Retired Employees

Local 705 International Brotherhood of Teamsters

Health & Welfare Plan For Retired Employees

Summary Plan Description

January 2017 Edition

Local 705
International Brotherhood Of Teamsters
Health & Welfare Plan For Retired Employees

1645 West Jackson Boulevard, Suite 700
Chicago, Illinois 60612
(312) 738-2811

Plan Administrator

Jack F. Witt
Local 705 International Brotherhood of Teamsters
Health & Welfare Plan
1645 West Jackson Boulevard, Suite 700
Chicago, Illinois 60612

Board of Trustees

Local 705 International Brotherhood of Teamsters
Health & Welfare Fund

Employer Trustees

Stephen F. G. Bridge
William W. Gianaras
Duane Mattingly
Dan Thomas

Union Trustees

Joseph M. Bakes
Juan C. Campos
Kenneth J. Emanuelson
Gregory R. Foster

Fund Co-Counsel

Stephen J. Rosenblat, Esq.
Baum Sigman Auerbach & Neuman, Ltd.
200 West Adams Street, Suite 2200
Chicago, Illinois 60606

James P. Daley, Esq.
Jackson Lewis, P.C.
150 N. Michigan Avenue, Suite 2500
Chicago, Illinois 60601

Benefits Consultant and Actuary

Segal Consulting
101 N. Wacker Drive, Suite 500
Chicago, Illinois 60606

Auditor

Bansley & Kiener, LLP
8745 W. Higgins Road, Suite 200
Chicago, Illinois 60631

Please take some time to review this booklet. If you are married, share the information in this booklet with your spouse. Contact the Fund Office at (312) 738-2811 if you have any questions about the benefits described in this booklet.

Table of Contents

INTRODUCTION 1

RETIRED EMPLOYEES SCHEDULE OF BENEFITS AS OF JANUARY 1, 2017 2

IMPORTANT CONTACT INFORMATION 4

ELIGIBILITY FOR BENEFITS 5
- Eligibility Requirements 5
- Dependent Coverage 7
- When Coverage Ends 7
- Rescission of Coverage 8

COMPREHENSIVE MEDICAL BENEFIT 9
- Annual Deductible 9
- Coinsurance and Copayments 9
- Out-Of-Pocket Maximum 9
- Maximizing Your Health Care Benefits 10
- Covered Comprehensive Medical Benefit Expenses 12
- Expenses Not Covered Under Comprehensive Medical Benefit 28

PRESCRIPTION DRUG BENEFIT 32
- How the Prescription Drug Program Works 32
- CVS/caremark Retail Pharmacy Program – 34-Day Supply or 90-Day Supply 32
- Maintenance Choice 33
- CVS/caremark Mail Service Pharmacy 33
- Specialty Pharmacy Program 33
- Covered Prescription Drug Expenses 34
- Generic Versus Brand Name Medications 34
- Expenses Not Covered Under Prescription Drug Benefit 34

GENERAL PLAN LIMITATIONS AND EXCLUSIONS 35

FAMILY STATUS CHANGES 37
- Notify the Fund Office 37
- Adding a Dependent 37
- In the Event of Your Death 37

COBRA CONTINUATION OF COVERAGE 38
- Self-Payment Opportunities 38
- COBRA Benefits 38

CLAIMS AND APPEALS 40
Filing Claims 40
Types of Claims 40
Claim Decisions 41
If a Claim Is Denied 43
Appealing a Denied Claim 43
Appeal Decisions 44
Medical Judgment 46
Authorized Representative 46
Sole Authority on Plan Benefits 47
External Review Procedures 47
After External Review 50
Payment of Claims 51
Elimination of Conflict of Interest 51
Coordination of Benefits 51
Privacy Policy 53
Subrogation and Reimbursement 54
PLAN INFORMATION 56
YOUR ERISA RIGHTS 59
GLOSSARY OF TERMS 61

This booklet contains only highlights of certain features of the Local 705 International Brotherhood of Teamsters Health & Welfare Plan for Retired Employees (or Plan). The Health & Welfare Plan for Retired Employees is maintained by the Trustees of the Local 705 International Brotherhood of Teamsters Health & Welfare Fund (Fund). Full details are contained in the Plan Documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the Plan Document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

INTRODUCTION

The benefits described in this booklet are available to Retired Employees who meet the eligibility requirements (see page 5).

The Plan offers comprehensive health care coverage to help you and your eligible Dependents stay healthy. This coverage can help provide financial protection against catastrophic health care bills. In addition to comprehensive medical benefits, the Plan also provides prescription drug benefits.

This Summary Plan Description (SPD) booklet is intended to give you an understanding of Plan benefits as of January 1, 2017. This edition, which includes all Plan changes adopted since the previous edition, replaces and supersedes any previous SPD.

RETIRED EMPLOYEES SCHEDULE OF BENEFITS AS OF JANUARY 1, 2017

The following chart highlights key features of the Health & Welfare Plan for Retired Employees. These benefits are described in detail in your Summary Plan Description booklet. All charges for medical expenses must meet the definition of an Eligible Expense as adopted by the Fund.

Comprehensive Medical Benefit	PPO Provider[1]	Non-PPO Provider
Annual Deductible	$400 per person $1,200 family	
Annual Out-Of-Pocket Maximum	$3,700 per person; $7,000 family maximum for major medical $2,500 per person; $5,000 family for prescription drugs	No Limit Not covered outside CVS/caremark pharmacies
Preventive/Wellness Care (e.g. routine well child care, OB/GYN visits, physicals)	Plan pays 100%, no copay	Not covered
Office Visits Primary Care Physician Specialist	 $20 Copayment; no deductible $40 Copayment; no deductible	 Not covered Not covered
Other Physician Charges	Plan pays 85% after deductible	Not covered
Outpatient Tests[2]	Plan pays 85% after deductible	Not covered
Emergency Room/Urgent Care Facility	Plan pays 85% after deductible	Plan pays 85% after deductible
Hospital Services[3]	Plan pays 85% after deductible	Not covered
Home Health Care[3] Annual Maximum	Plan pays 85% after deductible 40 visits	Not covered
Skilled Nursing Facility Care[3] Annual Maximum	Plan pays 85% after deductible 90 days	Not covered
Hospice Care 3	Plan pays 85% after deductible	Not covered
Mental Health/Chemical Dependency Inpatient Outpatient	Plan pays: 85% after deductible $20 Copayment	 Not covered Not covered
Physical Therapy 2	Plan pays 85% after deductible	Not covered
Chiropractic Care/Spinal Manipulations (Retired Employee & Dependent Spouse Only)	Plan pays 85% up to $100 of eligible charge per visit per day after deductible	Not covered
Ambulance Service	Plan pays 80% after deductible	Plan pays 80% after deductible
Durable Medical Equipment[2]	Plan pays 80% after deductible	Plan pays 80% after deductible
Utilization Management Penalties Hospital Confinements/Surgeries	$600 per occurrence	
Bariatric Surgery (Retired Employee and Dependent Spouse Only)[4]	Plan pays 75% after deductible; limited to once per lifetime	Not covered

[1] Except for Emergency Care, you must use a PPO provider for expenses to be covered under the Plan. If you do not have access to a PPO provider within 30 miles of your home, Covered Medical Expenses will be paid at 75% after the deductible.

[2] Eligible expense reduced by 50% if Utilization Management ("UM") is not notified.

[3] $600 penalty applies if UM not notified.

[4] Bariatric Surgery Benefits are payable only if pre-authorized and if specific criteria are satisfied. You are responsible for obtaining pre-authorization for you or your Dependent Spouse. Bariatric Surgery Benefits are payable only when a Blue Cross Center of Distinction Hospital for Bariatric Surgery is used.

Prescription Drugs Benefit		In-Network	Out-Of-Network
Retail Pharmacy (up to a 34-day supply)			
Generic Brand Name Specialty	 Formulary Non-Formulary[5] 	$5 Copay $25 Copay $50 Copay $75 Copay	Not covered
Retail Pharmacy (up to a 90-day supply)			
Generic Brand Name Specialty	 Formulary Non-Formulary[5] 	$12.50 Copay $60 Copay $125 Copay $182.50 Copay	Not covered
Mail Order (up to a 90-day supply)			
Generic Brand Name Specialty	 Formulary Non-Formulary[5] 	$12.50 Copay $60 Copay $125 Copay $182.50 Copay	Not covered

[5] Whenever available, prescriptions will be filled with Generic or formulary medications. If you elect to receive a Brand Name medication when a Generic is available, you will pay the higher Copayment amount plus the difference in cost between the Generic and Brand Name medication.

IMPORTANT CONTACT INFORMATION

The chart that follows shows the contact information for the various organizations that provide services under the Local 705 I. B. of T. Health & Welfare Plan for Retired Employees.

If You Have a Question or Need Information About	Contact	Phone Number/Web Site
Eligibility or Benefits	Fund Office	(312) 738-2811
PPO Network Providers	BlueCross BlueShield of Illinois	(800) 810-2583 www.bcbsil.com
Utilization Management	Med-Care Management	(800) 441-7705
Living Well with Diabetes Program	Med-Care Management	(866) 844-4222
Prescription Drug Benefit	CVS/caremark CVS/specialty	(866) 818-6911 www.caremark.com (800) 237-2767 www.cvsspecialty.com

ELIGIBILITY FOR BENEFITS

Eligibility Requirements

To be eligible for medical and prescription drug benefits from the Health & Welfare Plan for Retired Employees, you and your eligible Dependents must satisfy the eligibility requirements described below and make the required Self-Payments to the Fund for Plan coverage.

The following is a summary of the eligibility rules for Plan benefits under the Plan for Retired Employees. If you have any questions about how the Plan works, please contact the Fund Office.

Initial Eligibility

You are eligible for coverage as a Retired Employee if you are:

Retired from Industry Employment, and were in Covered Employment under the Health & Welfare Plan for the three (3) consecutive month period immediately prior to retirement and meet any of the following requirements:

(a) Have 20 or more years of Benefit Service and are receiving a Pension from the Pension Plan; or

(b) Have 20 or more years of Covered Employment under the Health & Welfare Plan; or

(c) Are eligible for a Disability Retirement under the Pension Plan and have applied for disability insurance benefits under the Federal Social Security Act.

Deemed Retired Employee

If you were not in Covered Employment under the Health & Welfare Plan for the three (3) consecutive month period immediately prior to retirement, but you meet the requirements to be a Retired Employee in all other respects, you will be deemed to be a Retired Employee if:

(1) You have a pending workers' compensation case, or

(2) All of the following conditions are met:

(A) The Employer from which you retired was at one time a Contributing Employer to the Health & Welfare Fund, who left the Health & Welfare Fund, and subsequently returned as a Contributing Employer to the Health & Welfare Fund:

(i) Within five (5) years of the date it last made contributions to the Health & Welfare Fund; or

(ii) By the day after the expiration date of the first Collective Bargaining Agreement between the Employer and the Union that did not require the Employer to contribute to the Health & Welfare Fund; and

(B) You retired from the Employer during the period after the Employer left the Health & Welfare Fund, but before the Employer returned to the Health & Welfare Fund; and

(C) The Employer had never previously left the Health & Welfare Fund and subsequently returned as a Contributing Employer to the Health & Welfare Fund; and

(D) The Employer makes three (3) complete months of contributions to the Health & Welfare Fund on your behalf at the Health & Welfare Fund's current rate for such contributions.

For the purposes of this Plan for Retired Employees, the terms Retired and Retirement will be defined as permanently leaving Industry Employment for reason other than death; the terms Benefit Service,

Disability Retirement, Industry Employment and Pension will be the same as in the Pension Plan, and the terms Collective Bargaining Agreement, Contributing Employer, Contributions, Covered Employment, Employer and Union will be defined as those terms are defined in the Health & Welfare Plan.

Deemed Retired Employee for Purposes of Dependent Coverage (but not including an adult Dependent child who is permanently and fully disabled)

Notwithstanding anything contained in this SPD to the contrary, if you satisfy the requirements of this paragraph you will be deemed to be a Retired Employee solely for purposes of the coverage eligibility under this Plan of your Dependent spouse or Dependent child who, but for your death, would be a Dependent spouse or Dependent child under this Plan. To be deemed a Retired Employee for this purpose, you, on the date of your death, must have:

(a) Satisfied each of the applicable requirements of a Retired Employee;

(b) Been covered under the Local 705 International Brotherhood of Teamsters Health & Welfare Plan; and

(c) Been entitled to be in pay status under the Pension Plan even though you were not actually receiving Pension Plan payments on that date.

If you are deemed to be a Retired Employee as described above, your Dependent spouse or Dependent child will be considered an eligible Dependent subject to the terms and conditions of Plan coverage. This provision for a "Deemed Retired Employee" does not apply to a Dependent child who is permanently and fully disabled.

Self-Payments

You must make Self-Payments for your coverage and for the coverage of each of your Dependents under the Plan for Retired Employees. The amount of the monthly Self-Payments depends on the number of Dependents that you are covering. The payment amount is determined by the Trustees and may change from time to time. You may call the Fund Office for information about the current Self-Payment amount.

You (or your Dependent spouse when your coverage ends) must make your Self-Payments on time to continue your eligibility for coverage under the Plan. To help you in making your Self-Payments on time, the Health & Welfare Fund coordinates an automatic deduction program with the Local 705 International Brotherhood of Teamsters Pension Fund. Under this program, the Pension Fund makes an automatic deduction from your monthly pension benefit and transfers the Self-Payment amount to the Health & Welfare Fund to pay for your retiree medical coverage. You must select such coverage and participation in the automatic deduction program. Contact the Fund Office for more information.

Continued Eligibility

Once you are covered under the Plan, you and your eligible Dependents will continue to be eligible provided the Fund Office receives your Self-Payments for coverage. Self-Payments are due on the first day of each month. If payment is not received by the last day of the month, coverage under the Plan will be retroactively terminated as of the first day of that month. Medical expenses incurred during that month will not be covered under the Plan.

Changes in Eligibility Rules

The Trustees reserve the right, at their discretion, to change, modify, or discontinue all or part of the Eligibility Rules or the benefits provided under the Plan, at any time.

DEPENDENT COVERAGE

Your spouse must be eligible for coverage at the time you are first eligible to participate in this Plan as a Retired Employee. Generally, your Dependent children become eligible for coverage on the date you become eligible, or, if later, on the date you acquire a covered Dependent. Eligible Dependents are defined in the Glossary beginning on page 61.

> **You Must Enroll When First Eligible**
>
> You cannot move in and out of the Plan.
>
> Any eligible individual who declines coverage when first eligible for coverage or who drops coverage after enrolling will not be able to enroll or reenroll in this Plan for Retired Employees at a later date.

WHEN COVERAGE ENDS

When coverage under this Plan for Retired Employees ends for you, your covered Spouse or your covered Dependent children, coverage cannot be reinstated. In addition, no conversion privileges are available. Your Dependents may continue coverage under COBRA (see page 38).

> **Important!**
>
> Your coverage under this Plan ends on the date that you become eligible for Medicare.
>
> You must notify the Plan if you become eligible for any part of Medicare.

For You

Your eligibility for benefits under the Plan will end on the earliest of the:

- Date you become eligible for Medicare (at age 65 or sooner if you are eligible for Medicare due to disability);
- Last day of the month for which you make the required Self-Payment, if you do not make the required Self-Payment for the following month;
- Date the Trustees discontinue the Plan; or
- Date of your death.

> ***When Eligibility Ends Example***
>
> The Fund does not receive the required Self-Payment for Scott in the month of June. If Scott chooses not to make Self-Payments to continue his eligibility for benefits, his eligibility for benefits under the Plan will end on May 31.

