WELFARE BENEFITS

TEAMSTERS LOCAL 786

BUILDING MATERIAL WELFARE PLAN

SUMMARY PLAN DESCRIPTION

EFFECTIVE DECEMBER 1, 2024

Teamsters Local Union 786
Building Material Welfare Fund

300 South Ashland Avenue, Suite 500
Chicago, Illinois 60607
(312) 666-1875
www.teamsters786benefits.org

Dear Employee:

The Trustees are pleased to provide this updated summary plan description, as of December 1, 2024, which describes your health and welfare benefits. We urge you to read this booklet carefully, and to share it with your spouse if you are married.

As an eligible employee represented by the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago, Local 786, you participate in an excellent benefits program. The program includes medical, prescription drug, dental, vision and accidental death and dismemberment (AD&D) coverage for you and your dependents, and life insurance and weekly disability coverage for you.

Although this booklet provides accurate and essential information about your welfare plan, it is not a complete description. If there is ever a conflict between this booklet and the plan's legal document, the plan document will be the final word. You can obtain a copy of the plan document from the Fund Office. The Fund Office can also answer any questions you may have about the plan. This booklet replaces any prior version of this booklet.

The Board of Trustees and the Fund Office stand ready to assist you in time of need and hope that you and your family remain in good health.

Sincerely,

Union Trustees	Employer Trustees
Eddie Rizzo	Steven Warnke
Bryant Smith	Jeffery Ozinga
James Goddard	Kevin Jarchow
Brandon Snow	Dave Mashek

The Board of Trustees will make all final determinations on questions of eligibility and any other provisions of the plan. The Board of Trustees reserves the right to change or modify the plan at any time. When the plan is amended, you will be notified.

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INTRODUCTION

The rest of this booklet describes your benefits in more detail. You'll be able to get the most from your Plan if you understand how the benefits work.

The provisions of this Summary Plan Description are effective as of September 1, 2025 unless another effective date is specified herein.

This Summary Plan Description contains only highlights of certain features of the Plan. 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 have the right to interpret the Trust Agreement, Plan regulations, the Plan, the Plan Documents and the procedures of the Plan. The Trustees' interpretation is binding on all involved individuals. The Trustees have the authority to increase, decrease, or change benefits, eligibility rules or any other provisions of the Plan.

Your work may be seasonal, but you need your benefits coverage all year. Our Plan has several provisions that can help you maintain your coverage.

IMPORTANT PHONE NUMBERS

For Plan Information ♦ Questions on eligibility or Plan coverage ♦ Claim forms ♦ Updating personal information	Welfare Fund Office 7:30 a.m.-4:00 p.m. Monday-Friday	(312) 666-1875 (877) 315-3758 www.teamsters786benefits.org
Voice Mail System ♦ Order claim forms ♦ Request a pension application ♦ Leave a general message for the Fund Office staff	Outside regular business hours	(312) 666-1875 Ext. 0
For Medical, Dental, and HRA Claim Processing Questions	Elite Administration (i.e., the Claims Administrator)	(312) 243-1265 (800) 762-4166
To Find a medical PPO Provider	BCBS	(800) 810-2583 www.bcbsil.com
To Find a dental PPO Provider	Dental Network of America (DNOA)	(866) 522-6758 www.dnoa.com
To find an in-network vision provider	EyeMed Vision Care LLC	(866) 800-5457 www.eyemed.com
For specific Life Insurance and AD&D Questions	Standard Insurance Company	(800) 628-8600
Before Hospital Admission, Surgery or Inpatient Mental Health/Substance Abuse Treatment ♦ Before any Hospital admission ♦ Before any surgical procedure ♦ Within 24 hours of an Emergency admission Call the Utilization Review Service for pre-certification	HealthCare Strategies, Inc. ("HCS")	(800) 582-1535
About Prescription Drugs ♦ Prescription Drug Card Program information ♦ Mail Service Pharmacy Program information	Sav-Rx	(800) 228-3108
For Help With Personal Matters ♦ Marital problems ♦ Financial worries ♦ Legal concerns ♦ Psychological concerns ♦ Family/Parenting issues ♦ Drug/Alcohol problems	Hope Assistance-Member Assistance Program (MAP)	(708) 594-9714 (800) 786-2948

Note. Any term that is capitalized in this booklet shall have the meaning assigned to it in the Glossary at the end of the booklet unless a different meaning clearly is assigned in the particular context.

YOUR BENEFITS AT A GLANCE

Who Is Eligible

You're eligible for coverage on the first day of the month after you work 6 weeks in Covered Employment in a consecutive two to three month period. Fund employees are also eligible for coverage under this Plan as are Trustees. Actual enrollment, however, is contingent upon you promptly providing the Fund all information it reasonably requests. Your failure to do so may result in a suspension of benefit payments and/or a denial or loss of eligibility.

Your Dependents' coverage begins when you become eligible or when you first acquire a Dependent, such as a spouse or a child.

Medical Benefits

The Plan covers many health care expenses for you and your family, including doctor, Hospital and surgical charges. After you meet a deductible ($500 per person, limited to $1,000 per family), the Plan pays 90% of most charges if you use providers who are in the Preferred Provider Organization (PPO) network and 80% if you use providers outside the PPO network. If your out-of-pocket expenses for one person should reach $2,000 (excluding the deductible) in a Calendar Year, the Plan pays 100% of most remaining expenses for that person for the rest of the year. Also, if your out-of-pocket expenses for a family should reach $4,000 (excluding the deductible) in a Calendar Year, the Plan pays 100% of most remaining expenses for all family members for the rest of the year.

Medical coverage also includes coverage of prescription drugs and a Member Assistance Program. Prescription drug charges count towards both the individual and family out-of-pocket limits, subject to certain limitations described below.

Dental Benefits

The Plan covers most routine exams, fillings, surgery, dentures and many other dental expenses. You pay a $25 deductible each Calendar Year, and the Plan pays 80%/70% (PPO/NonPPO, respectively) of covered dental expenses, up to $3,500 each Calendar Year.

Vision Benefits

The Plan pays benefits for routine eye exams and eyeglasses or contact lenses. You pay nothing for vision exams in-network, and there is a $200 allowance for frames purchased in-network, a $150 allowance for contact lenses, and a schedule of copayments applicable to lenses for glasses.

Disability Benefits

The Plan pays $400 per week if you can't work because of a non-occupational disability. Benefits begin on the first day of disability if you're injured or on the eighth day of disability if you're sick. Benefits continue until you recover, up to a maximum of 26 weeks.

Life Insurance

The Plan pays a life insurance benefit of $75,000 to your beneficiary.

Accidental Death And Dismemberment (AD&D) Insurance

AD&D benefits are paid if you or a Dependent dies or is seriously injured in an accident.

