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CENTRAL STATES JOINT BOARD HEALTH & WELFARE FUND
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HEALTH & WELFARE TRUST FUND

CENTRAL STATES JOINT BOARD

245 Fencl Lane • HILLSIDE, ILLINOIS 60162 • PHONE 312·738·0822

January 1, 2015

Dear Participant:

We are pleased to provide you with this updated summary describing the benefits provided by the Central States Joint Board Health & Welfare Plan. This booklet is called the "Summary Plan Description" or "SPD." This SPD is provided to help you understand the benefits which are currently available under the Plan. There have been important changes to the Plan since the last printing of this booklet. This SPD replaces any prior booklets you may have received.

If you have trouble understanding any part of this material, contact the Fund Office, in person or in writing, at 245 Fencl Lane, Hillside, Illinois 60162 or by calling (312) 738-0822 in the Chicago area. The phone number, if you are outside the Chicago area, is 1-800-258-6466. The Fund Office's hours of operation are Monday through Friday 8:30 a.m. to 4:30 p.m. On certain Mondays, the Fund Offices are open until 7:00 p.m.

The Plan is administered by a Board of Trustees made up of representatives of the participating Unions and the contributing Employers. The Plan's benefit program includes health care benefits and mail order prescription benefits. In addition to describing the Plan benefits, this booklet will tell you when you are eligible for benefits, how to claim benefits and your responsibilities under the Plan. You should read this booklet and share it with your family since many of the benefits may apply to them as well.

The provisions of the Plan are subject to the rules, regulations or procedures of the Plan in effect at the time of a claim. The Board of Trustees has the power and complete discretion to interpret, apply, construe, and amend the provisions of the Plan and make factual determinations regarding its construction, interpretation and application, and any decision made by the Board of Trustees is binding upon Employers, Employees, Participants, Dependents, Beneficiaries, and all other persons who may be involved or affected by the Plan.

The benefits described in this booklet are the result of continuous efforts of the Board of Trustees and we believe that the Plan provides an excellent package of benefits in keeping with sound financial management of the Fund. We request your assistance in using these benefits intelligently. Your prudent use of the benefits to which you and your Dependent(s) are eligible will help us to continue to provide you with a comprehensive program of quality benefits.

The ability of the Fund Office to assist you and your dependents in obtaining these benefits rests entirely on the information and data you give to them. It is most important that you notify the Fund Office of any change in your marital status, home address and dependent information. When adding a dependent to the Plan, please be prepared to document the name, date of birth, gender and social security number of the new dependent to the Fund Office.

We hope you always enjoy good health. However, if the need for **benefits** arises, we believe you will share with us the satisfaction of knowing you have the protection of this Plan.

Sincerely,

The Board of Trustees
January 1, 2015

El resumen de l adescripcion del plan esta tambien disponible en espanol.

Si necesita la version en espanol o si tiene problema entendiendo cualquier parte de este material. Ponerse en contacto con la oficina de fondo, o en persona o por escrito a 245 Fencl Lane, Hillside, Illinois 60162. O llamando a 312-738-0822 en Chicago. El numero de telefono si esta fuera de la area de Chicago, es 1-800-258-6466.

Las horas de operacion de la oficina de fondo son de Lunes a Viernes 8:30-4:30 pm.

En Ciertos Lunes, la oficina de fondo estara abierto hasta las 7:00pm.

DEFINITIONS

Active Service means an individual's service on any of his or her scheduled work days if he or she is performing the duties assigned on that day, either at the Employer's place of business or at some location to which he or she is required to travel for the Employer's business.

Allowable Expense means any Necessary, Reasonable and Customary Charge for medical care which is covered under of the Plan covering the person for whom a claim is made. The difference between the cost of a private and semi-private hospital room is not considered an allowable expense. When the Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

Brand Name Drug means a prescription drug which is or was at one time under patent protection.

Calendar Year means the twelve month period from January 1st through December 31st.

Case Management is the process by which the Fund or the Fund's Medical Consultant reviews and manages the services and care being provided so as to determine appropriateness of treatment, medical necessity and reasonableness of fees.

COBRA means the amendments made to ERISA by the Consolidated Omnibus Budget Reconciliation Act of 1985, and regulations thereunder, as amended from time to time.

Congenital Defect means a physical defect present at birth which may be inherited genetically, acquired during gestation or inflicted during labor and/or birth.

Continuation Coverage is the coverage provided under the Plan upon the Participant's election of COBRA coverage.

Contributing Employer means an employer who is obligated to make contributions to this Fund pursuant to a Collective Bargaining Agreement. It shall also include the Central States Joint Board, Midwest Pension Fund and the Central States Joint Board Health & Welfare Fund and any other Employer who is obligated by a written agreement to make contributions to the Fund on behalf of Covered Employees.

Co-Pay, Co-Payment or Co-Insurance is that portion of Covered Expenses for which the Employee is financially responsible.

Coordination of Benefits (COB) are the rules and procedures that apply to determine how Plan benefits are paid when the Covered Person is eligible for benefits under this Fund and another health plan.

Covered Expense is the cost of Medically Necessary, non-Experimental services or supplies that Participants and eligible Dependent(s) are entitled to receive under the terms and conditions of the Plan which shall be, with respect to an In-Network Health Care Provider that is party to an agreement to provide services or supplies to Covered Persons, the charge agreed to by the Provider under such agreement; or with respect to an Out-of-Network Health Care Provider, the lowest of:

1. the usual charge by the Health Care Provider for the same or similar service or supply; or

2. the usual, customary and reasonable fee, as determined by the Fund in its sole and exclusive discretion, which is regularly charged and received for a given service by a Health Care Provider which does not exceed the general level of charges being made by providers of similar training and experience when furnishing treatment for a similar Illness or Injury. The locality where the charge is incurred is also considered.

3. In no event shall any Covered Expense exceed the maximum rate that the Fund has determined will be paid for the service or supply.

Covered Employee means (1) an employee covered by a Collective Bargaining Agreement with a Contributing Employer in a position for which contributions are required to be made to the Fund, or (2) an employee in a position with an Employer for which contributions are required to be made to the Fund under a written agreement with the Fund. It shall also include employees of the Central States Joint Board, Central States Joint Board Health & Welfare Trust Fund and Midwest Pension Fund.

Covered Employment means employment in the jurisdiction of the Central States Joint Board, Metal Processors Union, Local No. 16, Plastic Workers Union, Local 18, Manufacturing Production & Service Workers Union, Local 24, and/or Chemical & Production Workers Union, Local 30, as stated in a Collective Bargaining Agreement or other agreement with an Employer who is required to make contributions to the Fund. It shall also mean employment with the Central States Joint Board, Central States Joint Board Health & Welfare Trust Fund and Midwest Pension Fund.

Covered Person means an Employee and his or her eligible Dependent(s) who have satisfied the requirements for eligibility under this Plan and have completed the enrollment process.

Customary Charge or Reasonable and Customary Charge means a charge that does not exceed the general level of charges being made by providers of similar training, experience and location, as determined by the Board of Trustees in their sole and exclusive discretion.

Dependent(s) means your legal spouse who lives with you. Same sex spouses are covered if you were married in a state that recognizes same sex marriage. Domestic Partners and those in civil unions are not covered. Common law spouses are not covered except in those states where the Covered Employee resides that recognize common law marriages. For example, Ohio recognizes common law marriages but Illinois does not.

Dependent also means your child from birth to the end of the day in which such child reaches 26 years of age. Dependent includes your unmarried children over 26 who are physically or mentally disabled, incapable of employment and self-support, and depend upon you for their principal support and maintenance. You must furnish satisfactory proof of the disability for the child within 31 days of the child's 26th birthday and at other times thereafter as required by the Fund Office.

Child includes a natural child, stepchild, adopted child, child placed with you for adoption, foster child and the children of your same-sex Spouse. Child also includes a child for whom you are appointed as legal guardian, but only if such child is dependent upon you for support and maintenance, and lives with you in a regular parent-child relationship. Dependent also includes someone who is provided benefits under this Plan pursuant to a Qualified Medical Child Support Order ("QMCSO"). The Fund will provide benefits to a child under a QMCSO even if the Participant does not have legal custody of the child, the child is not dependent on the Participant for support, and regardless of enrollment season restrictions that otherwise may exist for Dependent benefits. If the Fund receives a QMCSO and if the Participant does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Fund's procedures for determining whether an order is a QMCSO can be obtained from the Fund office.

Emergency Condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

Emergency Services are medical, surgical, Hospital and related health care services and testing, including ambulance services, required to treat an Emergency Condition.

Employer means an employer that has signed a Collective Bargaining Agreement and/or other Agreement obligating the Employer to make payments to the Fund for coverage of its Employees. It shall also mean the Central States Joint Board, Central States Joint Board Health & Welfare Trust Fund and Midwest Pension Fund.

ERISA means the Employee Retirement Income Security Act of 1974, and regulations thereunder, as amended from time to time.

Expense means a charge a Covered Person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

Expense Incurred means an expense when the service or the supply for which the expense is incurred is provided.

Experimental means the use of treatment, procedures, facilities, equipment, drugs, medical or pharmaceutical agents, devices or supplies which the Fund has determined in its sole and exclusive discretion are not yet generally recognized as accepted medical practice or any such services, facilities, equipment, drugs or supplies requiring federal or other government agency approval and for which such approval has not been granted at the time the services were rendered.

FMLA means the Family and Medical Leave Act of 1993, and regulations thereunder, as amended from time to time.

Fund means the Central States Joint Board Health & Welfare Trust Fund established under the Fund's Trust Agreement, and as may be amended from time to time.

Generic Drug means a prescription drug which is a multi-source drug and has never been under patent protection.

Health Plan means any plan providing benefits or services for medical/dental treatment, when such benefits or services are provided by (a) group insurance coverage, (b) an employer-sponsored plan, or other prepayment coverage, (c) any coverage under labor-management trusteed plans or employee benefits organization plans, including this Plan, (d) any coverage under governmental programs, (e) any coverage required or provided by statute (except Medicaid), (f) any mandatory "no-fault" coverage, and (g) student accident plans. Health Plan does not include a state plan under Medicaid; benefits under a law or plan when its benefits by law are excess to any private insurance plan; individual or family coverage except as described above; Medicare with respect to an actively employed Covered Person or spouse; disabled Covered Person; or school accident coverage. The term "***Health Plan***" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract, or other arrangement which reserves the right to take the benefits and that portion which does not reserve such right.

Hospital means an establishment that meets all of the following requirements: (1) holds a license as a hospital (if licensing is required in the state); (2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (3) provides 24 hours a day nursing service by registered or graduate nurses on duty or call; (4) has a staff of one or more Physicians available at all times; (5) provides organized facilities for diagnosis and surgery either on its premises or at an institution with which the establishment has a formal arrangement for the provision of such facilities; (6) is not primarily a clinic, nursing, rest or convalescent home or a Skilled Nursing Facility or a similar establishment and (7) is not (other than incidentally) a place for treatment of drug addiction. Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home or Skilled Nursing Facility is deemed with respect to the benefits provided by the Plan to be confinement in an institution other than a Hospital.

Immediate Family means the legal spouse, and dependents of the covered participant.

Injury means bodily injury caused by an accident occurring while a Covered Person and caused directly by such accident and independently of all other causes in loss covered by the Plan.

In-Network means service providers, including physicians, surgeons, diagnostic centers and hospitals that have an agreement with the Fund to provide services to eligible participants.

Intensive Care Unit means a section within a Hospital which is operated exclusively for critically ill patients. It must provide special supplies, equipment and constant audiovisual observation and care by registered nurses (R.N.'s) or other highly trained Hospital personnel. It does not include any facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Maintenance Drugs means a prescription medication for an on-going illness that can reasonably be expected to be taken for more than a 3 consecutive month period.

Medicaid is a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended from time to time.

Medicare means benefits under Title XVIII of the Social Security Act of 1965, as amended from time to time.

Medical Consultant means an individual or firm hired by the Trustees to provide medical advice to the Fund.

Mental, Nervous and Emotional Disorders and Ailments means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

Necessary Treatment means medical treatment that is consistent with currently accepted medical practice. Any confinement, operation, treatment or service not a valid course of treatment recognized by an established medical society in the United States is not considered "Necessary Treatment." No treatment or service, or Expense in connection therewith, that is experimental in nature, is considered "Necessary Treatment."

Out-of-Area Resident means a Covered Person who resides 30 miles or more from the nearest PPO Network Provider hospital.

Participant means an Employee on whose behalf contributions are made to the Fund and who has satisfied the Plan's eligibility rules. It shall also mean the covered dependents of the Employee.

Physician (Doctor) means a licensed Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.), a Doctor of Ophthalmology (O.D.) for optical afflictions, a Doctor of Dental Science (D.D.S.), a Doctor of Chiropractic Medicine (D.C.) or a Naprapath. Benefits shall be payable under Plan provisions only if the providers are licensed to practice medicine or surgery and/or are acting within the scope of their license at the time and place services are performed. Benefits shall also be payable for services rendered by a licensed Nurse Practitioner or Physician's Assistant when working under the supervision of a Physician.

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Preferred Provider means service providers, including physicians, surgeons, hospitals, diagnostic centers and labs, the Fund has contracted with to provide medical services to Covered Participants.

Prescription Drug means: (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; or (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order; or (d) injectable insulin.

Proof of Loss means the completed claim form along with all original, itemized bills or other documents required by the Plan.

Provider Organization (PPO) means a network of Participating Providers.

Psychiatrist means a Doctor of Medicine (MD) who specializes in the evaluation and treatment of Mental or Nervous Disorders.

Qualified Medical Child Support Order or QMCSO means a medical child support order which creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Participant or Beneficiary is eligible under this Plan, and which complies with certain rules and regulations of ERISA, the Code and the Plan.

Room and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Self-Pay Contributions means those contributions that are required to be paid by the Employee. In most instances, self-pay contributions are deducted from the Employee's pay and sent to the Fund Office.

Sickness means an illness or disease commencing while the Covered Person is covered under the Plan.

Substance Abuse Treatment Center means a facility which provides a medically supervised ambulatory program for the treatment of substance abuse or substance dependence; and which is certified as a substance abuse treatment facility by the division of substance abuse services.

Successive Periods of Confinement or Successive Surgical Procedures means two or more periods of Hospital confinement or surgical procedures due to the same or related causes and shall be considered one confinement or procedure unless (a) with respect to the Participant only, such Participant has returned to Covered Employment for at least one (1) full working day before the subsequent confinement or procedure begins, or (b) with respect to a Dependent only, they are separated by three (3) months or more.

Terminally Ill means the prognosis indicates a life expectancy of no longer than six (6) months.

Total Disability, for health benefits, means the inability to perform any of the substantial and material duties of the disabled person's occupation or employment. A child is deemed to be totally disabled if, as a result of injury or illness, is confined to the home or in a hospital. A dependent spouse is deemed to be totally disabled if such spouse is unable to work or perform any of the regular routine household activities or has been granted a Social Security Disability Award.

Trustees or Board of Trustees shall mean those representatives of the Unions and the Contributing Employers as appointed or elected to such position in accordance with the terms and provisions of the Trust Agreement.

Union or Unions shall mean the Central States Joint Board, Metal Processors Union, Local No. 16, Plastic Workers Union, Local 18, Manufacturing Production & Service Workers Union, Local 24, and Chemical & Production Workers Union, Local 30.

Urgent Care is medical, surgical, hospital or related health care service and testing which is not Emergency Service, but which is determined by the Fund in its sole and exclusive discretion using generally accepted medical standards, to be necessary to treat an unforeseen condition requiring immediate medical attention.

USERRA means the Uniformed Services Employment and Reemployment Act of 1994 providing for the right to elect continued coverage during periods of service in the U.S. Armed Forces.

ELIGIBILITY and ENROLLMENT

Initial Eligibility

As a full-time Employee, you are eligible to participate in this Plan if you are actively employed by a Contributing Employer who has a signed Collective Bargaining Agreement requiring contributions to be made to this Fund.

Your eligibility will be effective on the first day of the month for which your Employer is obligated to remit at least one full month of contribution on your behalf. For example, if your Employer is first obligated to make a payment on your behalf for March, you will be eligible for benefits from March 1st.

Continuing Eligibility

Once you have satisfied the initial eligibility requirement, your eligibility will continue for as long as you remain employed for an Employer who is making required contributions to the Fund on your behalf.

Dependent Eligibility

Your Covered Dependents will become eligible on the day your eligibility is effective provided you have completed all of the Funds enrollment forms. These forms are available from the Fund Office. ***Your dependents will not be eligible for benefits until they are properly enrolled. Any expenses incurred by or on behalf of your dependents prior to enrollment will not be covered.*** You will be required to provide the Fund Office with proof of birth or legal adoption or guardianship for all Dependent children as well as proof of marriage in a format satisfactory to the Fund Office. Failure to submit all of the necessary enrollment forms and documents to the Fund Office will result in denial of benefit payments.

Changes in Enrollment Status

You must provide written notice to the Fund Office about the addition of a new Dependent child. You will be required to include your name and Social Security Number with each addition or change. You will need to give the Fund Office the following information for each change in dependents:

a) copy of the child's birth certificate, or
b) copy of the adoption or guardianship papers
c) social security number
d) date of birth
e) sex
f) full name and relationship to you.

If you get married or wish to add a legal spouse, you must notify the Fund Office in writing and include the following information:

a) your full name and social security number
b) the full name of your spouse
c) your spouse's social security number
d) copy of your marriage certificate.

Likewise, should you become legally separated or divorced, you must file a copy of the legal Separation and/or Divorce documents with the Fund Office.

All documents required must be in a form satisfactory to the Fund Office. Failure to comply with these requirements will result in denial of benefit payments.

Tiered Contribution Rate System – You Must Elect a Level of Coverage

The monthly contribution required on your behalf will be based on the level of coverage you elect. Each year in December there will be an open enrollment period, where you can elect the coverage that is right for you. You have the option of electing:

- Employee only coverage;
- Employee plus children coverage; or
- Employee plus spouse coverage;
- Employee plus family coverage (which includes coverage for your spouse and children).

As with any change in your coverage, if you add or terminate coverage for a dependent, certain documentation must be provided. Please keep in mind that contribution rates are periodically reviewed and are subject to change at any time.

PLEASE NOTE: Contribution rates are determined based on the cost of providing coverage. Each employer, through the collective bargaining process, determines whether the entire contribution amount is paid by the employer or split between the employer and the participant. Your collectively bargained contribution rates are listed on your enrollment form.

