that Injuries or Illness that is the result of participation in an act of domestic violence will be covered by the Plan.
4. Charges for services received due to Injury or Sickness caused by or contributed to by:
    a. Engaging in an illegal act or occupation, except that Injuries or Illness that is the result of participation in an act of domestic violence will be covered by the Plan; or
    b. Committing or attempting to commit any crime, criminal act, or felonious act, except that Injuries or Illness that is the result of participation in an act of domestic violence will be covered by the Plan. The lack of a conviction or issuance of a citation by a law enforcement body is not conclusive as to whether or not the charges for services were caused by or contributed to by engaging in an illegal act.
5. 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 (BAC) being at a level proscribed by the law of the state where the accident occurred or was a result of the claimant's illegal drug use. A breathalyzer, blood, or urine test result that the claimant's BAC was prohibited by the law of the state where said motor vehicle accident occurred or that the claimant was utilizing an illegal drug at the time of the motor vehicle accident will be considered objective and conclusive evidence that alcohol or illegal drug use was a contributing cause of the Injury or Illness resulting from the motor vehicle accident. The claimant's failure to take a breathalyzer, blood, or urine test, or the lack of a conviction or issuance of a citation by a law enforcement body is not conclusive as to whether or not the alcohol or illegal drug use was a contributing cause of the Injury.
6. Any Injury, Illness, or dental treatment (a) for which the covered individual has received, or is reasonably entitled to receive, benefits under a workers' compensation or occupational disease law, or (b) that arises out of or in the course of any occupation or employment for wage or profit. However, if a case is disallowed by the Illinois Workers' Compensation Commission, benefits may be payable. For purposes of this exclusion and limitation, any Participant or beneficiary who volunteers (or otherwise foregoes wages) for a for-profit business entity shall be deemed to be working in an occupation or employment for wage or profit.
7. Expenses for which no charge would have been made had there been no coverage.
8. Expenses for which there is no legal obligation or financial liability to pay.
9. 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 due to Injury, Illness, or disability.

10. Services or supplies furnished, paid for, or otherwise provided by the U.S. government or its agencies.
11. Any charges that exceed the Allowable Charges.
12. 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, including personal comfort or convenience items such as radio, television, telephone, or guest meals.
13. 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.
14. Expenses related to prevention of pregnancy, including, but not limited to, condoms, drugs or medicines, the Norplant system, and other devices, except that tubal ligations and vasectomies are not excluded. Oral contraceptives that are not purchased through the mail-order prescription drug program are excluded.
15. Charges for infection control and commercial medical waste disposal.
16. Any expenses beyond the maximums listed on the *Schedule of Benefits* or as described under a particular benefit in this booklet.
17. 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.
18. 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.
19. Experimental or Investigative medical, surgical, or other health care services that, in the Plan's opinion 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 Evaluations;
        ii. The American Hospital Formulary Service Drug Information; or
        iii. The United States Pharmacopeia 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.
    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.
    g. Off-label drugs that are not FDA-approved and are not supported by one or more citations in the standard reference compendia for the off-label indication as required by the Plan.

However, routine expenses for approved clinical trials for cancer or other life-threatening diseases may be covered by the Plan, if the expense meets the conditions below.

Approved Clinical Trials: An "approved clinical trial" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. Federally funded clinical trials include those approved or funded by one or more of the following:

a. The National Institutes of Health (NIH),

b. The Centers for Disease Control and Prevention (CDC),

c. The Agency for Healthcare Research and Quality (AHRQ),

d. The Centers for Medicare & Medicaid Services (CMS),

e. A cooperative group or center of the NIH, CDC, AHRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA);

f. A qualified non-governmental research entity identified by NIH guidelines for grants; or

g. The VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

Qualified Individuals: You are eligible to participate in a clinical trial and receive benefits for routine services if:

a. You satisfy the eligibility requirements of the protocol of an approved clinical trial; and

b. Either your referring Physician is a participating health care provider in the plan who has determined that your participation in the approved clinical trial is medically appropriate, or you provide the Plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

Routine Costs: The Plan covers routine costs for services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a Participant or beneficiary not enrolled in a clinical trial. However, a plan does not have to cover non-routine services and supplies, such as: (1) the investigational items, devices, or services themselves; (2) items and services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

Network and Non-Network Coverage: If one or more of the Plan's participating network providers is participating in a clinical trial, the Plan may require that you use the network participating provider as long as the provider will accept the patient. The Plan only covers out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

20. Milieu therapy or any confinement in an institution primarily to change or control one's environment.

21. Any services, supplies, or treatment not specifically provided as a benefit in this document.

22. Examinations for the issuance of marriage licenses, insurance policies, maintenance of valid licenses, or other ancillary examinations, unless the examination is necessary to meet employment requirements.

23. Charges in excess of the specified maximum listed on the *Schedule of Benefits* or as described under a particular benefit in this booklet.
24. Bereavement counseling, pastoral counseling, financial, or legal counseling, such as estate planning or drafting of a will and funeral arrangements.
25. 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.
26. Respite care.
27. Services of any individual who normally lives in the covered individual's home or is a member of the covered individual's family or Dependent's family.

Medical Exclusions and Limitations

In addition to the general Plan exclusions and limitations, the following expenses are not covered under the Plan's medical benefits.

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. Charges for treatment of any intentionally self-inflicted Injury or attempted suicide, unless caused by an underlying physical or mental health condition.
3. Hospital charges and confinements not recommended or approved by a Physician.
4. Treatment by acupressure, hydrotherapy, massage therapy, or biofeedback.
5. Dental implants and/or charges related to orthodontic treatment, except as specifically listed as covered under the Plan's dental benefits.
6. Transportation for medical care other than local ambulance service.
7. Elective abortions unless the life of the mother is endangered if the fetus were carried to term; however, the Plan covers charges for complications resulting from the abortion.
8. 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 within six months of the accident, see page 41.
9. 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.
10. Reversal of voluntary sterilization.
11. Well-child care and immunizations that are received from an out-of-network provider, except when Well-Child Required Immunizations are received at a local health department.
12. 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 covered individual is 75% or more over his or her medically desirable weight;
    b. The obesity is a threat to the covered individual'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.

This exclusion does not apply with respect to otherwise covered medically necessary treatment for mental health conditions, such as treatment for an eating disorder.

13. Expenses related to sexual reassignment.
14. Services for the diagnosis and treatment of infertility.
15. Non-approved admission days as determined by the Preauthorization organization.
16. Inpatient Rehabilitation Services that can reasonably and appropriately be provided on an outpatient basis.
17. Drugs or medications, cosmetics, dietary supplements, vitamins, nutritional formulas, and beauty aids.
18. Orthoptics or vision training.
19. Private Hospital rooms and/or private duty nursing except when Medically Necessary as determined by the Plan.
20. Biofeedback for the diagnosis of attention deficit disorder or related disorders.
21. Charges related to orthodontic treatment, except as provided under the Plan's dental benefits.
22. Charges for wellness, preventive 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.
23. Services received that are not performed by a Physician or under the direct supervision of a Physician.
24. Wellness or preventive services received while confined in a Hospital, convalescent or extended care facility, nursing home, night care center, or similar institution.
25. Medicines, drugs, appliances, equipment, materials, or supplies, except as covered under the Plan's prescription drug benefit.
26. 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.
27. Full body scans, Ornish program (chips), heart scoring, or heart scans.
28. Hepatitis B immunizations not prescribed or ordered by a Physician during or at the time of the physical examination.
29. Services that should otherwise be payable under the employer-sponsored coverage of the Participant's spouse.