For Your Dependents

Your Eligible Dependents' coverage will end on the earliest of the:

- Date you cease to be eligible for Plan benefits for any reason other than death or eligibility for Medicare;
- Date you cease to be eligible for Plan benefits due to your death or eligibility for Medicare and your Dependent Spouse does not make the required Self-Payment;
- Date your Dependent fails to meet the Plan's definition of a Dependent;
- Last day of the month for which your Dependent Spouse makes the required Self-Payments, if he or she does not make the required Self-Payment for the following month;
- Date your Dependent becomes eligible for Medicare (at age 65 or sooner if your Dependent is eligible for Medicare due to a disability);
- Date the Trustees discontinue benefits for Dependents under the Plan;
- Date the Trustees discontinue the Plan; or
- Date your Dependent dies.

In addition to the dates listed above, coverage ends for an adult Dependent child who is permanently and fully disabled on the date that you are not covered under this Plan for Retired Employees, regardless of whether your Spouse remains covered by the Plan.

RESCISSION OF COVERAGE

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

The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.

The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

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

COMPREHENSIVE MEDICAL BENEFIT

ANNUAL DEDUCTIBLE

Each year, benefits begin once you satisfy the annual deductible. This means you must meet the annual deductible *before* the Plan begins to pay benefits. The amount of the annual deductible is listed on the *Schedule of Benefits* (on page 2) Once payments toward individual deductibles for your family reach the family maximum, individual deductibles for all family members will be met for the year.

When you need to see a Physician…

- Call BlueCross BlueShield of Illinois at (800) 810-2583 to see if your Physician is a participating provider.
- Go online at www.bcbsil.com/providers.
- Call to make an appointment.
- Write down any questions you may have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- Make a list of any medications you are taking. Be sure to note how often you take the medications.
- When you go to your appointment, make sure to show your BlueCross BlueShield of Illinois medical ID card so your provider knows where to file the Claim.

Benefits Not Subject to the Annual Deductible

The following benefits are not subject to the annual deductible:

- Preventive/wellness care including routine well child care, OB/GYN visits and physicals, provided through the PPO Network only;
- Co-payments;
- In-network office visits; and
- Prescriptions filled through network and mail order pharmacies.

COINSURANCE AND COPAYMENTS

Coinsurance, expressed as a percentage, is your share of the cost of covered services or supplies. Each year, after you or your family, meet the annual deductible, the Plan pays a percentage of covered charges, and you pay the rest, up to the out-of-pocket maximum. The percentage the Plan pays is listed on the *Schedule of Benefits* (on page 2). The Plan for Retired Employees does not provide benefits for treatment or services received from a non-PPO provider unless you do not have access to a PPO provider within 30 miles of your home. This means that you pay 100% of the cost for treatment or services received from a non-PPO provider.

A Copayment is a flat dollar amount. For example, when you go to a PPO Provider for Office Visits for examinations or consultations (not including laboratory services or blood work) or participating pharmacies, you pay a Copayment (as specified on the *Schedule of Benefits*), and the Plan pays 100% of the remaining covered charges. Any other services, such as laboratory services, x-rays, Surgery or blood work performed during an Office Visit is payable after you meet your deductible and is subject to the Coinsurance amount.

OUT-OF-POCKET MAXIMUM

The Plan limits the amount you pay out-of-pocket in a calendar year toward Covered Medical Expenses provided by PPO Providers related to deductibles, coinsurance, or copayments during a Plan Year. After you satisfy the annual deductible and any Coinsurance or Copayment amounts not paid by the Plan (as specified on the *Schedule of Benefits*, on page 2), the Plan will pay 100% of any additional PPO Provider Covered Medical Expenses you incur for the remainder of the calendar year. This limit never includes premiums, or health care the Plan does not cover. The amount of the annual out-of-pocket limits for Covered Medical Expenses and for the prescription drug benefit are shown in the *Schedule of Benefits* beginning on page 2.

The Plan will apply the individual Out-of-Pocket Maximum to each individual member of your family. This means that you or your family members will never have to pay more than the individual Out-of-Pocket Maximum specified in the *Schedule of Benefits* on page 2, even if the family Out-of-Pocket Maximum has not yet been met.

The Out-of-Pocket Maximum amounts for the Comprehensive Medical Benefits and for the Prescription Drug Benefits are separate. The Comprehensive Medical Benefits Out-of-Pocket Maximum does not include Prescription Drug Benefits, and the Prescription Drug Benefits Out-of-Pocket Maximum does not include Comprehensive Medical Benefits.

After you satisfy the Out-of-Pocket Maximum as specified in the *Schedule of Benefits*, the Plan will pay 100% of any additional PPO Provider Covered Medical Expenses and Emergency Care you may incur for the remainder of the calendar year.

Expenses Not Subject to the Out-Of-Pocket Maximum

Certain expenses do not apply toward your annual Out-of-Pocket Maximum:

- Non-PPO provider (Physician and facility) charges, except for Emergency Medical Care;
- Charges in excess of Medicare's 100 % allowance for Non-PPO;
- Charges for failure to comply with Utilization Management and MAP procedures when required; and
- Expenses not considered Covered Medical Expenses.

MAXIMIZING YOUR HEALTH CARE BENEFITS

The Plan has cost management programs designed to help manage certain health care costs:

- BlueCross BlueShield of Illinois Preferred Provider Organization (PPO), for medical providers;
- Med-Care Management Utilization Management (UM) Program, for medical preadmission, concurrent, and ongoing review services and preauthorization; and
- Med-Care Living Well with Diabetes Program, for education and information about living with diabetes.

To contact:

- BlueCross BlueShield of Illinois, call (800) 810-2583.
- Med-Care Management Utilization Management Program, call (800) 441-7705.
- Med-Care Management Living Well with Diabetes Program, call (866) 844-4222.

Preferred Provider Organization (PPO)

The Plan offers a Preferred Provider Organization (PPO) through BlueCross BlueShield of Illinois (BCBSIL). When you use a PPO Provider, you save money for yourself and the Plan because BCBSIL has an agreement with providers that participate in their network (PPO Providers) to charge a negotiated dollar amount. Contact BCBSIL at (800) 810-2583 to see if your Physician is a participating provider. The Plan for Retired Employees does not provide benefits for treatment or services received from a non-PPO provider unless you do not have access to a PPO provider within 30 miles of your home. This means you pay 100% of the cost for treatment or services received from a non-PPO provider.

PPO

- A network of providers that have agreed to charge negotiated rates. Since PPO Providers have agreed to these negotiated rates, you help control health care costs for you and the Plan when you use PPO Providers.
- It is your decision whether to use a PPO Provider. You always have the final say about the Physicians and Hospitals you and your family use.

PPO Provider Example		
Let's compare what John pays when using a PPO Hospital versus a non-PPO Hospital. John has satisfied his annual deductible.		
	PPO Hospital*	***Non-PPO Hospital***
Expenses Charged for a 2-day Hospital Stay	$5,000	$8,400
Plan Pays	$4,250 (85%)	$0 (0%)
John Pays	$750 (15%)	$8,400 (100%)
John saves $7,650 by using a PPO Hospital.		

* This example assumes a PPO savings rate of approximately 40%. The actual savings may vary depending on the actual Hospital confinement.

BlueCard Program

The BlueCard Preferred Provider Organization (PPO) Program gives you access to BlueCross BlueShield network providers throughout the country. This means that if you travel or reside outside the Illinois area and visit a participating BlueCard Physician or Hospital, your Plan pays most Covered Expenses at the PPO Provider rate (after you meet your annual deductible). To locate a participating provider, call BlueCard Access at 1-800-810-BLUE (2583) or visit www.bcbs.com.

Utilization Management (UM) Program

The Plan offers a Utilization Management (UM) Program through Med-Care Management (Med-Care). The Med-Care UM Program specializes in helping you receive quality medical treatment and, at the same time, helps you maximize your Plan's medical benefits. The UM Program consists of, but is not limited to:

- ***Preadmission Review:*** You or your Physician must notify Med-Care whenever you or your covered Dependent must undergo inpatient treatment. Call as soon as possible after your Physician recommends a Hospital stay. Med-Care evaluates whether the Hospital is the place you should be and, if it is, how long you can expect to be there. Sometimes Med-Care may suggest that you have certain diagnostic tests done on an outpatient basis before your admission. In the case of an Emergency admission, Med-Care must be notified by the next business day after the Emergency.
- ***Concurrent Review:*** Once you are admitted to a Hospital, Med-Care monitors your Hospital stay. If additional days are required because of complications or other medical reasons, your stay will be recertified for the appropriate number of additional days of inpatient care.
- ***Ongoing Review:*** In the event that you need ongoing care, a Med-Care representative will assist you in reviewing home health care, Hospice care, or the rental or purchase of Durable Medical Equipment.

MAKE THE CALL!

Call Med-Care at (800) 441-7705.

If your Physician recommends certain medical care, you must call Med-Care to preauthorize care. If you do not make this call, the benefits payable by the Plan will be reduced or denied.

If you receive Emergency Medical Care, you or a family member must call Med-Care by the next business day after the Emergency. Otherwise, the benefits payable by the Plan will be reduced or denied.

If your Physician recommends any of the following, you must call Med-Care to have your care preauthorized. If you do not preauthorize your care, the benefits payable by the Plan will be reduced as follows:

Type of Care/Service	Penalty Amount
Hospital Confinement, Extended Care or Skilled Nursing Care Facility Stay, Surgery, Home Health Care, Hospice Care	$600 per occurrence
Physical, Occupational, and/or Speech Therapy, Amniocentesis, Bone Scans, Endoscopy, Coronary Angiogram, CT Scan, Echocardiogram, Holter Monitor, Magnetic Resonance Imaging (MRI), Myelogram, RAST/MAST Allergy Testing, Durable Medical Equipment, Functional Capacity Tests for a non-occupational Injury/illness, Orthotics, Neuropsychological Testing, Genetic Testing/Studies	50% of eligible charges
Bariatric Surgery	Non-payment of Claim

These penalty amounts are in addition to any deductible or copayment amounts that you are responsible for paying, provided the services/treatments received are Medically Necessary and not otherwise excluded under the Plan.

As part of the UM services, Med-Care also provides participants of the Fund with access to the Living Well with Diabetes Program.

Living Well with the Diabetes Management Program

Having diabetes or having a family member with diabetes can be difficult and lead to serious complications if the disease is not appropriately managed. For this reason, the Fund provides you with access to Med-Care Management's Living Well with Diabetes Program. This voluntary program is available at no cost to you.

To Enroll For the Living Well with Diabetes Program

Simply call the program at (866) 844-4222. A nurse will enroll you in the Program and help you or your Eligible Dependent start the way to a healthier future.

The Living Well with Diabetes Program, which is administered by Med-Care Management, provides information about diabetes to you and/or a diabetic covered family member. This Program allows you and your family to learn self-management tools that can help you avoid acute flare-ups and long-term complications of the disease.

The goals of the Program are to:

- Increase the quality of life;
- Increase quality of time with family;
- Reduce your out-of-pocket costs;
- Reduce time out of school; and
- Make every day better and healthier.

All you or your Eligible Dependent need to do to take advantage of this voluntary program is call (866) 844-4222. A nurse representative will walk you through the enrollment process. Once you enroll, your nurse will call you and ask you a series of questions about your diabetes and overall health. The nurse may recommend one or more visits by a nurse to your home to continue discussions about your diabetes and its management. The nurse, who will be your personal contact to call if you have questions, will contact you on a regular basis to see how you are doing and will work with your Physician to help you better manage your diabetes.

In addition to having access to your nurse at the toll-free number any time you have questions or concerns, you will be sent information about diabetes and important aspects of diabetes control such as diet, blood glucose monitoring, exercise, and what to do when you are ill.

COVERED COMPREHENSIVE MEDICAL BENEFIT EXPENSES

Covered Medical Expenses include the Eligible Expense for the following services and supplies when Medically Necessary to treat a non-occupational bodily Injury or sickness covered under the Plan.

Hospital Benefit

The Plan covers daily room and board and ancillary service charges for a semiprivate or a private room for contagious or communicable diseases, intensive care units, and outpatient services.

Maternity Benefit

The Plan covers services and supplies for pregnancy and pregnancy-related conditions for you or your Dependent spouse. Coverage of childbirth is excluded for a dependent child. Covered items include (but are not limited to):

> If you have any questions about your medical benefits, contact the Fund Office at (312) 738-2811 and ask to speak to your benefit representative.

> You are not required to have a referral or prior authorization to obtain obstetrical or gynecological care.

- In-Hospital charges;
- If you have any questions about your medical benefits, contact the Fund Office at (312) 738-2811 and ask to speak to your benefit representative.
- Physicians' delivery fees;
- Prenatal laboratory and x-ray examinations;
- Home birth delivery by a qualified professional under the supervision or direction of a Physician;
- Sonograms and ultrasound testing;
- Prenatal Office Visits;
- You are not required to have a referral or prior authorization to obtain obstetrical or gynecological care.
- Anesthesia and its administration;
- Nursery charges for newborn children; and
- Services and supplies provided for care of a well newborn while the mother is Hospital confined (including inpatient charges, circumcision, and Physicians' visits).

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

Physician Services Benefit

Covered Physician services (either in or out of a Hospital) include:

> For Physician Services to be a Covered Expense, there must be direct personal contact. For example, a phone consultation or e-mail is not considered a Covered Expense.

- Surgical procedures;
- Anesthesia;
- Oncology;
- Radiology;
- Pathology;
- Medical care and treatment; and
- Medically Necessary assistant surgeon's and/or licensed Certified Surgical Assistant's (CSA) services, limited to a maximum payment of 25% of the Eligible Medical Expenses payable to the surgeon.

Surgical Benefit

If you or your covered Dependent needs to have Surgery, you must call Utilization Management to preauthorize any treatment. *If you do not preauthorize your treatment, you may have to pay a penalty.* Surgical benefits include the following:

- Second surgical opinions;
- Services and supplies provided in an outpatient surgical facility, Hospital outpatient department, Physician's office, clinic, or elsewhere because of a surgical procedure performed other than in a Hospital;
- Elective Surgeries only applicable to the Participant and their spouse: vasectomy, tubal ligations or salpingectomy surgical procedures performed for sterilization purposes, provided the procedure is performed by a legally qualified Physician or Surgeon; abortions when legal in the state where performed; and
- Benefits for reconstructive breast Surgery following a mastectomy are provided on the same basis as other surgical procedures covered by the Plan and include:
  - Reconstruction of the breast on which a mastectomy is performed;
  - Reconstructive Surgery on the other breast to produce a symmetrical appearance;
  - Prostheses (breast); and
  - Physical complications of any stage of mastectomy, including lymphedemas.

Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive Surgery, as described above.

Dental Treatment When Covered as Medical Benefit

The Plan covers treatment of Injury to the jaw or to sound natural teeth, including the initial replacement of such teeth and any necessary dental x-rays, provided the initial treatment is received within 48 hours of the Injury and any subsequent follow-up care is received within 12 months of the date of the Injury. Any dental restoration is not covered under this benefit.

> Sound natural teeth are virgin teeth that are healthy and exhibit no need for dental restoration and/or were not previously restored.

In the event treatment of the Injury exceeds the 12-month period, coverage may be extended for an additional six months (for a total of 18 months) if medical evidence, satisfactory to the Trustees, is furnished showing that the delay in treatment was due to:

- Damage to nerves in the oral cavity suffered at the time of the Injury, that required time to heal or regenerate;
- Care of a fractured jaw or jaws that required immobilization of the bone structure that prevented other treatment;
- Additional time required for stabilization of the Injury;
- In the case of a dependent child, allowance for the normal, growth process; or
- A delay in the healing process that can be demonstrated by an x-ray.

Preadmission Testing Benefit

The Plan covers x-ray examinations and/or laboratory tests made before a Hospital admission. Payment is made if the:

- Tests are ordered by the attending Physician or surgeon;
- Tests are performed in the outpatient department of the Hospital to which you are being admitted;
- Hospital confinement is scheduled to begin within 48 hours after the tests are performed; and
- Tests are medically valid at the time of the Hospital admission.