Health Reimbursement Account

The Plan provides a Health Reimbursement Account ("HRA") Benefit that is funded solely through Employer contributions to the Fund and that reimburses Eligible Participants for certain out-of-pocket "Qualifying Health Care Expenses" incurred by you or your Dependent.

When Coverage Stops

Coverage generally stops at the end of the month following the month when your Employer last makes a contribution on your behalf to the Fund. Your coverage may be extended if you become disabled or if you are in a circumstance that allows you to make self-payments to the Fund.

Advance Determinations of Coverage Not Binding

All determinations of coverage, including but not limited to whether an expense is Medically Necessary, or is Experimental or Investigative, will be made only after such expense has been incurred and a claim filed with the Fund Office or applicable insurance carrier, based on all facts and circumstances. The Fund Office may give informal opinions concerning the coverage of a particular treatment, drug, supply, device, or procedure ("expense") before such expense is incurred, but any such opinion will not be binding on the Fund, and no person or service provider may rely on such informal opinion.

Notice of Grandfathered Status

The Plan believes that the group health plan coverage it provides is "grandfathered" under the Patient Protection and Affordable Care Act ("ACA"). As permitted by the ACA, a grandfathered health plan may preserve certain basic health coverage that was already in effect when that law was enacted. Because it is a grandfathered health plan, the Plan may not include certain consumer protections of the ACA that apply to other plans (for example, the requirement for the provision of preventive health services without any cost sharing). However, grandfathered health plans must comply with certain other consumer protections in the ACA (for example, the elimination of lifetime limits on benefits).

Questions regarding which protections apply to a grandfathered health plan and what might cause a plan to lose its grandfathered health plan status can be directed to the Welfare Fund Office (see the "Important Phone Numbers" Section of this Summary Plan Description for contact information).

ELIGIBILITY AND PARTICIPATION

You're eligible when you complete 6 weeks of Covered Employment during a consecutive two or three-month period.

Employees

You are eligible for benefits under this Plan if:

- You are an active Employee of a participating Employer; and
- You've completed 6 weeks of Covered Employment during a consecutive two to three-month period. Covered employment means work for which your Employer contributes to the Fund on your behalf. Any week in which you work at least two days is considered a week of Covered Employment.

Your coverage begins on the first of the month after the required Contributions described above have been received by the Fund.

Coverage starts on the first day of the month after you meet the eligibility requirements.

You are also eligible (as described immediately above) if you are an Employee of the Welfare Fund or of the Building Material Local 786 Pension Trust Fund (the "Pension Fund"), or if you are a Trustee on whose behalf contributions are made by the Welfare Fund and/or the Pension Fund and who the Trustees determine is eligible in their discretion.

EXAMPLE

Example #1
John begins work for a participating Employer on June 1. If he works at least 6 weeks in Covered Employment during the following two-month period (June and July), John and his eligible Dependents will become Covered Under the Plan on August 1.

Example #2
Brad begins work for a participating Employer on June 1. He works one week in Covered Employment in June and one week in July. If Brad works at least 4 weeks in Covered Employment in August, John and his eligible Dependents will become Covered Under the Plan on September 1.

If you're not at work on the day your coverage is scheduled to begin, your weekly disability coverage may be delayed until you return to active employment. This delay does not apply to your medical, dental, vision, life insurance and AD&D insurance coverage.

Dependents

Your Dependents are eligible for medical, prescription drug, dental, vision and AD&D insurance coverage.

Your Dependents (as defined in the Glossary at the end of this booklet) are eligible for medical, prescription drug, dental, vision and AD&D insurance coverage. A Dependent becomes eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Dependent, whichever is later, subject to the 30-day enrollment requirement described below under "Special Enrollment Rights".

You may be required to provide proof, at any time, that your Dependents qualify or continue to qualify as Dependents as defined in this Plan.

Note that if both you and your spouse are eligible for coverage under this Plan, you may both enroll for Dependent coverage; however, only 100% of eligible expenses will be paid with respect to medical, prescription drug, dental and vision benefits. (See Coordination Of Benefits on page 72 for more information.)

Please contact the Fund Office immediately to initiate your coverage under the Plan and to update your enrollment and beneficiary cards if needed.

Special Enrollment Rights

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you are entitled to enroll your new Dependents provided that you request enrollment from the Fund Office within 30 days after the marriage, birth, adoption or placement for adoption. If the enrollment request is received within 30 days, coverage will begin as of the date you acquire the new Dependent. If the enrollment request is made more than 30 days after the respective event, the Dependent still may be added, but coverage will be prospective only.

Loss of Other Coverage. If you decline enrollment for yourself or for your Dependents because of other health insurance coverage, you may in the future enroll yourself and your Dependents in the Plan. If the enrollment request is received within 30 days after such other coverage ends, coverage will begin as of the date the other coverage is lost. If more than 30 days has elapsed, you may enroll yourself and your Dependents, but enrollment will be effective prospectively only as of the date administratively practicable following the Fund Office's receipt of the enrollment request. Lastly, if you decline enrollment for some reason other than having other coverage, you may later enroll yourself or your Dependents, but such enrollment also will be prospective only.

A loss of other coverage includes a loss of eligibility for coverage in the individual market, including coverage purchased through a Marketplace established under the Affordable Care Act (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact).

Children's Health Insurance Program Reauthorization Act Special Enrollment Rights. If you or your Dependent becomes eligible to participate in a premium assistance program under Medicaid or a state children's health insurance program, you and/or your Dependent will be entitled to enroll in coverage under the Plan. As described above, however, all eligible individuals and their Dependents usually already are enrolled in the Plan, and if they are not, they may enroll at any time on a prospective basis. If however, you notify the Fund Office within 60 days of becoming eligible to participate in such a program, you and/or your Dependent will be enrolled retroactively from the date of such event.

Waiver of Coverage

You may decline coverage for your Dependents at any time by completing a Waiver of Dependent Coverage form (available from the Fund Office). Enrollment/re-enrollment will be subject to the rules set forth above.

Continuing Eligibility

Once you are eligible, you will remain eligible until the end of the month following the month for which the Employer last makes Contributions to the Fund on your behalf. As long as one week of contributions is received for a month, your coverage will continue through the end of the following month.

So, for example, if the Employer contributes for one week in March, coverage will continue through April 30.

Eligibility During Periods of Disability

You will be credited with coverage for each week, up to a maximum of 26 weeks if:

- You become disabled after you have met the initial eligibility requirements and while you continue to be eligible, and
- You are unable to work due to a disability for which you are eligible for, receive, and continue to receive Workers' Compensation benefits, Illinois Occupational Disease benefits or the disability benefits set forth in the section of this Summary Plan Description entitled "Disability Benefits."

Eligibility during Lay-Off or Leave of Absence

If you are not working because of a lay-off or an approved leave of absence (for example, a military leave), you may remain eligible for Plan coverage for up to three months. This three-month extension starts at the end of the month for which Contributions last were received. In order to receive the three-month extension, when you no longer meet the "Continuing Eligibility" requirements above, you must have 25 weeks of contributions in the last nine months. Otherwise, your coverage will end on the last day of the following month.