Generally, the coverage you elect will be effective as of January 1 and that level of coverage will remain in effect through December 31 of that year (provided you remain eligible for coverage). However, under certain circumstances, you may change your coverage election. You are allowed to:

- Add coverage for your eligible dependent if you:
  - ♦ Did not enroll an eligible dependent because your dependent had other coverage and the other coverage ends (including a loss of coverage due to reaching a Plan maximum); or
  - ♦ Marry or acquire a new dependent child (through birth, adoption, or placement for adoption).
- Terminate coverage for your eligible dependent(s) if your:
  - ♦ Dependent loses eligibility for Plan coverage, such as your dependent child attaining the limiting age, the death of your spouse, or your divorce from your spouse; or
  - ♦ Dependent becomes covered under another plan, including Medicare.

- Change your coverage election upon the renewal of your collective bargaining agreement if your collectively bargained contribution rate changes.

You must request a change in coverage within 60 days of the date of the event that qualifies you for this special enrollment (as described above). If you do not notify the Fund Office within 60 days of the event, you will need to wait until the next enrollment period in December to request a change. Therefore, it is very important that you notify the Fund Office as soon as possible to request a special enrollment. For example, if you elect employee plus spouse coverage and you subsequently divorce, while your ex-spouse may be eligible to elect and self-pay for COBRA continuation coverage, if you do not notify the Fund Office within 60 days, your monthly contribution rate will not be reduced to the employee only amount.

Termination of Benefits

Your Benefits end automatically on the first day of the month:

a) following the month in which your employment is terminated for any reason including, but not limited to discharge, quitting, lay-off or retirement.
b) following the month in which you are no longer in an employment class that is eligible for benefits under the collective Bargaining Agreement, or
c) in which you are not working during which your Employer is not obligated to make contributions in your behalf, or
d) in which you enter military service.

Additionally, benefits will terminate as of the date the Plan is terminated. Benefits will also terminate if you are obligated, but fail to make the required self-payments or COBRA Payments in the time prescribed (See "Payment Provisions" on page 61 of this SPD).

Benefits for your eligible Dependent child will end on the day such Dependent reaches the age of 26. Dependent child benefits also ends on the day your child begins active military service, becomes an Employee covered by the Plan or becomes eligible for employer sponsored health insurance coverage. Dependent benefits will also end on the date your benefits ends as explained above.

Benefits for your legal spouse end on the date you become divorced or legally separated, or when your benefits end as explained above.

Special Disability Termination

If, at the time benefits end, a Covered Person is Totally Disabled, benefits will continue to be provided by the Plan for covered services and supplies directly related to the illness or injury causing such Total Disability provided the Total Disability occurred while he or she was a Covered Person under this Plan. In such instances, benefits will be payable as long as the Total Disability continues but not to exceed 90 days.

When benefits have ended for you or one of your enrolled dependents, you or such dependent may elect to continue certain health benefits as described in the COBRA Continued Coverage section of this booklet. (See pages 59 thru 63 for details of the COBRA Continued Coverage). Please call the Fund's COBRA Help Desk at (312) 738-0822 with any questions you may have relating to COBRA Continued Coverage.

HIPAA Certificate of Creditable Coverage

When your benefits end, you and/or your enrolled Dependent(s) are entitled by law to a Certificate of Creditable Coverage that indicates the period of time you and/or they were covered under the Plan. This Certificate can be provided to you upon request shortly after the Fund knows or has reason to know that benefits for you and/or your Dependent(s) has ended. In addition, this Certificate will be provided when a request for a Certificate that is received by the Fund Office within two years after the date benefits has ended. If you need a Certificate of Coverage, write to the Fund Office at the address listed in this booklet. The Fund Office will send you a Certificate at any time while you are still covered and up to two years after you lose benefits.

If, within 63 days after your benefits under this Plan end, you and/or your Dependent(s) become eligible for coverage under another group health plan, or if you buy for yourself and/or your Dependent(s) a health insurance policy, this Certificate may be necessary to reduce any exclusion for pre-existing conditions that may apply to you and/or your Dependent(s) in that group health plan or health insurance policy.

The Certificate will indicate the period of time you and/or your Dependents were covered under this Plan, and certain additional information that is required by law. The Certificate will be sent to you or to any of your Dependent(s) by first class mail within a reasonable time after your or their benefits under this Plan end. If you or any of your Dependent(s) elect COBRA coverage, another Certificate can be sent to you (or them if COBRA coverage is provided only to them) upon request by first class mail shortly after the COBRA coverage ends for any reason.

PARTICIPATION WAIVERS

Employees cannot waive their participation in this Fund. Dependents cannot waive their participation in this Fund.

For those Employees who were issued participation waivers prior to January 1, 1998, the waivers will continue to be maintained. Those Employees and their dependents that do not make required self-payments are excluded from participation in the Fund and receive no Plan benefits.

Employees on waiver are allowed to cancel the waiver once per year during the month of December and only if their present coverage status changes.

To request a cancellation of an existing waiver your written request <u>MUST:</u>

- be postmarked during December of the year prior to the year cancellation is requested;
- contain your Name, Social Security Number, and the name of your Employer;
- state the reason waiver cancellation is requested.

You and your Employer will be notified by the Fund Office if your waiver cancellation is approved. Once a waiver is cancelled, it will not be reissued.

SELF-PAY CONTRIBUTIONS

Self payment of contributions for actively employed Employees is not permitted, except in cases where the Employer is not required to make the full contribution for any month. In these cases, most Employers have agreed to make a payroll deduction and send in your portion of the required contribution.

In the cases where payroll deduction is not done, you are required to pay the difference on your own. You must send a check to the Fund Office by the 10th of the next month after the date the Fund mails you notice of your obligation to self-pay your portion of your contribution. Your Check must be made payable to the Central States Joint Board Health & Welfare Fund. If the Fund does not receive timely payment for the amount owed, benefits for you and your Eligible Dependents will end on the last day of the month a full month's contribution was received.

YOUR MEDICAL ID CARD

Once you have satisfied the eligibility requirements for benefits, you will receive two (2) medical identification cards. These ID cards will show that you may be covered for benefits under the terms and conditions of the Central States Joint Board Health & Welfare Plan. It will also show that your Plan has made arrangements with Preferred Provider Organizations to provide In-Network PPO benefits. Please show this ID card whenever you see a doctor or go to a hospital. The ID card will have the telephone number of the Fund Office and also of the Medical Care Review Program/Case Management Services. These are important numbers for you to remember. Please contact the Fund Office should you lose your card.

SCHEDULE OF BENEFITS

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
Calendar Year Deductibles		
Individual Medical Deductible	$700	$1,050
Maximum Family Medical Deductible	$2,100	$3,150
Individual Prescription Drug Deductible	$0	$0
See Pages 22 and 40		
Medical Maximum Out-of-Pocket Expense		
Per Covered Individual (After Deductible)	$2,800	$4,200
Per Family	$8,400	$12,600
Co-insurance (Cost Sharing)	Fund Pays 80%	Fund Pays 70%
	Claimant pays 20%	Claimant pays 30%
See Page 22		
Prescription Drug Maximum Out-of-Pocket Expense		
Per Covered Individual (After Deductible)	$2,000	$2,700
See Page 40		
Calendar Year Maximum Benefits		
Specific Calendar Year Maximums apply to certain expenses. They are:		
TMJ Disorder	$500	$500
Chiropractic Services	$500	$500
Podiatry/Foot surgery	$2,000	$2,000
See Pages 16-20		
Lifetime Maximum Benefits		
Specific lifetime maximums apply to certain expenses, they are:		
TMJ Disorder Maximum	$2,000	$2,000

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
Fertility/Conception/Impotence Max.	$5,000	$5,000
See Pages 16-20		
Hospital Pre-Admission Testing		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
See Page 27		
Hospital In-Patient Confinements		
Calendar year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
See Page 26	$500 Paid by the Claimant if the procedure is not pre-certified. The $500 co-pay is not part of your deductible or out of pocket expenses.	$500 Paid by the Claimant if the procedure is not pre-certified. The $500 co-pay is not part of your deductible or out of pocket expenses.
Hospital Out-Patient Treatment		
Services & Supplies		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
See Page 27		
Hospital Room		
Services & Supplies		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Co-Pay Applies?	Fund pays 80% Claimant pays 20%	Fund pays 70% Claimant pays 30%

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
A $100 co-pay will apply. The co-pay will be waived if hospital confinement follows within 48 hours of the ER visit. The $100 co-pay is not part of your deductible or out of pocket expenses.		
See Page 39		

Emergency Room Services		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 80%
	Claimant pays 20%	Claimant pays 20%
Emergency Room Co-Pay	$200	$200
See Page 38		

Surgi-Centers, Ambulatory Surgery Centers, Free Standing Surgery Facilities		
Calendar Year Deductible Applies?	YES	NO
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	
See Page 29		

Doctors Visits ***(Medical and Surgical)***		
Calendar Year Deductible Applies?	NO	NO
Primary Care Physician	Claimant pays $25	Claimant pays 30%
Specialist	Claimant pays $50	Claimant pays 30%
See Page 24		

Laboratory & Diagnostic Testing		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
See Page 24		

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
Mandatory Outpatient Surgery	$500 Paid by the Claimant if the procedure is not pre-certified. The $500 co-pay is not part of your deductible or out of pocket expenses.	Not Covered
(See Page 29 for a list of outpatient surgeries)		

Physical/Occupational/Speech Therapy		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
See Page 32		

Podiatric Care/Foot Surgery		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund Pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
Calendar Year Maximum	$2,000	$2,000
See Page 30		

Chiropractic Services		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
Calendar Year Maximum	$500	$500
See Page 31		

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
Special/Medical Equipment or Appliances		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
See Page 31		

Organ Transplants (Covered Person MUST get prior approval from Case Management Services before any treatment is rendered.)		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
See Page 39		

Preventative Care/Wellness Benefits		
Calendar Year Deductible Applies?	NO	
Out-of-Pocket Coinsurance	Fund pays 100%	Not Covered
	Claimant pays 0%	Not Covered
See Page 35		

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
Hospice Care for the Terminally Ill		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 80%
	Claimant pays 20% IF Hospice Care is arranged thru Case Management Service. If Case Management Service is not involved, the Fund will pay 70% and the Claimant must pay 30%.	Claimant pays 20% IF Hospice Care is arranged thru Case Management Service. If Case Management Service is not involved, the Fund will pay 70% and the Claimant must pay 30%.
See Page 48		

Home Health Care		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 80%
	Claimant pays 20% IF Home Health Care is arranged thru Case Management Service. If Case Management Service is not involved, and the Fund will pay 70% and the Claimant must pay 30%.	Claimant pays 20% IF Home Health Care is arranged thru Case Management Service. If Case Management Service is not involved, the benefit is limited to 40 visits and the Fund will pay 70% and the Claimant must pay 30%.
Calendar Year Maximum	60 visits IF Home Health Care is arranged thru Case Management Service. If Case Management Service is not involved, the benefit is limited to 40 visits	60 visits IF Home Health Care is arranged thru Case Management Service. If Case Management Service is not involved, the benefit is limited to 40 visits
See Page 47		

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
Skilled Nursing Facility		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 80%
	Claimant pays 20% IF Skilled Nursing is arranged thru Case management Service. If Case Management Service is not involved, the Fund will pay 70% and the Claimant must pay 30%.	Claimant pays 20% IF Skilled Nursing Care is arranged thru Case management Service. If Case Management Service is not involved, the Fund will pay 70% and the Claimant must pay 30%.
Calendar Year Maximum	150 Confinement Days IF Home Health Care is arranged thru Case Management Service. If Case Management Service is not involved, the benefit is limited to 120 days	150 Confinement Days IF Home Health Care is arranged thru Case Management Service. If Case Management Service is not involved, the benefit is limited to 120 days
See Page 46		

Fertility/Conception/Organic Impotence Benefit		
Benefits are for the Employee and eligible Spouse only. Dependent children are not eligible for these benefits		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
Lifetime Maximum Benefit	$5,000	$5,000
See Page 33		

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
Temporomandibular Joint Dysfunction (TMJ) Disorder		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
Calendar Year Maximum Benefit	$500	$500
Lifetime Maximum Benefit	$2,000	$2,000
See Page 31		

Preventative Services The Fund provides certain preventative services for adults and children.		
Calendar Year Deductible Applies?	No	
Out-of-Pocket Coinsurance	Fund pays 100%	NOT COVERED
	Claimant pays 0%	
See Page 35	*****	

Mental Health/Alcoholism and Substance Dependency Combined Benefit		
Inpatient Benefit		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
See Page 34		
Outpatient Benefit		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 70%
	Claimant pays 20%	Claimant pays 30%
See Page 34		

	IN-NETWORK PPO and OUT-of-AREA	**OUT-of-NETWORK**
Prescription Drug Benefit ***Mail and Non-Mail Service Program***	IN NETWORK and OUT OF NETWORK	MAIL ORDER
Out-of-Pocket Coinsurance You cannot file a claim to collect the coinsurance amounts for Prescription Drug Benefits under the Mail Service Program	Claimant pays 10% for each Generic Rx Claimant pays 35% for each Brand Name Rx plus 100% of the cost difference for each Brand Name Rx when a generic Rx is available The Claimant's maximum copay for each filled prescription is $200	Claimant pays 10% for each Generic Rx Claimant pays 35% for each Brand Name Rx plus 100% of the cost difference for each Brand Name Rx when a generic Rx is available The Claimant's maximum copay for each filled prescription is $200
See Page 40		
	OPTUMRX SPECIALTY PHARMACY	
Specialty Drugs ***You must use the OptumRx Specialty Pharmacy to receive specialty drug benefits***	Claimant pays 20% for each Specialty Rx, maximum copay of $250	

COMPREHENSIVE MAJOR MEDICAL PLAN OF BENEFITS

Deductibles

You and each of your Covered Dependents will be required to pay a Deductible each Calendar Year for most expenses before the Plan pays benefits. Page 13 (Schedule of Benefits) describes your Calendar Year Deductible requirements.

Family Maximum Deductibles

If more than one Covered Person in the same Immediate Family has injuries or illnesses in any Calendar Year, the total of the Deductibles incurred by the family could be a financial burden. To ease this burden, the Plan provides a maximum family limit on Deductibles of $2,100 if all covered family members use only PPO Network providers and $3,150 if covered family members use Out-of-Network providers.

Co-Payments and Coinsurance

Co-payments and Coinsurance are those parts of the charges you pay Out-of-Pocket for Covered Medical Expenses. Typically, for expenses you incur at a PPO Network provider your Out-of-Pocket Co-Payment is 20%, the Plan pays the remaining 80% after your Calendar Year Deductible (if applicable) is met. Please refer to the Schedule of benefits for details of the Coinsurance requirements.

For Covered Medical Expenses you incur at Out-of-Network providers, your Out-of-Pocket Co-Payment is typically 30%, the Plan pays the remaining 70% after your Calendar Year Deductible (if applicable) is met.

Your Out-of-Pocket Expenses Are Limited

The Plan places a limit on the amount of out-of-pocket expenses you have to pay each Calendar Year for your share of Covered Medical Expenses.

For Covered Medical Expenses you or your Dependent incur at PPO Network Hospitals, Physicians or other medical providers, the Out-of-Pocket Coinsurance limit is $2,800 for each Covered Person and $8,400 for your entire family.

For Covered Medical Expenses you or your Covered Dependent incur at Out-of-Network Hospitals, Physicians, or other covered medical providers, this Out-of-Pocket Co-Payment limit is $4,200 for each Covered Person and $12,600 for your entire family.

Note: These Out-of-Pocket Coinsurance limits **do not** include the Calendar Year Deductible amount that must be paid before the Plan provides benefit payments.

After you reach the Out-of-Pocket Co-Payment limit in a Calendar Year for each Eligible Covered Individual, the Plan will pay *100%* of the remaining Medically Necessary, Reasonable and Customary Covered charges for the rest of that Calendar Year.

The amount of the Deductibles, Co-Payments or Coinsurance is based on health care costs and may change from time to time. You will be notified of any such changes.

What This Means

This means that if you use **only** PPO Network hospitals, Physicians and other Medical Providers the Maximum you will pay Out-of-Pocket in a Calendar Year for **each** Covered member of your family is **$$700** for the Deductible and **up to $2,800** in Co-Payment expenses **for a total of $3,500**.

However, if you use Out-of-Network Hospitals, Physicians and other Medical Providers, every Calendar Year you will be required to pay Out-of-Pocket, for **each** Covered member of your family **$1,050** for the Deductible and **up to $4,200** in Co-Payment Expenses for a **total of $5,250**. In addition, if there are any Physician's charges over the Reasonable and Customary amount allowed by the Fund, you will also be responsible for these charges.

If, in a Calendar Year, you or your Covered Dependents switch between PPO Network and Out-of-Network, Hospitals, Physicians or other Covered Medical Providers, (except in cases of an Emergency Condition) you will be required to pay the higher Deductible and Out-of-Pocket Co-Payment for all Out-of-Network treatment, services or supplies received.

Reasonable and Customary Charges

The Plan considers for payment only the Reasonable and Customary Charges (R&C) for Medically Necessary Covered Medical treatment, services and supplies you and your Covered Dependents receive.

If your provider's charges or any Covered Expenses are greater than the R&C, you may have to pay the difference.

However, if you use PPO Network Physicians, these Physicians have agreed to accept the Plan's R&C payment, and you should not be billed for any additional R&C charges.

If you use Out-of-Network Physicians and their charges for your Covered Medical treatment, services and supplies are greater than the Plan's R&C allowed payment, you pay the difference.

YOUR CHOICES FOR MEDICAL BENEFITS

The Plan has arranged through contracts with Preferred Provider Organizations to provide a network of hospitals, physicians, surgeons, diagnostic centers, labs and other medical care providers. These providers have agreed to charge lower fees for the healthcare services provided to you and your eligible Dependents. This network of providers is referred to as the **In-Network PPO.**

When you or a Covered Dependent needs medical services, you may choose any hospital, physician, surgeon or other medical provider that is part of the Plan's **In-Network PPO**. To find a doctor or other medical provider nearest to your home, please check the website or call the toll free numbers listed on your Medical ID Card. Since new medical providers are continually being added to the PPO Network and some are being deleted, the most up to date provider directory will be available from the Preferred Provider Organization at their website, the number listed on your Medical ID Card or the Fund Office.

There are many advantages to choosing **In-Network PPO** providers:

- You do not have any claim forms to complete
- You pay lower Calendar Year Deductibles
- You have lower Co-payment and Coinsurance expenses.
- You are not responsible to pay for physicians that are above the fee levels agreed to with Preferred Provider Organizations.