No payments will be made for charges incurred for diagnoses, research, or survey purposes.

Physical Therapy Benefit

Physical Therapy provided by a Physician or a registered Physical Therapist under the direction of a licensed Physician is covered provided:

- There is an active written treatment regimen designed by the Physician that is regularly reviewed by the Physician and registered Physical Therapist;
- It is of a level of complexity that the judgment, knowledge, and skills of a qualified Physical Therapist are required and a qualified Physical Therapist renders such services;
- Services are provided with the expectation based on the Physician's assessment of the patient's restorative potential, that the patient will improve significantly in a reasonable, generally predictable, period; and
- Services are reasonable and Medically Necessary to the treatment of the condition and considered to be within the accepted standards of medical practice as specific and effective treatment for the patient's condition.

Physical Therapy benefits do not include chiropractic, osteopathic manipulations, massage therapy, or services provided by assistant therapists, or athletic/sports trainers.

Transportation Services Benefit

The following transportation services, provided within the United States, are covered:

- Emergency local transportation by a professional ambulance service, limited to the first trip to a Hospital for any one sickness or for all injuries sustained in any one incident; or
- Air or ground ambulance transportation if a Physician certifies that an individual's life is endangered or the disability requires specialized or unique treatment that is not available in a local Hospital.

Speech Therapy Benefit

The Plan covers services of a qualified registered Speech Therapist for Speech Therapy to restore speech loss or to correct an impairment due to a Congenital Defect for which corrective Surgery has been performed or due to any Injury or sickness. The treatment may be in or out of a Hospital but must be prescribed and recommended by the attending Physician. Benefits do not include Speech Therapy for the correction of a developmental delay. However, please note that some treatment for developmental delays, such as speech articulation and speech problems, may be available from public agencies.

Medical Supplies

Whole blood (if not replaced or donated) or blood plasma and its administration.

Surgical supplies including appliances for the initial replacement of physical organs or parts of organs. This includes artificial limbs, eyes, and larynxes. Subsequent expenses for such artificial limbs or eyes are subject to the following guidelines:

- Coverage is provided for a replacement prosthetic device for children up to age 18 when replacement is necessary due to growth of the child and is Medically Necessary as determined by the Physician.
- Coverage is provided for total replacement of such prosthetic device for adults, provided that five years have elapsed since the previous device was purchased. This replacement also must be Medically Necessary as determined by the Physician.
- Replacement because of damage, as might occur in an accident, is covered when Medically Necessary as determined by the Physician. Payment for repair or replacement may be contingent upon any third-party insurance that is liable for payments under the Plan's Subrogation and Reimbursement provisions.
- Oxygen and the rental of the equipment for the administration of oxygen.
- Rental of Durable Medical Equipment, unless purchase is determined to be more cost effective by the Plan Administrator. Durable Medical Equipment refers to multi-use equipment ordered by a Physician that is available for rent.
- Casts, splints, braces, and crutches.
- Medically Necessary orthotics, once in any 36-month period.
- Compression (JOB) stockings to prevent blood clots or treat varicose veins, once in any 12-month period.
- Original breast prosthetics and replacement prosthetics, once in any 24-month period.
- Post mastectomy surgical bra when no surgical reconstruction has occurred, once in any 24-month period.

Chiropractic Benefit

Active or corrective therapy to treat acute or chronic subluxation of the back, neck, spine, and vertebra due to strains, sprains, and nerve root problems of the back, up to the limitations indicated on the *Schedule of Benefits* (on page 2). This benefit does not cover x-rays, massage therapy, or MRIs ordered or performed by a chiropractor.

Additional Covered Services

- Services and supplies provided in an approved Ambulatory Surgical Facility, Emergency Treatment Center, Hospital Emergency room, or outpatient department for Emergency treatment of an Injury.
- X-ray examinations, laboratory examinations, tests, or analyses made for diagnostic or treatment purposes.
- X-ray, radon, radium, and radioactive isotope treatments.
- Nuclear medical tests, such as an MRI, CAT, or PET scan.
- Anesthetics and their administration.
- Chemotherapy – oncology.

> In the event that you are admitted to a Hospital after Emergency treatment, benefits are covered under the Plan's Hospital coverage for Room and Board Charges. However, remember that preauthorization is required or benefits will be reduced.

- Occupational Therapy provided by a registered Occupational Therapist when recommended by and provided under the direct supervision of a Physician due to a non-occupational Injury or sickness (supplies are not covered).
- Elective abortions are covered if performed on you or your Dependent spouse only. Services and supplies must be Medically Necessary services and rendered by a Hospital or by a clinic that is licensed by the state in which it is located to perform such services.

Home Health Care

Medically Necessary home health care services rendered in your home are covered if the Home Health Agency is licensed by the state, primarily engaged in providing skilled nursing care in patients' homes, operates under professionally developed policies and under the supervision of a Physician or registered nurse, and eligible for Medicare payments.

Home health care expenses are subject to the following provisions:

- The plan of home nursing care must be established and approved in writing by the patient's Physician within seven days following termination of an inpatient Hospital confinement; and
- The Physician must certify that the care is for the same or related condition for which the patient was hospitalized and that proper treatment of the patient's condition would require Hospital confinement in the absence of the services and supplies provided as part of the home plan of care.

Covered Medical Expenses include the following services and supplies, provided such services and supplies are provided by or through an organization that meets the Plan's definition of a Home Health Agency:

- Part-time or intermittent nursing care provided by or under the supervision of a professional registered nurse (services of an RN or LPN are covered if the patient's condition requires the professional services of a trained nurse);
- Part-time or intermittent home health aide services (home health aide services do not include Custodial Care);
- Medical supplies (other than drugs and biologicals) and the use of medical appliances;
- Medical services of interns and residents in training under an approved teaching program of a Hospital with which the Home Health Agency is affiliated; and
- Nursing Facility under arrangements made by the Home Health Agency and that involve the use of equipment that is not readily available to the individual in the individual's place of residence or that are furnished at such facility to which the individual has gone to receive any item or service involved in the use of such equipment (excluding transportation).

Hospice Care

The Hospice Care Program is a special program provided for individuals with terminal medical conditions. The program provides a system of care that allows a terminal individual to continue life with minimal disruption in normal activities while remaining primarily in the home environment. The program provides services and supplies that are not normally considered Covered Medical Expenses under the Plan.

An individual is considered terminal if a Physician certifies within two days after the individual begins Hospice care that the medical condition and prognosis indicates a life expectancy of six months or less. If an individual is using a Hospice Physician as the primary Physician, only one certification is required; if the individual is using a personal Physician as well as a Hospice Physician, both Physicians must certify the diagnosis.

A terminal individual who wishes to use the Hospice Care Program must elect to use the Hospice Care Program for care of his condition in lieu of receiving benefits under the regular provisions of the Comprehensive Medical Benefit. The individual must:

- Elect, by filling in an election form provided by Utilization Management, to receive Hospice care from a specific Hospice;
- Submit the election form through the Hospice *before* any Hospice care is provided; and
- Waive his/her right to payment of the regular benefits provided under the Comprehensive Medical Benefit for treatment of his terminal condition and agree to receive any and all treatment under the Hospice Care Program.

An individual may revoke his election to receive benefits under the Hospice Care Program at any time. If the individual does revoke his election, no further Hospice care will be provided to that individual under the Hospice Care Program and benefits for any further care and treatment of the individual's condition will be provided under the regular provisions of the Comprehensive Medical Benefit, subject to all applicable limitations and exclusions.

An individual who elects to receive treatment under the Hospice Care Program is entitled to Hospice care benefits during the remainder of his/her lifetime, subject to the applicable limitations specified on the *Schedule of Benefits* (on page 2) and Utilization Management review. Once the individual has received the maximum allowable amount of benefits under the Hospice Care Program, no further Hospice benefits will be payable on behalf of that individual. Any benefits for further care and treatment of the individual's condition will be provided under the regular provisions of the Comprehensive Medical Benefit, subject to all applicable limitations and exclusions.

Only expenses incurred for Hospice care of an individual's condition apply under the Hospice Care Program. If the individual incurs expenses for treatment of an Injury or sickness totally unrelated to the terminal condition, benefits will be provided for such expenses under the Plan's Comprehensive Medical Benefit provisions.

Expenses Covered Under the Hospice Care Program

- Nursing care by an RN or LPN and services of home health aides (such services may be furnished on a 24-hour basis during a period of crisis or if the care is necessary to maintain the individual at home).
- Medical social services.
- Counseling services and/or psychological therapy by a social worker or a Psychologist.
- Chaplaincy.
- Physical Therapy.
- Occupational Therapy.
- Speech language pathology.
- Non-prescription drugs utilized for palliative care.
- Medical supplies, bandages, equipment, drugs, and biologicals used for pain and symptom control.
- Skilled Nursing Facility short-term inpatient care to provide respite care, palliative care, or care in periods of crisis.

Expenses Not Covered Under the Hospice Care Program

- Bereavement counseling (counseling services provided to a terminally ill individual's family after the individual's death).
- Long-term inpatient care.
- Administrative services.
- Childcare and/or housekeeping services.
- Transportation (except in Emergencies).
- Surgical operations or Hospital confinements due to medical complications of the terminal condition (benefits for such services and supplies are payable under the regular provisions of the Comprehensive Medical Benefit).

Any services or supplies not provided as core services by the Hospice providing the Hospice care.

Skilled Nursing Facility Care

Services and supplies provided during an approved confinement in a Skilled Nursing Facility are covered under the Plan for up to 90 days per calendar year. The Skilled Nursing Facility must be a licensed institution that:

- Has a transfer agreement with a Hospital;
- Provides 24-hour inpatient nursing care under the supervision of a Physician or registered nurse;
- Is eligible for Medicare payments; and
- Every patient must be under the supervision of a Physician.

An approved confinement is one where the:

- Attending Physician certifies that such confinement and nursing care is essential for recuperation from an Injury or sickness and that it is not, other than incidentally, for Custodial Care;
- Confinement is preceded by at least three consecutive days of a Hospital confinement for which Plan benefits are payable;
- Confinement is due to an Injury or sickness that required the previous Hospital confinement;
- Confinement commences within three days after termination of a Hospital confinement or within three days after termination of a Skilled Nursing Facility confinement for which Plan benefits are payable; and
- Attending Physician continues to treat the individual and personally see the individual at least once each seven days and certifies that continuation of confinement is necessary for continued treatment of the Injury or sickness.

Bariatric Surgery

The following bariatric surgeries are covered for you and your spouse only:

- Roux en Y bypass
- Adjustable Silicone Gastric Banding
- Sleeve Gastrectomy; and
- Vertical Banded Gastroplasty.

You must obtain pre-authorization and certification for any bariatric surgery for you or your spouse. If you fail to pre-authorize or if it's not medically necessary, you will be responsible for the entire amount of the claim.

For you or your spouse to qualify for the surgery, a Physician must certify the bariatric surgery benefit based on the following criteria:

- Body mass index (a minimum BMI of 35);
- Serious co-morbidities (such as diabetes);
- Documented attempts at weight loss overseen by a Physician for at least a six-month period;
- Age (between 18 and 60 years old);
- A psychiatric evaluation; and
- Treatment must be at a Blue Cross Center of Distinction Hospital for Bariatric Surgery.

This surgery is only available once per lifetime, and it includes the bariatric surgery, appropriate counseling and any corrective follow-up concerning the same surgery. If the procedure is approved, the bariatric surgery benefit will be paid at a 75% co-insurance rate and subject to the calendar year deductible and the in-network out-of-pocket limits.

The following items are not covered:

- Other bariatric surgeries not explicitly named in this document or other procedures relating to weight reduction, including but not limited to, excess skin removal;
- Any surgery, treatment, or service to transition from one bariatric surgery benefit to another (such as, changing from adjustable silicone gastric banding to sleeve gastrectomy); and
- Coverage for complications from a procedure that did not follow appropriate guidelines.

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

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). Coverage is provided on an in-network basis only, with no cost-sharing (for example, no deductibles, coinsurance, or copayments), for the following services:

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

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

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

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

Preventive Services Benefit Overview

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

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

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

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

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

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

The Plan also covers the immunization of girls and young women, ages 13 to 33, and boys ages 11 and 12, to prevent the human papillomavirus (HPV), a virus that can cause cervical cancer and other diseases.

Please note that Well-Child Required Immunization charges will be reimbursed when the service is rendered by a local Public Health Department but only after proof of payment is submitted to the Fund Office.

Non-preventive Services are not covered without Cost-Sharing: The plan will impose cost-sharing for treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

Preventive Services for Dependents: All covered participants and dependents are eligible to obtain, without cost sharing, all required in-network preventive services applicable to them (e.g., for their age group). This includes ACA-required pregnancy-related preventive services and well woman visits, which must be provided to dependent children (up to age 26) where an attending provider determines that the services are age and developmentally appropriate.

Preventive Services Under the Affordable Care Act ("ACA")

The Plan covers certain Preventive Services required by ACA. Coverage of these services is provided by PPO providers only, with no cost-sharing (e.g., no deductibles, coinsurance, or copayments), for the following services:

1. Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations;
2. Services described in the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC);
3. Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics Bright Futures guidelines; and
4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by you or your Dependent. This means that the service will be covered at

100% of the Plan's allowable charge, with no coinsurance, copay, or deductible. If you receive preventive services from a non-PPO provider, you will not be eligible for coverage under this Preventive Services benefit.

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

Covered Preventive Services for Adults

1. Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.
2. Alcohol Misuse screening and counseling: screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
3. Aspirin to prevent cardiovascular disease when prescribed by a health care provider. A prescription must be submitted in accordance with plan rules.
4. Blood Pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a Physician visit.
5. Cholesterol screening (Lipid Disorders Screening) for men aged 35 and older and women aged 45 and older; men aged 20 to 35 if they are at increased risk for coronary heart disease; and women aged 20 to 45 if they are at increased risk for coronary heart disease.
6. Colorectal Cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The Plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The Plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.
7. Depression screening for adults.
8. Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
9. Diet counseling for adults at higher risk for chronic disease.
10. HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.
11. Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher.
12. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
13. Tobacco Use screening for all adults and cessation interventions for tobacco users.
14. Syphilis screening for all adults at increased risk of infection.
15. Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.
16. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.
17. Screening for hepatitis B virus infection in adults at high risk for infection.

Covered Preventive Services for Women, Including Pregnant Women

1. Well woman office visits for women ages 21 to 64, for the delivery of required preventive services.
2. Anemia screening on a routine basis for pregnant women.
3. Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
4. BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal, or peritoneal cancer.
5. Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.
6. Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by Physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. The Plan will also pay for risk-reducing medications (such as tamoxifen or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.
7. Comprehensive lactation support and counseling by a trained provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the Plan Administrator.
8. Cervical Cancer screening for women ages 21 to 65 with Pap smear every three years.
9. Human papillomavirus testing for women ages 30 and older with normal Pap smear results, once every three years as part of a well woman visit.
10. Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
11. FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.
12. Folic Acid supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only if the woman obtains a prescription.
13. Gonorrhea screening for all sexually active women age 24 and younger and in older women who are at increased risk for infection, provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.
14. Counseling for sexually transmitted infections, once per year as part of a well woman visit.

15. Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.
16. Hepatitis B screening for pregnant women at their first prenatal visit.
17. Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Younger women will be eligible for screening if their risk of fracture is equal to or greater than that of a 65-year old woman. The Plan will pay for the most cost-effective test methodology only.
18. Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
19. Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.
20. Tobacco Use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users.
21. Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.
22. Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.