So, for example, if the Employer contributes for one week in March, coverage will continue through April 30, with an additional extension possible depending upon the total weeks of Contributions over the preceding period. If 25 weeks of Contributions were made in the last nine months on your behalf, your coverage will run through the end of June. If less than 25 weeks of contributions were made in the last nine months, then no extension is available and coverage will end April 30. In no event will the total extension exceed three months.

Medicaid Eligibility

A person's Medicaid eligibility will not be taken into account by the Plan in determining the person's eligibility to participate in the Plan or entitlement to benefits under the Plan. The Plan shall pay benefits in accordance with any assignment of rights made by or on behalf of an Eligible Participant as required by a state Medicaid plan. To the extent that the Plan is required by law to pay primary to Medicaid and Medicaid has paid benefits already, the Plan shall make benefit payments in accordance with any state law that provides that the state has acquired the rights with respect to an Eligible Participant to such payment.

Qualified Medical Child Support Orders (QMCSOs)

This Plan recognizes qualified medical child support orders (QMCSOs) and provides benefits for a Dependent child 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 a free copy of the procedures.

Your Enrollment Card

When you first become eligible under the Plan, you'll need to complete an enrollment card.

You will also provide information about your children on your enrollment card. It is very important to keep this information up to date, as it is used to determine who is eligible for benefits under the Plan.

Your Beneficiary Card

When you first become eligible under the Plan, you'll need to complete a beneficiary card to name a beneficiary for life and AD&D insurance. Your beneficiary may be anyone you choose, and you may change your beneficiary at any time by completing a new beneficiary card and submitting it to the Fund Office. You may also name more than one beneficiary, but you'll have to decide how benefits will be divided between them.

If you don't name a beneficiary or if no named beneficiary survives you, your insurance benefits will be paid to the following if living in the following order: spouse, natural/adopted children equally, father and mother equally, siblings, or your estate.

Keep Personal Information Up to Date

Please let us know:

- *When you marry or have a new child;*
- *If you divorce or if a child reaches the maximum age; or*
- *If you or your spouse move or change your phone number or address.*

Contact the Fund Office immediately to update your enrollment and beneficiary cards if needed.

SITUATIONS AFFECTING YOUR COVERAGE

When your or a Dependent's coverage ends, you may be able to continue coverage as explained on page 11.

WHEN COVERAGE ENDS

In general, your coverage ends when your Employer stops making Contributions on your behalf. In some cases, coverage may be extended for a time.

When Your Coverage Ends

Your coverage will end at the earliest of these times:

- At the end of the month following the month for which Contributions were last received on your behalf if termination of your employment is due to retirement, voluntary termination, or dismissal from employment,
- At the end of the month following the month for which Contributions were last received on your behalf due to the Employer ceasing to contribute to the Fund for whatever reason (such as, but not limited to, the Employer going out of business or ceasing to be subject to a Collective Bargaining Agreement that requires the Employer to make Contributions to the Fund),
- On the date the Plan is terminated.
- On the date determined by the Fund if you commit an act of fraud or a material misrepresentation with respect to Plan benefits or coverage, in which case coverage may be terminated retroactively.
- At the end of the three-month extension if the Employee was on lay-off or leave of absence.

When Your Dependent's Coverage Ends

Your Dependent's coverage will end at the earliest of these times:

- On the date your coverage ends.
- On the date your Dependent spouse enters the armed forces on full-time active duty.
- On the date determined by the Fund if there is an act of fraud or a material misrepresentation with respect to Plan benefits or coverage, in which case coverage may be terminated retroactively.
- On the date the Plan is discontinued or no longer covers Dependents.
- For dependents turning 26, on the last day of the month in which the Dependent stops being an eligible Dependent.
- An administratively practical date following the Employee's request to waive coverage for the Dependent.
- For a Dependent spouse, on the date she or he ceases to be an eligible Dependent spouse.

Retroactive Rescission of Coverage

The Plan will not rescind coverage on a retroactive basis with respect to medical, dental, pharmacy and vision benefits. However, the Plan will terminate your coverage and your Dependents' coverage retroactively if benefits were provided due to fraud or intentional misrepresentation of material fact. Notice will be provided 30 days in advance if coverage will be terminated retroactively. Neither termination of coverage due to the failure to pay a premium nor termination of coverage due to fraud or misrepresentation is considered a rescission.

Extension Of Coverage If You Die

If you die while covered by the Plan, the Fund extends coverage automatically for your spouse and eligible Dependent children for three months beyond the normal termination date. So, for example, if you die on March 15, absent this extension, coverage would end on April 30. However, in fact due to the extension, coverage will last an additional three months until July 31.

The Family And Medical Leave Act

The Plan will comply with the Family and Medical Leave Act of 1993 (FMLA). Specifically, the Fund will maintain the Employee's eligible status under the Plan until the end of an Employee's FMLA leave, provided the Employer properly grants the leave under the FMLA, promptly provides written notification to the Fund that an application for an FMLA leave has been granted, and makes the required Employer Contributions to the Fund.

Extension Of Coverage During Disability

If you become disabled, all coverage under this Plan may continue without Employer Contributions until the first of the following occurs:

- 26 weeks have passed since the date of your Employer's last contribution; or
- Your disability ends.

To qualify for this continuation, your disability must be "certified." This means that you are receiving one of the following:

- Weekly disability benefits from this Plan; or
- Workers' Compensation or Illinois Occupational Disease benefits for a job-related accident that occurred while working for a participating Employer.

The Trustees will require evidence that you are receiving benefits from these sources as proof of disability.

If You Enter The Armed Forces

If you are called into military service (active duty or inactive duty training) for up to 31 days, your health care coverage will continue. If you are called into military service for more than 31 days, you may continue your coverage by making the required self-payment contributions for up to 18 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Your coverage will continue until the earliest of the following:

- The date you or your Dependents do not make the required self-payment contributions within 30 days of the due date;
- The date you reinstate your eligibility for coverage as an active Employee under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- At the end of the month in which the Employee enters military service, but not less than 31 days after the date the Employee enters military service on full-time active duty,
- The last day of the month after 24 consecutive months; or
- The date the Fund no longer provides any group health benefits.

For more information about self-payment contributions under USERRA, contact the Fund Office.

If You Do Not Continue Coverage Under USERRA

If you are called into military service for more than 31 days and do not continue coverage under USERRA, your coverage will end immediately when you enter active military service. Your Dependents will have the opportunity to elect COBRA Continuation Coverage.

When you are discharged or released from military service, you must apply for reemployment with your former Employer in accordance with the time provisions of USERRA to be eligible for coverage. Your eligibility and your Dependents' eligibility will be reinstated provided you return to Covered Employment within the period during which reinstatement rights are guaranteed by law under USERRA, and the required Contributions are made on your behalf after you return from military service.