If you do not use an **In-Network PPO** provider, your claim will be processed under the **Out-of-Network** Plan features. You may use any medical provider you choose. However, if you choose an **Out-of-Network** provider, you will be required to pay a larger portion of your medical costs, complete claim forms and may be required to pay the service provider first and file with the Plan for reimbursement.

The following chart shows the way medical expenses are paid under the **In-Network PPO** and **Out-of-Network** program:

Plan Feature	**In-Network PPO & (Out-of-Area Residents)**	**Out-of-Network**
Calendar Year Deductible per Individual	$700	$1,050
Maximum Calendar Year Deductible per Family	$2,100	$3,150
Coinsurance Payment (Plan pays/You pay)	80%/20%	70%/30%

Maximum Calendar Year Out-of-Pocket Expense per Individual.	$2,800 plus $700 Deductible	$4,200 plus $1,050 Deductible
Maximum Calendar Year Out-of-Pocket Expense per Family.	$8,400 plus $2,100 Deductible	$12,600 plus $3,150 Deductible

If your current family Physician is not a PPO provider, you can contact the Preferred Provider Organizations or the Fund Office with his name, address and phone number. The Preferred Provider Organizations may invite your family Physician to join the PPO. If he does, you will enjoy the higher level of benefits. If he does not join, you may choose to continue with this Physician and receive a lower level of benefits or you can select another Physician from the PPO listing.

Not all Physicians affiliated with PPO Hospitals are in the PPO Network. Again, you should call the Preferred Provider Organizations or the Fund Office to ensure that the Physician selected is in the PPO Network. If the Hospital is a PPO Hospital but the Physician used is not, you will receive the higher level of benefits for the Hospital stay, but you will be required to pay the additional Deductible and Co-Payment for the Out-of-Network Physician. The same applies if the Physician is a PPO provider but the Hospital used is Out-of-Network.

Out-of-Area Covered Participants

For Covered Individuals who live in rural areas that do not have a PPO Hospital within thirty (30) mile radius of their home, the Fund will consider those individuals as **"Out-of-Area"** and treat their covered medical expenses as if they had used the In-Network PPO medical providers.

DOCTORS VISITS

You can choose your Primary Physician for your medical care. If your Doctor is covered by the Plan's **In-Network PPO,** you pay only $25 for visits to your Primary Physician and $50 for visits to any specialist. If your Doctor is not covered by the Plan's **In-Network PPO,** you pay 30% of the charges for any visit to your Primary Physician and/or any specialist.

MAJOR MEDICAL HOSPITAL BENEFITS

Covered Benefits When You Go Into the Hospital

When you go into the Hospital, the Plan pays most of your Covered Expenses. However, you must meet the applicable Calendar Year Deductible before benefits are paid.

After you meet the Deductible, the Plan pays its portion of the Reasonable and Customary charges for Medically Necessary Covered Medical Expenses as listed on the Schedule of Benefits, Pages 13 thru 21.

Remember, if you use PPO Network Hospitals you receive greater benefits than if you go Out-of-Network.

Call the Plan's Case Management Medical Care Review Program at (1-800-810-2752) whenever you or a Covered Family Member is admitted to the Hospital.

The Plan covers room and board charges for a semi-private room. However, the Plan will cover private room charges for intensive/cardiac care units, for contagious or communicable diseases or when deemed Medically Necessary by the Plan, in its sole and exclusive discretion.

Nursery charges are covered for newborns, whether sick or well.

Services and supplies provided for care of a newborn while the mother is Hospital confined, including inpatient Hospital charges, circumcision, and Physician's visits are considered as expenses of the newborn child as a separate Eligible Individual.

In addition to room and board charges, the Plan pays its portion of the Reasonable and Customary charges of other Medically Necessary services and supplies while you're in the Hospital. These include:

- General or intensive care nursing provided by the Hospital.
- Medical and surgical supplies, such as bandages, braces, crutches, prescribed drugs and medications.
- Special equipment, such as heart or lung machines.
- Use of operating, delivery and recovery rooms.
- Anesthesia and its administration.
- Oxygen and its administration.
- Most X-rays, diagnostic services, and laboratory exams.

- Whole blood (if not replaced or donated) or blood plasma and administration of such substances.
- Radiation Therapy.

Only those services and supplies that are Medically Necessary to treat your condition are covered. Personal devices, such as telephones, televisions, and newspapers are not covered by the Plan.

Review the section called "Covered Medical Services, Treatment, and Supplies on Pages 30 thru 35 for additional covered benefits.

Keep in mind that the Plan does not cover Hospitalization for Friday and Saturday admissions unless it is due to an Emergency Condition.

Outpatient Hospital Benefits

Covered medical services performed by a Hospital on an Outpatient basis, or at a Covered Surgi-center, Urgent Care Center or Ambulatory Center or a Covered Outpatient Facility are subject to the Calendar Year Deductibles, applicable Co-Payments and Major Medical provisions of the Plan.

Remember, covered services received at PPO Network Facilities and by PPO Network providers are reimbursed at a higher rate than those Out-of-Network.

Pre-Admission Hospital Tests

Before you go into the Hospital, you may be required to have pre-admission tests which may be x-rays, examinations, laboratory tests or other Medically Necessary tests.

Pre-admission Hospital Testing must:

a. be ordered by the attending Physician or surgeon;
b. be performed in the Outpatient department of the Hospital where the eligible patient is being admitted;
c. be performed before admission to the Hospital and the confinement must begin within 48 hours after they are performed. (Remember – only Monday through Thursday admissions are covered, unless the admission is for an Emergency Condition.);
d. be medically valid at the time of admission;
e. not be for diagnosis, research, case of findings or surveys which are not covered by the Plan.

Plan payments for pre-admission testing are subject to any applicable Calendar Year Deductible shown in the Schedule of Benefits.

If you or your dependent refuses to undergo, cancels or postpones the surgical procedure, you or your dependents will be required to pay a $200 co-pay in addition to

your Calendar Year Deductible and Out-of-Pocket Co-Payment. This $200 additional co-pay will be applied unless the cancellation or postponement is due to:

1. the development of a medical condition which delays the surgical procedure;
2. the unavailability of a Hospital bed;
3. a condition being revealed which requires treatment prior to Hospital confinement or which makes the surgical procedure or the confinement medically inadvisable; or
4. other circumstances beyond the control of the Individual;

If You Need Surgery

The Plan pays, subject to the Calendar Year Deductible, its portion of the Reasonable and Customary Medically Necessary Covered Expenses for the Physician, surgeon and assistant surgeon (except for Podiatric Surgery).

If you use In-Network PPO providers, you will receive greater benefits than if you go Out-of-Network.

Call the Plan's Case Management Medical Care Review Program at 1-800-810-2752 as soon as your surgery is scheduled.

Multiple Surgical Procedures

If you have two or more surgical procedures performed through the same incision, your benefit will be one and one half (1½) times thesmok
benefit allowed for the most expensive procedure.

Consider This…

- Many surgeries can be performed safely on an Outpatient basis. Under this Plan, certain surgeries **must** be performed on an Outpatient basis, or you will be required to pay a $500 co-pay in addition to your Calendar Year Deductible and Out-of-Pocket Co-Payment.
- Having surgery done as an Outpatient can save you time and expense of a Hospital admission, while allowing you to recover in the comfort of your own home.
- You must have your testing done before you are admitted to the Hospital for surgery. This will save you a day or two in the Hospital - and a day or two of Hospital expenses.
- Before going ahead with surgery, it may be in your best interest to receive another opinion about your condition. In some cases, a second opinion may lead to a different form of treatment.
- Before having any elective surgery, you should discuss the surgeon's fee. Please be aware that if you are having multiple surgeries performed through the same incision, the Plan pays only 1½ times the benefit allowed for the most expensive procedure.

Surgi-Centers, Urgent Care Centers, Ambulatory Surgery Centers and Outpatient Facilities

The Plan considers Medically Necessary Covered Medical Expenses from Surgi-Centers, Urgent Care Centers, Ambulatory Surgery Centers and Out-Patient Facilities. Services received at these Centers/Facilities are subject to the Calendar Year Deductibles, Co-Payments, and Major Medical provisions of the Plan.

Remember, you must use a Center/Facility that is in the PPO Network or your Medical Expenses will not be covered. There is no coverage for Centers/Facilities that are Out-of-Network. (See Schedule of Benefits, Page 15).

Mandatory Outpatient Surgery

Certain types of surgery **must** be performed on an Outpatient basis.

If your Surgeon recommends that an inpatient stay is necessary in a case where the Plan requires surgery to be performed on an Outpatient basis, the Surgeon must present his reasons to the Plan in written form **before** you enter the Hospital as an inpatient. Based on medical information, the Plan may waive the Outpatient requirement.

If you do not receive prior approval from the Plan and you have surgery performed as an inpatient for one of the procedures listed here, **you will pay the first $500 of expenses in addition to your Annual Deductible and any Out-of-Pocket Co-Payment.**

The following are the surgeries that **must** be performed on an Outpatient basis. Your Surgeon will explain these procedures if one of them is recommended for you.

- Arthroscopy
- Biopsy
- Bunionectomy
- Carpal Tunnel Release
- Circumcision (except for an infant immediately after birth)
- Cystoscopy (examination of the bladder)
- Cataract surgery
- D&C
- Excision of minor mass, lipoma, or cyst
- Facial fracture repair
- Fracture, closed reduction (except skull or spinal)
- Hammer toe repair
- Hemorrhoidectomy (external)
- Hernia (inguinal, umbilical; child or adult)
- Hydrocelectomy (a fluid-removal procedure)
- Laparoscopy – diagnostic or with tubal (examination of abdomen)
- Myringotomy (inner ear surgery)
- Nasal surgery

- Toe surgery
- Tonsillectomy
- Vasectomy

COVERED MEDICAL SERVICES, TREATMENT, AND SUPPLIES

Medically Necessary Services, Treatment and Supplies

Subject to the Calendar Year Deductible and Co-Payment percentages shown in the Schedule of Benefits, the Plan pays Reasonable and Customary charges for Medically Necessary services, treatment and supplies which are recommended by the attending Physicians and required for treatment of a non-occupational accidental bodily injury or sickness and which are covered by the Plan.
Covered charges include:

- Physicians' services or diagnosis and treatment of an illness or injury. (Routine exams not related to an illness or injury are not covered.)
- X-rays and laboratory exams, tests or analyses to diagnose or treat an illness or injury.
- The first pair of contact lenses or eyeglasses required following cataract surgery.
- Anesthetics and their administration.
- Oxygen and the rental of equipment for the administration of oxygen.
- Whole blood (if not replaced of donated) or blood plasma and the administration of such substances.
- Drugs and medicines, identified by a prescription number, if dispensed by a licensed pharmacist and which may only be purchased on a written prescription of a Doctor, subject to the limitation specified in the Schedule of Benefits.
- Medically Necessary services and supplies given for the purpose of obtaining a voluntary second and surgical opinion.
- Radiation therapy.
- Treatments by X-ray, radium, and radioactive isotope.
- Medical and surgical supplies medically needed to treat an illness or injury, such as casts, splint, trusses, braces, and crutches.
- Podiatric-foot surgery subject to the limitations on the Schedule of Benefits.
- Services and supplies for the treatment of Temporomandibular Joint Dysfunction (TMJ) subject to the limitation on the Schedule of Benefits.
- Services of a Doctor of Chiropractic Medicine subject to the limitations on the Schedule of Benefits.
- Nursing services by a trained nurse (but not for custodial care or family convenience). Private-duty professional nursing services by a registered graduate nurse are also covered (in or out of the Hospital).
- Prevention inoculations including measles, polio and flu, for Dependent Children. Corresponding office visit charges will also be covered if they relate solely to the

preventative inoculation, subject to the limitations on the Schedule of Benefits, Page 20.

- Surgical supplies including appliances to replace physical limbs and organs or parts of limbs and organs which are lost while the Individual is covered under this Plan. These include such items as prosthetic arms and legs, eyes, and larynxes. Only the initial charge for any such appliances is covered. Also covered is the first charge for surgical supplies required to aid any impaired physical limb, organ or part of a limb or organ in its natural body function.
- Special Medical Equipment or Supplies, including a wheelchair, Hospital bed, iron lung, or other similar therapeutic equipment/appliances whether rented or purchased.
- Speech therapy by a registered speech therapist to restore speech loss, or to correct an impairment. The impairment must be from a congenital (birth) defect for which corrective surgery has been performed or from an injury or sickness. (Treatment of functional nervous disorder is not covered.) Treatments must be recommended by the attending Physician.

Transportation/Ambulance Services

The following transportation services are covered by the Plan:

a. Emergency local ground transportation by a professional ambulance service to and/or from a Hospital for any one sickness or for all injuries sustained by any one accident; or
b. If a Physician certifies that an Individual's disability requires specialized or unique treatment which is not available in a local Hospital, these transportation charges will be considered Covered Medical Expenses with the following limitations;
    1. The transportation must be by regular scheduled commercial airlines or railroads or by professional air ambulances;
    2. The transportation may only be from the city or town where the injury or sickness occurred to the nearest Hospital qualified to give the special treatment;
    3. Only charges for the first trip to and/or from the Hospital for any one sickness or for all injuries resulting from any one accident will be considered Covered Medical Expenses;
    4. The transportation may only be within the United States.

Pregnancy and Pregnancy Related Benefits

Benefits related to Pregnancy and Pregnancy-related conditions shall be a Covered Medical Expense for you your legal spouse and your dependent children. You must be covered under the Plan at the time the service and/or supplies are actually provided..

Included in these benefits are in-Hospital charges, Physician's delivery fees, prenatal laboratory and x-ray examinations, home birthing delivery by a Physician,

sonograms and ultrasound testing, prenatal office visits, and anesthesia and its administration.

All benefits related to pregnancy, including prenatal visits, will be processed at time of delivery and are not considered as separate services under the Plan. Voluntary abortions are not covered (See Plan Limitations Exclusions Page 52).

In accordance with applicable laws, Hospital stays for normal vaginal births will be at least 48 hours, and for births by Caesarean Section at least 96 hours. Mothers may, however, request their Physician to allow an earlier release.

To assure that the Mother is receiving appropriate care, the Plan's Case Management Service should be called at the number listed on your Medical ID Card as soon as your Physician confirms the pregnancy.

Physical/Occupational Therapy

Physical/Occupational Therapy given or recommended by a Physician or registered Physical/Occupational Therapist who gives treatment under the direction of a licensed Physician, regardless of where the therapy is performed, is subject to the following provisions:

a. The Therapy must be due to a non-work related illness or injury;
b. There must be an active written treatment program designed by the Physician or registered Physical/Occupational Therapist;
c. The services must be of such a level of complexity that the judgment, knowledge and skills of a qualified registered Physical/Occupational Therapist are required and the Therapist must be present when services are being given;
d. The services must be provided with the expectation, based on the Physician's assessment of the patient, that the patient will improve significantly in a reasonable, generally predictable, period of time;
e. The services must be reasonable and necessary to the treatment of the condition and considered within the accepted standards of medical practice for the patient's condition.

Obesity (Weight Condition)

Certain charges for obesity may be considered as Covered Medical Expenses if the Eligible Individual is under the care of a Physician and meets **ALL** of the following criteria:

a. The Individual is 100% over his/her medically desired weight, and;
b. The obesity is a threat to the Individual's life due to other complicating factors such as diabetes, heart conditions, hypertension, etc., and;
c. The Individual has a medical history of unsuccessful attempts to lose weight by other methods.

Elective Procedures-Plastic/Cosmetic Surgery

Charges for any treatment, service, supply, Hospital confinement or surgical procedure that are of an elective nature, including any non-Emergency plastic or cosmetic surgery of the body (including such areas as the eyelids, nose, face, breast or abdominal tissue) will be considered covered Medical Expenses under this Plan **only** under the following conditions:

a. It is Cosmetic surgery which is performed for the correction of defects incurred through traumatic injuries;
b. It is for the correction of congenital defects;
c. It is a corrective surgical procedure on organs of the body which perform or function improperly.

Accidental Injury to Jaw/Teeth

Services and supplies required for treatment of accidental injury to the jaw or to sound natural teeth, including the initial replacement of such teeth and any necessary dental X-rays, provided the service and/or supplies are received by the Individual within twelve (12) months from the date of the accident. Coverage may be extended for another 6 months (18 months total) if medical evidence satisfactory to the Trustees is supplied showing that the delay to in treatment was due to:

a. Damage to nerves in the oral cavity suffered at the time of injury that required time to heal or regenerate; or
b. Care of a fractured jaw(s) which required immobilization of the bone structure that prevented other treatment; or
c. Additional time was required for stabilization of the injury; or
d. In the case of a Dependent child, allowance for the normal growth process; or
e. A delay in the healing process which can be shown by X-ray.

Fertility – Conception – Organic Impotence Benefits

Any treatment, service, drugs or supplies used solely to induce, facilitate, enhance and/or inhibit fertility, conception or organic impotence shall be a Covered Medical Expense only for the Eligible Employee and the Covered Spouse of the Employee and only when deemed Medically Necessary.

This Benefit, which is subject to the limitations described in the Schedule of Benefits (Page 19), and the Plan Limitations (Pages 52 thru 56) includes, but is not limited to such conditions and supplies as:

- Infertility treatment, injections, medications
- Invitro-fertilization
- Vasectomies (but not the reversal of)
- Tubal ligations (but not the reversal of)
- Penile implants

- Birth control pills
- Erectile Dysfunction medication, which shall have an additional limitation of up to 8 pills per month.

BEFORE any Benefits are paid by the Fund or any prescriptions are filled by the Plan's Mail Service Prescription Drug Program and to determine the Medical Necessity, you **must** obtain a letter from the attending Physician which contains at least the following information:

a. The Medical condition(s) for which the treatment, service, drug or supply is to be rendered; and
b. The onset date of the medical condition; and
c. The treatment, service, drug or supply contemplated; and
d. The Medical Necessity of the treatment, service, drug or supply.
e.

This letter is subject to review by the Fund's Medical Consultants. You will be notified of the Fund's decision on the treatment or procedure. If you are using the Plan's Mail Service Prescription Drug Program they will also be notified of the decision.

Sclerotherapy

Sclerotherapy is a procedure for the treatment of varicose veins. The Plan provides coverage for Sclerotherapy treatment when the Plan Trustees determine, in their sole and exclusive discretion, that sclerotherapy treatment is medically necessary. All requests for sclerotherapy treatment must be pre-certified. The failure to pre-certify will result in the charges being denied. In no event will the Plan provide benefits for more than three sclerotherapy sessions for each leg. Sclerotherapy treatment will not be deemed medically necessary until other more conservative measures, such as wearing support hose/TEDS, elevation of legs, exercise such as walking, and weight loss, have been tried and failed. Any treatment that the Trustees, in their sole and exclusive discretion, determine to be cosmetic or not medically necessary will not be eligible for benefits.