Covered Preventive Services for Children

1. Well baby and well child visits from age newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:
   - Developmental screening for children under age 3, and surveillance throughout childhood.
   - Behavioral assessments for children of all ages.
   - Medical history.
   - Blood pressure screening.
   - Depression screening for adolescents ages 11 and older.
   - Vision screening
   - Hearing screening.
   - Height, Weight and Body Mass Index measurements for children.
   - Autism screening for children at 18, and 24 months.
   - Alcohol and Drug Use assessments for adolescents.
   - Critical congenital heart defect screening in newborns.
   - Hematocrit or Hemoglobin screening for children.
   - Lead screening for children at risk of exposure.
   - Tuberculin testing for children at higher risk of tuberculosis.
   - Dyslipidemia screening for children at higher risk of lipid disorders.
   - Sexually Transmitted Infection (STI) prevention counseling for sexually active adolescents.
   - Cervical Dysplasia screening at age 21.
   - Oral Health risk assessment.
2. Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).

3. Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.
4. Oral fluoride supplementation at recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.
5. Iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. Over-the-counter supplements are covered only with a prescription.
6. Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
7. HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.

Immunizations

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

Immunization vaccines for adults--doses, recommended ages, and recommended populations must be satisfied:

- Diphtheria/tetanus/pertussis (DTP).
- Measles/mumps/rubella (MMR).
- Influenza.
- Human papillomavirus (HPV).
- Pneumococcal (polysaccharide).
- Zoster.
- Hepatitis A.
- Hepatitis B.
- Meningococca.
- Varicella.

Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied:

- Hepatitis B.
- Rotavirus.
- Diphtheria, Tetanus, Pertussis.
- Haemophilus influenzae type b.
- Pneumococcal.
- Inactivated Poliovirus.
- Influenza.
- Measles, Mumps, Rubella.
- Varicella.
- Hepatitis A.
- Meningococcal.
- Human papillomavirus (HPV).

Office Visit Coverage

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

If a preventive item or service is billed separately from an office visit that is not part of a physical exam, then the Plan will impose cost sharing with respect to the office visit.

If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.

If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

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

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as Preventive Services and paid at 100%. Well woman visits are also treated as Preventive Services and paid at 100%.

Preventive Services Coverage Limitations and Exclusions

1. Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable Plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the Participant or Dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.
2. Services covered under the Preventive Services Benefit are not also payable under other portions of the Plan.
3. The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.
4. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered.
5. Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.

6. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
   - When required for travel, insurance, marriage, adoption, or other non-medical purposes;
   - When related to judicial or administrative proceedings;
   - When related to medical research or trials; or
   - When required to maintain employment or a license of any kind (except for Department of Transportation exams and required tests).
7. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.

Approved Clinical Trials

Covered Expenses include:

- Charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are those that are:
  1. Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if the individual were not participating in the Approved Clinical Trial; and
  2. Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

  A Participant or Dependent is eligible for payment of charges related to participation in an Approved Clinical Trial if he or she:

  1. Satisfies the protocol prescribed by the Approved Clinical Trial provider; and
  2. Either:
     a. The individual's network participating provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or
     b. The individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

  For the purposes of this provision, an Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA); (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Excluded Expenses include:

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

Expenses Not Covered Under Comprehensive Medical Benefit

Benefits are only paid for eligible, Medically Necessary expenses incurred as the result of care and treatment provided to you or your Eligible Dependent as the result of a non-occupational bodily Injury or Sickness, unless otherwise specified as covered.

The exclusions listed below are not all-inclusive, only representative of the type of charges for which benefits are limited or not payable under the Plan. Just because a service or supply is not listed as an exclusion does not mean it is a Covered Expense. Only benefits listed as covered are considered Covered Expenses under the Plan. In addition, benefits are not payable for amounts in excess of allowable expenses as defined by the Plan.

The Plan will not provide coverage for the following charges:

1. Any care, treatment, service, surgical procedure, supply, or Hospital confinement that, upon review by the Trustees, is not Medically Necessary.
2. Any Injury or sickness for which an individual is not under the regular care of a Physician or, when provided otherwise by the Plan, a licensed professional health care provider.
3. Any care, treatment, service, surgical procedure, supply, or hospital confinement that is rendered by or received from or on the recommendation of a physician who does not meet the Plan's definition of a Physician or that is received from or in a hospital that does not meet the Plan's definition of a Hospital.
4. Any care, treatment, service, surgical procedure, supply, or Hospital confinement that is not recommended or approved by the attending Physician.
5. Any care, treatment, service, surgical procedure, supply, or Hospital confinement that is not rendered for the treatment or correction of, or in connection with, a specific non-occupational bodily Injury, sickness, or Congenital Defect unless specifically identified as being covered under the Plan.

   But note: This exclusion does not apply to routine medical care of a well newborn child during the mother's confinement if the child is the Dependent of a Retired Employee and is born while the Retired Employee is eligible for Plan benefits. In addition, this exclusion does not apply to physical, vision, and hearing examinations that are required by the Department of Transportation.

   > **Congenital Defect**
   >
   > A Congenital Defect is generally considered a deformity present at birth that impairs bodily function.

6. Care or treatment of an Eligible Retired Employee or Dependent where the person providing the care or treatment is related by blood or marriage to the Retired Employee or Dependent or who ordinarily lives in the Retired Employee's or Dependent's home.
7. Education, training, or Room and Board Charges while the individual is confined in an institution that is primarily a school or institution of learning or training.

8. Physical Therapy, Speech Therapy, or any other type of therapy if either the prognosis or history of the individual receiving the treatment or therapy does not indicate to the Trustees that there is a reasonable chance of improvement or that is deemed by the Trustees to be Maintenance Care. This includes Speech Therapy due to developmental delay.
9. Charges incurred while an individual is confined in an institution that is primarily a place of rest, place for the aged, or nursing home (other than a Skilled Nursing Facility).
10. Charges incurred as the result of any bodily Injury, sickness, or disease sustained while performing any act of employment, doing anything pertaining to any occupation or employment for remuneration or profit, or for which benefits are or may be payable in whole or in part under any workers' compensation, employer liability, occupational disease, or similar law whether or not such benefits are claimed or received.
11. Services rendered while confined in a Hospital operated by the U.S. Government or an agency of the U.S. Government or, with respect to a Hospital confinement in any other Hospital, for charges that the individual is not required to make payment.
12. Charges incurred by or on account of a Dependent for any medical expense during or in connection with a period of Hospital confinement before the date the Dependent becomes covered under the Plan.
13. Travel charges, whether or not recommended by a Physician, unless otherwise specified as covered under the Plan.
14. Patent medicines or other drugs or medicines that can be obtained without a Physician's prescription.
15. Treatment of chemical dependency (i.e., alcoholism and/or drug abuse) in a treatment facility that does not meet this Plan's definition of a Treatment Facility for Chemical Dependency.
16. Treatment for being overweight or obese, except as specifically covered under the Bariatric Surgery Benefit. The following items are **not** covered under the Bariatric Surgery Benefit:
    - Other bariatric surgeries not explicitly named in this document or other procedures relating to weight reduction, including, but not limited to, excess skin removal;
    - Any surgery, treatment, or service to transition from one bariatric surgery benefit to another (such as, changing from adjustable silicone gastric banding to sleeve gastrectomy); and
    - Coverage for complications from a procedure that did not follow appropriate guidelines.
17. Charges as a result of an abortion, pregnancy, or a pregnancy-related condition of any individual other than a female Retired Employee or the Dependent spouse of a Retired Employee. This item 17 does not apply to a Dependent child solely for the purposes of the Preventive Services provided in this Plan.
18. Any treatment, service, supply, Hospital confinement, or surgical procedure that is of an elective nature, including any non-Emergency plastic or cosmetic Surgery on the body (including but not limited to such areas as the eyelids, nose, face, breasts, or abdominal tissue). This does not apply to:
    - Cosmetic Surgery performed for the correction of defects incurred through traumatic injuries sustained by an individual because of an accident while covered under the Plan.
    - Correction of a Congenital Defect.
    - Corrective surgical procedures on organs of the body that perform or function improperly.
    - Voluntary vasectomies and other sterilization procedures performed on a Retired Employee or Dependent spouse of a Retired Employee.
    - Reconstructive breast Surgery following a mastectomy and Surgery and reconstruction of the other breast to produce a symmetrical appearance.

19. Reversal of, or attempts to reverse, a previous elective sterilization, such as but not limited to vasectomy or tubal ligation.
20. Hormone therapy, artificial insemination, or any other direct attempt to induce or facilitate fertility or conception.
21. Consultations and sessions with other family members, even if such consultations and sessions are required as part of a psychological or psychiatric treatment.
22. Treatment or consultation with a naprapath, naturopath, or homeopath.
23. Any operation or treatment in connection with sex transformations.
24. Acupuncture.
25. Confinement in a facility providing nursing services unless the facility meets the Plan's definition of a Skilled Nursing Facility and the confinement meets the criteria for an approved confinement as specified by the Plan.
26. Home nursing care program unless the nursing care is provided through a provider that meets this Plan's definition of a Home Health Agency.
27. Hospice care other than as specified by the Plan.
28. Any treatments, services, or supplies furnished or provided by a clinic, center, or other provider for helping individuals to stop smoking, except as provided by the Preventive Services Benefit.
29. Any treatments, care, procedures, Hospital confinements, services, or supplies in excess of any limitations or maximum benefits specified by the Plan.
30. Surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, radial keratotomy (RK), anterior lens keratotomy (ALK), and laser in situ keratomileusis (LASIK). While these expenses are not covered by the Plan, the Fund has contracted with QualSight to provide discounts if you use the QualSight Lasik Surgery Network.
31. Dental implants or charges relating to pre-implant Surgery or any Surgery to facilitate dental implants.
32. Personal hygiene, comfort, and convenience items or items commonly used for other than medical purposes, such as but not limited to air conditioners, humidifiers, air purifiers, physical fitness equipment, televisions, telephones, etc.
33. Treatment of injuries sustained while committing any illegal or criminal activities.
34. Treatment of injuries sustained while piloting a glider, ultra-light, or experimental aircraft, hang gliding, skydiving, or bungee jumping.
35. Massage therapy.
36. Custodial Care, domiciliary care, or respite care, unless specified otherwise by the Plan.
37. Treatment of impotence when there is not a diagnosed underlying medical cause for sexual dysfunction.
38. Pharmacological regimens or nutritional procedures or treatments.
39. Sclerotherapy, except when performed in lieu of other, more invasive Surgery for a non-cosmetic purpose.
40. Weight loss programs, exercise programs, fitness instruction, water exercises, educational instruction and training programs, supplemental instructions for lifestyle changes and behavior modification, except for individual dietary consultation with a registered nutritionist when recommended by the attending Physician for treatment of a specific illness or condition.

41. Mechanical improvements to your dwelling or vehicle to accommodate life change requirements, such as ramps, elevators, lifts, special tubs, etc.
42. Medical expenses incurred that are payable by any automobile insurance or third party liability insurance, in accordance with the Plan's subrogation provisions.
43. Supportive devices such as orthotics, shoe inserts for flat foot conditions, orthopedic shoes, except Medically Necessary orthotics once in any 36-month period.
44. Medical care and treatment received outside the United States and its territories and possessions, unless a true life threatening medical Emergency exists.
45. Surgical support stockings or any other similar stockings, except compression (JOB) stockings once in any 12 month-period.
46. Wigs or cranial prosthesis.
47. Neuropsychological testing, unless preauthorized under the UM or MAP (depending on the diagnosis).
48. Genetic testing or any prophylactic treatment or Surgery, except those tests that are specifically listed or mandated by law to be covered.
49. Human Growth Hormone (HGH) therapy.
50. Functional capacity tests for occupationally related evaluations or when done solely for occupational evaluation without a preceding Injury or illness.
51. Special post-mastectomy prosthesis and bras when there was no surgical reconstruction, except for the original purchase and subsequent purchases once in any 24-month period.

PRESCRIPTION DRUG BENEFIT

Prescription drug benefits can play an important role in your overall health coverage. Recognizing the importance of this coverage, the Fund offers prescription drug benefits to you and your Eligible Dependents through CVS/caremark.

You do not need to satisfy the annual deductible before prescription drug benefits are payable under the Plan.

When you have a prescription filled, you pay less when you have it filled with a generic or formulary brand name medication.

HOW THE PRESCRIPTION DRUG PROGRAM WORKS

If you are having a long-term prescription filled for the first time, your first prescription may be filled for up to a 34-day supply at a retail pharmacy. After this, your prescription must be for a 90-day supply. This will give you the opportunity to use the medication first, to ensure the dosage is correct and the medication is effective before purchasing a long-term supply.

The Plan provides prescription drug benefits through CVS/caremark, including a:

- Retail pharmacy program for your short-term prescriptions (up to a 34-day supply);
- Retail pharmacy program for your long-term prescriptions (up to a 90-day supply);
- Mail order pharmacy service for your long-term prescriptions (up to a 90-day supply);
- Specialty pharmacy program for your specialty prescriptions (up to a 90-day supply).

CVS/CAREMARK RETAIL PHARMACY PROGRAM – 34-DAY SUPPLY OR 90-DAY SUPPLY

You can go to any CVS/caremark retail pharmacy to have your short-term prescriptions filled for up to a 34-day supply or to any CVS/pharmacy or the CVS Mail Service pharmacy for long-term prescription filled for up to a 90-day supply. The Fund has contracted with the CVS/caremark network of pharmacies (called network pharmacies) to provide prescription drugs at discounted prices.

When you have your prescription filled at a network pharmacy and present your CVS/caremark ID card, there are no Claims to file. Generally, when you pick up your prescription, you pay your Copayment for up to a 34-day supply or 90-day supply of your prescription at the time it is filled and the Plan pays the rest. The amount of Copayment, which is listed on the *Schedule of Benefits* (on page 2), depends on whether the prescription is filled with a generic, formulary brand name, non-formulary brand name or specialty medication and the amount prescribed by your Physician. The Copayment for the 90-day supply is less than three times the amount of Copayment for the 34-day supply.

For benefits to be payable under the CVS/caremark retail pharmacy program, you need to have your prescriptions filled at a CVS/caremark network pharmacy and present your CVS/caremark ID card. Prescriptions filled at a non-network pharmacy are not covered under the Plan.

Network Pharmacies

The CVS/caremark pharmacy network available to you includes most major chain pharmacy locations. Remember that prescriptions filled at a Walgreens, Wal-Mart or Sam's Club pharmacy are not covered under the Plan.

To find out if a particular pharmacy is in the network:

- Ask the pharmacy;
- Call CVS/caremark at (866) 818-6911; or
- Visit www.caremark.com.

If you have any questions regarding your prescription drug benefits or need to locate a network pharmacy near you, contact CVS/caremark at (866) 818-6911 or www.caremark.com.

MAINTENANCE CHOICE

With the CVS/caremark Maintenance Choice Program, you can get a 90-day supply of your medication filled at any CVS/pharmacy.

When you have a prescription filled through Maintenance Choice, you pay the Copayment amount for each 90-day supply. The amount of the Copayment, which is listed on the *Schedule of Benefits* (on page 2), depends on whether the prescription is filled with a generic, formulary brand name, non-formulary brand name or specialty medication.

> If you are taking a maintenance medication (a medicine you take for a chronic condition on an ongoing basis), you will only be allowed to fill one 34-day supply of that medication at a retail pharmacy. Thereafter, all prescriptions must be filled for a 90-day supply at a CVS/pharmacy through the Maintenance Choice Program or through the mail service pharmacy.

CVS/CAREMARK MAIL SERVICE PHARMACY

The CVS/caremark mail service pharmacy is also available to fill your long-term prescription needs. Long-term medications are those that you take on an ongoing basis, such as high blood pressure, arthritis, heart conditions, and diabetes medications.

Through mail service pharmacy, you can receive up to a 90-day supply (plus refills when appropriate) of your long-term medications delivered right to your home. When you have a prescription filled through the mail service pharmacy you pay the Copayment amount for each 90-day supply. The amount of Copayment, which is listed on the *Schedule of Benefits* (on page 2), depends on whether the prescription is filled with a generic, formulary brand name, or non-formulary brand name medication.