Home Health Care Exclusions and Limitations

In addition to the general Plan exclusions and limitations, the following home health benefits are not covered.

1. Services or supplies not specified in the Home Health Care Plan.
2. Home health care services of any social workers.
3. Home health care transportation services.

Substance Abuse Exclusions and Limitations

In addition to the general Plan exclusions and limitations, the following substance abuse benefits are not covered.

1. Treatment and services received from anyone other than a licensed medical professional appropriately suited for the delivery of medically necessary care and working within the scope of their license.
2. Treatment involving the family of the person for whom a claim is submitted when they are part of the therapy.
3. Treatment received for the satisfaction of a court order or DUI (driving under the influence) conviction, except medically necessary treatment otherwise covered under the Plan.

Second Surgical Opinion Exclusions and Limitations

In addition to the general Plan exclusions and limitations, the following second surgical opinion benefits are not covered.

1. A consultation by a Physician who is not a legally qualified Physician.
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.

Preventive Services Coverage Limitations and Exclusions

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

1. The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.
2. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered.

3. Examinations, screenings, tests, items or services are not covered when they are Investigative or Experimental, as determined by the Plan.
4. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
    a. When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;
    b. When related to judicial or administrative proceedings;
    c. When related to medical research or trials; or
    d. When required to maintain employment or a license of any kind, unless performed as part of the in-network annual physical examination.
5. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over the counter, are not covered under the Preventive Services benefit. For example, the following drugs, medicines, vitamins, and supplements are not covered:
    a. Aspirin for any reason, including for prevention;
    b. Chemoprevention for any indication, including, but not limited to, for breast cancer;
    c. Supplements, including, but not limited to, oral fluoride supplements and folic acid supplements; and
    d. Tobacco-cessation products, drugs, or medicine with a Physician's prescription or over the annual limit.

Prescription Drug Exclusions and Limitations

In addition to the general Plan exclusions and limitations, the following expenses are not covered under the Plan's prescription drug benefits.

1. Over-the-counter medications not requiring a prescription.
2. Medications lawfully obtainable without a prescription.
3. Devices or appliances, support garments, or other non-medicinal substances.
4. Administration fees for drugs or insulin.
5. Experimental or Investigative drugs.
6. Unauthorized refills.
7. Prescription drugs covered under federal, state, or local programs for which there is no charge.
8. Medications used for cosmetic purposes, such as Rogaine.
9. Medications when confined to a rest home, nursing home, sanitarium, extended care facility, Hospital, or similar entity.
10. Retin-A, except for the treatment of acne vulgaris.
11. Copayments from other group health insurance drug programs.
12. Charges for Viagra without prior approval of the Physician or for more than 12 pills per month, unless prior authorization is received from the Plan.
13. Any injectable medication without prior Physician approval.

14. Non-sedating antihistamines. If a Physician writes a letter saying that over-the-counter Claritin (Claritin OTC) cannot be tolerated, then a prescription substitute may be authorized.
15. Weight-loss medications.
16. Gene Therapy.

Dental Exclusions and Limitations

In addition to the general Plan exclusions and limitations, the following expenses are not covered under the Plan's Dental benefits.

1. Charges for services that are more than the calendar-year maximum benefit as listed on the *Schedule of Benefits*.
2. Work done for appearance (cosmetic) purposes, except for (a) conditions resulting from Injuries, scars, tumors, or diseases; (b) posterior composite fillings; and (c) dental implants.
3. Work done while not covered under this Plan, except as provided under the Plan's Extension of Dental Benefits provision (see page 65).
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 the covered individual's responsibility to pay.
5. Extra sets of dentures or other appliances.
6. Treatment that is otherwise free of charge.
7. Treatment furnished or payable by the armed forces or any civil unit of any government for which a covered individual is not obligated 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 that 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 Plan's Orthodontic services (see page 67) and only up to the maximum benefit level allowed by the Plan's dental benefits.
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 infection control and medical waste disposal.
20. Charges for more than one denture reline per calendar year.
21. Any services, supplies, or treatment not specifically provided as a benefit in this booklet.

Vision Exclusions and Limitations

In addition to the general Plan exclusions and limitations, the following expenses are not covered under the Plan's vision benefits.

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 listed on the *Schedule of Benefits* within a calendar year.
3. Special procedures such as orthoptics or vision training and special supplies or non-prescription sunglasses and subnormal vision aids.
4. Visual analysis that does not include refraction.
5. Services or supplies not listed as Covered Charges under the Plan's vision benefits. (Vision care expenses connected with Illness or Injury are covered under the Plan's medical benefits.).
6. Non-prescription safety glasses.
7. Orthoptics or vision training.

Hearing Exclusions and Limitations

In addition to the general Plan exclusions and limitations, the following expenses are not covered under the Plan's hearing benefits.

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. 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.

Loss of Time Exclusions and Limitations

In addition to the general Plan exclusions and limitations, no benefits will be paid under the Plan's Loss of Time benefits for any of the following.

1. Period of disability during which the covered individual is not under the direct care of a Physician.
2. 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 the covered individual is entitled to or pursuing entitlement to benefits under the applicable workers' compensation, occupational disease, or similar laws.
3. Disability that begins while the covered individual is not eligible or while the North Central Illinois Laborers' Health and Welfare Fund does not have primary responsibility for the individual's coverage as defined under the Plan's Coordination of Benefits provisions (see page 107).
4. Disability that is due to Injuries or Illnesses resulting directly or indirectly in the commission of or by engaging in an illegal act or occupation or committing or attempting to commit any crime, criminal act, or felonious act. The lack of a conviction or issuance of a citation by a law enforcement body is not conclusive as to whether or not the charges for services were caused by or contributed to by engaging in an illegal act.
5. 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 (BAC) being at a level proscribed by the law of the state where the act occurred or was a result of the claimant's illegal drug use. A

breathalyzer, blood, or urine test result that the claimant's BAC was prohibited by the law of the state where said motor vehicle accident occurred or that the claimant was utilizing an illegal drug at the time of said motor vehicle accident will be considered objective and conclusive evidence that alcohol or illegal drug use was a contributing cause of the Injury or Illness resulting from the motor vehicle accident. The claimant's failure to take a breathalyzer, blood, or urine test, or the lack of a conviction or issuance of a citation by a law enforcement body is not conclusive as to whether or not the alcohol or illegal drug use was a contributing cause of the Injury.

6. Periods of disability during which the covered individual is considered a retiree under the North Central Illinois Laborers' Health and Welfare Fund and is receiving a monthly pension benefit.
7. Periods of disability during which the covered individual is eligible for benefits under this Plan as an Eligibility B Employee.

Life Insurance Exclusions and Limitations

In addition to the general Plan exclusions and limitations, no Life Insurance benefit is payable if your death is caused directly or indirectly, wholly or partly, by:

1. Injuries or Illnesses resulting directly or indirectly in the commission of or by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, or felonious act. The lack of a conviction or issuance of a citation by a law enforcement body is not conclusive as to whether or not the charges for services were caused by or contributed to by engaging in an illegal act.
2. War or act of war.
3. Injuries or Illness sustained in a motor vehicle accident where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (BAC) being at a level proscribed by the law of the state where said motor vehicle accident occurred or that the claimant was using an illegal drug at the time of said motor vehicle accident will be considered objective and conclusive evidence that alcohol or illegal drug use was a contributing cause of the Injury or Illness resulting from the motor vehicle accident. The claimant's failure to take a breathalyzer, blood, or urine test, or the lack of a conviction or issuance of a citation by a law enforcement body is not conclusive as to whether or not the alcohol or illegal drug use was a contributing cause of the Injury or Illness.