Treatment of Mental Health and/or Alcohol/Substance Dependency

If you or a Covered Dependent requires care and treatment of Mental Health disorders and/or Alcohol/Substance Dependency, benefits are paid in accordance with the following provisions:

1. You or another family member must call the Plan's Case Management Service at the number listed on your Medical ID Card before receiving treatment.
2. The approved treatment plan recommended by the Physician is to be followed for the treatment to be covered by the Plan.
3. Charges by a Psychologist or Licensed Clinical Professional Counselor are covered.

4. Only the patient's charges for consultations and other sessions (excluding sessions and treatments by marriage counselor, naturopaths or social workers) are covered.

This benefit is subject to the Plan's Limitations and Exclusions, Pages 52 thru 56 and the Schedule of Benefits, Page 20.

PREVENTIVE/WELLNESS SERVICES

Certain Preventive/Wellness services, will be covered at 100% when services are prescribed by a doctor and rendered by an In-Network provider. If the services are rendered by an In-Network provider, the services of any Radiologist, Anesthesiologist and Pathologist will also be covered at 100% even if the Radiologist, Anesthesiologist and Pathologist are not In-Network providers. Unless otherwise noted, consultations and screenings are limited to one per calendar year. For purposes of preventive/wellness services, the terms counselling and screening have the following meaning:

Counseling – a consultation or discussion between a patient and physician where the physician makes a recommendation as to care and treatment (e.g., Your physician discusses your weight loss goals, which may include dietary recommendations as well as methods of incorporating more exercise into your daily routine.).

Screening – screening tests when performed without any clinical sign of disease (e.g., a mammography screening).

Covered Preventive Services for Adults
(Adults are Individuals Ages 19 and Older)

Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked **Alcohol Misuse** screening and counseling **Aspirin** use to prevent cardiovascular disease for men age 45 to 79 or women age 55 to 79 **Blood Pressure** screening **Cholesterol** screening for Men age 35 and older and Men and Women who have heart disease or risk factors for heart disease (Limit 2 screenings per year). **Colorectal Cancer** screening once every five (5) years for adults ages 50-75 **Depression** screening **Type 2 Diabetes** screening for adults with high blood pressure. (Limit 2	**Immunization vaccines** for adults: • Hepatitis A • Hepatitis B • Herpes Zoster • Human Papillomavirus • Influenza (Flu Shot) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Tetanus, Diphtheria, Pertussis • Varicella **Obesity** screening and counseling for all adults **Sexually Transmitted Infection (STI)**

screenings per year). **Diet** counseling for adults at higher risk for chronic disease (Limit 4 sessions per year **HIV** screening for everyone ages 15 to 65, and other ages at increased risk	prevention counseling for adults at higher risk **Syphilis** screening for all adults at higher risk **Tobacco Use** screening for all adults and cessation interventions for tobacco users

Covered Preventive Health Services for Women
(Women include Dependent Children where the services are age and developmentally appropriate.)

Anemia screening on a routine basis for pregnant women **Breast Cancer Genetic Test Counseling** (BRCA) for women at higher risk for breast cancer **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40 **Breast Cancer Chemoprevention** counseling for women at higher risk **Breastfeeding** comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women **Cervical Cancer** screening for sexually active women **Chlamydia Infection** screening for younger women and other women at higher risk **Contraception**: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs) **Domestic and interpersonal violence** screening and counseling for all women **Folic Acid** supplements for women who may become pregnant	**Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes **Gonorrhea** screening for all women at higher risk **Hepatitis B** screening for pregnant women at their first prenatal visit **HIV** screening and counseling for sexually active women **Human Papillomavirus (HPV) DNA Test** every 3 years for women with normal cytology results who are 30 or older **Osteoporosis** screening for women over age 60 depending on risk factors **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk **Sexually Transmitted Infections** counseling for sexually active women **Syphilis** screening for all pregnant women or other women at increased risk **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users **Urinary tract or other infection** screening for pregnant women **Well-woman visits** to get recommended services for women under 65

Covered Preventive Services for Dependent Children
(Newborns are individuals less than one month old)
(Children are individuals from birth thru age 18)
(Adolescent children are individuals age 12 thru 18)

Autism screening for children at 18 and 24 months **Behavioral assessments** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years. **Blood Pressure** screening for children at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years. **Cervical Dysplasia** screening for sexually active females **Depression** screening for adolescents **Developmental** screening for children under age 3 **Dyslipidemia** screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years. **Fluoride Chemoprevention supplements** for children without fluoride in their water source **Gonorrhea preventive medication** for the eyes of all newborns **Hearing** screening for all newborns **Height, Weight and Body Mass Index measurements** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years. **Hematocrit or Hemoglobin** screening for children **Hemoglobinopathies or sickle cell** screening for newborns **HIV** screening for adolescents at higher	**Immunization vaccines** for children from birth to age 18: • Diphtheria, Tetanus, Pertussis • Haemophilus influenzae type b • Hepatitis A • Hepatitis B • Human Papillomavirus • Inactivated Poliovirus • Influenza (Flu Shot) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Rotavirus • Varicella **Lead** screening for children at risk of exposure **Medical History** for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years , 11 to 14 years , 15 to 17 years. **Obesity** screening and counseling Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years. **Phenylketonuria (PKU)** screening for this genetic disorder in newborns **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk **Tuberculin testing** for children at higher risk of tuberculosis at the following ages: 0

risk **Hypothyroidism** screening for newborns **Iron supplements** for children ages 6 to 12 months at risk for anemia	to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years. **Vision** screening for all children.

EMERGENCIES

What is an Emergency?

For this Plan, an "Emergency Condition" is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

If you or a Covered family member have symptoms as stated above and go to an Emergency Room for treatment but the final diagnosis is another condition, this may still be considered Emergency Services under the Plan after all requested Medical records are reviewed by the Fund.

Additionally, if you or your Covered family member goes to the Emergency Room for a medical condition that results from an accident that appears extremely serious and threatening, this condition may be considered Emergency Services under the Plan.

If you or your Covered family member has a medical condition and are taken to the nearest Hospital or trauma center by the police, fire department or ambulance, under circumstances where the patient has no control, this condition may also be considered Emergency Services under the Plan (except when the patient is being transported for treatment of injury or sickness related to the use of alcohol or non-legal use of controlled substances).

Benefits for Emergency Services

Emergency Room/Facility costs are very expensive and these facilities should be used only for Emergency Conditions as defined above. (See page 39 for Emergency Room benefit payments). If you use the Emergency Room/Facility for non-Emergency Conditions you will receive a lower level of benefits.

If the patient is admitted for observation or in-patient care, or if there is follow-up care, these benefits are considered under the regular benefits of the Plan.

Emergency Room Co Pay

When you or your Covered Dependent go to the Emergency Room, you will need to pay a $200 co-pay. This co-pay is not subject to any Calendar Year or Lifetime Maximum. The $200 co-pay will be waived if you or your Dependent is admitted to the hospital within 48 hours of the Emergency Room treatment.

Covered Medical Expenses for "Emergency Services" include:

a. charges for use of Emergency Room/Facility;
b. anesthesia;
c. Physician charges;
d. charges for local ambulance services to the nearest Hospital Emergency Room or other approved Emergency Facility;
e. Medically Necessary medical/supplies to treat the Emergency illness/injury;
f. Any charges deemed appropriate by the Plan for the Emergency treatment.

In order to determine whether an Emergency Condition existed or whether Emergency Services were medically necessary, the Plan requires that you obtain the Emergency Room report from the Hospital/Facility or authorize them, in writing, to release the information to the Plan and that you provide any additional documentation requested by the Fund Office. **Failure to supply any requested documentation will result in your claim being denied**.

TRANSPLANT BENEFITS

Human Organ and Tissue Transplant Benefit

The Plan provides a human organ and tissue Transplant benefit for you and your Covered Dependents.

To be eligible for these benefits you **must** call the Plan's Case Management Service at the number on your Medical ID Card when you first become aware that a transplant is required and **BEFORE** any treatment is given. (See Schedule of Benefits, Page 17).

Covered Transplant procedures are limited to the following human to human organ and tissue Transplants:

a. bone marrow
b. heart
c. heart/lung
d. liver
e. lung
f. pancreas

g. kidney/pancreas h. cornea.

Covered Services

Covered Medical Expenses include charges for the following services and supplies:

1. Organ and tissue procurement when both the donor and the recipient are Covered Employees/Dependents of this Plan;
2. Charges for HLA or other tests or procedures to find a donor match;
3. Transportation, lodging and meal costs for the recipient and a companion or two companions if the recipient is a minor;
4. Hospital room, board and medical supplies;
5. Diagnosis, treatment, and surgical procedures performed by a Physician, including pre-operative and post-operative procedures;
6. Private nursing care by a Registered Nurse or a Licensed Practical Nurse;
7. Rental of a wheelchair, hospital-type beds, and respiratory therapy equipment;
8. Local ambulance services;
9. Medications, including anti-rejection medications;
10. X-rays and other diagnostic services, laboratory tests and oxygen;
11. Surgical dressings and supplies;
12. Home care.

Centers of Excellence

The Trustees of the Plan may approve Transplant or Centers of Excellence Networks, for organ, tissue, and bone marrow Transplants services. If this is done, Plan participants will be notified.

PRESCRIPTION DRUGS

Prescription Drug Copayments

You (or your dependent) will be able to get your prescription drug without having to meet a deductible. For up to a 90-day supply, you pay:

- 10% of the cost for a generic medication;
- 35% of the cost of a brand name medication when a generic is *not* available; or
- 35% of the cost of a brand name medication when a generic *is* available, **plus** 100% of the difference in cost between the generic and brand name medication.
- Prescription medications are limited to a maximum copayment of $200 per prescription.

The Plan's retail prescription drug benefit is a separate benefit from the medical benefits.

- 20% of a specialty medication with a maximum copayment of $250;

Your Out-of-Pocket Expenses Are Limited

The Plan places a limit on the amount of out-of-pocket expenses you have to pay each Calendar Year for your share of Covered Prescription Drug Expenses.

For Covered Prescription Drug Expenses you or your Dependent incur, the Out-of-Pocket Coinsurance limit is $2,000 for each Covered Person, and $2,700 for each covered Family.

After you reach the Out-of-Pocket Co-Payment limit in a Calendar Year for each Eligible Covered Individual, the Plan will pay 100% of the remaining Medically Necessary, Prescription Drug Covered charges for the rest of that Calendar Year.

OptumRx

OptumRx is the Fund's pharmacy benefit manager (PBM), which means you have access to their extensive network of retail pharmacies, a mail order program, and discounted pricing on your prescriptions.

There are three broad categories of medications – Acute illness medications, maintenance medications and specialty medications.

Acute illness drugs are those that you need immediately, such as an antibiotic. This type of drug will be filled at your local pharmacy through the Retail Pharmacy Program.

Maintenance drugs are those that are taken over extended periods of time, such as antihistamines for allergies or drugs for high blood pressure. These must be filled through the OptumRx Mail Service Pharmacy.

Specialty medications are injectable medications and other medication therapies involving complex administration methods, expensive and difficult-to-find medications, or those with special storage, handling, and delivery requirements. Specialty medications are used to treat ongoing conditions, such as Hepatitis C, Multiple Sclerosis, and Rheumatoid Arthritis. Specialty medications must be filled through the OptumRx Specialty Pharmacy.

Retail Pharmacy Program

When you have your acute illness prescription filled at a participating retail pharmacy, you simply show your ID card and pay your copayment for the prescription at the time it is filled. While you can still go to any pharmacy except Sam's Club or WalMart to have your acute illness prescription filled, having your prescription filled at a OptumRx participating pharmacy will be a lot easier, and will cost you less. When you have your acute illness prescriptions filled at a OptumRx participating pharmacy, you won't have to file claim forms to be reimbursed for prescription drug expenses.

Here's how the retail pharmacy prescription drug card program works:

- Go to any OptumRx participating pharmacy.
- Show your ID card when you have your acute illness prescription filled.
- Pay your copayment for your acute illness prescription.

And, that's it!

Before having a prescription filled ask your pharmacy if they participate in the OptumRx network. If not, to find a participating pharmacy you can:

- Visit www.optumrx.com or
- . Call 1-800-797-9791

Please note that when you have your acute illness prescription filled at a OptumRx participating pharmacy, you will receive your prescription at *discounted* prices. If you do not have your acute illness prescription filled at a participating pharmacy, you will have to pay the full cost of the prescription when you have it filled and then submit a claim for reimbursement from the Plan. The Plan will then reimburse you, based on the cost, minus your copayment. This means that you will be paying more for your prescription at a non-participating pharmacy since you pay a percentage of the *undiscounted* amount.

How Using a Participating Pharmacy Can Save You Money

When you have your acute illness prescription filled at a OptumRx participating pharmacy, you receive your prescription at discounted prices. Since you pay a percent of the cost, when you have your prescription filled at a participating pharmacy and receive your prescription at discounted prices, you pay less because you pay a percentage of a lower amount.

Mail Service Pharmacy

If you take a maintenance medication on an ongoing basis (for example, for arthritis, high blood pressure, heart conditions, or diabetes), you must fill your prescription through the OptumRx Mail Service Pharmacy. The Mail Service Pharmacy provides a safe, convenient way for you to have up to a 90-day supply of your medication delivered right to your home. When you use the Mail Service Pharmacy, standard shipping by a major carrier is free.

For a first time prescription, just call 1-800-797-9791 and OptumRx will request a new prescription from your doctor. You will need to provide the medication name(s), strength, dosage, and full name and phone number of your doctor. If you prefer ordering by mail, you can complete a prescription order form and return it with your payment and prescription(s).

Your prescription will usually arrive within seven working days after your order is received. Included with your medication will be a reorder form, detailed instructions on how to take the medication, advice about possible side effects, and other information, such as OptumRx toll-free number that connects you to their Registered Pharmacists to get answers to any questions.

For refills, you can order refills by phone, mail, or online at www.optumrx.com. You can find out how many refills you have left by looking at the reorder form included

with your prescription. This information is also available on the web site or by calling 1-800-797-9791**.** Refills are usually processed within 48 hours, and you can order three weeks before your medication runs out.

To learn more about the Mail Service Pharmacy or to find out the copayment amount for your prescription, call 1-800-797-9791. Customer Service representatives are available 24 hours a day, 7 days a week. ForTTY service, call 711.

How Using the Mail Service Pharmacy Can Save You Money

When you have your prescription filled through the Mail Service Pharmacy, you receive your prescription at discounted prices. Since you pay a percent of the cost, when you have your prescription filled through the Mail Service Pharmacy and receive your prescription at discounted prices, you pay less because you pay a percentage of a lower amount.

Generic Medications

Many prescription medications have two names – a generic name and a brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. However, on average, generic medications can cost half as much as the brand name medication; and, for some medications, this savings can be as great as 90%. The Fund requires that you have your prescriptions filled with generic medications whenever possible. This will save you money and help the Fund control the cost of prescription drug coverage.

It is common pharmacy practice to substitute generic medications for brand name medications whenever appropriate and allowed by your doctor and applicable law. However, if you choose to have a prescription filled with a brand name when a generic is available, you will be responsible for 100% of the difference in cost between the generic and the brand name medication, in addition to your copayment for the prescription. This requirement applies to prescriptions filled at a retail pharmacy and through the Mail Service Pharmacy.

When you or your dependent needs a prescription, you may want to ask your doctor or pharmacist whether a generic medication is available. When you use generic medications, you pay less.

How Generics Can Save Money

Jake needs to have a prescription filled for a medication that is available as a generic and as a brand name medication. The following information shows what Jake could pay for his prescription.

Here is what Jake could pay for a generic medication at a participating pharmacy:

Cost of generic medication	$70.00
Jake's 10% generic copayment	x 10%
Jake's generic copayment amount at a participating pharmacy	$7.00

Or, here is what Jake could pay for a brand name medication at a participating pharmacy:	
Discounted cost of brand name medication	$125.00
Jake's 35% brand name copayment	x 35%
	$43.75
The difference in cost between the generic and brand name medication ($125 - $70)	+ $55.00
Jake's brand name copayment amount at a participating pharmacy	$98.75
Or, here is what Jake could pay for a brand name medication at a non-participating pharmacy:	
Retail cost of brand name medication	$155.00
Jake's 35% brand name copayment	x 35%
	$54.25
The difference in cost between the generic and brand name medication ($155 - $70)	+ $85.00
Jake's brand name copayment amount at a non-participating pharmacy	$139.25

As you can see, if Jake requests a generic medication and has his prescription filled at a participating pharmacy, he pays only $7 for his prescription – that's *$92.75 less* than he would pay for a brand name medication at a participating pharmacy and *$132.25 less* than he would pay for a brand name medication at a non-participating pharmacy!

Prior Authorization Program

Some medications are approved to be used or proven effective in treating specific illnesses. At times, these medications are used off-label to treat other conditions. Prior approval may be necessary for conditions requiring special diagnostic confirmation or may be prescribed for off-label uses where safety and efficacy are not well established. Members can request prior authorization, where necessary, by contacting the OptumRx customer service center toll-free at 1-800-797-9791. A member service representative will send a prior authorization form to your doctor.

Quantity Limits

On some prescriptions, you will find quantity limitations. Quantity limits are based upon FDA guidelines published clinical recommendations, such as the Journal of the American Medical Association (JAMA), as well as manufacturer packaging and labeling instructions. Limits are intended to encourage appropriate dosing. Exceptions are generally limited to chronic conditions that necessitate a quantity greater than "normal." These limits are not intended to restrict access to quantities of medications where limits would not be considered functional or appropriate.

Step Therapy Program

The Step Therapy Program encourages the use of the best medication for your condition. It applies to first-time users of certain categories of drugs such as psychotropic, asthma, proton pump inhibitors, hypertension, and cholesterol. Under this program, when you start on one of these medications you must first try a well-established

treatment that is known to be safe and effective. This is called "first-line therapy," and it is the preferred therapy for most people. It also usually has the lowest co-payment. If your doctor has found the first-line drug has not been very successful for you, he or she may request a second-line therapy. However, no second-line therapy will be approved unless the first-line therapy has been tried.

Specialty Program

This program is designed to help manage expenses for specialty medications, which can be some of the most costly forms of medication. Specialty medications are used to treat ongoing conditions, such as Hepatitis C, Multiple Sclerosis, and Rheumatoid Arthritis. The program focuses on injectable medications and other medication therapies involving complex administration methods, expensive and difficult-to-find medications, or those with special storage, handling, and delivery requirements.