To get started with mail service or to print a mail service order form, visit www.caremark.com.

Filling Prescriptions

When you have a long-term prescription you want to fill, follow these steps:

- Ask your Physician for a written prescription for up to a 34-day supply that you can have filled at a retail pharmacy; and
- Then for a 90-day supply you can have filled at a CVS/pharmacy through the Maintenance Choice Program; or
- Through the mail service pharmacy, plus refills if appropriate.

> Have your Physician write two prescriptions – one for up to a 34-day supply to be filled at a network pharmacy and the second for up to a 90-day supply (plus refills if appropriate) to be filled at a CVS/pharmacy or to send to the mail service pharmacy.

Refilling Prescriptions

If your written prescription indicates that refills are available, you can refill your prescription at a CVS/pharmacy or through the CVS mail service pharmacy.

SPECIALTY PHARMACY PROGRAM

If you or your Dependent is undergoing treatment with specialty drug therapy, CVS/caremark offers a Specialty Pharmacy Program. Specialty drugs may be shipped to the location of choice (home, work, doctor's office, etc.) or may be picked up at CVS/pharmacy retail locations. Certain medications may require prior authorization. The Copayments are listed on the *Schedule of Benefits* on page 2. Specialty drugs share some of the following characteristics:

- High cost;
- Unique storage or shipping requirements;
- May require patient compliance and safety monitoring;
- Potential for significant waste due to the high costs; and
- Prescribed for complex conditions such as Hepatitis C, Multiple Sclerosis, Rheumatoid Arthritis, Cancer, as well as others.

If you need a Specialty medication, contact CVS/specialty at (800) 237-2767 or visit www.cvsspecialty.com at least seven days before your prescription is due for a refill.

Covered Prescription Drug Expenses

Covered Expenses include federal legend drugs that require a written prescription from a Physician or Dentist. A licensed pharmacist must dispense these prescriptions.

Generic Versus Brand Name Medications

Almost all prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. A generic drug is a copy of a brand-name drug that is no longer protected by a patent. A generic drug serves the same purpose as the original drug, but the generic's purchase price is less than the brand name. If you or your Dependent requests a Brand Name medication when a Generic substitute (equivalent) is readily available, you will be responsible for paying the higher Copayment amount plus the difference in cost between the Generic and Brand Name medication.

Expenses Not Covered Under Prescription Drug Benefit

Prescription drug benefits do not provide coverage for all products. Coverage is not provided for any drugs or medications that do not require a written prescription by a Physician or that do not have to be dispensed by a licensed pharmacist. In addition, some prescription drugs are not covered under the Plan. In general, these exclusions include, but are not limited to:

> Be sure to bring a copy of the CVS/caremark formulary with you when you go to your doctor's office. A formulary list can be obtained at www.caremark.com. When you or your Dependent needs a prescription, you may want to ask your doctor whether a Generic or preferred (formulary) medication is available. When you use Generics or preferred medications, you pay less.

1. Weight loss medications.
2. Dietary supplements.
3. Nicotine or anti-smoking products.
4. Cosmetic agents, hair growth or removal agents, bleaching agents, as well as others.
5. Fertility drugs.
6. Retin A for individuals over age 26.
7. Human growth hormone.
8. Prescription drugs obtained through a pharmacy in or operated by Wal-Mart, Sam's Club or Walgreens, or any of its or their subsidiaries or affiliated companies, are not considered Covered Expenses under the Plan and are not eligible for reimbursement under the Plan.
9. Products not approved by the U.S. Food and Drug Administration (FDA).
10. Over-The-Counter (OTC) drugs.

GENERAL PLAN LIMITATIONS AND EXCLUSIONS

The following general Plan limitations and exclusions apply to all comprehensive medical benefits. These limitations and exclusions are in addition to any exclusion listed elsewhere throughout this booklet.

Benefits are only payable for eligible, Medically Necessary care and treatment provided to an eligible individual as the result of a non-occupational bodily Injury or sickness, unless an expense is specifically listed as a Covered Expense under this Plan. Contact the Fund Office for more information.

No payment will be made for the following under the Plan.

1. Any care, treatment, service, surgical procedure, supply, or Hospital confinement rendered or provided on any date on which the individual is not eligible for Plan benefits.
2. Charges that would not have been made if this Plan did not exist or if the patient were not covered by any group insurance plan.
3. Any medical care or service for which an eligible individual would not be legally required to pay.
4. Services or supplies furnished by or payable under any plan or law of any government, federal or state, dominion or provincial, or any political subdivision thereof.
5. Services or supplies furnished, paid for, or otherwise provided for due to past or present service of any individual in the armed forces of a government.
6. Charges incurred as a result of any bodily Injury or sickness caused or contributed to by war or any act of war (whether war is declared or undeclared), any act of international armed conflict, any conflict involving the armed forces of any international body, insurrection, or riot.
7. Charges for completing Claims (or forms required by the Plan for the processing of Claims) by a Physician or other provider of medical services or supplies.
8. Any care, treatment, service, surgical procedure, supply, or Hospital confinement once the individual has already received Plan benefits aggregating any specified maximum benefit for that type of care and treatment.
9. Any care, treatment, service, surgical procedure, supply, or Hospital confinement in excess of any limitation or maximum benefit specified by the Plan.
10. Any care, treatment, service, procedure, supply, facility, equipment, drug, or device that is Experimental or Investigative. The Trustees, or their delegate, have the sole authority to determine whether treatment is Experimental or Investigative.
11. Charges for eye refractions, eyeglasses, or contact lenses (except the first pair of contact lenses or eyeglasses) required following cataract surgery, including any charges made for the fitting of any of these appliances.
12. Services and supplies provided as a result of dental surgery, dental x-rays, dental treatment, or any other care and treatment of the teeth, the gums (other than for tumors), or other associated structures primarily in connection with the treatment or replacement of teeth, including treatment rendered in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, or for dental prosthetic appliances or the fitting of any of these appliances.
13. No payment will be made for charges incurred for services and supplies rendered outside the United States and its territories and possessions, unless a life-threatening Emergency exists.

14. Charges incurred as the result of any bodily Injury, sickness, or disease for which benefits are or may be payable in whole or in part under any workers' compensation, employer liability, occupational disease, or similar law, whether or not such benefits are claimed or received.
15. Any service, supply, treatment, or care that is Experimental, Investigative, and/or not approved for use with the condition being treated.

The above list of limitations and exclusions is not all-inclusive. It is only representative of the types of charges or situations for which Plan benefits are limited or not payable.

FAMILY STATUS CHANGES

At some point in your life, you will probably experience a change in family status that affects your benefits. It is important that you understand what you or your Eligible Dependents need to do when you experience a change in family status.

> Notify the Fund Office of any change in your family status as soon as possible. You will be required to submit original documents which the Fund Office will copy and return to satisfy your change in family status.

> Contact the Fund Office to update your address if you move.

NOTIFY THE FUND OFFICE

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

- New Eligible Dependents, such as through birth, adoption, etc.; or
- When a covered Dependent is no longer eligible for coverage, such as due to legal separation, divorce, death, a dependent child losing eligibility due to change in age, or otherwise, etc. (you may want to continue their coverage through COBRA).

When you experience a change in family status, you should contact the Fund Office within 30 days of such an event. It is important that you return all requested information to the Fund Office because it helps ensure that the Fund Office has your correct address and family information on file. It also enables the Fund Office to keep updated marital status, Dependent information, and information about whether you or your Eligible Dependents have other benefits coverage. This information helps in processing your Claims quickly and accurately.

ADDING A DEPENDENT

If you are eligible for benefits and you acquire a covered Dependent through *birth of a child*, *adoption of a child*, or *placement for adoption,* coverage for that covered Dependent begins immediately. You should notify the Fund Office within 30 days of the date that one of these events occurs for coverage to be effective as of that date. You may add a Dependent after 30 days; however, coverage will only be available for future Claims as of the date notification is received by the Fund Office. Depending on your situation, there may be paperwork that you will need to submit to the Fund Office.

Dependent Loses Eligibility for Coverage

When your Dependent child reaches age 26, his or her eligibility will normally end. If your covered Dependent loses eligibility for coverage and wants to continue coverage under COBRA, contact the Fund Office within 60 days from the date your covered Dependent loses eligibility. See the Glossary beginning on page 61 for the definition of an Eligible Dependent Child for more information about COBRA Continuation Coverage.

In The Event of Legal Separation or Divorce

In the event of a legal separation or divorce, if your ex-spouse was covered under the Plan and wants to continue coverage under COBRA, you or your ex-spouse have 60 days from the date of the legal separation or divorce to request COBRA Continuation Coverage information from the Fund Office. See page 38 for more information about COBRA Continuation Coverage.

Qualified Medical Child Support Order (QMCSO)

This Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and provides benefits for a Dependent child(ren) as determined by a court order in the event of a divorce or other family law action. Orders must be submitted to the Plan Administrator who will determine whether the order is a QMCSO, as required under federal law. Contact the Fund Office for more information regarding QMCSOs or for a copy of the Fund's procedures.

IN THE EVENT OF YOUR DEATH

In the event of your death, your surviving spouse or Eligible Dependents should contact the Fund Office. Your surviving Eligible Dependents may be eligible to continue coverage under the Plan (see page 7).

COBRA CONTINUATION OF COVERAGE

SELF-PAYMENT OPPORTUNITIES

Under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, the Retired Employee's Eligible Dependents ("qualified beneficiaries") have the right to make Self-payments to extend coverage temporarily after coverage would otherwise end due to a "qualifying event." This extension is called COBRA Continuation Coverage.

Qualified beneficiaries are the Retired Employee's Spouse, and the Retired Employee's Dependent child(ren) who were covered by the Plan on the day before the qualifying event. Children born, adopted or placed for adoption during the period of COBRA Continuation Coverage have the same rights as a Retired Employee's Spouse or Eligible Dependents who were covered by the Plan on the day of the event that triggered COBRA Continuation Coverage.

The Retired Employees' Spouse and Dependent child(ren) do not have to show that they are insurable for COBRA Continuation Coverage. It is offered if the Retired Employee's Eligible Dependents lose coverage because of a qualifying event. Qualifying events that result in a loss of Plan coverage may include:

- The Retired Employee's death;
- The Retired Employee and the Retired Employee's Spouse are legally separated or divorced; or
- The Retired Employee's child loses Dependent status under the Plan.

COBRA BENEFITS

Under COBRA Continuation Coverage, the Retired Employee's Eligible Dependents may elect coverage for medical (which includes prescription drugs) for up to 36 months.

> You should notify the Fund Office of any qualifying event within 60 days of the later of the qualifying event or the date you lose coverage due to a qualifying event. Failure to notify the Fund Office may prevent you and/or your Dependents from obtaining or extending COBRA Continuation Coverage.

Your Notification Responsibility

For other qualifying events (divorce or legal separation of the Retired Employee and a spouse, or an Eligible Dependent child's loss of Dependent status), you must notify the Fund Office within 60 days following the later of the following:

- The date of the qualifying event;
- The date that your beneficiary would lose coverage on account of the qualifying event; or
- The date written notice of the general right to continuation of coverage is provided to your beneficiary.

In addition, your Eligible Dependent should notify the Fund Office within 60 days of the date of the Retired Employee's death. If notice is not provided to the Fund Office in writing in accordance with Fund Office procedures and within the 60-day time period, affected beneficiaries shall not be entitled to elect to continue coverage on account of a qualifying event.

The Plan's Notification Responsibility

Within 14 days of the date the Fund Office is timely notified of a qualifying event, an election (Self-payment) notice and Self-payment election form will be sent to any Eligible Dependent(s) who would lose coverage due to the qualifying event. The notice will inform the Retired Employee's Eligible Dependent(s) of their right to elect COBRA Continuation Coverage, the due dates for returning the election form and the amount of the Self-payment, as well as other necessary information.

Electing Coverage

To protect your family's rights, you should keep the Fund Office informed of any change in your address or in the addresses of family members.

Each qualified beneficiary has a separate right to elect COBRA Continuation Coverage. Parents may elect COBRA Coverage for their children.

The Retired Employee's Eligible Dependents must complete the election form and send it back to the Fund Office to elect COBRA Continuation Coverage. The following rules apply to the election of COBRA Continuation Coverage:

- The Retired Employee's Eligible Dependents (including the Retired Employee's Spouse and the Retired Employee's Eligible Dependent children) have the right to elect COBRA Continuation Coverage for themselves.
- The person electing COBRA Continuation Coverage has 60 days after the election notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed form. An election of COBRA Continuation Coverage is considered to be made on the date the election form is mailed back to the Fund Office. A person also has the right to waive a previous election and make a new election within the 60-day period.
- If the election form is not mailed back to the Fund Office within the allowable period, the Retired Employee's Eligible Dependents will be considered to have waived their right to COBRA Continuation Coverage.

Update your information on file with the Fund Office. To protect your and your Eligible Dependent's rights, you should notify the Fund Office, in writing, of any address change for you or your Eligible Dependents. You should also keep a copy, for your records, of any notice you send to the Fund Office.

Self-Payments for COBRA Coverage

Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. The Fund Office will notify the Retired Employee's Eligible Dependents of the cost of the COBRA Continuation Coverage when it notifies the Retired Employee's Eligible Dependents of their right to coverage. The cost for COBRA Continuation Coverage is determined by the Board of Trustees on a yearly basis and will not exceed 102% of the cost to provide this coverage. The following rules apply to Self-payments for COBRA Continuation Coverage:

1. COBRA Continuation Coverage Self-payments must be made monthly.
2. The amounts of the monthly Self-payments are determined by the Trustees based on federal regulations. The amounts are subject to change, but not more often than once a year, unless substantial changes are made in the benefits.
3. The Retired Employee's Eligible Dependents who are electing COBRA Continuation Coverage must make the initial Self-payment for coverage within 45 days of their timely submission of the signed election form to the Fund Office.
4. The due date for each following monthly payment is the first day of the month for which payment is due. A payment will be considered on time if it is received within 30 days of the due date.
5. If the Retired Employee's Eligible Dependent(s) do not make a Self-payment within the time allowed, COBRA Continuation Coverage for all family members for whom the payment is being made will end. The Retired Employee's Eligible Dependent(s) may not make up the payment or reinstate coverage by making up missed payments.

Termination of Coverage

COBRA Continuation Coverage may be terminated before the end of the coverage period, as of the first to occur of these events:

- A correct and on-time Self-payment is not made to the Plan;
- The Plan no longer provides group health coverage to any Retired Employee;
- The Retired Employee's Eligible Dependent(s) becomes entitled to Medicare coverage;

The person electing COBRA Continuation Coverage becomes covered under another group health plan (as an employee or Dependent) that does not limit or exclude benefits that would otherwise be provided by this Plan; or Death.

CLAIMS AND APPEALS

FILING CLAIMS

Once you are eligible for coverage, you must file timely benefit claims to ensure that you receive all the benefits to which you are entitled. Most health care providers will submit Claims for you. Be sure to show your ID card so your provider knows where to submit the Claim. If your provider does not submit a Claim for you, it then is your, your Dependent's, or your authorized representative's responsibility to do so.

Receipt of Claims, itemized bills from providers, and itemized receipts for payment of covered services or supplies are considered as notice of Claim and must be submitted within 60 days of the occurrence of such an Injury or sickness, or as soon thereafter as is reasonably possible. In no case will the Fund pay Claims submitted later than the end of the calendar year following the calendar year in which the loss or expense was incurred. If you do not meet this deadline, your Claim will be denied.

Reimbursement for Covered Expenses will be made to you unless benefits have been assigned, in which case payment will be made to the provider of the service.