AD&D Insurance Exclusions and Limitations

In addition to the general Plan exclusions and limitations, no benefits will be paid under the Plan's AD&D Insurance benefit for death, disability, or Injury resulting from any of the following:

1. Suicide or attempted suicide, while sane or insane.
2. An intentionally self-inflicted Injury, or any attempt to inflict a self-Injury, while sane or insane.
3. Sickness, whether the loss results directly or indirectly from the Sickness.
4. Medical or surgical treatment of Sickness, whether the loss results directly or indirectly from the treatment.
5. Any entry into the body of poison, gas, alcohol, or a controlled substance, drug, or sedative unless taken as prescribed by a Physician.
6. Disabilities, Injuries, or Illnesses resulting directly or indirectly in the commission of or by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, or felonious act. The lack of a conviction or issuance of a citation by a law enforcement body is not conclusive as to whether or not the charges for services were caused by or contributed to by engaging in an illegal act.

7. War or an act of war, declared or undeclared, or any act of terrorism.
8. Participation in an insurrection or riot.
9. An accident that occurs while you are serving on a full-time active-duty basis for more than 90 days in any armed forces of any country or international authority. This exclusion does not include Reserve or National Guard active duty for training.
10. Disability, Injuries, or Illness sustained in a motor vehicle accident where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (BAC) being at a level proscribed by the law of the state where said motor vehicle accident occurred or that the claimant was using an illegal drug at the time of said motor vehicle accident will be considered objective and conclusive evidence that alcohol or illegal drug use was a contributing cause of the Injury or Illness resulting from the motor vehicle accident. The claimant's failure to take a breathalyzer, blood, or urine test, or the lack of a conviction or issuance of a citation by a law enforcement body is not conclusive as to whether or not the alcohol or illegal drug use was a contributing cause of the Injury or Illness.

Claims and Appeals

Filing Claims

You should file any initial claim for Plan benefits **within one year** after the date you received treatment. If you do not, your claim may be denied. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed by the Trustees.

Claims should be filed within **one year** of the date services are received, or your claim may be denied.

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.

Medical Claims

When you receive medical treatment, you must present your identification (ID) card at the time of your visit. All network providers submit claims for you. Benefits are then paid directly to the Physician or Hospital providing the services. You will receive an Explanation of Benefits (EOB) for all claims received. Your ID card provides the group and identification number the provider will need to submit your claim. While it is preferred that all claims be submitted electronically, paper claims may be submitted. If you need to submit a claim, you can request a claim form from the organizations listed on the *Contact Information* page 3.

If you or an eligible Dependent has coverage under more than one health care plan, benefits are coordinated (see page 107).

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.

With each claim, be sure to attach an itemized statement that includes:

- ☐ Patient's name;
- ☐ Date of service;
- ☐ Itemized charges;
- ☐ Procedure codes;
- ☐ Diagnosis;
- ☐ Receipts (if applicable); and
- ☐ Provider's name, address, phone number, and tax ID number.

MAP benefit claims are treated the same as medical benefit claims.

Prescription Drug Claims

Each time you need a prescription filled, be sure to present your ID card. Participating pharmacies submit claims electronically for you.

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 an appeal regarding the denial.

Dental Claims

If you need a dental claim form, please contact Delta Dental of Illinois as listed on page 3. Delta Dental of Illinois will check the records of your hours worked and will forward the claim forms to you if you are eligible for benefits under the Plan.

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.

Vision, Hearing, and Loss of Time Benefit Claims

If you need a claim form, please contact the Claims Administrator as listed on page 3. Be sure to submit your claim forms as soon as possible. When completing your claim form, be sure to:

- Fill in the front of the claim form completely, and sign it. If the claim is connected to an accident, be sure to fill in all information related to the accident. If someone else is at fault for the accident, you may be required to sign a Reimbursement Agreement (see page 112) before the Plan will pay benefits for your claim.
- Have your Physician fill in and sign the Physician's section.

Life Insurance and AD&D Insurance Benefit Claims

Contact the Fund Office about how to file a claim for Life and Accidental Death and Dismemberment Insurance benefits. Your claim should be filed within 90 days of the loss. However, if that is not possible, your claim should be filed within one year after the initial 90-day period.

Claim Procedures

A claim for benefits is a request for Plan benefits made in accordance with the Plan's claims procedures. To file a claim for Plan benefits, you or the provider must submit a completed claim, 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 Preauthorization of a benefit that does not require Preauthorization 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 claims for you. The following information must be completed for your request for benefits to be a claim, and the Claims Administrator to be able to decide your claim:

- Participant's name;
- Patient's name;
- Patient's date of birth;
- Participant's or retiree's Social Security number;
- Date of service; and
- If treatment is due to accident, accident details.

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, Ninth 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; and
- Billing name and address.

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 do not 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

Urgent care claims may be made orally by telephone to Professional Benefit Administrators, Inc. at 800-435-5694 if you are covered under the Cigna medical program or to Valenz at 800-367-9938 if you are covered under the Blue Cross and Blue Shield medical program. You must then follow-up your telephone claim with a written claim.

Urgent Care Claims

You may submit urgent care claims (defined on page 94) by telephone but you must follow up your phone call in writing within 24 hours with the information listed to the left.

Network medical claims will be filed for you. No claim form is necessary. Your claim will be considered filed as soon as it is received by the appropriate organization.

If you are in the Blue Cross and Blue Shield medical program, you should file pre-service claims with Valenz. You should file post-service medical claims (including post-service mental health or substance abuse claims) with Professional Benefit Administrators.

If you are in the Cigna medical program, you should file pre-service and post-service claims (including claims for mental health or substance abuse) with Professional Benefit Administrators.

For dental benefits, file all dental claims with Delta Dental of Illinois as listed on the *Contact Information* page.

File all other claims with the Claims Administrator as listed on the *Contact Information* page.

Health Care Benefit Determination Procedures

Procedures for determination of health care claims (which include medical, prescription drug, dental, vision, and hearing) are different for the following types of claims:

- **Pre-service** (applicable to certain services depending on whether you are on the BCBS PPO or Cigna PPO, as listed on pages 94);
- **Urgent care** (applicable to certain services depending on whether you are on the BCBS PPO or Cigna PPO, as listed on pages 94;
- **Concurrent care** (applicable to certain services depending on whether you are on the BCBS PPO or Cigna PPO, as listed on pages 95); or
- **Post-service** (applicable to all other health care claims).

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 Preauthorization for certain services as listed in pages 39-40.

Example

You request Preauthorization of your inpatient mental health treatment after your Physician recommends the hospitalization or other treatment for your Illness.

The Plan will not deny benefits for pre-service claims if:

- It is not possible for you to obtain Preauthorization; or
- The Preauthorization process would jeopardize your life or health.

If you improperly file a pre-service claim, you will be notified as soon as possible, but no later than 15 days after receipt of 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 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 Plan's control. 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 this 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 decided on the basis of the information that the Plan has, and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or 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 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

You request Preauthorization of your inpatient surgery after your Physician recommends the hospitalization or other inpatient treatment for your Illness.