If you are seeking work in the jurisdiction of the Fund, but are unable to find work, be sure to notify the Union within the USERRA required time period after your discharge or release from military service.

Reinstatement When You Return To Work

If your coverage ends, you may be reinstated on the first day of the month following your return to work in Covered Employment with a contributing Employer, provided that Employer contributions on your behalf have not lapsed for twelve months or more.

If your coverage has lapsed for twelve months or more, you must meet the eligibility requirements for new Employees as described on page 6.

COBRA CONTINUATION COVERAGE

When your coverage ends, you and/or your Dependents can continue health care coverage for a period of time by making self-payments.

Continued coverage is available as required under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Pursuant to COBRA, the Fund offers continued coverage for up to 18, 29, or 36 months depending on the circumstances surrounding the loss of coverage (as explained below). In addition, the Fund has adopted a self-payment period extension that allows you to continue coverage for up to a total of 36 or 60 months—if eligible. (This extension is described on page 20).

To continue health care coverage, you and your Dependents are required to pay the entire cost plus an administrative fee, as allowed by law. The following outlines when you and/or your Dependents are eligible for COBRA Continuation Coverage.

Layoff, Low Employment Or Termination

If you lose your coverage because of layoff, reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct), you and your Dependents may continue coverage for up to 18 months.

When A Dependent Is No Longer Eligible

Your Dependent may continue coverage for up to 36 months if he or she loses coverage because:

- You die.
- You and your spouse are divorced or legally separated.
- Your Dependent child is no longer eligible for coverage (for example, because of the age limit).
- You become entitled to benefits under Medicare.

Notice Obligations of the Fund and the Employee or Dependent

The Fund Office will notify you or your Dependents when a termination of employment or reduction in hours makes COBRA Continuation Coverage available. The Fund Office also will notify your Dependents within 60 days of their right to continue coverage if your Dependents lose coverage because of your death or your entitlement to Medicare. You and/or your Dependents must then decide whether or not to continue coverage within 60 days of the later of this notification or the date benefits terminate.

You or your Dependents must notify the Fund Office within 60 days if you become divorced or legally separated or if your child no longer meets the eligibility requirements. The Fund Office, in turn, will notify your Dependents of their right to continue coverage. They must then decide whether or not to continue coverage within 60 days of the later of this notification or the date benefits terminate.

The notice sent by you or your Dependent to the Fund Office must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. If mailed, the notice must be postmarked no later than the deadline. If hand-delivered, the notice must be received no later than the deadline. Notice sent via facsimile (312-666-2258) is also acceptable but

Qualifying Events

A loss of coverage for which you or a Dependent can elect continued coverage under COBRA is called a "qualifying event." Qualifying events are:

- *termination of employment,*
- *death,*
- *reduction in hours,*
- *divorce,*
- *losing Dependent status, and*
- *entitlement to Medicare.*

You must elect COBRA Continuation Coverage within 60 days of the later of notice or loss of coverage or you will lose the opportunity to do so.

notice that is sent via e-mail is not. The notice may be provided by you, another qualified beneficiary who would lose coverage as a result of the event, or a representative acting on behalf of either one.

The notice must contain the Plan name, the name of the Contributing Employer, the Employee's name, address, birth date, and social security (or other identification) number, the name and address of any impacted spouse or dependent child, a description of the qualifying event, the date of the event, and adequate documentation of the event (such as divorce decree or decree of legal separation, or copy of the dependent child's birth certificate). A form for providing this notice may be available from the Fund Office but need not be used so long as all the relevant information is included in the written notice.

If you provide a written notice that does not contain all of the information and documentation required, such a notice will nevertheless be considered timely if all of the following conditions are met:

- The notice is mailed or hand-delivered to the individual and address specified;
- The notice is provided by the deadline;
- From the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan;
- From the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (the divorce, legal separation, or child's loss of Dependent status), and the date on which the qualifying event occurred; and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for this notice).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan Administrator will treat the notice as having been provided on the date that the Plan Administrator receives all of the required information and documentation but will accept the notice as timely.

When You Elect COBRA

If you and/or your Dependents choose COBRA Continuation Coverage, you and/or your Dependents will be offered the same level of benefits as other participants. In addition, you can add a newborn or an adopted child (or child Placed for Adoption) during the COBRA Continuation Coverage period. Your newborn or adopted child's coverage begins immediately.

COBRA Continuation Coverage includes the following benefits (to the extent that you were eligible for such benefits prior to the occurrence of the qualifying event):

- Medical;
- Member Assistance Program;
- Prescription Drug;
- Dental; and
- Vision.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period described in the Plan's COBRA Election Notice will lose his or her right to elect COBRA continuation coverage.

Disability, life and accidental death and dismemberment (AD&D) insurance benefits are not included under COBRA Continuation Coverage.

Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered employees (and the spouse if a qualified beneficiary) may elect COBRA Continuation Coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA Continuation Coverage on behalf of their children.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period described in the Plan's COBRA Election Notice will lose his or her right to elect COBRA continuation coverage.

You may elect COBRA Continuation Coverage even if you are enrolled in Medicare or in another group health plan on or *before* the date on which COBRA is elected. However, as discussed below, your COBRA Continuation Coverage will terminate if you first become enrolled in Medicare or another group health plan *after* the date on which you elect COBRA.

Newborns and Adopted Children

Under HIPAA, if a child is born to you or placed for adoption with you during a period of COBRA Continuation Coverage, that child will be eligible for COBRA Continuation Coverage. In accordance with the terms of the Plan and the requirements of federal law, the newborn or child placed for adoption can be added to COBRA Continuation Coverage and become a qualified beneficiary under COBRA upon proper notification to the Plan Administrator in care of the Fund Office within 30 days of the birth or adoption or during open enrollment (if the Plan offers open enrollment) and payment of any required additional premium. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Special considerations in deciding whether to elect COBRA

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

How much does COBRA Continuation Coverage cost?

Generally, each qualified beneficiary is required to pay the entire cost of COBRA Continuation Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, as discussed below, 150 percent) of the cost to the group health plan (including both Employer and employee contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving continuation coverage.

If you do not make your first payment for COBRA continuation coverage in full within 45 days of the date of your election, you will lose all continuation coverage rights under the Plan.

When and how must payment for COBRA continuation coverage be made?

All COBRA premiums must be paid by personal check or money order.

First payment for COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment with your election. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date your election is post-marked, if mailed, or the date your election is received by the Plan Administrator in care of the Fund Office, if hand-delivered.) If you do not make your first payment for COBRA continuation coverage in full within 45 days of the date of your election, you will lose all continuation coverage rights under the Plan.

Your first premium payment must include payment for the period from the date that you lost (or otherwise would have lost) coverage until the date of your election, and each regularly scheduled monthly premium that became due during the period between your election and the first payment.