TYPES OF CLAIMS

Health care Claims, which include medical (including mental health and chemical dependency) are divided into four types of Claims:

- **Urgent Care:** An urgent care claim is a claim for medical care or treatment that would:
  - Seriously jeopardize your life or health or ability to regain maximum function if normal pre-service standards were applied; or
  - Subject you to severe pain that cannot be adequately managed without the care or treatment for which preauthorization is sought, in the opinion of a Physician with knowledge of your condition.
- **Pre-Service:** A pre-service claim is a claim for Plan benefits where preauthorization is required before you obtain care. You are required to obtain preauthorization for any Medically Necessary:
  - Hospital confinement;
  - Extended care facility stay;
  - Surgery;
  - Home health care;
  - Hospice care;
  - Physical, Occupational, and/or Speech Therapy;
  - Amniocentesis;
  - Bone scan;
  - Endoscopy;
  - Coronary angiogram;
  - CT scan;
  - Echocardiogram;
  - Genetic tests/screenings except those tests that are specifically listed or mandated by law to be covered;
  - Holter monitor;
  - Magnetic Resonance Imaging (MRI);
  - Myelogram;

- ♦ RAST/MAST allergy testing;
- ♦ Durable Medical Equipment;
- ♦ Orthotics;
- ♦ Neuropsychological testing; and
- ♦ Bariatric surgery.

- **Concurrent:** A Concurrent care claim is a claim for Plan Benefits that is reconsidered after it is initially approved and the reconsideration results in reduced benefits or termination of the benefits.
- **Post-Service:** A Post-Service claim is a claim for Plan benefits that you have already received.

Generally, when PPO Providers submit the Claims, payment is made directly to the Provider. PPO Providers handle all the paperwork for you. However, if you submit the Claim, payments are generally made directly to you, unless you assign benefits to the Provider. In the event of your death, any outstanding medical benefits are paid to the Provider or your estate.

The Claims procedures for benefits are different for each type of Claim, as described in the following sections.

Claim Decisions

When a Claim is submitted, the responsible Plan provider/representative will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. Claims can be submitted by you or an authorized representative representing you, your Eligible Dependent, or qualified beneficiary as determined by the Plan Administrator. All Claims will be processed promptly after complete Claim information is received. The Plan will make an initial benefit determination within certain timeframes, as follows:

- Health Care Claims:
  - ♦ ***Urgent Care Claims:*** An initial determination request will be made within 72 hours from receipt of the Claim. Notice of a decision on an urgent care Claim may be provided orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process the Claim, notification will be provided within 24 hours of receipt of the Claim. You then have up to 48 hours to respond. The Plan will notify you of its determination within 48 hours of the later of receipt of the additional information or the end of the 48-hour period for you to provide the additional information.
  - ♦ ***Pre-Service Claims:*** An initial determination will be made within 15 days from receipt of the Claim. If additional time is needed to make a determination, due to matters beyond the control of the Plan, written notification will be provided within the initial 15-day deadline that up to 15 additional days may be needed. If additional information is needed to process the Claim, the initial period will be suspended and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a benefit determination will be made before the end of the initial period, which begins to run again.
  - ♦ ***Concurrent Claims:*** In general, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If an extension of approved urgent care treatment is requested (i.e., longer than the prescribed period or number of treatments), the Plan will act on the request within 24 hours after receiving it, as long as the Claim is received at least 24 hours before the expiration of the approved treatment. If a concurrent care Claim does not involve urgent care treatment or is filed less than 24 hours before the expiration of the previously approved period or number of treatments, the Plan will respond according to the type of Claim involved.

- ♦ ***Post-Service Claims:*** An initial benefit determination will be made within 30 days from receipt of the Claim. If additional time is needed to make a determination, due to matters beyond the control of the Plan, written notification will be provided within the initial 30-day deadline that up to 15 additional days may be needed. If additional information is needed to process the Claim, the initial period will be suspended and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a benefit determination will be made before the end of the initial period, which begins to run again.

Once the Fund makes payment on a Claim (benefit determination), no further payment will be made.

Notice of Claim Denial or Adverse Benefit Determination

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

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

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

- The identity of the claim involved;
- The specific reason or reasons for the claim denial or other adverse benefit determination, including any Plan standards used in denying the claim;
- Specific reference to the pertinent Plan provisions upon which the decision is based;
- A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
- A copy of the Plan's internal appeal procedures and external review processes, time periods to appeal your claim, and information regarding how to initiate an appeal;
- A statement that you have the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- A statement that you may bring a lawsuit under ERISA Section 502(a) after the appeal of your claim is completed;
- If the denial was based on an internal rule, guideline, protocol or similar exclusion or limit, a statement that a copy of such internal rule, guideline, protocol, or similar criteria that was relied on will be provided free of charge to you, upon request;

- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of such scientific or clinical judgment for the denial will be provided free of charge to you upon request; and
- A description of the expedited review process applicable to urgent care claims if the notice is a denial of an urgent care claim.

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

If a Claim Is Denied

If your Claim is denied, in whole or in part, you will be provided with oral and/or written (or electronic, if possible) notice in the form of an EOB not later than the period permitted to make the determination (as previously described).

When the Plan notifies you of its initial denial on a Claim, the written notice will include:

- The specific reason(s) for the adverse benefit decision or denied Claim including any Plan standards used in denying the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A description of any additional information or material needed to properly process your Claim and an explanation of why it is needed;
- A statement that you have the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- A copy of the Plan's internal and external review processes and time periods to appeal your Claim; and information regarding how to initiate an appeal including:
  - ♦ A description of the expedited review process for urgent care Claims, if applicable; and
  - ♦ A statement that you may bring a civil action under ERISA following the appeal and review of your Claim.

If your Claim or adverse benefit determination is denied based on:

- Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or
- Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.

Appealing a Denied Claim

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

When appealing a Claim, you may authorize a representative to act on your behalf.

If your Claim (or benefit determination) is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed.

In general, you or your authorized agent should send your written request for an appeal to the Plan Administrator at the Fund Office as soon as possible. For urgent care Claims, your appeal may be made orally. If your Claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within 180 days from the date of the initial determination.

Your written appeal must explain the reasons you disagree with the decision on your Claim. When filing an appeal, you may:

- Submit additional materials, including comments, statements, or documents;
- Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination;
  - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination; or
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

APPEAL DECISIONS

If you file your appeal on time and follow any applicable required procedures, a new, full, and independent review of your claim will be made and the decision will not be deferred to the initial benefit decision. An appropriate fiduciary of the Plan will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The appropriate fiduciary of the Fund that conducts the review will not be:

- The individual who made the initial decision to deny the Claim; or
- An individual who reports to or works for the individual who made the initial decision to deny the Claim.

The Plan will notify you, in writing, of the decision on any appeal within the time frames set below. However, oral notice of a determination on your urgent care claims may be provided to you sooner.

Trustee Appeal Committee

As part of your request for review, you may also ask for an opportunity for you and your representative to appear before the Trustee Appeal Committee to present your case. You or your representative may inspect all documents relating to your Claim. If you request an appearance, you will be notified, in writing, of the date, time, and place of the meeting. If you request an appearance but do not appear at the meeting, your appeal will be considered based on the written information submitted.

Appeal Timeframes

The Plan's determination will be made within certain timeframes. The deadlines differ for the different types of Claims as follows:

- Health Care Appeals:
  - ♦ ***Urgent Care Appeals:*** A determination will be made within 72 hours from receipt of the appeal. If an adverse determination is made on the appeal, the Trustee Appeal Committee will perform a second level appeal review if requested. If necessary, a second level appeal determination will be made within 72 hours.
  - ♦ ***Pre-Service Appeals*****:** A determination will be made within 15 days from receipt of the appeal. If an adverse determination is made on the appeal, the Trustee Appeal Committee will perform a second level appeal review if requested. If requested, a second level appeal determination will be made within 15 days of receipt of the second level appeal request.
  - ♦ ***Concurrent Appeals:*** A determination will be made before reduction or termination of the benefit, if possible. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

    If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service frames, whichever applies.

    Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination is the result of a Plan amendment or Plan termination.
  - ♦ ***Post-Service Appeals*****:** A determination will be made within 30 days from receipt of the appeal. If an adverse determination is made on the appeal, the Trustee Appeal Committee will perform a second level appeal review if requested. If requested, a second level appeal determination will be made within 30 days of receipt of the second level appeal request.

If circumstances require an extension of time for making a determination on a Claim, written notification will be provided stating the special circumstances for the extension and the date a determination is expected.

Information Requirements

Written notification of the denial of an appeal will include:

- The identity of the claim involved;
- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A statement that you have the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- A statement that you may bring a lawsuit under ERISA following the appeal and review of your Claim;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement of any voluntary Fund appeal procedures; and
- If your appeal is denied based on:

- ♦ Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or
- ♦ Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.

Medical Judgment

A medical judgment includes the denial of a Claim on the basis that it is:

- Experimental;
- Investigative;
- Not Medically Necessary; or
- Appropriately excluded from medical coverage.

The Plan's appeal procedures require independent medical review if a denial is based on medical judgment. If a Claim is denied based on a medical judgment, the decision-maker on appeal will consult with a health care professional who:

A. Has appropriate training and experience in the field of medicine involved in the medical judgment; and

B. Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your Claim.

The review will identify the medical or vocational experts whose advice was obtained on behalf of the Fund, whether or not the decision-maker relied on the advice.

Authorized Representative

Unless otherwise elected, you will be considered the authorized representative for your Dependent spouse and children and your Dependent spouse will be considered the authorized representative for you and any Dependent children. You may authorize an individual to act on your behalf to file an appeal of an adverse benefit determination on your behalf.

You will need to submit a written statement authorizing this individual. Your authorized representative will be responsible for, and will receive all information related to, your appeal. An authorized representative under this Plan also includes a healthcare provider. Under this Plan, you do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal.

The following will be recognized as your representative upon receipt of a written statement from you:

- Health care provider;
- Dependent child age 18 or older;
- Parents or adult siblings;
- Grandparent;
- Court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator; or
- Other adult.

For an urgent care Claim, a health care professional with knowledge of your condition will be recognized as your authorized representative without a written statement from you.

Sole Authority on Plan Benefits

Under the documents creating the Benefit Fund (and the terms of the Plan), the Trustees have sole discretionary authority to make final determinations regarding any application for benefits, the interpretation of the Plan and any administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if and when the Board of Trustees or persons to whom such decision making authority has been delegated by the Trustees, in their sole discretion, decide the participant or beneficiary is entitled to benefits under the terms of the Plan.

The decision of the Trustees is final and binding and will receive judicial deference to the extent that it does not constitute an abuse of discretion. If a decision of the Trustees is challenged in court, the decision will be upheld unless the court finds that it is arbitrary and capricious. Individual Trustees, Employers, or Union representatives do not have the authority to interpret the Plan on behalf of the Board of Trustees or to act as agents of the Board with respect to interpretation of the Plan. You may only rely on information regarding the Plan that is communicated to you in writing and signed on behalf of the full Board of Trustees either by the Trustees, or, if authorized by the Trustees, signed by the Administrator.

You must follow the Plan's claims and appeals procedures completely before you bring any legal action under the Employee Retirement Income Security Act of 1974 (ERISA) to obtain Plan benefits. You or any other claimant may not begin any such legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and review procedures described in this booklet. You may have, at your own expense, legal representation at any stage of the review process. If a provision of the Trust Agreement or the Plan, or any amendment to the Trust Agreement or the Plan, is determined to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan. Failure to exhaust all administrative remedies may bar your ability to bring a legal action or administrative proceeding.

External Review Procedures

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

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

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

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

- External Review of Standard Claims

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

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

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

- Preliminary Review
  - ♦ Within five (5) business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:
    - (a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
    - (b) The Adverse Determination concerns a claim involving medical judgment or rescission of coverage;
    - (c) The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;
    - (d) You have exhausted the Plan's internal claims and appeals process; and
    - (e) You have provided all of the information and forms required to process an external review.
  - ♦ Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:
    - (a) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
    - (b) If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.
- Review By Independent Review Organization (IRO)

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

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

  - ♦ The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim. Such additional information must be submitted within ten (10) business days. Information submitted after ten (10) business days may not be considered by the IRO.
  - ♦ Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.

- If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

  (a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial);

  (b) The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;

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

  (d) A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

  (e) A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;

  (f) A statement of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

  (g) A statement that judicial review may be available to you; and

  (h) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

- Expedited External Review of Claims

  You may request an expedited external review if:

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

- Preliminary Review of Request for Expedited Review

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

- Review By Independent Review Organization of Request for Expedited Review

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

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

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

AFTER EXTERNAL REVIEW

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

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

Payment of Claims

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

Elimination of Conflict of Interest

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

Coordination of Benefits

The Plan has been designed to help you meet the cost of health care expenses. It is not intended, however, that you receive greater benefits than your actual health care expenses. Medical benefits are coordinated when you and/or your Dependent are covered by this Plan as well as by another plan. When two or more plans cover an individual, no more than 100% of the Eligible Expenses will be paid between the two plans.

If you or your Eligible Dependents are covered under another plan, you must report such duplicate group coverage to the Plan Administrator to secure reimbursement of allowable expenses incurred.

This Plan's secondary benefits will be limited if, under this Plan's coordination of benefits rules:

- This Plan's coverage is secondary; and
- The primary plan includes a provision that results in the primary plan paying a lesser benefit when there is secondary coverage.
- In this situation, as the secondary payer, this Plan will limit benefits to no more than the lesser of the:
- Difference between the amount that the covered person's primary plan would have paid if the primary plan had been the only plan providing coverage and the total amount of covered charges; or
- Amount that this Plan would have paid had this Plan's coverage been primary.

This rule takes precedence over any contrary provision in the primary plan and applies whether the coverage under the primary plan is provided through a sub-plan, wrap-around plan, or any other designation.

Eligible Expenses include any necessary, Reasonable and Customary Charges, at least part of which is covered under one of the plans covering you or your covered Eligible Dependents for which benefit payment is made. If a plan provides benefits in the form of services or supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an allowable expense) will be considered both an allowable expense and a benefit paid. Eligible Expenses under medical benefits are not considered allowable expenses under dental benefits and vice versa. Eligible Expenses include deductibles and coinsurance amounts. **This Plan does not reimburse copayment amounts as Eligible Expenses.**

Other plan means any plan providing benefits or services for health care that are provided by:

- Group insurance coverage;
- Service plan contracts, group practice, individual practice, and other prepayment coverage (such as franchise coverage);

- Coverage under a labor-management trusteed plan, union welfare plan, employer organization plan, employee benefit organization plan, or any other group arrangement or employer provided individual coverage; or
- Coverage under government programs and any coverage required or provided by any law, except that this Plan pays benefits primary to Medicaid.

Order of Benefit Determination

If you or your covered Dependents are covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The secondary plan, will adjust their benefit payment so that the total benefits payable do not exceed 100% of allowable expenses incurred, but no more than the plan's actual benefit.

Non-dependent

For coordination of benefit purposes, a non-dependent includes an active Employee or a retiree, but not the Dependents of the active Employee or retiree.

The following rules determine which plan is the primary plan:

- A plan that does not have a coordination of benefits provision is always primary.
- A plan that covers an individual as a non-dependent is primary over a plan that covers the individual as a Dependent, regardless of whether the plan is for active participants or retirees.

The second provision above is known as the Dependent/non-dependent provision. The Plan's Dependent/non-dependent provision supersedes all other coordination provisions of this Plan. For example, if a retiree is also covered as a Dependent under an active plan, the plan that covers the retiree as a retiree pays before the plan that covers the retiree as a Dependent.