How the Specialty Program Works

With the OptumRx Specialty Program, when you or a dependent have a prescription filled for one of the medications covered under the Specialty Program, you will be contacted by a OptumRx Patient Care Coordinator (PCC). Working with your physician and licensed pharmacists, your PCC will monitor your medication intake to minimize any adverse reactions and maximize the benefit you receive from your therapy.

Your PCC is the person to call with any questions you have about your medicine and supply deliveries or the Specialty Pharmacy in general. However, if you are not able to reach your PCC or just want to contact the Specialty Pharmacy Program, call **1-866-218-5445**, to be connected to the Specialty Pharmacy Team. OptumRx has clinical pharmacists, who specialize in specialty therapies, available 24/7 to answer your specialty medication questions. If you have any questions, call the specialty team at 1-866-218-5445 or visit www.optumrx.com

Once you are in the Specialty Program, all specialty medications, which will be provided through the OptumRx Specialty Pharmacy, will be shipped overnight, with deliveries scheduled Tuesday through Friday. Orders can be shipped either to your doctor's office or to your home, depending on where the medication is administered. Your PCC will work with you to establish these arrangements when setting up your initial delivery.

In addition, your PCC will contact you about a week before your next scheduled delivery to verify your remaining supplies and answer any questions you may have. If you are running short of your medication or supplies at any time, call your PCC; don't wait until you are completely out. And, be sure to let your PCC know if your delivery has not arrived by the scheduled time.

Specialty Program Copayments

You pay 20% of the cost of your specialty medication. If your medication is available as a generic and you choose the brand name medication, in addition to your

copayment, you will pay 100% of the difference in cost between the generic and brand name medication.

All specialty medications are limited to a maximum copayment of $250per prescription. If you cannot meet your co-pay there are foundations that may be available to assist you. Contact the Fund office at 312 738-0822 or OptumRx at 1-866-218-5445 for more information.

Medically Necessary and Appropriate Treatment

Of course, like other benefits available under the Plan, your prescription drugs must be medically necessary and appropriate treatment for illness or injury in order to be covered. Some drugs, like proton pump inhibitors, are considered medically necessary for short term treatment, but not necessarily for long term treatment or as maintenance drugs. For these drugs, the Plan will pay for the first 90 day supply without restriction. Afterwards, the Plan needs additional authorization from your doctor demonstrating the continued medical necessity and appropriateness of the treatment in order to obtain additional medications.

BENEFITS FOR TREATMENT AT ALTERNATE SITES

While Hospitalization is sometimes necessary, you don't always need to be hospitalized to get quality care. Often, you can receive high-quality – and less expensive care at an alternate site, such as a Skilled Nursing Facility, Hospice, or even in your own home.

Before you make a decision on this care, you or a family member must call the Fund's Case Management Service at the number listed on your Medical ID Card. They will help arrange and monitor the care you receive. You will also receive a higher benefit.

All benefits for treatment at alternate sites as listed are subject to the limitations on the Schedule of Benefits, Pages 18.

Skilled Nursing Facility

A Skilled Nursing Facility must be an institution or distinct section of an institution that is licensed by the State and eligible for Medicare payments and that is primarily engaged in providing 24 hour in patient skilled nursing care under the supervision of a Physician. (See Schedule of Benefits Page 18).

An **approved confinement** is one that meets **ALL** of the following criteria:

a. It must be monitored by the Plan's Case Management Service; and
b. The attending Physician must certify, in writing, that the confinement and nursing care is essential for recuperation from an injury or sickness and that it is not for custodial care or the convenience of the patient's family; and

c. It must be preceded by at least 3 consecutive days of a Hospital confinement for which Plan benefits are payable; and
d. It must be due to the injury or sickness which required the previous Hospital confinement; and
e. It must begin within 7 days of the end of a Covered Hospital confinement or within 7 days of the end of a Covered Skilled Nursing Facility confinement; and
f. The attending Physician must continue treatment of the patient and personally see the patient at least once each 14 days and must certify that the continued confinement is necessary for continued treatment of the injury or sickness.

Skilled Nursing Facility - Covered Expenses

During confinement the following Reasonable and Customary Medically Necessary charges are considered Covered Medical Expenses by the Plan:

1. Semiprivate room and board charges;
2. General nursing care (Physician's visits, private duty or special nursing care is excluded);
3. X-rays and laboratory examinations;
4. Physical, Occupational or Speech Therapy;
5. Oxygen and gas therapy;
6. Drugs, solutions, dressing, casts; and
7. Other related Reasonable and Customary, Medically Necessary services customarily provided to patients.

Home Health Care

Home Health Care is becoming more common as health care professionals explore effective ways to shorten expensive Hospital stays. Many times patients recover faster and more comfortably in their own homes.

Before you arrange for Home Health Care you should contact the Plan's Case Management Service (1-800-810-2752) who will assist you in arranging for quality cost effective care and will monitor the care being received. You will also receive a higher benefit by using the Case Management Medical Care Review Program.

All benefits for Home Health Care are subject to the limitations on the Schedule of Benefit, Page 18.

A Home Health Care Agency must be licensed by the State, primarily engaged in providing skilled nursing care in the patient's home, operated under professionally developed polices, eligible for Medicare, and each patient must be under the supervision of a Physician or Registered Nurse.

To receive these benefits:

a. A Home Health Care Plan must be developed and approved, in writing, by the patient's Physician; and

b. The Home Health Care must begin within 14 days after a Hospital stay that lasts at least 3 days (unless arranged in less time by the Plan's Case Management Service); and
c. The Physician must certify that the Home Health Care is for the same, or related, condition for which the patient was in the Hospital and that if Home Health Care was not available, the patient would again be hospitalized.

Home Health Care - Covered Expenses

Covered expenses include the following services and supplies, provided they are supplied by an organization which meets the Plan's definition of a Home Health Agency and are planned and authorized by the attending Physician:

1. Part-time or intermittent nursing care by or under the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
2. Medical social services provided under the direction of a Physician;
3. Medical supplies (other than drugs and biologicals) and the use of medical appliances;
4. Medical services of interns and residents in training under an approved teaching program of a Hospital affiliated with the Home Health Agency;
5. Physical, Occupational, and Speech Therapy;
6. Any services or supplies provided on an Outpatient basis at a Hospital or Skilled Nursing Facility under arrangement with the Home Health Agency involving the use of equipment not readily available for home use or which can only be provided at the Facility outside the home.

One (1) Home Health Care Agency visit is defined as each visit by a nurse/aide, intern/resident, or therapist or each 4 hours of care by a Licensed Practical Nurse (LPN).

Services of any person who ordinarily or temporarily live in the patient's home or who is a relative/family member are not covered.

Charges for transportation, custodial/convenience care, or any time period when the patient is not under the care of a Physician are not covered.

Hospice Care Program

The Hospice Care Program is a special program of care for Covered patients with terminal medical conditions.

This Program offers a system of care which allows a Terminal patient to continue life with minimal disruption in normal activities while remaining primarily in the home or homelike environment. The Program, when arranged and monitored by the Plan's Case Management Service (1-800-810-2752), provides services and supplies which are not normally considered Covered Expenses under the Plan.

What is a Hospice?

A Hospice is a public agency or private organization, or part of either, that is primarily engaged in providing a coordinated set of specified services at home, in outpatient settings, or in institutional setting for patients suffering from Terminal conditions.
The agency or organization must meet **ALL** of the following criteria in order to be considered an approved Hospice under this Plan:

a. It must be eligible for Medicare participation;
b. It must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse;
c. It must maintain central clinical records on all patients;
d. It must meet the standards of the National Hospice Organization (NHO); and
e. It must directly, or under arrangements, provide the following "care services" when they are needed; physical therapy, occupational therapy, speech language pathology, home health aide and homemaker services, medical supplies (including drugs and biologicals for palliation), and short term in-patient care.

The following are Definitions relating to Hospice Care that you should be aware of:

1. Terminal – The patient's prognosis indicates a life expectancy of six months or less.
2. Palliative Care – Care which is given to a Terminal patient for the purpose of relieving or alleviating without curing.
3. Respite Care – Short-term in-patient care (not to exceed three (3) days) for a Terminal patient only when necessary to relieve family members or persons caring for the patient.
4. Periods of Crisis – A period when the Terminal patient requires continuous care predominantly provided by a Licensed Nurse. The care must be necessary to achieve palliation or management of active medical service.

Before a Covered Individual is eligible to receive benefits under the Hospice Care Program, the condition must be certified, in writing, no later than two (2) days after beginning Hospice Care, as Terminal by a Physician.

If a Hospice Physician is the primary Physician, only one certification is required; if there is a personal Physician only one certification is required; if there is a personal Physician as well as the Hospice Physician, both Physicians must certify the Terminal Diagnosis.

Special Benefits Provisions for Hospice Care

a. The eligible Terminal patient who is to receive treatment under the Hospice Care Program will, upon coordination of care and monitoring by the Plan's Case Management Service, be entitled to hospice Care benefits during the remainder of his lifetime, subject to the limitations specified on the Schedule of Benefits, Page 18.

b. When the Plan has paid the Maximum Benefits allowed under the Hospice care Program, there will be no further Hospice benefits payable. Any further benefits will be provided under the normal Comprehensive Major Medical Expense benefit and will be subject to all limitations and exclusions.
c. Only expenses for Hospice Care of a patient's Terminal condition apply under the Hospice Care Program. If there are expenses for treatment of an injury or sickness unrelated to the Terminal condition, benefits for such expenses are provided under the normal Comprehensive Major Medical provisions of this Plan and are subject to all applicable limitations and exclusions.
d. All charges incurred and benefits paid under the Hospice Care Program shall apply to any Calendar Year and Lifetime Maximum Benefits of the Plan.
e. All benefits for charges incurred under the Hospice Care Program shall automatically be assigned to the service provider.

Hospice Care Program Covered Expenses

The Plan will consider for payment all Reasonable and Customary charges subject to the limitations of the Schedule of Benefits (Page 18) for:

1. Room and board charges in a Hospice facility;
2. Nursing care by a Registered Nurse or Licensed Practical Nurse and services of homemakers and Home Health Aides (such services may be furnished on a 24 hour basis during Periods of Crisis or as the care is necessary to maintain the patient at home);
3. Counseling services and/or psychological therapy by a social worker or a psychologist;
4. Medical social services;
5. Physical therapy
6. Speech language pathology;
7. Non-prescription drugs utilized for Palliative Care;
8. Medical supplies, bandages and equipment, drugs and biological used for pain and symptom control; and
9. Skilled Nursing Facility short-term inpatient care to provide Respite Care, Palliative Care, or care in Period of Crisis. (Respite Care not to exceed three (3) days and allowed only when authorized by the Plan's Case Management Service and approved by the Plan Manager).

Expenses Not Covered Under the Hospice Care Program

Covered Expenses under the Hospice Care Program do <u>NOT</u> include charges for the following services and supplies:

1. Bereavement counseling (counseling services provided to a Terminal patient's family after their death);
2. Long-term inpatient care;
3. Administrative services;
4. Childcare and/or housekeeping services;
5. Transportation (except for Emergency Conditions);

6. Surgical operations or Hospital confinements due to medical complications of the Terminal condition (benefits for these services and supplies are payable under the normal provisions of the Comprehensive Major Medical Expenses Benefit);
7. Chaplaincy;
8. Any service or supplies not provided as “core services” by the Hospice.

GENERAL LIMITATIONS AND EXCLUSIONS

Limitations and Exclusions

The individual benefit descriptions in this booklet may contain limitations and exclusions that apply to that particular benefit. The following exclusions and limitations apply to all benefits under this Plan. The Plan will not pay for:

- Any care, treatment, service, surgical procedure, supply, or Hospital confinement which, in the opinion of the Trustees, is not Medically Necessary.
- Charges in connection with any injury or sickness for which the Covered Individual is not under the care of a Physician.
- Charges from a physician that does not meet this Plan's definition of a Physician or a hospital which does not meet this Plan's definition of a Hospital.
- Charges for any care, treatment, service, surgical procedure, supply or Hospital confinement not recommended by the attending Physician.
- Charges for care or treatment provided by a person who is related by blood or marriage to you or your Covered Dependents or who ordinarily lives with you.
- Charges for any special education regardless of the type or purpose of the education, or that it was recommended by a Physician or because of the qualifications of the instructor.
- Charges for any type of custodial care which is care that is primarily to assist in meeting the activities of daily living regardless of what the care is called.
- Charges for education, training or room and board while confined in an institution which is primarily a school or institution of learning or training.
- Charges for Physical/Occupational, Speech or other therapy if either the prognosis or history of the patient does not indicate to the Trustees that there is a reasonable chance of improvement or similar charges if not pre-approved by the Plans Medical Care Review—Case Management Program.
- Charges while confined in an institution which is primarily a place of rest, a place for the aged or a nursing home (other than a Skilled Nursing Facility).
- Charges as a result of any accidental injury, sickness or disease incurred while performing or doing any act or duty pertaining to any occupation or employment for pay or profit, or for which benefits may be made under any Worker's Compensation Law, Employer's Liability Law, Occupational Injury or Diseases, Law or similar law.
- Charges while confined in a Hospital operated by the U.S. Government or an agency of the U.S. Government or in any Hospital where the patient is not required to make payment.
- Charges by, or on account of, a dependent for services performed prior to the date the dependent becomes covered under the Plan.
- Voluntary abortions.
- Reversal of, or attempts to reverse, a previous elective sterilization.
- Charges for consultation and sessions with other family members even if they are required as part of a psychological or psychiatric treatment.
- Charges incurred for treatment or consultation with a marriage counselor, naturopath or social worker, except as specified under the Hospice Care Program.

- Charges for any operation, treatment, or supplies in connection with sex transformations of any type.
- Charges for, or related to, acupuncture, hypnosis or biofeedback.
- Charges for any treatment, services or supplies furnished or provided by a clinic, center or other provider for the purpose of aiding individuals to stop smoking, regardless of what the program is called.
- Charges for Keratotomy, such as radial (RK), anterior lens (ALK), LASIK, and/or any other procedure for the correction of eye refraction.
- Charges for dental implants, pre-implant surgery or any surgery to facilitate dental implants.
- Charges for treatment of injuries sustained while engaged in any illegal or criminal activities, however, this provision does not exclude treatment for injuries that result from an act of domestic violence.
- Charge for treatment for any bodily injury or disease caused by or arising out of races or other competitions whether sanctioned or not, involving motorized vehicles of all types.
- Massage Therapy.
- Charges for a surgical assistant for podiatric surgery.
- Charges for a nurse anesthetist, unless no other anesthetist is available.
- Charges for custodial care, domiciliary care or respite care, except as provided under The Hospice Care Program.
- Charges for pharmacological regimens or nutritional procedures or treatments.
- Megavitamin therapy, psychosurgery, or nutritional based therapy for alcoholism/substance dependency.
- Sclerotherapy, unless done in compliance with the provisions of this Plan.
- Charges due to an intentionally self-inflicted injury.
- Charges incurred as a result of a Friday or Saturday Hospital admission unless for Emergency Conditions.
- Electrolysis and epilation.
- Charges for any care, treatment, service or supply obtained outside the United States, except in cases of Plan approved Emergency Services.
- Routine physical exams, including gynecological exams and any other type of exam or test primarily for prevention, prophylactic or screening for sickness or disease where there have been no symptoms, except for Covered Preventative Care
- Any services, supplies or treatments which are preventative in nature and to prevent contraction of any sickness/disease, such as flu shots except for Covered Preventative Care.
- Well baby or well child care except for necessary routine medical care provided during Hospital confinement immediately following birth, except for Covered Preventative Care.
- Charges for patent medicines or other drugs or medicines which can be obtained without a Physician prescription, except for Covered Preventative Care.
- Hearing aids, eyeglasses, contact lenses and the examinations and fittings for them, except as allowed after cataract surgery.
- Expenses for illnesses or injuries that are caused by war, or by any act of war, declared or undeclared.
- Experimental/Investigative Procedures, medical treatment, service, supplies, or surgery.

- Charges for confinement in a facility providing nursing services (except as provided by a Skilled Nursing Facility.
- Charges for a program of home nursing care unless the provider meets the Plan's criteria of a Home Health Agency.
- Charges for any treatment, care, procedures, Hospital confinements, services or supplies which exceed any Lifetime Maximum Benefits, Calendar Benefits or any other limitations by the Plan, or which are specially excluded, specified as not payable or not Covered Expenses of the Plan.

PRE-CERTIFICATION OF HEALTH CARE

Pre-certification

To be covered, all non-emergency inpatient hospital stays and outpatient surgical procedures whether done in the physician's office or at the hospital must be pre-certified in advance by Case Management Medical Care Review Program. Case Management is the independent firm hired by the Welfare Plan to help make sure you get an appropriate level of care, in an appropriate setting. Case Management conducts pre-hospital reviews, continued stay reviews, outpatient diagnostic review and other utilization review activities that can help all of us manage our health care expenses.

When you call Case Management to pre-certify an inpatient hospital stay or outpatient surgical procedures, Case Management's medical staff will determine whether your treatment is medically necessary. This service lets you know in advance whether the treatment you're planning can be covered by the Plan.

Remember, only medically necessary care is covered by the Plan.

To pre-certify your care, call Case Management at 1-800-810-2752 within seven business days prior to admission to the hospital or receipt of services, whichever is earlier. The telephone number is on your Plan Medical ID Card. Have the following information ready:

- Your name, address, phone number and social security number.
- The reason for your planned inpatient admission.
- The date you plan to be admitted.
- Your doctor's name, address and phone number.
- Your hospital's address and phone number.

Case Management will then pre-certify your care. That means they'll work with your doctor to determine whether the care is medically necessary. They'll also pre-certify the length of your hospital stay. Once you're admitted to the hospital, Case Management will again review your care to make sure the pre-certified number of days is still appropriate. This process is referred to as case management. Once Case Management is managing your hospital stay and care for a particular condition, you do not need to continue to pre-certify care for that hospital stay and condition. However, if a new

condition arises that is not directly related to the condition under case management, you must pre-certify the new hospitalization.

For emergency hospitalizations or other Urgent Care, you or your doctor must call Case Management to submit your Urgent Care claim by telephone and follow up with a written claim within 24 hours of your call that provides all of the information above.

There are other services provided by the Case Management Medical Care Review Program which, if used, will increase the benefits you receive from the Plan. These include:

- Covered Speech Therapy;
- Covered Special Medical Equipment/Appliances;
- Covered Physical/Occupational Therapy;
- Sclerotherapy
- Home Health Care;
- Hospice Care;
- Skilled Nursing Facility Care.

The Plan provides for Transplant Benefits (See Page 39). However, to be eligible to receive benefits you **MUST** call the Case Management Service when you first become aware that a transplant is required and **BEFORE** any treatment is given.