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.

The Plan may make a determination on your claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the Plan. If the determination is provided orally, it will also be confirmed in writing within three days after the oral notice.

If an urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, you will be notified as soon as possible, but no later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be decided on the basis of the information that the Plan has, and your claim may be denied. Notice of the decision will be provided no later than 24 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 preauthorized benefit (other than by Plan amendment or termination). However, you will be notified of the decision:

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

Example

Your inpatient Hospital stay is originally preauthorized for five days, and your stay is reviewed at three days to determine if the full five days is appropriate.

If you request an extension of approved urgent care treatment, the Plan will 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 health care benefits that are not pre-service claims. When you file a post-service claim, you have already received the services in your claim.

Example

You have diagnostic tests performed and then make your claim for benefits afterwards.

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 the Claims Administrator 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 Plan's control. 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 decided on the basis of the information that the Plan has, and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a post-service claim and notify you of the determination.

No Surprises Act Services Claims

The out-of-network Provider will receive an initial payment or denial of payment from the Plan for No Surprise Act Services within 30 days receipt of all information necessary to adjudicate the claim.

If a claim is subject to the No Surprises Act, the participant or dependent cannot be required to pay more than the cost-sharing amount under the in-network Plan and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing amount.

The Plan will pay a total plan payment directly to the out-of-network provider that is equal to the amount by which the Out-of-Network Rate for these services exceeds the cost-sharing amount for the services, less any initial payment amount.

Loss of Time Benefit Determination Procedures

For Loss of Time benefits, the Claims Administrator will make a decision on the claim and notify you of the decision within 45 days. If the Claims Administrator requires an extension of time due to matters beyond the control of the Claims Administrator, the Claims Administrator 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 Claims Administrator notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Claims Administrator notifies you, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision.

If an extension is needed because the Claims Administrator needs additional information from you, the extension notice will specify the information needed. In this 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 decided on the basis of the information that the Plan has, and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Claims Administrator's request for the information, you will be notified of the Claims Administrator's decision on the claim within 30 days.

For Loss of Time benefits, 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 the Claims Administrator.

Life and AD&D Insurance Benefit Determination Procedures

You will receive a decision on your Life Insurance or AD&D claim within 90 days of your claim. The Life Insurance benefit will be paid in full, in accordance with the terms of the Life Insurance benefit or Accidental Death and Dismemberment Insurance benefit provisions of the Plan, after the Fund Office receives a copy of a certified death certificate.

Notice of Claim Denial or Adverse Benefit Determination

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for, a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:
  - A determination of an individual's eligibility to participate in a plan;
  - A determination that a benefit is not a covered benefit; or
  - A beneficiary's eligibility to participate in this Plan;
- A reduction in a benefit resulting from the application of any utilization review decision, source-of-Injury exclusion, network exclusion, or other limitation on otherwise covered benefits, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigative or not Medically Necessary or appropriate; or
- Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

Contents of Notice of Adverse Benefit Determination: The Plan will provide you with a notice of the initial adverse benefit determination on your claim within certain time frames after your claim is received, as previously described. The notice will provide:

- The identity of the claim involved;
- The specific reason or reasons for the claim denial or other adverse benefit determination, including any Plan standards used in denying the claim;
- Specific reference to the pertinent Plan provisions upon which the decision is based;
- A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;

- A copy of the Plan's internal appeal procedures and external review processes, time periods to appeal your claim, and information regarding how to initiate an appeal;
- A statement that you have the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- A statement that you may bring a lawsuit under ERISA Section 502(a) after the appeal of your claim is completed;
- If the denial was based on an internal rule, guideline, protocol, or similar exclusion or limit, a statement that a copy of such internal rule, guideline, protocol, or similar criteria that was relied on will be provided free of charge to you, upon request;
- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of such scientific or clinical judgment for the denial will be provided free of charge to you upon request;
- A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes; and
- 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.

Contents of Notice of Adverse Benefit Determination related to Loss of Time Benefits Filed on and After April 1, 2018: The Plan will provide you with a notice of the initial adverse benefit determination with respect to your Loss of Time benefits claim within certain timeframes after your claim is received, as previously described. The notice will provide:

- The specific reason or reasons your claim was denied;
- Reference to the specific Plan provisions on which the denial was based;
- A description of any additional information you need to submit in support of your claim;
- An explanation of why the additional information is needed;
- An explanation of the Plan's claim review procedures and applicable time limits;
- The specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist;
- An explanation of the clinical or scientific judgment for the determination, applying the terms of the Plan to your medical circumstances, if the adverse benefit determination was based on Medical Necessity or other similar exclusions, or a statement that such explanation will be provided free of charge upon request;
- A discussion of the decision, including an explanation of the basis for (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable); (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable); and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);

- Statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records, and other information to your claim for benefits;
- Statement of your right to present evidence and testimony in support of your claim during the appeal/ review process;
- Statement that before the Plan can issue an adverse benefit determination on review of a disability claim, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. The evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under the Plan to give you a reasonable opportunity to respond prior to that date;
- Statement that before the Plan can issue an adverse benefit determination on review of a disability claim based on a new or additional rationale, the Plan shall provide you, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under the Plan to give you a reasonable opportunity to respond prior to that date; and
- A statement of your rights, under the Employee Retirement Income Security Act of 1974 (ERISA), to bring a civil action.

If applicable, the notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

Right to Appeal a Claim Denial

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 the Fund Office. Your written application for an appeal must include the specific reasons you feel the denial was improper. You may submit any document you feel appropriate, as well as submitting your written issues and comments. The Fund Office will prepare your appeal file for review by the Executive Board and decision by the full Board of Trustees.

In general, you should send your written request for an appeal to the Fund Office as soon as possible. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

- 180 days from the date of a decision for health care or Loss of Time benefit claims; or
- 60 days from the date of a decision for Life or AD&D Insurance benefit claims.

Review Process

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;
- Was submitted, considered, or generated in the course of making the benefit determination (regardless of whether it was relied upon);
- Demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or
- 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 that originally denied the claim. The Board will not give deference to the initial adverse benefit determination. 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 Experimental or Investigative), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Appeal Decision

- **Pre-Service Claims:** You will be sent a notice of decision on review within 30 days of receipt of the appeal by the Fund Office.
- **Urgent Care Claims:** You will be sent a notice of a decision on review as soon as possible and no later than within 72 hours of receipt of the appeal by the Fund Office.
- **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 five days after the date of the meeting at which the decision was reached.
- **Loss of Time Benefit, Life Insurance Benefit, and Accidental Death and Dismemberment Insurance Benefit 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 identity of the claim involved;
- The specific reason(s) for the determination, as well as any Plan standards used in denying the claim, and a statement that you have the right to request, free of charge, the denial code and its corresponding meaning;
- 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;
- An explanation of the Plan's external review procedures, along with any time limits and information regarding how to initiate an external review; and
- 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 Investigative, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the Plan's terms to your claim, or a statement that it is available upon request at no charge.