You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator in care of the Fund Office to confirm the correct amount of your first payment.

Claims for reimbursement may not be processed and paid until you have elected COBRA and made the first payment.

Monthly payments for COBRA continuation coverage

After you make your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent month of coverage. Under the Plan, each of these monthly payments for continuation coverage is due on the first of the month for that month's COBRA Continuation Coverage. If you make a monthly payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that coverage period without any break. If you do not make a monthly payment on or before the first day of the month, your coverage may be suspended pending payment. The Plan is not required to send monthly notices of payments due for these coverage periods. It is your responsibility to pay your COBRA premiums on time, regardless of whether you receive a monthly bill.

Grace periods for monthly payments

Although monthly payments are due on the first day of each month of COBRA continuation coverage, you will be given a grace period of 30 days to make each monthly payment. Your COBRA Continuation Coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan.

How Long Does COBRA Continuation Coverage Last?

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both; applicable only to retiree coverage), the Employee's divorce or legal separation,

or a Dependent's losing eligibility as a dependent, COBRA Continuation Coverage may last for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA Continuation Coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event may last until up to 36 months after the date of Medicare entitlement. For example, if an Employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA Continuation Coverage for his Dependent(s) who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA Continuation Coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA Continuation Coverage generally may last for only up to a total of 18 months.

The COBRA Continuation Coverage periods described above are maximum coverage periods (subject to extension as discussed below).

COBRA Continuation Coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing COBRA Continuation Coverage, under another group health plan,
- an Employee becomes entitled to Medicare benefits (under Part A, Part B, or both; applicable only to retiree coverage) after electing COBRA (does not apply to retirees and their family members entitled to COBRA due to a bankruptcy), or
- during a disability extension period (as explained below), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

COBRA Continuation Coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA Continuation Coverage (such as fraud).

You must notify the Plan Administrator in care of the Fund Office in writing within 30 days if, after electing COBRA Continuation Coverage, you or one of your family members enrolls in another group health plan or becomes entitled to Medicare (Part A, Part B, or both). This notice should include the name and address of the covered or former covered employee, the type and date of the initial qualifying event, the name and address of the qualified beneficiary who has become covered by Medicare or another group health plan and the date that Medicare or other coverage began. Documentation of the date of Medicare entitlement or other group health coverage should be included (for example, a copy of the Medicare card or health insurance card). The notice may be provided by the covered or former covered employee, a qualified beneficiary, or a representative acting on behalf of either, and such notice will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries. (A form for providing this notice may be available from the Fund Office.) The Plan reserves the

right to terminate your COBRA Continuation Coverage retroactively and to require reimbursement of all benefits paid after the date of commencement of the other health coverage or Medicare, regardless of whether or when notice is provided.

There are two ways in which the 18-month period of COBRA Continuation Coverage resulting from a termination of employment or a reduction of hours may be extended, as explained below.

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in care of the Fund Office in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA Continuation Coverage of a covered employee's termination or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination or reduction of hours and must last at least until the end of the period of COBRA Continuation Coverage that would be available without the disability extension (generally 18 months, as described above). The disability extension is available only if you (i) apply for the determination and (ii) give written notice to the Plan Administrator in care of the Fund Office of such application prior to the start of or within the 18-month period. Further, your notice to the Plan Administrator must be provided within 60 days of the date of your application to the Social Security Administration, unless you applied prior to the commencement of continuation coverage, in which case, notice must be provided within the first 60 days of the 18-month period. Finally, once you receive the actual determination from the SSA, a copy must be provided to the Plan Administrator. If you receive this determination more than 60 days prior to the expiration of the 18-month period, you must provide a copy to the Plan Administrator within 60 days. If you receive the determination less than 60 days prior to the expiration of the 18-month period, you must provide a copy to the Plan Administrator by the later of 30 days after receipt or the expiration of the 18-month period. If the SSA determines that you in fact are not entitled to Social Security disability benefits, your continuation coverage will end by the later of the expiration of the 18 months or the last day of the month next following the month containing the date on which you received the determination.

The notices described in the paragraph above must be mailed or hand-delivered; oral notice, including notice by telephone, is not acceptable. If mailed, the notice must be postmarked no later than the deadline. If hand-delivered, the notice must be received no later than the deadline. Notice sent via facsimile also is acceptable, but notice that is sent via e-mail is not. The notification must include the Plan name, the name of the employee and any other covered Dependents that have elected COBRA Continuation Coverage, the employee's social security (or other identification) number, the date of the employee's termination or reduction in hours, the date that the disabled qualified beneficiary became disabled (according to the SSA determination), and, as applicable, a copy of your application for

an SSA determination, or, when available, the SSA determination. The notice may be provided by the covered employee (i.e., the employee or former employee who is or was covered under the Plan), another qualified beneficiary who lost coverage to the covered employee's termination or reduction in hours and is still receiving COBRA Continuation Coverage, or a representative acting on behalf of either one. A form for providing this notice may be available from the Fund Office, but need not be used so long as all the relevant information is included in the written notice. There will be no disability extension of COBRA continuation coverage unless notice is properly provided.

If you provide a written notice to the Plan Administrator that does not contain all of the information and documentation required, such a notice will nevertheless be considered timely if all of the following conditions are met:

- the notice is mailed or hand-delivered to the individual and address specified;
- the notice is provided by the deadline;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan and a qualified beneficiary's disability;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), and the date on which the covered employee's termination of employment or reduction of hours occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for this notice).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan Administrator will treat the notice as having been provided on the date that the Plan Administrator receives all of the required information and documentation but will accept the notice as timely.

If the disabled person is determined by SSA to no longer be disabled, you must notify the Plan in writing of that fact within 30 days after SSA's determination. This notice should include the name and address of the covered or former covered employee, the type and date of the initial qualifying event, the name and address of the qualified beneficiary whose disability has ended, the date that the disability ended, and the date of the SSA determination regarding cessation of disability. A copy of the SSA determination regarding cessation of disability should be included. The notice may be provided by the covered or former covered employee, a qualified beneficiary, or a representative acting on behalf of either, and such notice will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries. Provided that the original 18-month period already has elapsed, COBRA Continuation Coverage for all qualified beneficiaries will terminate (retroactively, if applicable) as of the first day of the month that is more than 30 days after a final determination that the qualified beneficiary no longer is disabled, regardless of whether or when the notice is provided. The Plan will require repayment of all benefits paid after the termination date.