Normally, benefits for these services have a maximum dollar limit on benefits (See Schedule of Benefits), but, if you have the Case Management Medical Care Review Program arrange and monitor the services, treatment and/or supplies **before** they are received, these limits may be increased.

If you or your spouse is pregnant, you must contact, the Case Management Service so they can monitor the care being received. The number is on your Medical ID Card.

If you do not pre-certify with Case Management according to these guidelines, you will have to pay a $500 penalty. Any penalty you pay will not apply to your out-of-pocket maximum. in addition, if you do not pre-certify with Case Management, your benefits may be limited or reduced. Any reduction amount that you pay will not apply to your out-of-pocket maximum. You may appeal Case Management's decision. Please refer to Case Management Standard Appeals Process.

If the services are not medically necessary, all expenses related to the confinement, surgery, physician's charges and/or diagnostic testing will not be payable by this Plan.

Please Remember

Pre-certification by the Case Management Medical Care Review Program cannot determine your eligibility or the eligibility of your Dependents to receive benefits under the Plan. Eligibility and Benefits can only be determined by the Fund Office.

MEDICAL CARE REVIEW PROGRAM – CASE MANAGEMENT

Case Management

Sometimes, we don't know where to turn to find the kind of care we need, especially for a serious illness. This is why your Plan provides a Medical Care Review Program.

Some medical conditions require complex care. Examples include certain cancers, traumatic injuries, extended psychiatric treatment, pregnancy and AIDS. In such cases, several Physicians with different specialties may be involved. Treatment can continue for a long time and may be delivered in a number of different settings.

It is in cases like these that your health care benefits are most needed. Coordination of care and effective use of your benefits are especially important. But the more complicated or long-term the treatment, the more difficult managing all the details can be. That's where the Case Management feature of your medical Plan comes in. They will help you find quality cost-efficient options for your treatment.

If you or a Covered Dependent needs to be Hospitalized, you or a family member must call the Case Management Medical Care Review Program before you or your Covered Dependent enter the Hospital. If this is not possible, you should request that the Hospital representative call the Case Management Service. The telephone number is 1-800-810-2752. It is printed on the back of your Plan Medical ID Card.

A specialized Case Management representative will contact you and your doctor. Your Case Management specialist helps coordinate care by various providers. He or she can arrange for specialized consultation and can describe for you and your Physician how benefits are paid for various treatment methods.

When medically advisable, your Case Management specialist can help arrange for treatment in a Skilled Nursing Facility or at home. Professionals with the Case Management Service can also help review options for Hospice care. Throughout the course of treatment, your Case Management specialist is available to answer questions and discuss alternatives.

If you have any questions about the services offered through the Case Management Medical Care Review Program, call the Fund Office or the Medical Care Review Program offices at 1-800-810-2752.

Please Remember

The Case Management Medical Care Review Program cannot determine your eligibility or the eligibility of your Dependents to receive benefits under the Plan. Eligibility and Benefits can only be determined by the Fund Office.

IMPORTANT NOTICES

This SPD booklet contains a Schedule of Benefits on pages 13thru 21. This Schedule provides a general overview of the benefits provided. More detailed benefit information is included throughout this SPD. Please call the Fund Office at (312) 738-0822 (Chicago Area) or 1-800-258-6466 (Outside Chicago Area) for any additional information you may need or if you require additional explanation or clarification of your benefits.

The Fund may not be able to process your benefit payments unless it has complete and current information on you and your dependents. It is your responsibility to notify the Fund Office of any change in address, marital status or dependent status. The Fund will require that you furnish copies of marriage certificates, birth certificates, social security number, divorce papers or other court documents that might affect coverage for you and your dependents.

The Covered Person, or a family member, must call the Case Management Medical Review Program at 1-800-810-2752 as soon as they know of a pending hospital confinement. In cases of Emergency Admissions, the Covered Person must ask the hospital representative to make the call. Additionally, the Covered Person must call the Case Medical Management Medical Review Program before treatment for each pregnancy, organ transplant, hospice care, home health care, nursing facility care, physical therapy, occupational therapy or speech therapy.

The Covered Person must file a claim for benefits within one (1) year of the date of service. The Covered Person must be eligible for coverage as of the date of service.

Only the Fund Office can determine your eligibility and benefit payment status. Please call only the Fund Office if you have a question about your coverage.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT ("COBRA")

The Consolidated Omnibus Budget Reconciliation Act, more commonly known as COBRA, generally requires that group health plans offer Employees and their Dependent(s) the opportunity to temporarily continue their health coverage at group rates when benefits under the Plan would otherwise end. This extended coverage is called "COBRA coverage." COBRA coverage will include all benefits that a person was entitled to before the Qualifying Event (defined below) except Life Insurance, Accidental Death and Dismemberment Benefits and Disability Income Benefits. If you, your spouse and/or Dependent children are covered under the Plan, you and/or your spouse or children can continue coverage for a time if benefits ends for one of the several reasons (called "Qualifying Events"), even if you or they are already covered by another group health plan or Medicare.

Qualifying Events

If any of the following events result in a loss of Plan benefits, the Covered Person can elect to continue coverage under the Plan:

1. Your termination of Employment (for reasons other than gross misconduct) or retirement.
2. Reduction in your hours of Employment.
3. Your entitlement to Medicare.
4. Your death.
5. Your divorce or legal separation.
6. A Dependent child ceasing to satisfy the Plan's definition of an eligible Dependent.

Important-If you and/or your Dependent(s) do not elect COBRA coverage, your and/or your Dependent(s)'s group health benefits will end if one of these Qualifying Events occur.

Reporting Requirements

Your Employer must notify the Fund Office if Qualifying Events (1) through (4) occur. This notification must be in writing and must be provided within 30 days of the Qualifying Event.

The Participant or the affected Dependent(s) must notify the Fund Office within 60 days of Qualifying Events (5) or (6). The Participant or the affected Dependent(s) is responsible for this notice. If you or your Dependent(s) fail to give written notice to the Fund Office within the required 60 days, the affected person will lose the right to COBRA coverage.

Notices should be mailed or hand delivered to the Fund Office, Attention: COBRA Department, at the following address: Central States Joint Board Health &

Welfare Plan, 245 Fencl Lane, Hillside, Illinois 60162. Written notice of a Qualifying Event must include the following information: name and address of affected Participant and/or beneficiary, Participant's Social Security number, and date of occurrence of the qualifying event. In addition, you must enclose evidence of the occurrence of the qualifying event (for example, a copy of the divorce decree, separation agreement, death certificate, dependent's birth certificate). Once the Fund receives timely notification that a qualifying event has occurred, COBRA coverage will be offered to Participants and Dependents, as applicable.

It is most important that Employees and Dependents keep the Fund informed of their current addresses. If you or a covered family member experience a change of address, immediately inform the Fund Office. Participants should also keep a copy, for their records, of any notices they send to the Fund Office.

Financial Responsibility for Failure to Give Notice

If a Covered Person fails to give written notice within 60 days of the date of the Qualifying Event, or an Employer within 30 days of the Qualifying Event, and as a result, the Plan pays a claim for a Covered Person whose benefits terminated due to a Qualifying Event and who does not elect COBRA coverage under this provision, then the Covered Person or the Employer, as appropriate, must reimburse the Plan for all claims that should not have been paid. If the Covered Person or Employer does not reimburse the Fund, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the Covered Person was his or her Dependent(s).

In addition, you or your eligible Dependent must notify the Fund Office immediately if you or they become covered by any other plan of group health benefits whether through your employment or your spouse's employment or otherwise. You must repay the Fund for any claims paid in error as a result of your failure to notify the Fund Office of any other health coverage.

Notice and Election Form

COBRA coverage requires timely election of the coverage. The Fund Office will, after receiving notice of the Qualifying Event, send to the affected Covered Person a COBRA Notice and Election Form. This form will describe the cost of coverage and the conditions under which the COBRA coverage will terminate. In order to obtain COBRA coverage, the election form must be completed and returned to the Fund Office within 60 days after receipt.

Coverage may be continued for any eligible Dependent who is properly enrolled on the day before the event resulting in loss of eligibility (listed above). Each eligible Dependent has the independent right to elect or reject COBRA continuation coverage. The Participant may elect coverage on behalf of his or her spouse and family members. An election on behalf of a Dependent child can be made by the child's parent or legal guardian.

Details of Continuation Coverage

If you choose COBRA coverage, the coverage provided is identical to the benefits provided under the Plan to similarly situated Covered Persons, except Life Insurance, Accidental Death and Dismemberment Benefits and Disability Income Benefits are not provided. If the benefits provided under the Plan are modified after you elect COBRA Coverage, your coverage also will be modified.

Children born to or placed with you for adoption during the COBRA period also may receive coverage for the duration of your COBRA Coverage period, provided you enroll the child in accordance with the fund's rules. Coverage for the newborn or adopted child will continue for the same time as coverage for dependent children who were properly enrolled in the Fund on the day before the qualifying event. Newborn or adopted children added to your COBRA coverage also become qualified beneficiaries.

Payment Provisions

COBRA coverage requires that you make timely monthly payments. The payment due date is the first day of the month in which COBRA coverage is sought. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of COBRA coverage must include payment for the period of time dating back to the date that benefits terminated. If you fail to pay the full payment by each due date (or within the thirty day grace period for payments other than your initial payment) you will lose all COBRA coverage. There is an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected.

The monthly cost of COBRA Coverage is based on 102% of the full monthly cost of the benefits under the Plan. The monthly cost of COBRA coverage is set by the Board of Trustees each year. If any individual or family coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits (described below), the cost of COBRA coverage is based on 150% of the full monthly cost of the benefits under the plan during the 11-month extension of COBRA coverage. The Fund Office will tell you the cost of COBRA coverage at the time you receive your notice of entitlement to COBRA coverage. There is then a grace period of 30 days to pay any subsequent amounts due. If payment of the amounts due is not received by the end of the applicable grace period, the COBRA coverage will terminate.

Once a timely election of COBRA coverage has been made, it is the responsibility of the Covered Person seeking COBRA coverage to make timely payment of all required payments. The Fund need NOT send notice that a payment is due or that it is late, or that COBRA coverage is about to be or has been terminated due to the untimely payment of a required payment. The Fund's failure to provide a notice will not serve to extend the time that COBRA payments are due.

The Trustees will determine the monthly cost for the COBRA continued coverage. The monthly cost will not necessarily be the same as the amount of the monthly contribution that an Employer makes on behalf of a covered employee. The

monthly cost will be fixed, in advance, for a 12-month period. The COBRA monthly cost will be calculated at the same time every year for all COBRA beneficiaries, therefore, the monthly cost may change every year for an individual beneficiary before he or she has received 12 months of COBRA coverage.

If you become entitled to Medicare, and within 18 months of becoming entitled to Medicare, you become entitled to COBRA due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for your dependents may be continued for up to 36 months from the date you became entitled to Medicare.

Maximum Periods of COBRA Coverage for Each Qualifying Event

COBRA coverage continues subject to a maximum time period as set forth in the chart below:

	Participant	Spouse	Dependent Children
Participant terminated (or retires) (for other than gross misconduct)	18 months	18 months	18 months
Participant dies	N/A	36 months	36 months
Participant becomes divorced or legally separated	N/A	36 months	36 months
Participant becomes entitled to Medicare	N/A	36 months	36 months
Dependent child ceases to have Dependent status	N/A	N/A	36 months

If your Dependent(s)'s coverage is continued for 18 months as a result of a Qualifying Event listed above and, during the COBRA period, a second Qualifying Event occurs that entitles the Dependent(s) to continue coverage, your Dependent(s) may elect to continue coverage up to a combined maximum of 36 months. For example, if you retire and you and your Dependent(s) elect COBRA coverage from May 1, 2005 and you then become entitled to Medicare on November 1, 2005, your Dependent(s) can elect to continue coverage for the balance of 36 months, measured from May 1, 2005.

Entitlement to Social Security Disability Income Benefits

If you or an eligible Dependent(s) is determined by the Social Security Administration to be disabled at the time of the Qualifying Event or within 60 days after the Qualifying Event, coverage may be continued for all family members for up to an additional 11 months, for a maximum of 29 months from the date of the Qualifying Event. The Social Security Administration must make the determination of disability before the end of the 18-month coverage period and you must notify the Fund Office before the end of the 18 months and within 60 days of the date of the determination in order to be eligible for the extended coverage. If you do not notify the Fund Office within these time limits, you will not be eligible for the 29 month extended coverage. This extended coverage will stop earlier if the Social Security Administration determines that the individual is no longer disabled. The disabled person must notify the Fund Office if the person is no longer disabled within 30 days of a final determination of the Social Security Administration that the person is no longer disabled.

Termination of COBRA Coverage

If you and/or your Dependent(s) elect COBRA coverage, the COBRA coverage will cease on the first of the following dates:

1. The date the Plan terminates or the Plan no longer provides **benefits** to similarly situated Participants or Dependent(s).
2. The date a required payment is due and unpaid. Coverage may be reinstated if payment is made during the applicable grace period.
3. The date you and/or your Dependent(s) first become covered under another group health plan as long as it is after the Qualifying Event. This may not apply if you and/or your Dependent(s) have a pre-existing condition that is not covered under the new plan. Contact the Fund Office for additional information when you and/or your Dependent(s) become covered under another group plan.
4. The date you or your Dependent(s) first become eligible for Medicare, as long as it is after the Qualifying Event.
5. The date the applicable period of COBRA coverage ends.
6. The first month that begins more than 30 days after the date of the Social Security Administration's determination that you or your Dependent(s) are no longer disabled in situations where coverage was being extended for eleven months, so long as the period of continuation coverage does not exceed 29 months.
7. If your Employer ceases to maintain any group health plan for its Employees through the Fund, the date your Employer makes health coverage available to a class of Employees formerly covered under the Plan.

Contact for Additional Information

If you have any questions or wish to get additional information about COBRA coverage, please contact the COBRA Help Desk by calling (312) 738-0822 or by writing to:

COBRA Department
Central States Joint Board
Health & Welfare Plan
245 Fencl Lane
Hillside, Illinois 60162

Trade Act Rights

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 1-866-628-4282. TTD/TTY callers may call toll-free 1-866-626-4282.

More information about the Trade Act is also available at www.doleta.gov/tradeact/benefits.cfm. This program is offered by the federal government and the Fund Office has no role in its administration.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, Plans may generally not 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, the federal law does not prohibit the Mother's or Newborn's attending provider, after consulting with the mother, from discharging earlier. The Plan does not require that an attending provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 (or 96) hours.

WOMEN'S HEALTH AND CANCER RIGHTS

Federal law (H.R. 4328, Public Law 105-277), known as the Women's Health and Cancer Rights Act of 1988, required group health plans and insurance companies that provide coverage for mastectomies to provide certain mastectomy-related benefits or services to plan participants or beneficiaries. This annual notice is intended to inform you, in a summary fashion, of your rights under the law.

Under this law, a health plan participant or beneficiary who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with the mastectomy is entitled to the following:

1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and treatment of physical complications at all stages of mastectomy, including lymph edemas.

Coverage for these benefits or services will be provided in consultation with the participant's or beneficiary's attending physician.

If you are currently receiving, or in the future receive, benefits under a group medical contract in connection with a mastectomy, you are entitled to coverage for the benefits and services described above in the event that you elect breast reconstruction. Your qualified dependents are also entitled to coverage for those benefits or services on the same terms.

Coverage for the mastectomy-related services or benefits required under the Women's Health Law are subject to the same deductibles and coinsurance or co-payment provisions that apply with respect to other medical or surgical benefits provided by your group medical contract(s).

If you have any questions regarding this notice or your health care coverage, please call the Fund Office at (312) 738-0822 in the Chicago Area or (800) 258-6466, Outside Chicago Area.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 ("USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), and the regulations thereunder, require that the Plan provide the right to elect continuous health coverage for up to 18 months, beginning on the date in which the Participant's absence from employment begins, to Participants and their Dependent(s) who are absent from Employment due to military service, including Reserve and National Guard Duty, as described below.

If you are absent from Employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your Dependent(s) under the provisions of USERRA. This coverage will include the same health benefits offered under COBRA Continuation Coverage. Your Coverage also will include any other benefits that you would be entitled to if you were on leave of absence. The period of coverage for the Participant and Dependent(s) ends on the earlier of:

1. the end of the 18 month period beginning on the date on which your absence begins; or
2. the day after the date on which you are required to but fail to apply for or return to a position of Employment. For example, for periods of service over 180 days, generally you must reapply for Employment within 90 days of discharge.

You may be required to pay a portion of the cost of your benefits. If your military service is less than 31 days, there is no charge for this coverage beyond the Co-Pays you would pay if you were employed. If your military service extends 31 days or more, you must pay the cost of the coverage. The cost that you must pay to continue benefits will be determined in the same manner as the premium for coverage under COBRA.

You must notify your Employer and the Fund Office that you will be absent from Employment due to military service unless you cannot give notice because of military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. You also must notify the Fund Office if you wish to elect continuation coverage for yourself or your eligible Dependent(s) under the provisions of USERRA. If you satisfy the Plan's eligibility requirements at the time you entered the uniformed services and you qualify for coverage under USERRA, you will not be subject to any

additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service.

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The Family and Medical Leave Act of 1993 ("FMLA") requires employers with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave:

1. To care for your newly born or adopted child;
2. To care for the spouse, child or parent who has a serious health problem; or
3. If you have a serious health problem that prevents you from performing your job.

Your benefits may also be continued if you qualify under the Family and Medical Leave Act.

In order for you to be eligible for such leave, your Employer must have been obligated to make contributions to the Fund on your behalf for at least 1,250 hours in the preceding 12 month period. You must also have worked for that Employer for at least 12 months immediately preceding the date your leave will commence.

However, not all Employers are covered by the Family and Medical Leave Act. To be subject to the Act, an Employer must have at least 50 employees for each working day for each of 20 work weeks in the current or preceding calendar year. Additionally, you must:

1. Work at a location where the Employer has at least 50 employees; or
2. Work within 75 miles of one or more work sites where the Employer has 50 or more employees.

Your Employer must notify the Fund that you are on leave for one of the purposes described in the Act, must continue to include you on its monthly remittance report to the Fund, and must continue to make contributions on your behalf.

While you are on leave, you (and other eligible Dependent(s), if any) will continue to participate in the Plan just as if your Employment has not stopped, unless you or your Employer fails to make the required contribution for you.