Notice of Decision on Review With Respect to Loss of Time Benefits Filed on and After April 1, 2018

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

- The specific reason for the denial;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you have the right to request a free copy of all documents, records, and information relevant to your appeal;
- The specific internal rule, guideline, protocol, standard or other similar criterion, if any, relied upon in making the determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist;
- An explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on Medical Necessity or other similar exclusion or limitations, or a statement that such explanation will be provided free of charge upon request;
- An explanation for (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable); (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable); and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
- That you may bring a civil action suit under the Employee Retirement Income Security Act of 1974 (ERISA);
- Any Plan-imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the specific expiration date for bringing suit; and
- If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

If the Plan has failed to comply with the Claims and Appeals Procedure requirements for Loss of Time benefit claims, you will not be prohibited from filing suit or seeking court review of a claim denial based on a failure to exhaust the administrative remedies under the Plan unless the violation was the result of a minor error or considered "de minimis." This would mean: (a) non-prejudicial, (b) attributable to good cause or matters beyond the Plan's control, (c) in the context of an ongoing good-faith exchange of information, and (d) not reflective of a pattern or practice of non-compliance by the Plan.

Legal Proceedings

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

- Before you have exhausted all your remedies under the Plan's claims and appeals procedures; and

- After three years from the expiration of the time allowance within which you were required to file your claim with the Plan.

Notwithstanding the foregoing, any legal action must be initiated within 12 months of the date the Plan issues an adverse benefit determination on your appeal.

Any action in court must be brought in the United States District Court for the Central District of Illinois, where the Plan is administered.

External Review Procedures

For purposes of this section, references to "you" or "your" include you, your covered Dependents, and you and your covered Dependents' authorized representatives; and references to "Plan" include the Plan and its designees.

This External Review process is intended to comply with the external review requirements of the Patient Protection and Affordable Care Act of 2010 (ACA), as set forth in Interim Final Regulations implementing the Act, in Technical Release 2010-01, in an amendment to the Interim Final Regulations issued on June 22, 2011, and in Technical Release 2011-02.

If your appeal of a claim, whether pre-service, post-service, or urgent care claim, is denied, and that adverse benefit determination involved a medical judgment or a rescission of coverage, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

NOTE that if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan, external review is not available.

I. External Review of Standard Claims

Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of an initial adverse benefit determination or adverse Appeal Claim benefit determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them differently.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for Appeal Claim Benefit Determinations.

You do not need to exhaust the internal review and appeals process if the Plan fails to follow all the requirements for internal review. However, this does not apply to the Plan's minor violations of regulatory procedures or actions that are not prejudicial, are attributable to good cause, or are beyond the control of the Plan and made in the context of a good-faith exchange of information or are not reflective of a pattern or practice of non-compliance.

A. *Preliminary Review*

1. Within five business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:
    a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Determination concerns a claim involving medical judgment or rescission of coverage;

c. The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;

d. You have exhausted the Plan's internal claims and appeals process (except in limited, exceptional circumstances); and

e. You have provided all the information and forms required to process an external review.

2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:

   a. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

   b. If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

B. ***Review by Independent Review Organization (IRO)***

If the request is complete and eligible, the Plan will assign the request to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan will rotate assignment among IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim. Such additional information must be submitted within 10 business days. Information submitted after 10 business days may not be considered by the IRO.

2. Within five business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.

3. If you submit additional information related to your claim, the assigned IRO must, within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if, upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

4. The IRO will review all the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it were new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice

guidelines, the Plan's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer(s).

5. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.
6. The assigned IRO's decision notice will contain:
    a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount [if applicable]), and the reason for the previous denial);
    b. The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
    c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    d. A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    e. A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;
    f. A statement of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
    g. A statement that judicial review may be available to you; and
    h. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

II. Expedited External Review of Claims

You may request an expedited external review if:

1. You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
2. You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

A. *Preliminary Review*

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in section I.A.1, are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in section I.A.2.

B. *Review By Independent Review Organization*

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, at the above section I.B. In reaching a decision, the assigned IRO must review the claim *de novo* (as if it were new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above in section I.B.6, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

III. After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

IV. Payment of Claims

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under state or federal law. In addition, such otherwise binding decisions do not preclude the Plan from making payments on the claim or providing benefits to the claimant at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. The Plan must provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, or termination) or retention will not be made on the basis of whether that person is likely to support a denial of benefits.

Authorized Representatives

An authorized representative, such as your spouse or other individual, may file a claim for you if you are unable to do so yourself. Contact the Fund Office for the form needed 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, later defined, without your having to complete the

Fund's special authorization form. The special authorized form must, however, be completed for all other claims.

Assignment of Benefits

The benefits in this Plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You may not sell, assign, pledge, transfer, or grant any interest in or to these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against the Plan and imposes no duty or obligation on the Plan. The Plan will not honor any such purported sale, assignment, pledge, transfer, or grant.

Neither you nor your beneficiary may transfer or assign any Life Insurance 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 this 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 the 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 the person; or
- By the Trustees directly for the support, maintenance, and welfare of the 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.

Improper or False Claims

If you (as the claimant) furnish false information on any material subject to the Plan, or to any of its agents or employees, the Trustees may deny all or part of your claim and may charge you for any expenses incurred relating to the false information. If benefits have already been paid, based on the false information on a material subject, the Trustees may recover the benefits from you, plus expenses incurred in such recovery, including attorney's fees, costs, and any and all other expenses, and/or may reduce future benefits for your claims until the Plan has recovered the benefits paid.

Forfeiture of Payments Issued

Any check or payment issued to a Participant or beneficiary or to a provider of services on behalf of a Participant or beneficiary must be cashed within one (1) year from the date of issuance of the check. Any check that is not cashed within one (1) year shall be void, and the entire amount of the check payment shall be forfeited in its entirety. Notwithstanding the foregoing, a check or payment issued to a provider of services shall not be forfeited if a forfeiture is not permitted by an applicable provider and/or network agreement. The Fund will not provide any further notice that the payment has been forfeited.

Coordination of Benefits

When members of a family are covered under more than one plan, there may be instances of duplication of coverage—two plans paying benefits for the same expenses. The Plan's Coordination of Benefits (COB) provision coordinates the benefits payable by this Plan with benefits under other health plans. All medical and dental benefits provided under this Plan are subject to Coordination of Benefits.

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

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 another plan or plans, will not exceed 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.

Allowable Expenses are any Allowable Charge for Medically Necessary medical or dental services, treatment, or supplies:

- That you or your Dependent incurs during a calendar year and while eligible for Plan benefits;
- Part or all of which are covered under any of the plans covering you or your Dependent; and
- That are not exclusions under this Plan.

Although payments by this Plan cannot be more than would normally be paid if the COB provisions 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.

In this section, "plan" means any plan providing medical, dental, vision, and/or hearing benefits, services, or treatment under:

- Group insurance;
- Group practice, group Blue Cross, group Blue Shield, or 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.

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 for single coverage to have secondary coverage under this Plan. The COB provisions 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. This does not apply to spouses of retired Participants. See page 22 for a more detailed explanation.