The following rules determine which plan's benefits are primary if a Dependent child is covered under more than one plan:

- If the parents are not divorced or legally separated:
  - ♦ The plan that covers the parent whose date of birth occurs earlier in the calendar year, excluding the year of birth, is primary;
  - ♦ If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary;
  - ♦ If none of the above applies, the plan covering the patient the longest will be primary.
- If the parents ***are legally separated or divorced***, the order of payment used to determine the primary plan is as follows:
  - ♦ Where there is a court decree that establishes financial responsibility for expenses, the plan covering the Dependent child of the parent who has financial responsibility will pay first; or
  - ♦ Where there is no court decree, the plan of the:
    - Parent with custody is primary;
    - Step-parent with custody of the child pays second; and
    - Parent not having custody of the child pays third.

This Plan will only pay expenses required by a managed care or Health Maintenance Organization (HMO) plan as described below:

- If a covered Dependent has primary coverage under a managed care or HMO plan, this Plan will only consider out-of-pocket expenses required by that plan as allowable expenses.
- If a covered Dependent has primary coverage under a managed care or HMO plan and the covered Dependent does not follow the rules for obtaining care outside the managed care or HMO plan, the expenses incurred will not be considered allowable expenses under this Plan.

For coordination of benefits with managed care or HMO plans, eligible out-of-pocket expenses include, but are not limited to, Copayments and expenses that are not covered by the plan. Any charge that would have been covered by a managed care or HMO plan had the covered person, for whom such plan would have been the primary payer, used the services of a participating provider, or that is in excess of what the participating provider has agreed to accept as payment in full, is not considered an allowable expense under this Plan.

- If a Retired Employee is covered as a Dependent under a managed care or HMO plan and incurs expenses while utilizing the HMO, this Plan will only consider out-of-pocket expenses required by that plan as allowable expenses.

If you or your Eligible Dependents receive benefits from the Fund while not eligible to receive such benefits, the Fund may recover and collect those payments from you, your Eligible Dependents, or such other organization(s) that may be liable to the Fund for such repayments.

Eligible Expenses include any necessary, Reasonable and Customary Charges, at least part of which is covered under one of the plans covering You or Your covered Dependents for which benefit payment is made. If a plan provides benefits in the form of services or supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an allowable expense) will be considered both an allowable expense and a benefit paid. Eligible Expenses under medical benefits are not considered allowable expenses under dental benefits and vice versa. Eligible Expenses include deductibles and Coinsurance amounts. This Plan does not reimburse Copayments as Eligible Expenses.

Coordination of Benefits with Medicare

This Plan will pay its normal benefits with respect to allowable expenses before Medicare makes payment for a period of 30 months for a Retired Employee who participates in Medicare due to End Stage Renal Disease (ESRD). After 30 months, Medicare will be the primary coverage and this Plan will pay second.

Coordination of Benefits Implementation

To implement the provisions in this Coordination of Benefits section, the Trustees or the Plan Administrator may, without the consent of, or notice to, any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Fund deems to be necessary for such purposes. Any person claiming benefits under this Plan must provide to the Trustees or to the Plan Administrator such information as may be necessary to implement the provisions of this section or to determine their applicability. These information gathering provisions are subject to the Plan's Privacy Policy, as summarized in the following section.

Privacy Policy

The Plan is required to protect the confidentiality of your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

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

Your rights under HIPAA include the right to:

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

If you need a copy of the Privacy Notice, please contact the Plan's Privacy Official at the Fund Office.

SUBROGATION AND REIMBURSEMENT

In the event the Fund pays, or is obligated to pay, benefits on behalf of a participant or an Eligible Dependent for Illness or injury to the participant or Eligible Dependent and the participant or Eligible Dependent has the right to recover the amounts of such benefits from any other person, corporation, insurance carrier, governmental agency, including uninsured or underinsured insurance coverage, or any other first-party or third-party contract or claim, the Fund will be subrogated to all of the participant's or Eligible Dependents' right of recovery against such person, corporation, or other first-party or third-party contract or claim, to the full extent of payments made by the Fund.

Once the Fund makes or is obligated to make payments on account of the claim, the Fund is granted, and the participant or Eligible Dependent consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment that the participant or Eligible Dependent receives from any source.

The participant or Eligible Dependent, or the participant acting on behalf of a minor Eligible 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 subrogation agreement) to the Fund as the Fund may require. The participant or Eligible Dependent will do whatever else is necessary to secure the rights of the Fund, including allowing the intervention by the Fund or the joinder of the Fund in any claim or action against the responsible party or parties or any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim.

If the participant or Eligible Dependent does 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 legal action or claim against the responsible party or parties, any uninsured or underinsured insurance coverage, or any other first-party or third-party contract or claim in the name of the Fund or Trustees that the Fund may recover all amounts paid to the participant or Eligible Dependent or paid on their behalf.

In the event of 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 Fund's attorney's fees expended in the collection of the subrogation lien, if any, will be deducted first. 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 the participant or Eligible Dependent and their attorneys, if applicable. In the event of any failure or refusal by the participant or Eligible Dependent to execute any document requested by the Fund or to take other action requested by the Fund to protect the interests of the Fund, the Fund may withhold payment of benefits or deduct the amount of any payments from future claims of the participant or Eligible Dependent. After making a claim for benefits from the Fund, the participant or Eligible Dependent will take no action that might or could prejudice the rights of the Fund.

In the event the participant or Eligible Dependents recover any amount by settlement or judgment from or against another party or by payment from any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, the Fund will request repayment of the full amount of benefits paid by the Fund. If the participant and/or Eligible Dependent refuses or fails to repay such amount, then, the Fund will be entitled to recover such amounts from the participant and/or Eligible Dependent by instituting legal action against the participant and/or Eligible Dependent and/or by deducting such amounts as may be due on future claims submitted by the participant and Eligible Dependents. Once a settlement or judgment is reached on the claim, additional bills cannot be submitted with respect to the same injury. The Fund's right of subrogation is from the first dollar received by the participant or Eligible Dependent and takes effect before the whole debt is paid to the participant or Eligible Dependent.

Facility of Payment

Whenever payments that should have been made under this Plan, in accordance with its provision, have been made under any other plans, the Fund will have the right, exercisable alone and at its sole discretion, to pay any organization making such other payments any amounts it determines to be warranted.

If any Plan benefits become payable to the estate of a participant or to an Eligible Dependent who is a minor or otherwise not competent to give a valid release, the Plan may pay up to $1,000 in benefits to that person's relative, by blood or by marriage, who the Trustees find is equally entitled thereto.

Any payment made by the Plan in good faith under this provision will fully discharge the Plan to the extent of such payment.

Right of Recovery

Whenever claim overpayments, payments in error or excess payments have been made by the Fund, the Fund will have the right to recover such payments, from among one or more of the following:

- Any individual to whom, or for whom, such payments were made; or
- Any insurance company, Hospital, Physician, or any other organization.

PLAN INFORMATION

Plan Name

Local 705 International Brotherhood of Teamsters Health & Welfare Plan for Retired Employees

Plan Number

502

Plan Administrator's Identification Number

36-2688697

Plan Year

January 1 – December 31

Plan Type

The Local 705 International Brotherhood of Teamsters Health & Welfare Plan for Retired Employees is maintained for the purpose of providing comprehensive medical and prescription drug benefits for participants and their Eligible Dependents who meet the eligibility requirements, as described in this booklet.

The Plan does not replace and is not affected by any requirement for coverage under workers' compensation, employer liability, occupational disease, or similar law. Benefits that would otherwise be payable under the provisions of such laws are not paid by the Plan.

Eligibility Requirements

A summary of the Plan's requirements for eligibility for benefits is shown in this booklet. Circumstances that may cause you to lose eligibility are also explained. All Plan benefits are made available to you and your Dependents by the Plan as a privilege and not as a right.

Legal Document

This booklet highlights the provisions of the official legal Plan Document governing the Local 705 International Brotherhood of Teamsters Health & Welfare Plan for Retired Employees. All of your rights and benefits are governed by the official legal Plan Document, as are all final decisions. If you wish, you may examine the legal Plan Document at the Fund Office, or obtain a copy for yourself for a reasonable copying charge. It is also available from the Administrator.

Plan Sponsor

The Plan is sponsored by the Board of Trustees of the Local 705 International Brotherhood of Teamsters Health & Welfare Fund, consisting of four Union and four Employer representatives. If you wish to contact the Board of Trustees, you may use the address and telephone number below:

Local 705 I.B. of T. Health & Welfare Plan
1645 W. Jackson Blvd., Suite 700
Chicago, Illinois 60612
(312) 738-2811

The Trustees of this Plan, who can all be reached at the Fund's address and phone number above, are:

Employer Trustees

Stephen F. G. Bridge
William W. Gianaras
Duane Mattingly
Dan Thomas

Union Trustees

Joseph M. Bakes
Juan C. Campos
Kenneth J. Emanuelson
Gregory R. Foster

Plan Administrator

The Board of Trustees has named Jack F. Witt as Plan Administrator. It is his responsibility to see that your questions are answered, that eligibility and Contribution records are maintained, that benefits are properly figured and paid promptly, and that the Plan is operated in accordance with the legal documents governing it. You may write him at the address shown for the Fund Office in this booklet.

The Plan Administrator is also the agent for service of legal process concerning the Plan. Legal process may be served on the Administrator or any member of the Board of Trustees.

Agent for Service of Legal Process

The Plan Administrator is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Plan Administrator at the address of the Fund Office. However, such documents may also be served upon any individual Trustee.

Plan Funding

The Plan for Retired Employees pays benefits from a Trust Fund established for the Plan. Retired Employee Self-Payments and COBRA Continuation Coverage contributions are deposited in this Trust Fund and are used to pay claims under the Plan. In addition to these amounts, Plan assets are also used to pay administrative expenses. A portion of Fund benefits is allocated for reserves to carry out the objectives of the Plan.

Service Providers

Various organizations provide services under the Plan:

Service	Provider
PPO Network Providers	BlueCross BlueShield of Illinois
Utilization Management	Med-Care Management
Living Well with Diabetes Program	Med-Care Management
Prescription Drug Benefits	CVS/caremark

Plan Amendment and Termination

The Board of Trustees expects that the Plan will be permanent. However, the Trustees have the authority to increase, decrease, or change benefits, eligibility rules, or other provisions of the Plan as they determine to be in the best interests of Plan participants and beneficiaries. Any such amendment, which will be communicated in writing, will not affect valid Claims that originated before the date of the amendment.

This Plan may be discontinued or terminated under certain circumstances, as described in the documents that establish this Plan. In such event, all coverage for eligible individuals will end immediately. Any such discontinuation will not affect valid Claims that originate before the termination date of the Plan as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets and benefit payments will be limited to the assets available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the documents governing this Plan.

Trustees' Discretionary Authority

The Trustees have the exclusive right and sole discretionary authority to make any finding of fact necessary or appropriate for any purpose under the Trust Agreement or any plan or program established there under, including, but not limited to, final determination as to the eligibility of any individual to participate in any plan or program and to receive benefits thereunder. The Trustees have the exclusive right and sole discretionary authority to interpret and construe the terms and provisions of the Trust Agreement and any plan or program established thereunder and to determine any and all questions arising with respect to the construction and interpretation of the Trust Agreement and any such plans or programs, including, without limitation, the right to remedy or resolve possible ambiguities, inconsistencies, or omissions and to construe disputed, doubtful, or uncertain terms. All findings of fact, determinations, interpretations, and decisions of the Trustees are intended to be conclusive and binding upon all persons having or claiming to have any interest or right under any plan or program established pursuant to the Trust Agreement and will be accorded judicial deference in any administrative or court proceeding. If a decision of the Trustees or those acting for the Trustees is challenged in court or in an administrative proceeding, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Assignment of Benefits

This Plan is intended to pay benefits only for you or your Eligible Dependents. Payments generally are made directly to you, unless you assign benefits to the provider. Your benefits cannot be used as collateral for loans or assigned in any other way except in connection with certain domestic relations orders or medical child support orders. You will be notified if such an order is received with respect to your benefits.

YOUR ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

To assure that your request is handled promptly and that you are given the information you request, the Trustees have adopted certain procedures that you should follow:

- Your request should be in writing.
- It should specify what materials you wish to look at.

It should be received at the Fund Office at least three days before you want to review the materials at the Fund Office.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for your spouse or Dependents if there is a loss of coverage under the Plan because of a qualifying event. Your Dependents 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

Enforce Your Rights

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 the 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. You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your Claim. If you are not satisfied with the reply, you feel you are unable to obtain a satisfactory answer, and if you want to take the matter further, you may wish to contact your lawyer or the Employee Benefits Security Administration of the U.S. Department of Labor to obtain further action.

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

If you have a Claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's Claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the courts may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Women's Health and Cancer Rights Act

The Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Call your Plan Administrator at (312) 738-2811 for more information.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the EBSA at:

National Office:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
(866) 444-3272

Nearest Regional Office:
Employee Benefits Security Administration
Chicago Regional Office
233 S. Dearborn St., Suite 2100
Chicago, Illinois 60604
(312) 353-0900

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

GLOSSARY OF TERMS

Administrator means an individual designated by the Trustees to act as executive administrative officer of the Trust Fund.

Ambulatory Surgical Facility means a specialized facility established, equipped, operated, and staffed primarily for performing surgical procedures. A facility must be:

- Licensed as an ambulatory surgical center; and
- Operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.

An ambulatory surgical center that is part of a Hospital, as defined by the Plan, is also considered an Ambulatory Surgical Facility.

Chiropractor means a duly licensed Doctor of Chiropractic Medicine (DC).

Claim means notification in a form acceptable to the Plan that a service or supply has been rendered or furnished to a covered individual. This notification must include full details of the service or supply received and must include:

- The covered individual's name and identification number;
- The provider's name and address;
- An itemized statement of services or supplies rendered or furnished and the date rendered or furnished; and
- Any other information that the Plan may request.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, and as may be amended time to time. The term is generally used to refer to the health continuation coverage provided under the act.

Coinsurance means that portion of Eligible Expenses for which an eligible individual has financial responsibility. In most instances, the responsibility is for paying a percentage of Covered Expenses in excess of the deductible.

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

Copayment or **Copay** means the set dollar amount an eligible individual is responsible for paying when incurring certain Eligible Expenses.

Covered Medical Expenses or **Covered Expenses** means the charges for expenses covered under the Plan (as specified by the Plan's legal documents) that are actually incurred by an eligible individual upon the recommendation or approval of the attending Physician for services and supplies that are Medically Necessary and required for treatment of the individual as a result of a non-occupational bodily Injury or sickness and for which benefits are payable by the Plan in accordance with Plan provisions and schedule of maximum allowances.

The Plan will cover Covered Medical Expenses without regard to the type of health care provider as long as that individual is licensed under State law, and performing within the scope of their practice, as defined under State law. A "health care provider" shall include:

- Doctors of medicine or osteopathy authorized to practice medicine or surgery by the State in which the doctor practices; and

- Podiatrists, clinical psychologists, and chiropractors (limited to manual manipulation of the spine to correct subluxation as demonstrated by X-ray to exist), authorized to practice and performing within the scope of their practice, as defined under State law.

Notwithstanding the foregoing, the Plan shall not be required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan.

Custodial Care means services and supplies for care:

- Furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment; or
- That can safely and adequately be provided by persons who do not have the technical skills of a covered practitioner.

Care that meets one of the conditions above is Custodial Care regardless of:

- Who recommends, provides, or directs the care;
- Where the care is provided; or
- Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.

Dependent means your:

- Spouse (if not divorced or legally separated);
- Your child(ren) under age 26, married or unmarried. The term "child" includes any:
  - Natural born child;
  - Legally adopted child or child placed with you for adoption; and
  - Stepchild (meaning any child of your current spouse born to or legally adopted by your spouse before your marriage).

Child(ren) for whom the Retired Employee is the court-ordered guardian under Illinois law up to the date the child becomes 18.

Child(ren) age 26 or older who is permanently and fully disabled. Coverage for this child will continue for as long as you are covered under the Plan, provided the child:

- Meets all of the requirements of the definition of a Dependent except for age;
- Became permanently and fully disabled before reaching age 26; and
- Remains permanently and fully disabled.