Your eligibility for continued benefits under the Family and Medical Leave Act will be terminated upon occurrence of any of the following events:

1. You or your Employer fails for any reason to make the required contributions to the Fund on your behalf while you are on leave; or
2. You exhaust the 12 weeks of leave to which you are entitled under federal law; or

3. You or your Employer notify the Fund that you do not intend to return to the Employer's Employment. (Note: If you do not return to work for your Employer at the end of your leave, you may be responsible for repaying the Employer contributions made on your behalf during the leave.)

In the event your Employer ceases to make contributions on your behalf, or when you exhaust your FMLA leave, you will be provided an opportunity to elect continuation coverage in accordance with COBRA.

COORDINATION OF BENEFITS (COB)

This Plan will not duplicate payments that you may be entitled to under other health plans. This means the amount paid under any other health Plan or by any other payor, plus whatever benefit is provided from this Plan, will not exceed one hundred percent (100%) of your incurred Customary Charge. However, in no event will this Plan pay more than what would have been payable if there were not other health plans or providers involved.

All benefits provided under this are subject to the terms of all provisions of this Coordination of Benefits provision.

Effect on Benefits

(a) This Coordination of Benefits provision will apply in determining the benefits for a Covered Person for Expenses for any Claim Determination Period, if for the allowable Expenses incurred by that Covered Person during that Claim Determination Period the sum of:
   (1) the benefits that would be payable under this Plan in the absence of this provision; and
   (2) the benefits that would be payable under all other health plans in the absence of provisions in those health plans of similar purpose to this provision;

   would exceed the allowable Expense.

(b) As to any Claim Determination Period to which this provision applies, the benefits that would be payable under this Plan in the absence of this provision for the allowable Expenses incurred by the Covered Person during the Claim Determination Period will be reduced to the extent necessary, so that the sum of the reduced benefits and of all of the benefits payable for the allowable Expenses under all other health plans (except as provided in item (c) immediately below will not exceed the total of the allowable Expenses.

   Benefits payable under other health plans include the benefits that would have been payable had a claim been made.

(c) The rules for determining which health plan has the primary responsibility for benefits payment are as follows:

(1) If one health plan does not contain a Coordination of Benefits provision, it will automatically be primary;

(2) If the claimant is an employee under one health plan and a dependent under the other, then the health plan under which the claimant is an employee is primary;

(3) If the claimant is a dependent child under both health plans, the health plan covering the parent whose birth date falls earlier in the Calendar Year is primary. However, if the health plan with which this Plan is coordinating benefits bases its coordination on sex, then the rule in the other plan will determine the order of payment, except if the parents are divorced or legally separated.
In the event that the parents are divorced or legally separated, the following rules will apply:
   (A) When a court decree has established which parent has financial responsibility for the child's health care Expenses, then that parent's health plan will be primary;
   (B) When financial responsibility has not been legally established, then the health plan that covers the child of the parent with legal custody will be primary;
   (C) If the parent with legal custody remarries, then the primary responsibility will lie with the health plan that covers the first applicable of the following:
      (i) the natural parent with whom the child resides;
      (ii) the step-parent with whom the child resides;
      (iii) the natural parent not having custody of the child;

(4) If a Participant or Dependent has Medicare as primary coverage, the benefits will be coordinated in accordance with federal law regarding Medicare coverage;

(5) If none of the above applies, then the health plan in which the claimant has been enrolled the longest will be primary.

(6) In the event that both you and your spouse are Covered Employees under this Plan, the Plan will pay 100% of your reasonable and customary Covered Medical Expenses provided an in network provider, other than any Primary Care Physician and Specialist co-pays.

For the purpose of determining the applicability and implementation of the terms of this provision of this Plan or any provision of similar purpose of any other health plan, this Plan may release to or obtain from any insurance company or other organization or person any information with respect to any person that the Fund considers to be necessary for those purposes. Any person claiming benefits under this Plan must furnish to the Fund, or any of the providers under contract to the Fund, any information that may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other health plans, the Fund will have the right, exercisable alone and in its sole discretion, to pay over to any organization making the other payments any amounts that it may determine to be warranted, in order to satisfy the intent of this provision. Amounts so paid will be considered to be benefits paid under this Plan and to the extent of those payments the Fund will be fully discharged from liability under this Plan.

Right of Recovery

Whenever payments have been made by the Fund with respect to allowed Expenses in a total amount at any time in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Fund will have the right to recover these payments to the extent of any excess from among one or more of the following, as the Fund may determine: you or any persons to or for or with respect to whom these payments were made; any insurance companies; or any other organizations.

COORDINATION OF BENEFITS WITH MEDICARE

When you become Medicare eligible, you must enroll in Medicare Part A. If you fail to do so, any increase in the cost to the Fund as a result of your failure to enroll in Medicare Part A will not be treated as a covered expense. The Fund will coordinate benefits with Medicare as follows:

Active Participants Age 65 and Over and Their Dependents

If you work for a Contributing Employer with fewer than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Calendar Year, and the Fund has obtained an exception from the Health Care Financing Agency for your Contributing Employer, then Medicare shall be primary for you and your Dependents.

If you work for an employer with more than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Calendar Year, this Plan will be primary for any person age sixty five (65) and older who is a Participant and for any spouse, age sixty-five (65) and older of a Participant of any age.

Disabled Employees or Disabled Dependents Under 65

This Plan is primary for Participants or their Dependents who are under age sixty-five (65), and who are not entitled to Medicare benefits due to total disability.

End Stage Renal Disease

This Plan will remain primary for End Stage Renal Disease for the first thirty (30) months of your entitlement to Medicare due to End Stage Renal Disease, to the extent required by law. Please consult the Fund for a more detailed explanation if this may apply to you.

NOTICE OF PRIVACY PRACTICES

This section describes how medical information about you may be used and disclosed under the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Further, this notice tells you how you can get access to your personal health information (PHI). We suggest you read this notice carefully.

The Privacy Rules of HIPAA limit the access and use of your PHI solely for purposes of making or obtaining payment for your health care and conducting the necessary health care operations of your Plan. Your Board of Trustees has established a policy to guard against unnecessary disclosure of your PHI. The following is a summary of the circumstances under which your PHI may be used and disclosed:

To Make or Obtain Payment

The Plan may use or disclose your personal health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your benefits or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations

The Plan may use or disclose personal health information for its own operations to facilitate the administration of your Plan and as necessary to provide benefits and services to the Plan's participants. Health care operations include such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Plan, including customer service and resolution of internal grievances.

For Treatment Alternative

The Plan may use and disclose your personal health information to tell you about or recommend possible treatment options or alternatives that may be applicable to you.

For Distribution of Health-Related Benefits and Services

The Plan may use or disclose your personal health information to provide to you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor

Your Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of your Plan. In addition, the Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. Your Plan also may disclose to the plan sponsor information on whether you are participating in the health plan.

When Legally Required

Your Plan will disclose your personal health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities

The Plan may disclose your personal health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings

As permitted or required by state law, the Plan may disclose your personal health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes

The Plan may disclose protected health information to law enforcement officials for law enforcement purposes under certain circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's

request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if the Plan suspects that criminal activity caused the death; (5) when the Plan believes that protected health information is evidence of a crime that occurred on its premises; and (6) when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

In the Event of a Serious Threat to Health or Safety

The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions

In certain circumstances, federal regulations require the Plan to use or disclose your personal health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Worker's Compensation

The Plan may release your personal health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

Authorization to Use or Disclose Health Information

Other than as stated above, the Plan will not disclose your personal health information without your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights With Respect to Your Health Information

You have the following rights regarding your personal health information that the Plan maintains:

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your personal health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Central States Joint Board Health & Welfare Plan, 245 Fencl Lane, Hillside, Illinois 60162.

Right to Receive Confidential Communications

You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your personal health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Official at Central States Joint Board Health & Welfare Plan, 245 Fencl Lane, Hillside, Illinois 60162. The Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Official at the address and phone number shown above. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information

If you believe that your PHI records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the information is maintained by the Plan. A request for an amendment of records must be made in writing to the Privacy Official at the address and phone number shown above. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your personal health information records were not created by the Plan, if the personal health information you are requesting to amend is not part of the Plan's records, if the personal health information you wish to amend falls within an exception to the PHI you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

Right to an Accounting

You have the right to request a list of certain disclosures of your health information that the Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Privacy Official at the address and phone number shown above. The request should specify the time period for which you are requesting the information. Accounting requests may not be made for periods of time going back more than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Official at the address and phone number shown above.

Duties of the Plan

The Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all personal health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to Central States Joint Board Health & Welfare Plan, 245 Fencl Lane, Hillside, Illinois 60162, or call (312) 738-0822 in the Chicago Area or (800) 258-6466, outside the Chicago Area.

The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The Plan has designated the Fund Chairman and Plan Manager as its Privacy Officials for all issues regarding patient privacy and your privacy rights. You may contact the Privacy Official, Central States Joint Board Health & Welfare Plan, 245 Fencl Lane, Hillside, Illinois 60162 or call (312) 738-0822 in the Chicago Area and (800) 258-6466, outside the Chicago Area.

Security Safeguards

The Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan,
2 Ensure that the adequate separation discussed in this section, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

A claim for health benefits and all supporting documents must be provided to the Fund Office within one year of the date the claim was incurred. The claim must include a completed claim form (if requested by the Fund Office), a completed and fully executed Reimbursement Agreement (if required under the Reimbursement rules), and all documents necessary to process the claim. Each of these documents and all information necessary to process the claim must be provided within the one-year claim filing deadline. It is your responsibility to provide the Fund Office with all information necessary to process each claim and to do so within the time limits. The Fund Office is located at 245 Fencl Lane, Hillside, Illinois 60162.

Claims Processing and Appeal Procedures for All Claims

The Fund Office will make every effort to process your claims accurately, efficiently and as quickly as possible once the claim is received. If additional information is required to process the claim, the Fund Office will notify you explaining what additional information is required to complete the claim. You are responsible for submitting any such additional information within the claim filing deadline indicated above.

If a claim is denied in whole or part, or if a claim is denied because the Plan believes it was filed on behalf of someone who is ineligible for benefits under the Plan, you will be notified in writing within 60 days and advised of the reason for the denial.

If you are still dissatisfied, you may within 60 days, request a review by the Board of Trustees upon written application addressed to the Fund Office at 245 Fencl Lane, Hillside, Illinois 60162. A decision will be made by the Board no later than the date of the next regularly scheduled Board meeting following the receipt of the request. However, if the request for review is received within 30 days prior to the meeting, then a decision may be made at the time of the second meeting following the request for review. You will then be notified, in writing, within 60 days and given specific reasons for the decision.

Legal Actions to Recover Benefits

You and your Dependent(s) may not file legal action against the Fund to recover benefits prior to exhausting your rights of appeal in accordance with the appeal procedures described above. In any event, no legal action may be filed against the Fund to recover benefits under this Plan more than one year after the date of the notice of the Trustees' decision on appeal.

Naming an Authorized Representative

You may name a representative to act on your behalf during the entire claims procedure. To do so, you must notify the Fund in writing of the representative's name, address, and telephone number and authorize the Fund to release information (which may include medical information) to your representative. The Fund may establish procedures for determining whether an individual has been authorized. Please contact the Fund's

office for a form. The Fund will then send all information regarding your claim to your representative.

CLAIMS AND APPEALS PROCEDURES FOR HEALTH CLAIMS

Where to Submit Your Claim Form

The Fund Office can assist you in obtaining the proper Claim Forms. When the Claim Form has been completed and you have signed it, send it together with all itemized bills or required documents to the location shown below:

Central States Joint Board Health & Welfare Plan
245 Fencl Lane
Hillside, Illinois 60162

Time Limitations for Filing Your Claim

Claims must be filed and perfected, that is, all supporting documentation necessary to process the claim must be submitted, within one year after the charges have been incurred. Claims perfected after the one-year period will be denied unless it is determined that there is a satisfactory explanation for the delay. In no event will the Fund pay a claim filed more than one year from the date the claim was incurred. A chart is shown below that summarizes the time requirements under these Claims and Review procedures.

Length of Time Required to Process Claims

The length of time required to process the claim depends upon the type of claim. The Plan differentiates between four types of claims, divided according to their urgency.

Urgent Care Claim

An Urgent Care claim is one that must be processed quickly to prevent serious jeopardy to you or your dependent's life or health. Additionally, Urgent Care claims include those claims that, in the opinion of your doctor, would subject you to severe pain that cannot be managed without the care or treatment requested under the claim.

Your Urgent Care claims will be processed within 72 hours after receipt (through either written or oral communication) by the Fund. If it is determined that more information is necessary to process the claim, you will have 48 hours to provide the necessary information. The Fund then has 48 hours to decide the claim after receipt of this information. An Urgent Care claim to extend Concurrent Care (described below) will be decided within 24 hours (if you make the claim at least 24 hours before treatment expires).

If your Urgent Care claim is filed improperly, then you will be notified by telephone and given a chance to correct it within 24 hours. If you do not provide the information requested, or do not properly refile the claim, the Plan will have to decide the claim based on the information it has, and your claim may be denied. Due to the nature of an Urgent Care claim, you may be notified of a decision via telephone. This will be followed by a written notice of the same information within three days of the oral notice.

Pre-Service Claim

A Pre-Service claim is one that requires pre-approval under the terms of the Plan. Your Pre-Service claims will be decided within 15 days of receipt by the Fund. If it is determined that an extension of this time is necessary, the claim will be decided within 30 days of receipt (unless the period is extended while the Fund awaits receipt of information requested from you). You will be notified of the need for an extension within 15 days of receipt of the claim and the reasons why the extension is needed.

If the Fund needs more information from you to process the claim, you will have 45 days to provide the needed information to the Fund. If your claim is filed improperly, you will be notified of the problem within five days of filing the claim. If you do not provide the information requested, or do not properly refile the claim, the Fund will have to decide the claim based on the information it has, and your claim may be denied.

Post-Service Claim

A Post-Service claim is any other type of claim under the Plan, such as a payment for covered services after a doctor visit. The Fund strives to process your claim and notify you of the decision on your claim within 30 days after receipt of the claim. If it is determined that an extension of this time is necessary to decide the claim, the claim may be decided within 45 days of receipt (unless the period is extended while the Fund awaits receipt of information requested from you). You will be notified of the need for an extension within 30 days of receipt of the claim and the reasons why the extension is needed.

If the Fund needs more information from you to process the claim, you will have 45 days to provide the needed information to the Fund. If you do not provide the information requested, the Fund will have to decide the claim on the information it has, and your claim may be denied.

Concurrent Care Claim

A Concurrent Care claim is a claim that the Fund is asked to approve, or has already approved for an ongoing course of treatment or a certain number of treatments over time. If the Fund determines that treatment is no longer necessary, you will be notified of the denial within a sufficient amount of time to allow an appeal before the Fund ceases or reduces coverage for your treatment. If you ask that Concurrent Care treatment be extended beyond the initially determined time, your claim will be decided no later than 24 hours after your claim is received by the Fund (if you make the claim at least 24 hours before the period or number of treatments expires).

How a Decision Regarding Your Claim is Made

The Board of Trustees in making decisions regarding claims, including appeals, will apply the terms of the Plan and any applicable guidelines, rules and schedules, and strives to ensure that benefit determinations are made in accordance with such documents, and where appropriate, applied consistently with respect to similarly situated claimants. Additionally, the Fund and Trustees will take into account all information you submit in making decisions on claims and on appeal, and may consult its own experts for guidance.

The Fund, at its own expense, has the right to have a Physician examine you or your Dependent as often as is reasonably required while a claim is pending. The Fund also has the right to have an autopsy performed at its own expense, where not prohibited by law.

If the Fund has all of the information needed to process the claim, it will be processed. If your claim was for Urgent Care or a Pre-Service claim, you will receive notice regarding payment of your claim.

Notice if Claim is Denied

If your claim is denied, you will receive a written explanation that describes the specific reason for the denial, the specific provisions of the Plan on which the decision was based, any additional information necessary in order for the Fund to reconsider your claim (and the reasons why that information is necessary), and the Fund's appeal procedures and the time limits for use of those procedures. The explanation will also advise you of your rights under ERISA. If your claim concerned Urgent care and was denied, you may receive timely oral notification, however, you will also receive written notification within three (3) days after the oral notification. Your notice will also include a description of the expedited review process.

If the Fund relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, guideline or protocol or a statement that it was relied upon and is available upon request and free of charge. Additionally, if the Fund based its decision on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the judgment related to your condition or a statement that such an explanation is available upon request and free of charge.

How to Appeal a Decision to Deny Benefits

If your benefits are denied, in whole or in part, and you wish to appeal the Fund's decision, you (or your representative) should request that the Board of Trustees review your benefit denial by submitting a written appeal to the Trustees. If you are appealing an Urgent Care claim denial, you may do so orally or in writing. The Trustees or a designated committee of the Trustees will review your appeal.

Your written appeal should state the reason for your appeal. You may submit written comments, documents, records, and other information relating to the claim. If

you choose to appeal, upon request you can receive, free of charge, access to and copies of all documents, records and other information relevant to your claim.

Your appeal should be sent to:

Central States Joint Board Health & Welfare Plan
245 Fencl Lane
Hillside, Illinois 60162

Time Limitations for Submitting an Appeal

You have 180 days from the day you received notice of the initial determination to appeal that decision.

Length of Time to Issue a Decision Regarding Your Appeal

Once your appeal is received by the Trustees, the time to issue a decision will depend on the type of claim.

Urgent Care Claims

Appeals of Urgent Care claims will be decided within 72 hours after the Trustees receive the appeal. You may appeal denials of Urgent Care claims either orally or in writing. All information necessary to decide the appeal may be transmitted via telephone, facsimile or other available method.

Pre-Service Claims

Appeals of Pre-Service claims will be decided within 30 days after the Trustees receive the appeal.

Post-Service Claims

If the Board of Trustees is holding regularly scheduled meetings at least quarterly, appeals of Post-Service claims will be decided at the next quarterly meetings of the Trustees (or a designated committee of Trustees) immediately following the receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of the time for review by the Trustees, you will receive a decision no later than the third quarterly meeting, and you will be notified in writing of the need for the extension, why the extension is needed, and when a decision is expected. The Trustees will send you a notice of this decision within 5 days of the decision.

If the Board of Trustees is holding regularly scheduled meetings less often than quarterly, appeals of post-service claims will be decided within a reasonable time but in

no event will you be notified of the determination later than 60 days after receipt of the appeal.

Concurrent Care Claims

Appeals of Concurrent Care claims are governed by the provisions above for Urgent Care, Pre-Service or Post-Service claims, whichever applies to the particular claim.

Notice of Denial of Appeal

If your claim is denied on appeal, you will receive a written explanation that describes the specific reason for the denial, the specific provisions of the plan document on which the decision was based, any additional information necessary to reconsider your claim (and why that information is necessary), notice that you may receive on request access to and free copies of documents and records relevant to your claim, and a statement of your right to bring a lawsuit under ERISA.