Second qualifying event extension of COBRA Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage due to the covered employee's termination of employment or reduction of hours (including COBRA continuation coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA Continuation Coverage can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

You must notify the Plan Administrator in care of the Fund Office in writing within 60 days after a second qualifying event occurs if you want to extend your continuation coverage. The notice must be mailed or hand-delivered; oral notice, including notice by telephone, is not acceptable. If mailed, the notice must be postmarked no later than the deadline. If hand-delivered, the notice must be received no later than the deadline. Notice sent by facsimile also is acceptable, but notice that is sent via e-mail is not. This notice must include the Plan name, the employee's name, address, birth date, and social security (or other identification) number, the name and address of any impacted spouse or dependent, a description of the qualifying event, the date of the initial qualifying event (the termination of employment or reduction in hours) and the date of the second qualifying event, and adequate documentation of the event (such as a death certificate or published obituary, divorce or legal separation decree, a copy of the employee's Medicare card, or a copy of the dependent's birth certificate). The notice may be provided by the covered employee (i.e., the employee or former employee who is or was covered under the Plan), another qualified beneficiary who lost coverage to the covered employee's termination or reduction in hours and is still receiving COBRA coverage, or a representative acting on behalf of either one. There will be no extension of COBRA Continuation Coverage unless notice is properly provided.

If you provide a written notice to the Plan Administrator that does not contain all of the information and documentation required, such a notice will nevertheless be considered timely **if all of the following conditions are met**:

- the notice is mailed or hand-delivered to the individual and address specified;
- the notice is provided by the deadline;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event, and the date on which the second qualifying event occurred; and

- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for this notice).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan Administrator will treat the notice as having been provided on the date that the Plan Administrator receives all of the required information and documentation but will accept the notice as timely.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator in care of the Fund Office at the telephone number and address indicated in the section entitled "Plan Operation" towards the end of this Summary Plan Description.

For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Keep Copies of Notices

You also should keep a copy, for your records, of any notices you send to the Plan Administrator.

EXTENSION OF COVERAGE BEYOND THE COBRA CONTINUATION PERIOD

The Plan allows you to continue coverage beyond the COBRA continuation period under certain circumstances. The extension is called the "self-payment period" extension. If you are eligible and elect the extension, your Dependents also may be covered if they meet the definition of "Dependent" (see page 86) and if they are not eligible for Medicare.

You are eligible to elect the extended coverage if you meet all of the following requirements:

- You initially lose coverage due to a layoff, reduction in hours of employment, or termination of employment (for other than gross misconduct).
- You elect and pay for COBRA Continuation Coverage throughout the COBRA continuation period for yourself and any Dependents wishing to obtain the self-payment period extension coverage.
- You elect the self-payment period extension at the time you initially elect COBRA Continuation Coverage.
- You are not eligible for Medicare at the time the self-payment period extension begins. (Even if you are eligible for Medicare at that time, so long as your spouse is not, she/he may elect the extended coverage.)

The duration of the extension depends on the number of years that you have had coverage in the Plan for any part of the year from the time you are first eligible until COBRA Continuation Coverage began. COBRA Continuation Coverage does not count toward your years of participation in the Plan. If you were a participant in this Plan for.

- Less than five years before COBRA Continuation Coverage began, then you may make self-payments for a maximum of 18 months after the COBRA Continuation Coverage period ends.
- Five or more years before COBRA Continuation Coverage began, then you may make self-payments for a maximum of 42 months after the COBRA Continuation Coverage period ends.

If you were eligible for the 11-month disability extension under COBRA Continuation Coverage, the maximum number of months you may make self-payments under this provision is seven months if you were a Plan participant for less than five years or 31 months if you were a Plan participant for five years or more.

Your coverage under this extension will end if:

- You do not make timely self-payments,
- You become eligible for Medicare or any other group health plan, or
- You reach the end of your self-payment period, whichever is earlier.

Notwithstanding the above, your spouse may continue coverage until the earlier of the date that:

- A timely self-payment is not made,
- Your spouse no longer meets the definition of a Dependent,
- Your spouse becomes eligible for Medicare or any other group health plan, or
- Your spouse reaches the end of your extension period.

Our self-payment period extension allows up to five years of continued coverage.

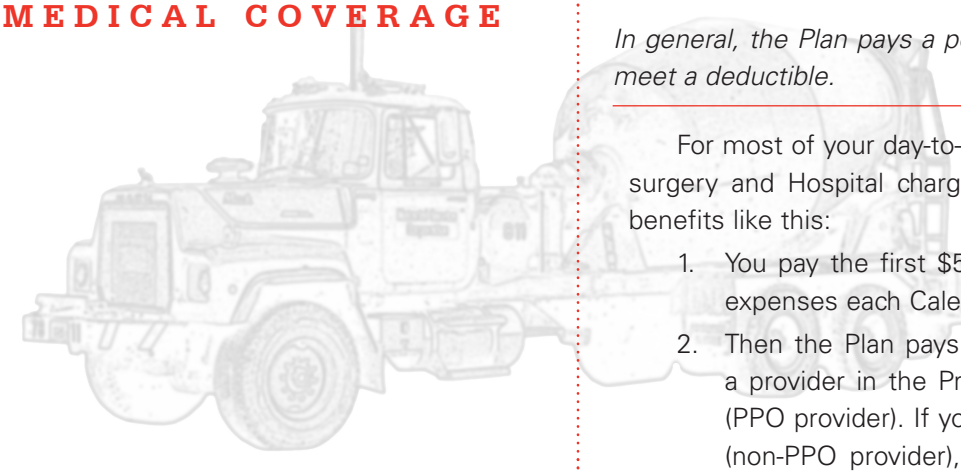
Your eligible Dependent child will be covered until the earlier of the date that:

- A timely self-payment is not made,
- The person no longer meets the definition of Dependent,
- The Dependent becomes eligible for Medicare or any other group health plan coverage,
- Your coverage ends or your spouse's coverage ends, whichever is later; or
- The end of your extension period.

The amount of your self-payment is determined by the Trustees, based on the cost of providing this coverage. This amount is reviewed periodically and is subject to change.

The HRA benefits described beginning on page 56 will not be available to an Eligible Participant during his self-payment period.

MEDICAL COVERAGE



HOW YOUR MEDICAL COVERAGE WORKS

In general, the Plan pays a portion of your health care expenses after you meet a deductible.

For most of your day-to-day medical expenses such as doctors' visits, surgery and Hospital charges when you're ill or injured, the Plan pays benefits like this:

1. You pay the first $500 (limited to $1,000 per family) of covered expenses each Calendar Year—called the deductible.
2. Then the Plan pays 90% of the negotiated PPO rate if you use a provider in the Preferred Provider Organization (PPO) network (PPO provider). If you use a provider outside of the PPO network (non-PPO provider), the Plan pays 80% of most charges up to the Reasonable and Customary Charge. You pay the remaining percentage of charges. This is called your Coinsurance.
3. Once your Coinsurance for most expenses reaches the $2,000 out-of-pocket maximum during the Calendar Year, the Plan pays 100% of Reasonable and Customary (R & C) Charges for most covered expenses for the rest of that year. Additionally, once Coinsurance paid by you and any covered family members reaches the $4,000 out-of-pocket maximum during the Calendar Year, the Plan will pay 100% of Reasonable and Customary (R & C) Charges for most covered expenses for the rest of that year, even if each individual family member has not met the $2,000 individual out-of-pocket maximum.