To be eligible, your child(ren) for whom you are the court-ordered guardian under Illinois law up to age 18 and your disabled children age 26 and older must:

- Receive at least 51% of their support from you;
- Be claimed by you as a dependent on your federal income tax return; and
- Maintain a permanent residence with you in your principal place of abode.
- In the event such child does not live with you, the child will be a dependent, provided that the:
  - Child's parents are:
    - Divorced or legally separated under a decree of divorce or separate maintenance;
    - Separated under a written separation agreement; or
    - Live apart at all times during the last six months of the calendar year;
  - Child's parents provide over one-half of the child's support; and

- ♦ Child is in the custody of one or both of his or her parents for more than one-half of the calendar year; or
- ♦ Is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO) approved by the Board of Trustees.

Procedures for qualifying Medical Child Support Orders are available from the Fund Office, upon request, at no cost;

- You must furnish written proof to the Trustees of the child's Disability within 60 days before the date coverage under the Plan for the Dependent child would otherwise end due to the child's attainment of age 26. If proof is not received and accepted by the Trustees within six months from the date the child reaches age 26, the child will not be considered an Eligible Dependent beyond the date he/she attains age 26, even though the child continues to be Disabled. In addition, you must furnish written proof to the Trustees of your child's continued Disability when requested.
- You must furnish the Trustees with any requested documentation relating to your Dependents.

Disabled or Disability means an eligible Retired Employee is permanently and Totally Disabled as defined in Internal Revenue Code Section 22(e)(3) and thereby unable to engage in substantial, gainful activity by reason of any medically determinable physical or mental impairment that can be expected to last for a continuous period of not less than 12 months. The Trustees, or their delegate, have sole discretion to determine when an Eligible Dependent is Totally Disabled.

> Disabled means permanently and fully disabled, as defined in Internal Revenue Code Section 22(e)3. An individual is permanently and totally disabled if he or she is unable to engage in substantial, gainful activity by reason of any medically determinable physical or mental impairment that can be expected to last for a continuous period of not less than 12 months.

Durable Medical Equipment means equipment that:

- Can withstand repeated use;
- Is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or illness; and
- Is not disposable or non-durable.

Eligible Medical Expense or **Eligible Expense** means expenses for medical services or supplies that are:

- Medically Necessary;
- Reasonable and Customary Charges;
- For services or supplies not excluded under the Plan; and
- Within the maximum Plan benefits for those services or supplies.

Emergency or **Emergencies** means a medical condition manifesting acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (not a medical professional) who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, if pregnant, the health of the unborn child) in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part.

Emergency Medical Care means services provided for initial outpatient treatment, including related diagnostic services, of the sudden and unexpected onset of a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences.

Emergency Treatment Center means a freestanding facility primarily engaged in providing minor Emergency and episodic medical care to its patients. A Physician, registered nurse, and registered x-ray technician must be in attendance at all times when the center is open. The center's facilities must include x-ray and laboratory equipment and a life support system.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

Experimental or **Investigative** means the use of any treatment, procedure, facility, equipment, drug, device, or supply not yet generally recognized as accepted medical practice, including the use of any of such items requiring federal or other governmental agency approval for which such approval had not been granted at the time such service or supply was rendered or provided. Services or supplies available only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health are considered Experimental.

Fund, Trust Fund, or **Health & Welfare Fund** means the Local 705 International Brotherhood of Teamsters Health & Welfare Fund and the Trust Fund created, and as amended, pursuant to the Trust Agreement.

Fund Office means the office responsible for administering the Fund.

Home Health Agency means a program of care provided by a public agency or private organization, or a subdivision of such agency or organization that:

- Is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;
- Has established policies for governing the services it provides, such policies being established by a group of professional personnel associated with the agency or organization, including one or more Physicians and one or more registered nurses;
- Provides for the supervision of its services by a Physician or registered nurse acting under a Physician's direction;
- Maintains clerical records of all patients;
- Is licensed according to the applicable laws of the State of Illinois and of the locality in which it is located or provides services; and
- Is eligible to participate under Medicare.

Home Health Care Team means a group of providers consisting of Physicians, nurses, therapists, home health aides, and others who work with attending Physicians as a liaison to provide quality, cost-effective care in the home setting.

Hospice means an agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a life expectancy of six months or less. The agency must:

- Be approved by Medicare;
- Be licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required:
    - Provide 24 hour-a-day, seven day-a-week service;
    - Be under the direct supervision of a duly qualified Physician;
    - Have a full-time administrator;
    - Have a nurse coordinator who is a registered nurse with four years of full-time clinical experience (two of these years must involve caring for terminally ill patients);
    - Have a main purpose of providing Hospice services;

- ♦ Maintain written records of services provided to the patient; and
- ♦ Maintain malpractice insurance coverage.

A Hospice that is part of a Hospital will be considered a Hospice for the purposes of this Plan.

Hospital means an institution engaged primarily in providing medical care and treatment to sick and injured individuals on an inpatient basis at the patient's expense and that fully meets the following requirements:

- It is a Hospital accredited by The Joint Commission (TJC);
- It is a Hospital, psychiatric Hospital, or tuberculosis Hospital, as defined by Medicare, that is qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare; and
- It is an institution that:
  - ♦ In return for payment from its patients, provides on an inpatient basis, diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment, and care of injured and sick individuals under the supervision of a staff of Physicians licensed to practice medicine;
  - ♦ Provides on the premises 24-hour-a-day nursing services by or under the supervision of registered graduate nurses;
  - ♦ Is operated continuously with organized facilities for operative Surgery on the premises; and
  - ♦ Is not a place for rest, for the aged, residential treatment facility, or nursing or convalescent home.

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

Limited License Practitioner (LLP) is a professional licensed to perform certain health services in independent practice (for example, podiatrists and chiropractors).

Maintenance Care means services and supplies provided primarily to maintain, support, and/or preserve a level of physical or mental function rather than to improve such function.

Medically Necessary or **Medical Necessity** means only those services, treatments, or supplies provided by a Hospital, Physician, or other qualified provider of medical services and supplies that are required, in the judgment of the Trustees, based on the opinion of a qualified medical professional to identify or treat an eligible individual's Injury or sickness. To be considered Medically Necessary, the service, treatment, or supply must:

- Be consistent with the symptoms or diagnosis and treatment of the eligible individual's condition, sickness, Injury, disease, or ailment;
- Be appropriate according to standards of good medical practice;
- Not be solely for the convenience of the eligible individual, Physician, or Hospital; and
- Be the most appropriate that can safely be provided to the eligible individual.

Medicare means the Health Insurance for the Aged Program under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97) and as such program is currently constituted and as it may later be amended.

Mental or Nervous Disorder or **Mental Health Disorder** means a recognized neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or sickness of any kind.

Occupational Therapist means a duly licensed occupational therapist.

Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

Office Visit means a direct personal contact between a Physician and a patient in the Physician's office for diagnosis or treatment associated with the use of the appropriate Office Visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT-4 coding. Neither a telephone discussion with a Physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is considered an Office Visit for the purposes of this Plan.

Ophthalmologist is a duly licensed Physician who is also board certified as a specialist in diseases of the eye.

Optometrist means a duly licensed Doctor of Optometry (OD).

Other Hospital Services and Supplies means the actual charges made by a Hospital, Skilled Nursing Facility, or Treatment Facility for Chemical Dependency on its own behalf for Medically Necessary services and supplies for treatment of and rendered to an eligible individual. Not included as Other Hospital Services and Supplies are Room and Board Charges, the professional services of a Physician, health care practitioner, or any private duty or special nursing services (including intensive nursing care by whatever name called), regardless of whether such services are rendered under the direction of the Hospital, facility, or otherwise.

Physical Therapist means a duly licensed physical therapist.

Physical Therapy means the treatment of a disease, Injury, or condition by physical means by a Physician or a registered professional Physical Therapist under the direction of a licensed Physician and that is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

Physician means a physician or surgeon duly licensed to practice medicine in all of its branches. A Physician or surgeon may be a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

Plan, Benefit Plan, or **Plan of Benefits** means the Health & Welfare Plan or program of benefits, as described in the Plan Document, including any other written document designated by the Trustees as constituting a part of the Plan, established, and as it may from time to time be amended, by the Board of Trustees pursuant to the provisions of the Trust Agreement.

Plan Year means the 12-month period starting on January 1 and ending on December 31.

PPO Provider means a group or network of providers and/or facilities under contract with the Plan to provide health services and supplies at agreed-upon discounted rates and accept those rates as payment in full.

Psychiatrist means an M.D. who has specialized in psychiatric medicine or who has acquired a specialized competency sufficient to render psychiatric evaluation and treatment of Mental or Nervous Disorders.

Psychologist means an individual who has a Ph.D. in psychology, who is a specialist in the science of mental functions, and who is licensed to practice psychology if the state in which he or she is performing the psychological services provides licensure for such services.

Qualified Medical Child Support Order (QMCSO) is a court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent child and

requiring that benefits payable on account of that Dependent child be paid directly to the health care provider who rendered the services or to the custodial parent of the Dependent child.

Reasonable and Customary Charge means as applied to:

- *Medical Expenses:* The charges for Medically Necessary services or supplies will be determined by the Trustees in their sole discretion or their designee to be the lowest of:
  - ♦ 100% of Medicare eligible charges;
  - ♦ With respect to a PPO Provider, the charge set forth in the agreement between the PPO Provider and the PPO or the Plan; or
  - ♦ The provider's actual charges.
- A Reasonable and Customary Charge will not exceed charges actually incurred.

Retired Employee means a person who has Retired from Industry Employment, and who was in Covered Employment under the Health & Welfare Plan for the three (3) consecutive month period immediately prior to retirement and meets any of the following requirements:

A. Has 20 or more years of Benefit Service and is receiving a Pension from the Local 705 International Brotherhood of Teamsters Pension Plan ("Pension Plan"); or

B. Has 20 or more years of Covered Employment under the Health & Welfare Plan; or

C. Is eligible for a Disability Retirement under the Pension Plan and has applied for disability insurance benefits under the Federal Social Security Act.

A person who was not in Covered Employment under the Health & Welfare Plan for the three (3) consecutive month period immediately prior to retirement, but who meets the requirements to be a Retired Employee in all other respects, will be deemed to be a Retired Employee if:

A. The person has a pending workers' compensation case, or

B. All of the following conditions are met:
   1. The Employer from which the person retired was at one time a Contributing Employer to the Health & Welfare Fund, who left the Health & Welfare Fund, and subsequently returned as a Contributing Employer to the Health & Welfare Fund:

      a. Within five (5) years of the date it last made contributions to the Health & Welfare Fund; or

      b. By the day after the expiration date of the first Collective Bargaining Agreement between the Employer and the Union that did not require the Employer to contribute to the Health & Welfare Fund; and
   2. The person retired from the Employer during the period after the Employer left the Health & Welfare Fund, but before the Employer returned to the Health & Welfare Fund; and
   3. The Employer had never previously left the Health & Welfare Fund and subsequently returned as a Contributing Employer to the Health & Welfare Fund; and
   4. The Employer makes three (3) complete months of contributions to the Health & Welfare Fund on behalf of the Retired Employee at the Health & Welfare Fund's current rate for such contributions.

For the purposes of this Retiree Welfare Plan, the terms Retired and Retirement will be defined as permanently leaving Industry Employment for reason other than death; the terms Benefit Service, Disability Retirement, Industry Employment and Pension will be the same as in the Pension Plan.

Notwithstanding anything contained in this Plan document to the contrary, a person who satisfies the requirements of this paragraph will be deemed to be a Retired Employee solely for purposes of the

coverage eligibility under this Plan of a Dependent Spouse or Dependent child of the person at the time of the person's death who, but for the person's death, would be a Dependent Spouse or Dependent child under this Plan. To be deemed a Retired Employee for this purpose, such person, on the date of the person's death, must have:

A. Satisfied each of the applicable requirements of a Retired Employee as provided in this definition;

B. Been covered under the Local 705 International Brotherhood of Teamsters Health & Welfare Plan; and

C. Been entitled to be in pay status under the Pension Plan even though the person was not actually receiving Pension Plan payments on that date.

Any Dependent Spouse or Dependent child of a person who is deemed to be a Retired Employee as described above will be considered an Eligible Dependent subject to the terms and conditions of Plan coverage.

Room and Board Charges means all charges made by a Hospital, Skilled Nursing Facility, Hospice facility, or Treatment Facility for Chemical Dependency on its own behalf for room, board, general duty nursing, and any other charges that are regularly made by the Hospital or facility as a condition of occupancy of the class of accommodations occupied, but not including charges for professional services of Physicians or private duty nurses. Such charges are based on a confinement or stay of 24 hours or any shorter period for which the Hospital or facility regularly charges a full day's room and board rate.

Self-Payments means payments made to the Fund by eligible Retired Employees for the purpose of maintaining eligibility for Plan benefits.

Sickness means illnesses, pain or fever not caused by an accident. This term also includes pregnancy and childbirth of the Employee or spouse. This term also includes the pregnancy, but not childbirth, of a Dependent child solely for purposes of the Preventive Services provided in this Plan.

Skilled Nursing Facility means a nursing facility that:

- Is an institution, or a distinct part of an institution, that has in effect a transfer agreement with one or more Hospitals;
- Is primarily engaged in providing inpatient skilled nursing care and related services for individuals who require medical or nursing care;
- Is duly licensed by the appropriate governmental authorities;
- Has one or more Physicians and one or more registered nurses responsible for the care of inpatients;
- Requires that every patient must be under the supervision of a Physician;
- Maintains clinical records on all patients;
- Provides 24-hour-a-day nursing services;
- Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
- Has in effect a utilization management plan;
- Is eligible to participate under Medicare; and
- Is not an institution that is primarily for the care and treatment of mental diseases or tuberculosis.

Speech Therapist means a duly licensed speech therapist.

Speech Therapy means the treatment for the correction of a speech impairment resulting from disease, trauma, Congenital Defects or anomalies, or previous therapeutic processes and that is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

Surgery means the performance of any medically recognized, non-Investigative surgical procedure, including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as approved by the Plan.

Temporomandibular Joint (TMJ) Dysfunction or **Temporomandibular Joint (TMJ) Syndrome** means the temporomandibular (or craniomandibular) joint that connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, severe aching pain in and about the TMJ (sometimes made worse by chewing), limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring, or hissing in one or both ears), and/or hearing impairment, often associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly) or ill-fitting dentures.

Treatment Facility for Chemical Dependency means a rehabilitation facility for the treatment of individuals suffering from chemical dependency (i.e., alcoholism and/or drug abuse). Such a facility may be a freestanding facility or may be a designated portion of a Hospital or other facility, provided such designated portion is solely for providing rehabilitative treatment for individuals suffering from chemical dependency (i.e., alcoholism and/or drug abuse). To be considered an approved treatment facility for purposes of this Plan, the facility must be accredited by The Joint Commission (TJC) and must be approved by the Trustees.

Trust Agreement means the Amended Agreement and Declaration of Trust, including all amendments, establishing the Trust Fund and its rules of operation.

Trustee, Trustees, or **Board of Trustees** means a Trustee or the Trustees designated of the Local 705 International Brotherhood of Teamsters Health & Welfare Fund.

Trustee Appeal Committee means the Board of Trustees or its appointed representatives.

Utilization Management (UM) is a process to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during, or after the services are rendered and may include, but is not limited to:

- Pre-admission and/or preauthorization;
- Concurrent and/or continued stay review;
- Discharge planning;
- Surgery review;
- Diagnostic testing review;
- Home health/Hospice care review;
- Durable Medical Equipment review; and
- Physical Therapy.

Union means Truck Drivers, Oil Drivers, Filling Station and Platform Workers Union, Local 705 International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, and such other labor organizations as the Trustees approve in writing.