If the Trustees relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, guideline, or protocol or a statement that it was relied upon and is available upon request and free of charge. If the Trustees based their decision on medical necessity, experimental treatment or a similar exclusion or limitation, you will receive either an explanation of the scientific or clinical judgment related to your condition or a statement that such an explanation is available upon request and free of charge. If the Fund received the advice of any medical or vocational expert with respect to your claim, the Fund will identify the expert upon your request.

If the initial decision on a medical claim was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination or a subordinate of such person. In reviewing a denied medical claim, the Trustees will not automatically presume that the initial decision was correct. Rather, the medical claim will be reviewed with no reliance on the record used in making the initial benefit determination, and, by a named fiduciary of the plan who did not make the determination you are appealing and who is not a subordinate of any individual who made the determination that you now appeal.

Time Limits

Type of Claim/Plan	For Plan to notify claimant of initial benefits determination after receipt of claim	For Plan to extend initial benefits determination	For Plan to notify claimant of an improperly filed claim or of missing claim information	For Claimant to provide missing information	For Claimant to make appeal after initial adverse benefit determination	For Plan to make determination of appeal after claimant's request for review	For Plan to extend determination of appeal
Group Health Plan—Urgent Care	72 hours	None	24 hours	48 hours minimum	180 days	72 hours	None
Group Health Plan—Non-Urgent Care Pre-Service Claims (relating to care that has not yet been provided)	15 days	15 days	5 days	45 days	180 days	30 days (15 days if the plan has two appeals)	None
Group Health Plan—Non-Urgent Care Post Service Claims (reimbursement of costs for medical care)	30 days	15 days	30 days	45 days	180 days	60 days (30 days if the plan has two appeals)	None
Welfare other than Group Health or Disability	90 days	90 days	No time limit specified	No time Limit specified	60 days	60 days	60 days
Disability Income	45 days	30 days A second 30 day extension is allowed	45 days	45 days	180 days	45 days	45 days

External Review Procedure

If you are not satisfied with the decision of the Board of Trustees on your appeal, you may take an External Appeal to an Independent Review Organization (IRO).

You or your representative may file a request for an External Review with the Fund Office within four (4) months after the date of receipt of an adverse Internal Appeal Decision. If there is no corresponding date four (4) months after the date of receipt, i.e. receive on October 30 and there is no February 30, the request must be filed by the first day of the fifth month following the receipt of the notice. If the last filing date falls on a Saturday, Sunday or federal holiday, the filing deadline is extended to the next business day.

Upon receipt of your request for External Review, the Fund Office will perform a preliminary review of your request to determine whether it is eligible for External Review. In order to be eligible for External Review the following factors must be met:

A. You are or were covered under the Plan at the time the health care item, service, or other benefit was requested or, in the case of a retrospective review, at the time the health care item, service, or other benefit was provided;

B. The adverse Internal Appeal determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

C. You have exhausted the Plan's Internal Appeal process or you are not required to exhaust the Internal Appeals process under the applicable federal regulations or in accordance with this procedure; and

D. You have provided all of the information and forms required to process an External Review.

If your request for External Review is complete, but not eligible for External Review, the Fund will provide you with a notice including the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the request complete and the Fund will allow you to perfect the request for External Review within the later of the four-month filing period or within 48 hours following the receipt of the Notice.

If your request for review is complete and your request is eligible for External Review, the Fund Office shall forward your request to the IRO to conduct the External Review.

Upon receipt of the External Review, the IRO may:

A. utilize legal experts where appropriate to make coverage determinations under the Plan;

B. timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit any additional information that the IRO requests in writing within ten (10) business days following the date you receive this notice. The IRO may, but is not required, to accept and consider additional information submitted after ten (10) business days.

The Fund Office will provide the IRO with any documents and any information considered in making the adverse benefit determination or the adverse Internal Appeal determination. If the Fund Office fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the adverse benefit determination or the adverse Internal Appeal determination, and so notify you and the Fund Office.

If you submit any additional information, the IRO will forward such information to the Fund Office. Upon review of the additional information, the Fund may reconsider its adverse benefit determination or adverse Internal Appeal determination. The External Review may be terminated if the Fund determines during reconsideration to reverse the previous determination and provide coverage or payment on your claim.

The IRO will review all information and documents timely received and review the claim and all evidence de novo. The IRO is not bound by any decisions or conclusions reached during the initial benefit determination or the Internal Appeal. In addition to the documents and information provided, the IRO will consider the following, as it determines appropriate, in reaching an External Review decision:

1. your medical records;

2. the attending health care professional's recommendation;

3. reports from appropriate health care professionals and other documents submitted by you, your treating Provider or the Fund;

4. the terms of the Plan (unless contrary to applicable law);

5. appropriate medical practice guidelines, including evidence-based standards;

6. any applicable clinical review criteria developed and used by the Plan (unless contrary to the Plan or applicable law);

7. the opinion of the IRO's clinical reviewer.

The IRO will issue its written External Review decision within 45 days after the IRO receives the request for External Review.

The IRO's final External Review decision will contain:

(i) a general description of the reason for the request for External Review, including: sufficient information to identify the claim (date or dates of service, Provider, claim amount, diagnosis code and corresponding meaning, treatment code and corresponding meaning, and reason for previous denial);

(ii) the date the IRO received the assignment to conduct the External Review;

(iii) the date of the IRO's final External Review decision;

(iv) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;

(v) an explanation of the principal reason or reasons for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;

(vi) a statement that the determination is binding except to the extent that other remedies may be available under federal law to either you or the Plan; and

(vii) a statement that judicial review may be available to you;

The IRO must maintain records of all claims and notices associated with the External Review for six (6) years. An IRO must make such records available for examination by you, the Fund, or state or federal government oversight agency upon request unless such disclosure would violate state or federal privacy laws.

Expedited External Review:

Expedited External Review shall be undertaken when you have a medical condition that necessitates Expedited External Review because the time frame for completion of the standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the adverse Internal Appeal determination concerns an admission, availability of care, continued stay, or health care item, service, or other benefit for which you received emergency services, but have not been discharged from a Provider's facility, or the claim qualifies for Urgent Care review.

The Fund Office shall immediately upon receipt of the request for the Expedited External Review, perform the Preliminary Review provided above and shall complete such review as soon as possible. Upon its determination of the Preliminary Review, the Fund Office will immediately send the notice described above.

Upon a determination that the request is eligible for Expedited External Review, the Fund Office shall forward the request to the IRO and transmit or provide all documents and information described above electronically or by telephone or facsimile or by any other available expeditious method.

The IRO will provide its final External Review decision and notice of such decision 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 of the Expedited External Review decision is provided by the IRO other than in writing, then within 48 hours of the date such notice is provided the IRO will provide written confirmation of the decision to you and the Fund Office.

Reversal of Adverse Determination:

In the event the adverse benefit determination or the adverse Internal Appeal determination is reversed by the Fund or the IRO, respectively, the Fund will provide coverage or payment for the claim in accordance with applicable law and regulations, but

reserves the right to pursue judicial review or other remedies available or that may become available to the Fund under applicable law and regulations.

Limitations on Action Against Fund:

No lawsuit shall be brought to recover benefits under this Fund unless:

(i) the Claimant has exhausted the appeal procedure provided by the Plan; and

(ii) such lawsuit is filed within one year from the date of the Internal Review Decision or, if applicable, the External Review decision.

FUND'S RIGHT TO REIMBURSEMENT

Were you or your Dependent(s) injured in a car accident or other accident in which someone else is liable? If so, that person (or his/her insurance) is responsible for paying your (or your eligible Dependent(s)'s) medical and disability expenses and these expenses would not be covered under the Plan. However, waiting for a third party to pay for these injuries may be difficult. Recovery from a third party may take a long time (you may have to go to court) and your creditors may not wait patiently. Because of this, as a service to you, the Fund may advance you or your Dependent(s) benefit payments based on the understanding that you are required to reimburse the Fund in full from any recovery you or your Dependent(s) may receive, no matter how it is characterized. The Fund retains complete discretion on whether to advance benefit payments. It has no obligation to do so.

You and/or the Dependent(s) are required to notify the Fund within ten days of any accident or injury for which someone else may be liable. Further, the Fund must be notified within ten days of the initiation of any lawsuit arising out of the accident or injury and of the conclusion of any settlement, judgment or payment relating to the accident or injury.

In the event a claim is made by or on behalf of you or your Dependents for illness or injury to you or your Dependents and you or your Dependents have the right to recover the amounts of such benefits from any other person, corporation, insurance carrier or governmental agency, including uninsured or underinsured insurance coverage, or any other first party or third-part contract or claim (Third Party Liability), the Fund will not be required to make any payments until all claims of Third Party Liability are resolved. As an accommodation to you or your Dependent, the Fund may, in its sole discretion, pay covered expenses prior to the determination of Third Party Liability if you or your Dependent and any attorney(s) representing you or your Dependent execute a reimbursement agreement on a form developed and maintained by the Fund. The reimbursement agreement will, at a minimum, require you, your Dependent and any attorney(s) representing you and/or your Dependent to reimburse the Fund first out of any monies received by you or your Dependent by judgment, settlement or otherwise from any other responsible party and/or the responsible party's agent, representative, insurance company, or others, for the amount of the Fund's payments. You, your Dependent and any attorney(s) representing you and/or your Dependent will also be required to reimburse the Fund for any costs or attorney's fee incurred by the Fund in enforcing the reimbursement agreement. In no event will the Fund be held liable for the attorney's fee and/or costs incurred by you, your Dependent and/or any attorney(s) representing you and/or your Dependent in seeking any recovery against a Third Party.

By applying for and accepting benefits from the Fund, you and/or your Dependent and any attorney representing you and/or your Dependent disavows the "Common Fund" doctrine and any other statutory or common law principles limiting the Funds right of full recovery.

You or your Dependents or the participant acting on behalf of a minor Dependent, and any attorney representing you or your Dependent will execute and deliver such documents and papers (including but not limited to an assignment of the claim against the other party or parties, assignment to the minor child of any parental claim to recover medical expenses of the minor child, and/or a Reimbursement Agreement) to the Fund as the Fund may require to preserve and protect its rights. You or your Dependent will do whatever else is necessary to secure the rights of the Fund.

In the event that the Fund pays or is obligated to pay any benefits on behalf of you and/or your Dependent involving a claim of Third Party Liability, in addition to any rights of reimbursement, the Fund will be subrogated to all of you or your Dependents' right of recovery against such person, corporation, insurance carrier, governmental agency or uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, to the full extent of payments made by the Fund.

If you or your Dependents do not attempt a recovery of the benefits paid by the Fund or for which the Fund may be obligated, the Fund will, if in the Fund's best interest and at its sole discretion, be entitled to institute a legal action or claim against the responsible party or parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all amounts paid to you or your Dependents or paid on your or your Dependent's behalf.

In the event the Fund obtains any recovery by judgment or settlement against the responsible party or parties or by payment by any uninsured or underinsured insurance coverage or any other first party or third party contract or claim, the reasonable costs of collection including the Fund's fees will first be deducted. The Fund's subrogation interest to the full extent of benefits paid or due as a result of the occurrence causing the injury or illness, will next be deducted. The remainder or balance of any recovery will then be paid to you or your Dependents and their attorneys, if applicable.

In the event of any failure or refusal by you, your Dependents or any attorney representing you or your Dependents, to execute any document requested by the Fund or to take other action requested by the Fund or protect the interests of the Fund, the Fund may withhold payment of benefits or deduct the amount of any payments previously made from future claims of you or your Dependents. After making a claim for benefits from the Fund, you or your Dependents will take no action that might or could prejudice the rights of the Fund.

In the event you or your Dependents recover any amount by settlement or judgment from or against another party or by payment from any uninsured or uninsured insurance coverage or any other first-party or third-party contract or claim, whether recovery is full or partial, you or your Dependent will reimburse the Fund the full amount of benefits paid by the Fund. The Fund will be fully reimbursed first and with priority for the full amount of benefits paid regardless of whether you or your Dependent has been "made whole." The "make-whole" doctrine does not apply to the Fund's right of reimbursement and subrogation. In no event will the Fund be liable for payment of any

costs or attorneys fees incurred by you or your Dependent in obtaining any recovery. You are responsible for your own legal fees and costs for any recovery. By applying for and accepting benefits from the Fund, you and/or your Dependent and any attorney representing you and/or your Dependent disavows the "Common Fund" doctrine and any other statutory or common law principles limiting the Fund's right of full recovery. If you and/or your Dependents refuse or fail to reimburse the Fund, then the Fund will be entitled to recover the full amount of benefits paid, plus any costs, and attorneys fees incurred by the Fund in obtaining the recovery from you and/or your Dependent and/or any attorney representing you and/or your Dependent by instituting legal action against you and/ or your Dependent and/or any attorney representing you and/or your Dependent and/or by deducting such amounts as may be due on future claims submitted by you and/or your Dependents. Once a settlement or judgment is reached on the claim, additional bills cannot be submitted with respect to the same injury.

The Funds' right of reimbursement is from the first dollar received by you or your Dependent and takes effect before the whole debt is paid to you or your Dependent.

The Trustees of the Fund will have the sole and complete discretion to decide whether the provisions of this section have been complied with, and any decision rendered by the Trustees will be final and binding on you, your Dependent and any attorney representing you and/or your Dependent.

Any overpayment or any other amount due to the Fund can be deducted from future benefits.

YOUR RIGHTS UNDER ERISA

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Board of Trustees complies fully with this law and encourages you to first seek assistance from the Fund Office when you have questions or problems that involve the Plan.

ERISA provides that all Participants are entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and Union halls, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security and Administration (EBSA).
2. Obtain copies of all Plan documents and other Plan information upon written request to the Fund Office including insurance contracts, collective bargaining agreements, forms 5500 and the latest summary plan description. The Fund may make a reasonable charge for the copies.

3. Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
4. File suit in federal court, if any materials requested are not received within 30 days of the Participant's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Plan Administrator to pay up to $110 for each day's delay until the materials are received.
5. Continue health care coverage for yourself, Dependent spouse or Dependent(s) if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependent(s) may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA Continuation Coverage rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people responsible for the operation of the Plan. These persons are referred to as "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.

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.

If you are improperly denied a welfare benefit in full or in part, you have the right to file suit in a federal or state court. If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe Plan fiduciaries are misusing the Plan's money, you have the right to file suit in a Federal court or request assistance from the United States Department of Labor. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including attorneys' fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or your rights under ERISA, you should contact the Fund Administrator or the nearest Area Office of the Pension and Welfare Benefits Administration of the United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

SUMMARY PLAN INFORMATION

Plan Name

Central States Joint Board Health & Welfare Plan

Plan Sponsor

Board of Trustees
Central States Joint Board Health & Welfare Plan
245 Fencl Lane
Hillside, Illinois 60162

Employer Identification Number (EIN)

The EIN assigned to the Plan Sponsor by the IRS is 36-2376645

Plan Number Assigned to This Plan

The Plan Number assigned to this Plan by the Plan Sponsor is 501.

Type of Plan

This is a welfare plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and is designed to provide health care benefits such as hospitalization, medical, surgical and prescriptions benefits.

Type of Administration

The Plan is administered by a joint labor/management Board of Trustees. The Board of Trustees is the Plan Administrator and establishes the rules and regulations of the Plan and is otherwise responsible for the operation of the Plan. The Board of Trustees shall have the discretion and exclusive right to construe the terms of the Plan provisions and to determine all questions, whether legal or factual, of the nature, amount, and duration of benefits. The decisions of the Board of Trustees regarding the terms of the Plan shall be considered as final and binding.

The hospital and medical/surgical Plan is self-insured but utilizes the :

Blue Cross Blue Shield of Illinois Network
300 East Randolph Street
Chicago, Illinois 60601-5099

The Prescription Drug Plan is self-insured and administered by OptumRx:

OptumRx
2300 Main Street
Irvine, CA 92614

Name of Plan Administrator

The Plan Administrator is the Board of Trustees. The Plan Manager reports directly to the Board of Trustees.

Agent for Service of Legal Process

The Agent for Service of legal process is the Board of Trustees at the address listed above. Service may also be made on the Plan Manager.

Sources of Contribution

The Fund was established pursuant to collective bargaining agreements between Employers and the Union and has been maintained through succeeding agreements under which Employer contributions to the Fund are required. You may request in writing a list of the participating Employers and employee organization sponsoring the Plan from the Plan Administrator.

Funding Medium

Welfare plan contributions are made to a qualified tax-exempt Fund. This money is reserved irrevocably for payments on behalf of Plan Participants. It cannot be used for any other purpose and it cannot be withdrawn by either the Employer or the Union. Medical, hospital, surgical, anesthesia and prescription benefits are paid from the Fund's accumulated assets. All benefits are self-funded. The Fund has a contract with preferred provider organizations to provide discounted rates for hospitals and doctors. These contracts are renewed periodically and subject to change at the discretion of the Fund's Trustees

Fiscal Year/Plan Year

The Plan's fiscal year is the 12-month consecutive period ending December 31st.

Amendment, Termination, and Interpretation

It is intended that the Plan be maintained indefinitely. However, the Board of Trustees reserves the right to amend or terminate the Plan in whole or in part at any time without prior notice. This right to amend includes the right to curtail or eliminate benefits for any treatment, procedure or service, regardless of whether you are receiving such treatment for an Illness or Injury contracted before the effective date of the amendment. Active Participants, Pensioners, and their Dependent(s), could be affected by future Plan changes or termination of the Plan.

The Board reserves the right, in its sole discretion, to interpret, apply, construe, and amend the provisions of the Plan and make factual determinations regarding its construction, interpretation and application, and any decision made by the Board of Trustees is binding upon Employers, Employees, Participants, Dependents, Beneficiaries, and all other persons who may be involved or affected by the Plan. Modification or amendments to the Plan may be made retroactively. If the Plan is terminated, the rights of the participants are limited to expenses incurred before termination.

The Plan is administered so as not to discriminate in favor of any individual Participant. The amount of Plan payment towards similar claims may vary because the charges by Physicians, Hospitals, etc. are different and the Plan is designed to cover certain basic costs. Similarly, the Fund may enter into agreements where health care providers and preferred provider organizations will accept our Plan allowance as paid-in-full settlement of the bill

The Trustees intend that the Plan's terms are legally enforceable. If a provision of this Plan is held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof and this Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included.

A QUICK FIND GUIDE

To help you find information about a particular part of your plan of benefits, simply look for the topic that matches your question or interest and turn to the pages(s) indicated.