Which Plan Pays First

A plan without a coordination provision is always the primary plan. When all (or any) plans have COB provisions, the first of the following rules that applies determines which plan will pay benefits first:

- If a plan covers the claimant as an employee, then that plan pays 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 pays first; except if both parents' birthdays are on the same day, the plan covering the parent for the longer period pays 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:
  - If a plan covers a child as a dependent of a parent who is ordered by court decree to provide health coverage, then that plan pays benefits first.
  - If a court decree charges each parent with equal responsibility to provide health coverage for the dependent child, the birthday rule will apply so that the parent whose birthday anniversary is earlier in the calendar year pays first; except that if both parents' birthdays are on the same day, the plan covering the parent for the longer period pays first. If a plan does not adhere to the "birthday rule" in determining the order of benefits, then that plan must pay first.
  - If no court decree requires a parent to provide health coverage to the dependent child, the following rules will apply:
    - If the parent who has custody of the child has not remarried, that parent's plan pays first; or
    - If 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.
- If an adult child is employed and/or married, the plan covering the child as an employee is the primary plan, the plan covering the child as a spouse is secondary, and the plan covering the child as a dependent child will pay third. A plan that pays third will only pay benefits if there are unpaid allowable expenses after the first and second plans have paid.
- If a person is a covered active employee under one plan and a covered retired or laid off employee under another plan, the plan that covers the person as an active employee or a dependent of an active employee is the primary plan.
- If a person covered under a right of continuation pursuant to federal or state law is also covered under another plan, the plan that covers the person as an employee, member or subscriber is the primary plan and the plan providing continuation coverage is secondary.
- If the order described above fails to establish the order of payment, then the plan that has covered the person for the longest period of time is the primary plan.

In the event that you or your Dependent is covered by another group medical plan which, by its terms:

- The plans cannot agree on the primary versus secondary order; or
- Provides that it is secondary to other health plans, and the provisions of this Plan would make coverage under this Plan secondary to other applicable health plan coverage;

then the payments by this Plan will automatically be reduced by 50% and will be paid to the health provider or the employee as applicable, and this Plan will have no further obligations with respect to such medical expenses.

Regardless of the order outlined above, in the event a Covered Person is injured in any way due to an Accident, and any no-fault, personal Injury protection ("PIP") and/or medical payments coverage(s) are found to be available, these First Party coverages are primary and must be paid out (exhausted) in their entirety before a payment under this Plan is to be considered eligible.

The Plan Administrator has the right:

- To obtain or share information with an insurance company, Plan Administrator, or other organization regarding coordination of benefits without the claimants consent;
- To require that the claimant provide the Plan Administrator with information on such Other Plans so that this provision may be implemented; and
- To refund the amount due under this Plan to an insurer, plan, or other organization if this is necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

Once the order of payment is determined, the 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, in accordance with the HIPAA privacy 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 to satisfy the intent of these rules.

Your Dependent spouse cannot be covered under this Plan, if he or she has or has available, medical coverage of any kind under the plan from your Dependent spouse's employer, unless your Dependent spouse's employer provides the same maximum benefits to all its employees, irrespective of, or without regard to, the coverage the Dependent spouse may have in another plan.

Same maximum benefits means that the plan of the Dependent spouse's employer must offer the same insurance options to all employees. For example, if the plan of your Dependent spouse's employer automatically enrolls an individual in a wraparound plan due to other coverage, that plan will not offer the same maximum benefits as this Plan. The term "the same maximum benefits" does not require the plan of the Dependent spouse's employer to have the same coverage as this Plan.

If your Dependent spouse is adversely affected by this provision, he or she can file an appeal to the Board of Trustees for determination of hardship exceptions based upon circumstances beyond the control of the Dependent spouse. Your Dependent spouse must assign to the Board of Trustees, any available remedies the Dependent spouse has against his or her employer, the plan of the Dependent spouse's employer, and/or the insurer of the Dependent spouse's employer.

Coordination of Benefits With Medicare

Medicare is a multi-part program:

- Hospital Insurance benefits for the Aged and Disabled (commonly referred to as Medicare Part A) covers Hospital benefits, although it also provides other benefits.
- Supplementary Medical Insurance benefits for the Aged and Disabled (commonly referred to as Medicare Part B) primarily covers Physician's services, although it, too, covers a number of other items and services.
- Medicare Advantage (commonly referred to as Medicare Part C) is Medicare's managed care programs.
- Medicare Prescription Drug Coverage (commonly referred to as Medicare Part D) covers prescription drug benefits.

> ***NOTE:*** It is important to enroll in Medicare Part A and Part B or Medicare Part C when you are eligible. If you are not actively working, your benefits will be calculated as though you are enrolled in Medicare, if you are eligible, but choose not to enroll.

If you become totally disabled and entitled to Medicare because of disability, you will no longer be considered actively employed. As a result, once you become enrolled in Medicare because of your disability, you are no longer eligible for benefits under the Plan.

If your Dependent becomes totally disabled and entitled to Medicare because of a disability, Medicare pays first and this Plan pays second.

If, while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first, and Medicare pays second for 30 months starting the **earlier** of:

- The month in which Medicare ESRD coverage begins; or
- The first month in which the individual receives a kidney transplant.

Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Coordination of Benefits With Medicaid

The Plan will pay primary to Medicaid.

Subrogation

Throughout this section, the term "you" or "your" refers to you and/or your Dependent.

Subrogation gives the Plan the right to recover all the benefits, including Loss of Time benefits that it has paid to you or your Dependent, 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.

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, including Loss of Time benefits, from the automobile insurance company or from you if they were paid to you.

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

- **Another Person** or **Entity** means any individual, corporation, municipality, other governmental entity, partnership, 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/or 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 the 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 Plan's Coordination of Benefits provisions.
- **Compensable Injury** means any Injury for which you may recover payment from Another Source.
- **Compensated Injury** means any Injury for which your expenses have 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 due to 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.

Agreement to Reimburse Plan for Other Payments

Whenever you have an Injury expense that may be paid for by Another Person or Entity, you must complete a Reimbursement Agreement to receive benefits from the Plan. Signing the 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 Agreement. You 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 your Injury expenses. The Plan does not recognize the "make whole" doctrine.
- 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 attorney's fees and expenses you paid to obtain the Recovery. The Plan does not recognize the "common-fund" doctrine.
- The Reimbursement Agreement gives the Plan an equitable 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 Agreement. The lien is valid whether or not the 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 benefits is in addition to any other legal rights the Plan may pursue to recover benefits. If you obtain a Recovery from Another Person or Entity or Another Source, you must hold the Recovery or an amount equal to the total claims and benefits paid by the plan in trust pending reimbursement to the Plan and/or pending resolution of the Plan's lien. Further, it will be considered and deemed to be held in trust for such purpose.
- 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 Subrogation Right

Your agreement to repay in the Reimbursement Agreement and the Plan's Subrogation rights are separate and distinct rights and obligations. If either the Agreement or the Plan's Subrogation right fails or is considered invalid in some way, it will not affect the validity of the other.

- The provisions in the previous section, *Agreement to Reimburse Plan for Other Payments*, also apply to the Plan's Subrogation right. 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. However, the Plan is not required, by this provision, to pursue your claim against Another Person.
- If you recover benefits from Another Source and do not repay the Plan, the Plan may sue you to recover the amount 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 Subrogation right 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 your 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 Subrogation right for medical expenses that were incurred and paid before you recovered the expenses from your Injury.

Privacy Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Plan protect the confidentiality and security of your protected 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 periodically, as required by HIPAA rules, or when changes are made to the 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 Plan benefit or employee benefit plan.

The Plan 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.

Protection and Security of Protected Health Information (PHI)

The Plan Sponsor:

- Implements administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensures that an adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, by supporting reasonable and appropriate security measures;
- Ensures that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect electronic PHI; and
- Reports to the Plan any security incident of which it becomes aware concerning electronic PHI.

Plan's Use and Disclosure of Protected Health Information (PHI)

The Plan will use your 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 PHI 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 a retirement plan, disability plan, reciprocal benefit plan, and/or workers' compensation insurers for purposes related to administration of these plans.