The chart below shows the amount the Plan pays and the amount you pay for most covered expenses.

First You Pay This Annual Deductible:	Then the Plan Pays:	And You Pay: the Remaining	Up to the Annual Out-of-Pocket Maximum:
$500 per person (limit of $1,000 per family)	• 90% for PPO provider charges; or • 80% of R & C for non-PPO provider charges	• 10% for PPO provider charges; or • 20% for non-PPO provider charges	$2,000 per person (excluding the deductible,) and $4,000 per family (excluding the deductible)

Benefit levels for some covered expenses may differ—for example, pre-admission testing and prescription drugs. See the sections describing covered charges for more information.

The deductible, Coinsurance, out-of-pocket maximum and lifetime maximum are explained in more detail below and on the following pages.

Medical Expense Benefit Payment Provisions

Payment of benefits will be governed by any and all applicable provisions, including but not limited to the maximum out-of-pocket expense amounts, deductible amounts, and all exclusions and limitations.

You will be responsible for paying, on behalf of yourself and your Dependents, all incurred charges in the amount of the Calendar Year deductible Amount, the percentage not payable by the Plan, expenses not considered to be Covered Medical Expenses, and any amounts not considered to be Reasonable and Customary Charges.

The Plan considers expenses to have been incurred as of the date the service was rendered or the purchase was made from which the expense or charge arises.

In any case where the amount of benefits provided for a specific type of cause, condition, care, or treatment is limited to a specific maximum benefit during a Calendar Year, once a person has received Plan benefits equaling such maximum benefit during a Calendar Year, including all payments made during all periods of eligibility or coverage during that Calendar Year, as a result of such type of cause, condition, care, or treatment, no further benefits will be payable on behalf of that person as a result of such type of cause, condition, care, or treatment for the remainder of that Calendar Year.

The Deductible

Before most benefits begin, you first pay a calendar-year deductible. Covered medical charges for several different illnesses or injuries may be added together to meet the deductible.

The individual deductible is $500. Each covered person is subject to the $500 individual deductible until the family deductible is met. The family deductible is met when payments toward individual deductibles reach $1,000. Once you meet the family deductible, your family won't have to pay any more in deductibles for the rest of that Calendar Year. The example on page 25 shows how the deductible works.

There are three ways in which your deductible requirement may be reduced:

- A deductible is not required before some charges are paid.
- If you have health care expenses during the last three months of the Calendar Year that are used to meet the deductible, those expenses will also count toward the next year's deductible.

  For example if you have no expenses until November 2024 and then incur $200 in Covered Medical Expenses in November your individual deductible for 2025 will be $300.
- If two or more family members are injured in the same accident, only one individual deductible is required for all health care expenses related to that accident in that year and the following year.

Wellness Incentives

You and your spouse can each receive a $250 prepaid VISA gift card if you participate in the wellness benefit program offered by the Fund's wellness provider, UIC Wellness. The program is free to you and requires you to complete, among other things, a comprehensive medical exam, blood analysis, urinalysis, cancer screening, and a lung function test.

(No family medical history data or related genetic information shall be collected as part of such health risk assessment.) Alternatively, you may be eligible for a $125 credit towards your Health Reimbursement Account if your personal physician performs a comparable physical exam, and you provide the results to Health Care Strategies. This alternative is referred as the "Health Reach" program. You are eligible to receive either (but not both) a new $250 gift card or a $125 HRA credit as frequently as every twelve months, so long as you complete the wellness benefit program.

The reward for participating in this wellness program is available to all participants and their spouses. If you think you might be unable to complete the program due to medical reasons, you might qualify for an opportunity to earn the same reward by different means. Contact the Fund Office at (312) 666-1875 or (877) 315-3758 to find a wellness program with the same reward that is right for you in light of your health status.

Coinsurance

Your Coinsurance is the portion of charges you pay for covered expenses. The portion the Plan pays depends on whether you use providers who are part of the PPO network or providers outside of the PPO network.

The PPO Network

If you use PPO providers, your expenses are lower because the Plan pays a higher percentage of a lower overall cost.

Our Plan has an arrangement with a Preferred Provider Organization (PPO) network. The PPO network includes preferred doctors, Hospitals and other health care providers. The providers have agreed to charge lower costs for health care services to Fund members and their families. If you need a list of PPO providers, contact Blue Cross/Blue Shield.

Each time you receive medical care, you can decide whether to use a PPO provider or non-PPO provider. If you use a PPO provider, the Plan pays 90% of most eligible expenses. If you use a non-PPO provider, the Plan generally pays 80% of most eligible expenses, subject to only a few exceptions.

For some expenses, the Plan pays benefits at different rates. For example, the Plan pays some charges at 100%—whether or not you use PPO providers. More information is provided in the Schedule of Benefits and elsewhere in this Summary Plan Description.

Annual Out-Of-Pocket Maximum

The Plan limits the amount of money you pay out of your pocket in a Calendar Year for your share of covered expenses. If you reach this out-of-pocket maximum, the Plan pays 100% of most covered expenses for the rest of the year. The annual out-of-pocket maximum is $2,000 (excluding the deductible) per covered person and $4,000 (excluding the deductible) per family.

The following charges do *not* count toward this out-of-pocket maximum:

- Any additional charges you pay for not following the second surgical opinion procedures or pre-admission review (see pages 28 and 40).
- Any additional charges you pay for a Brand Name Drug or device when a generic equivalent is available and your doctor allows the Generic Drug to be substituted for the Brand Name drug.
- Any charges that are not covered by the Plan or that exceed Reasonable and Customary Charges or any other Plan limits.

Reasonable And Customary Limits

The Plan pays benefits up to the Reasonable and Customary Charge as defined in the "Glossary."

EXAMPLE

Joe, his wife Sarah, and their two children are all Covered Under the Plan. Over the course of the year 2025, the family has $5,500 in Covered Medical Expenses as shown in the table below. Here's how benefits would be determined under the Plan.

NOTE: This example assumes that all family members use PPO providers and that the medical expenses incurred are covered at the 90% level.