Payment Defined

Payment includes activities undertaken by the Plan to obtain premiums, or determine or fulfill its responsibility for Plan coverage and provision 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., benefit cost, 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/or 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 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, Social Security number, payment history, account number, and name and address of the provider and/or health plan); and
- Reimbursement to the Plan.

Health Care Operations Defined

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, 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 or development or improvement of methods of payment or coverage policies; and
- 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.

Plan's Disclosure of Protected Health Information (PHI) to the Board of Trustees

For purposes of the Plan's privacy rules, the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only as long as this Plan Document incorporates 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/Plan Document or as otherwise 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 Health and Human Services for the purposes of determining compliance by the 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 Administrative Manager; and
- Staff designated by the Plan Administrative Manager.

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/Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Important Information About the Plan

Plan Name. 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 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 numbers below:

Board of Trustees
North Central Illinois Laborers' Health and Welfare Fund
4208 W. Partridge Way, Unit 3
Peoria, Illinois 61615
866-692-0860 [toll-free]
309-692-0860 [phone]
309-692-0862 [fax]
ncil@ncil.us [e-mail]

As of January 1, 2025, the Plan's Trustees are:

Employer Trustees

David Anspaugh
Northern IL Building Contractors Assn.
1111 S. Alpine Rd., Suite 202
Rockford, IL 61108

Jason Brewer
Felmley-Dickerson Co
803 E Lafayette St
Bloomington, IL 61701

Joe Cowan
Iroquois Paving Corp.
1889 E. U.S. Highway 24
Watseka, IL 60970

Mike Cullinan
R.A. Cullinan & Son
121 W. Park St.
Tremont, IL 61568

Carla Jockisch
Greater Peoria Contractors & Suppliers Assn.
1811 W. Altorfer Drive
Peoria, IL 61615

Amy McNally
Illinois Valley Contractors Assn
1120 First St
LaSalle, IL 61301

Union Trustees

Matt Bartolo
Laborers' Local 165
4509 N. Catalina Dr.
Peoria, IL 61615

Kevin Dale
Laborers' Local 393
322 N Main Street
Marseilles, IL 61341

Ron Paul
Laborers' Local 362
PO Box 3248
Bloomington, IL 61702

Tony Penn
Great Plains Laborers' District Council
4208 W. Partridge Way, Unit 2
Peoria, IL 61615

Fortunato "Lucky" Salamone
Laborers' Local 32
7404 Cherryvale North Blvd.
Rockford, IL 61112

Michael Smith
Laborers' Local 751
1390 Stanford Dr.
Kankakee, IL 60901

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

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

Identification Numbers. The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 30-0088171.The Plan Number (PN) assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

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 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. Upon written request, you and/or your Dependents may obtain:

- Information about whether an Employer is required to pay contributions to the Plan;
- The address of a Contributing Employer; and
- Copies of the collective bargaining agreement.

You or your Dependents may also examine these documents and information at your local union office.

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, including any amendments and attachments.

Contribution Source. Plan benefits described in this 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 11. All benefits are self-funded and paid from Fund assets, except Life and Accidental Death and Dismemberment Insurance benefits, which are insured.

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.

Plan Type. This Plan is maintained to provide medical, prescription drug, dental, vision, hearing, disability, and death benefits. Plan benefits are described in this booklet and are listed on the *Schedule of Benefits*.

Plan Year. The Plan Year begins on July 1 and runs through the following June 30. However, the Plan benefit year is a calendar year that runs January 1 through December 31.

Eligibility. The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet. The Plan Administrator has broad discretion to determine eligibility for benefits and interpret Plan language. In any court action or administrative proceedings, the Plan Administrator's decisions will receive judicial deference to the extent they do not constitute an abuse of discretion. Participation in the Plan or eligibility for benefits is not a guarantee of employment.

Claim and Appeal Procedures. The procedures to follow for filing a claim for benefits are described on page 91. If all or any part of your claim is denied, you may appeal that decision, as explained on page 99.

Insurance Companies/Vendors. The Plan is sponsored and administered by the Board of Trustees. However, the Trustees have delegated administrative responsibilities to other individuals or organizations as follows:

- Fund Office:
  - Maintains eligibility records;
  - Accounts for Employer and self-payment contributions;
  - Answers Participant inquiries; and
  - Handles other routine administrative functions.
- Professional Benefit Administrators, Inc.:
  - Administers the medical claims for individuals covered under both the Cigna program and the Blue Cross and Blue Shield of Illinois program;
  - Handles Preauthorization for individuals covered under the Cigna program; and
  - Administers the vision, hearing, and loss of time claims.
- Valenz handles Preauthorization for individuals covered under the Blue Cross and Blue Shield of Illinois program.
- Blue Cross and Blue Shield of Illinois and Cigna provide access to PPO providers for medical care.
- AllOne Health provides the Member Assistance Program (MAP).
- Sav-Rx provides access to participating pharmacies and administers the prescription drug mail-order program.
- Delta Dental of Illinois administers and pays claims for dental benefits.
- MetLife insures the Plan's Life and Accidental Death and Dismemberment Insurance benefits, which are the only insured benefits provided under the Plan.
- RelyMd handles telehealth services.

Refer to the *Contact Information* on page 3 for the addresses, phone numbers, and/or e-mail addresses for the various organizations that provide these services under the Plan.

Plan Amendment or Termination. This Plan may be amended, changed, or discontinued at any time without the consent of any covered individual by a majority vote of Trustees present and voting at a meeting where a quorum is present. An amendment may be effective prospectively or retroactively and is subject to the limitation of the Trust Agreement and to applicable law and administrative regulations.

If the Plan is modified or terminated, you will be notified in writing or as otherwise required by law. The Trust may be terminated because of the expiration of all collective bargaining agreements requiring payment of contributions to the Fund or for any other reason deemed necessary by the Trustees.

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

Plan Interpretation. The Trustees possess the discretion to determine eligibility for benefits and to construe the terms of the Trust and/or this Plan. The decisions of the Trustees as to the granting or denial of benefits and the construing of terms of the Trust and this Plan are reviewed under the "arbitrary and capricious"

standard of judicial review by a reviewing court as enunciated by the United States Supreme Court in *Firestone and Rubber Company, et al. v. Richard Bruch.*

Your ERISA Rights

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan's operation. These include insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description/Plan Document. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan because of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description/Plan Document and other documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. For instance, if you request a copy of the Summary Plan Description/Plan Document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide

the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at:

Nearest Regional Offices:

Illinois (northern):
Chicago Regional Office
230 S. Dearborn Street, Suite 2160
Chicago, IL 60604
312-353-0900

Illinois (southern):
Kansas City Regional Office
2300 Main Street, Suite 1100
Kansas City, MO 64108
816-285-1800

National Office:

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

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

Definitions

Allowable Charge means the amount that is the contracted rate for a service or supply provided by network providers and a set rate determined by the Board of Trustees for non-network providers, except in the case of No Surprises Act Services.

Ancillary Services: Subject to rulemaking by the Secretary of the U.S. Department of Health and Human Services and with respect to services furnished by an out-of-network provider at an in-network Health Care Facility, the term "Ancillary Services" means the following:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services;
- Item and services provided by other specialty practitioners, as specified through rulemaking by the federal government; and
- Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

Contributing Employer or **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.

Covered Charge means the Allowable Charge for services and treatments that are:

- Covered under this Plan;
- For a medical condition covered under this Plan; and
- Based on valid medical need according to accepted standards of medical practice.

Custodial Care means 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.

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

Dependent means:

- Your lawful spouse or partner in a civil union;
- Your child, until the end of the month in which his or her 26th birthday occurs, who is your:
  - Natural child;
  - Legally adopted child or child placed for adoption; or
  - Stepchild;
- Child who is named as an alternate recipient in a child support order, if the Plan determines the support order to be a Qualified Medical Child Support Order (QMCSO);

- An unmarried child for whom you have been appointed legal guardian, as specified in the order appointing guardianship if the child lives with you for more than half the calendar year and receives more than half his or her financial support from you during the calendar year;
- Your unmarried child listed above, at any age, who is permanently and totally disabled, due to a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more, provided the child:
  - Sustained such disability before the child reached age 26,
  - Is dependent upon you for more than half his or her support for the calendar year (for the full year for legal guardianship);
  - Resides with you for more than half the calendar year; and
  - Is dependent upon you for lifetime care and supervision.

  You must provide proof of incapacity and dependency when requested by the Plan, but not more often than once a year.

Doctor's Office Visit means Physician's services only. Additional services such as tests or medications are not covered in the visit expense.

Donor means a person who undergoes a surgical operation to donate 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.

Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Services means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department (meaning, a Health Care Facility that is geographically separate and distinct from a Hospital under applicable state law and provides Emergency Services, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).
- Emergency Services furnished by an out-of-network provider or at an out-of-network hospital (regardless of the department of the hospital in which such items or services are furnished) or an independent

freestanding emergency department also include post stabilization services (i.e., items and services provided after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

- The attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation; and
- The patient or their representative is supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, an estimate of the charges for treatment and any advance limitations that the Plan may put on the treatment, the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and
- The patient or their representative gives informed written voluntary consent to continued treatment by the out-of-network provider, acknowledging that the patient understands that continued treatment by the out-of-network provider may result in greater costs to the patient.

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;
- Are not yet recognized as having proven beneficial outcomes;
- Are primarily confined to a research setting; and
- Are not appropriate based on:
  - Medical circumstances;
  - 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 sole authority to determine whether a treatment, service, or supply is Experimental or Investigative.

Gene Therapy means a therapy that typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. Examples of Gene Therapy include, but are not limited to, Chimeric Antigen Receptor T Cell (CAR-T) therapies, such as Kymriah and Yescarta, as well as other therapies, such as Luxturna and Zolgensma.

Habilitative Services means non-restorative treatment or care for medical and mental health conditions, including, but not limited to, occupational therapy, physical therapy, behavioral therapy, and speech therapy. An example includes Physician-prescribed therapy for a child who is not walking or talking at an accepted age.

Health Care Facility (for non-emergency services) means each of following:

- A Hospital (as defined in section 1861(e) of the Social Security Act);
- A Hospital outpatient department;
- A critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

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 your or 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 Facility is a facility or organization:

- Licensed as a hospice by the jurisdiction where it is located; and
- 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;
- Is licensed or certified as a Hospice Care Agency by the jurisdiction where it is located; and
- Provides skilled nursing services, medical social services, and psychological and dietary counseling to the Terminally Ill.

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, habilitation services, and Rehabilitation Services of injured, disabled, or sick persons;
- Maintains clinical records on all patients;
- Has bylaws in effect with respect to staff Physicians;
- Has a requirement that every patient be under the care of a Physician;
- Provides 24-hour nursing services rendered or supervised by a registered 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 otherwise, the term Hospital does not include any institution, or part thereof, that is used principally as a rest facility, nursing facility, convalescent facility, facility for the aged, inpatient rehabilitation or habilitation facility, or facility for the care and treatment of substance 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 or **Sickness** means a 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 Insurance benefits.

Medically Necessary or **Medical Necessity** means care, services, or supplies required to identify or treat an Illness or Injury that are, as determined by the Plan:

- Consistent with the symptoms, diagnosis, and treatment of the covered individual's condition, Illness, or Injury;
- In accordance with recognized standards of care for the condition, Illness, or Injury;
- Appropriate with regard to standards of good medical practice;
- Not solely for the convenience of the covered individual, Physician, Hospital, or other health care provider; and
- The most appropriate level of service that can be safely provided.

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

No Surprises Act Services: The No Surprises Act (Public Law 116-260, Division BB) was signed into law on December 27, 2020, as part of the Consolidated Appropriations Act of 2021. The term "No Surprises Act Services" means the following, to the extent covered under the Plan: (1) out-of-network Emergency Services, (2) out-of-network Air Ambulance Services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by an out-of-network provider at an in-network facility; and (4) other out-of-network non-Emergency Services performed by out-of-network provider at an in-network facility with respect to which the provider does not comply with written federal notice and consent requirements.

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

Out-of-Network Rate: With respect to No Surprises Act Services, the term "out-of-network rate" means one of the following in order of priority:

- If the state has an All-Payer Model Agreement, the amount that the state approves under that system;
- Applicable state law;
- The amount parties negotiate; or
- The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

Participant means an employee qualified for coverage due to satisfying the eligibility rules described in this booklet.

Physician means a legally qualified Physician or surgeon, provided the Physician is a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) and is licensed to practice medicine in all of its branches. A dentist (DDS), podiatrist (DPM), or chiropractor (DC) is also considered a Physician under the Plan for services performed within the scope of such individual's specialty within the provisions and limitations of the Plan.

Preauthorization means the process adopted by the Plan of prior authorization of certain services, as listed on pages 37.

Preauthorization is performed for the Plan by:

- Valenz for the Blue Cross and Blue Shield of Illinois PPO plan
- Cigna for the Cigna PPO plan .

Preauthorization is not a guarantee of benefits. Please refer to your *Schedule of Benefits* for coverage information.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the plan or issuer for the item or service in the geographic region.

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

Recognized Amount means (in order of priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

For Air Ambulance Services furnished by out-of-network provider, the Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

Rehabilitation Services means treatment modalities that are a part of a rehabilitation program that include physical therapy, occupational therapy, and cardiac rehabilitation performed on an inpatient or an outpatient basis. Inpatient Rehabilitation Services refer to services performed at an inpatient facility, including a Skilled Nursing Facility or a facility that provides Residential Treatment, whose purpose is to provide the services described in this paragraph. The Plan covers rehabilitation, subject to copayments, deductibles, Preauthorization requirements, and limitations on the number of days of inpatient treatment and the number of outpatient visits.

Residential Treatment means a non-acute Hospital, intermediate inpatient setting with 24-hour level of care that operates seven days a week, for individuals with medical disorders or behavioral health disorders, including, mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by the Plan, a facility must be licensed as a Residential Treatment facility (licensure requirements for this residential level of care may vary by state). .

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 care, nursing care, or Rehabilitation Services for 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 nurses, to govern the skilled nursing care and related medical or other services it provides;
- Has a Physician, a registered 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 Medical Condition;

- Maintains clinical records on all patients;
- Provides 24-hour nursing service that is sufficient to meet nursing needs in accordance with the facility policies and has at least one registered 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.

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

Transplant Surgery means the transfer of a body organ(s) or tissue from a Donor to a Recipient.

Treatment Facility for Substance Abuse is a rehabilitation facility for the inpatient or outpatient treatment of individuals suffering from substance abuse. The 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 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 (TJC) and must be approved by the Trustees or their administrative designees.

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.