		Covered Medical Expenses	*Minus* Payment Toward Deductible (your expense)	Remaining Amount (used to calculate benefits)	90% Coinsurance Plan Pays	10% Coinsurance You Pay
January	Joe	$800	$500	$300	$270	$30
	Sarah	$200	$200	$0	Does not apply	Does not apply
February	Child 1	$950	$300*	$650	$585	$65
March	Sarah	$200	$0	$200	$180	$20
April						
May						
June	Sarah	$300	$0	$300	$270	$30
July	Joe	$50	$0	$50	$45	$5
August						
September						
October						
November	Child 1	$1,000	$0	$1,000	$900	$100
December	Child 2	$2,000	$0	$2,000	$1,800	$200
Total		**$5,500**	**$1,000**	**$4,500**	**$4,050**	**$450**

Of the $5,500 in covered expenses, the family pays $1,450 ($1,000 to satisfy the family deductible and $450 in Coinsurance). The Plan pays $4,050. If any of the individual family members' payments toward Covered Medical Expenses (excluding the deductible) reached the Plan's individual $2,000 out-of-pocket maximum, or the family's payments toward Covered Medical Expenses (excluding the deductible) reached the Plan's family $4,000 out-of-pocket maximum, the Plan would pay 100% of remaining covered expenses for the rest of the Calendar Year for that individual or the family, as applicable.

* Once Child 1 pays $300 toward the deductible, the $1,000 maximum family deductible is satisfied. Deductibles for all family members are now satisfied for the rest of the year.

We Need Your Help
By working together, we can help keep health care costs down.

TIPS FOR HOLDING DOWN MEDICAL COSTS

Rising health care costs hurt all of us. When costs go up, amounts you pay increase, the Welfare Fund pays higher claims, and your Employer must pay higher Contributions. We're working to hold down costs with the cost management features of the Plan—the PPO program, the second surgical opinion program and the preadmission Hospital review program. We want to work with you and your health care providers to manage costs.

Here are some important ways to keep costs down:

- Take good care of yourself. Exercise, eat well, practice other good health habits, and don't smoke.
- Use PPO network providers.
- Check all statements you receive from your Physician, Hospital and the Plan to be sure that you actually received the services shown. If you see an error, contact your Physician or the Hospital immediately to have the bill corrected.
- Become familiar with and use the cost management features of the Plan.
- Don't use an emergency room for conditions that aren't true Emergencies.
- If your Physician recommends surgery, ask whether your surgery can be safely performed in your Physician's office or in the outpatient department of a Hospital, rather than as an inpatient. Seek a second opinion before having surgery.

Note: The fact that certain providers or facilities are "in-network," should not be construed as a recommendation, referral or any other statement as to the ability or quality of such providers or facilities, and neither the Plan nor the Plan Administrator bears any liability for any act or omission of such providers or facilities. Conversely, the fact that certain providers or facilities are "out-of-network" should not be construed as a statement, negative or positive, as to the skill or quality of such provider or facility.

Your Responsibility

It is important to remember that the Plan is not designed to cover every health care expense. The Plan pays charges for eligible expenses, up to the limits and under the conditions established by the Board of Trustees. The decisions about how and when you receive health care are up to you and your doctor—not the Plan. The Plan determines how much it will pay, but you and your doctor must decide what medical care is best for you.

The following pages describe coverage of medical expenses. Unless otherwise noted, benefits are paid after you meet the annual deductible. All benefit maximums stated below apply to PPO and non-PPO provider services combined.

COVERED MEDICAL EXPENSES

Among other things, the Plan covers Hospital care, Physician services and other medical services. The Plan covers charges up to the Reasonable and Customary limits.

Physician's Charges	PPO	Non-PPO
Physician's charges for treatment of an illness or Injury.	90%	80%
Certified physician assistant services.	90%	80%
Telehealth/Virtual Visits with Your Physician Deductible does not apply.	100%	80%
Hospital Charges	**PPO**	**Non-PPO**
Hospital room and board, up to the Hospital's average semi-private room rate (if a PPO Hospital offers only private rooms, then the private room rate will be covered). ***You must call HCS at (800) 582-1535 before being admitted to a Hospital or within 24 hours following an Emergency admission. Otherwise, benefits are reduced by 20%. See Pre-Admission Review Program section for details.*** ***No Hospital benefits are paid for non-Emergency admissions over a weekend when your condition is not actively treated until the following Monday.***	90%	80%
Intensive care accommodations, up to three times the Hospital's semi-private room rate (if a PPO Hospital offers only private rooms, then the private room rate will be covered).	90%	80%
Breast reconstruction, mastectomy and post-mastectomy as required under Women's Health and Cancer Rights Act of 1998, as explained below.	90%	80%
Services and supplies provided by a Hospital during confinement.	90%	80%
Emergency treatment.	90%	90%
Diagnostic Tests	**PPO**	**Non-PPO**
General	90%	80%
Colorectal cancer screenings: a colonoscopy once every five years beginning at: ♦ Age 45; Note: At-home colon cancer screening tests, such as Cologuard, are not covered due to their lower accuracy rate.	90%	80%
Annual prostate cancer screenings for male participants beginning at: ♦ Age 50; or ♦ Age 40 for covered persons who have immediate family history of colorectal cancer.	90%	80%
Mammograms for women age 35 and older once each Calendar Year.	100%; deductible doesn't apply.	

Surgery	PPO	Non-PPO
Physician's charges for surgery.	90%	80%
Hospital charges related to surgery.	90%	80%
Anesthesia and its administration.	90%	80%
Second Surgical Opinions If you need a surgical procedure, you must call HCS at (800) 582-1535. HCS will tell you if a second surgical opinion is required for the procedure. If a second surgical opinion is required, then the Plan will pay for the second opinion in full, with no deductible. If a second surgical opinion is required and you do not get one, your benefits for the surgery will be reduced by 20%. If a second surgical opinion is not required, then the Plan will pay for the opinion in the same way as any other Covered Medical Expense, 90% for PPO and 80% for non-PPO providers, after the deductible. When you get a second opinion, regardless of the result, the decision of whether to have surgery is entirely yours. If the second opinion does not confirm the need for surgery, a third opinion also is covered in the same way as the second opinion. Second surgical opinions must be obtained by a specialist who is not associated with the doctor who recommends surgery and will not perform or assist in the proposed surgery.	90%	80%

Therapy	PPO	Non-PPO
X-ray, radium, chemotherapy and Radiation Therapy.	90%	80%
Physician's charges for radiotherapy procedures.	90%	80%
Speech therapy by a licensed speech therapist. (Subject to prior authorization after the first 18 visits)	90%	80%
Occupational therapy by a licensed occupational therapist. (Subject to prior authorization after the first 18 visits)	90%	80%
Applied Behavioral Analysis (ABA) therapy by a licensed professional acting within the scope of such license. (Subject to prior authorization after the first 18 visits.)	90%	80%
Physical Therapy by a licensed physical therapist. (Subject to prior authorization after the first 18 visits.)	90%	80%
Chiropractic care (with any services that are considered Essential Health Benefits subject only to the annual maximum for Essential Health Benefits). Physical Therapy provided by a chiropractor must meet the definition of Physical Therapy.	90% up to $1,000 annual benefit maximum for any chiropractic care deemed to be a non-essential health benefit.	80% up to $1,000 annual benefit maximum for any chiropractic care deemed to be a non-essential health benefit.

Diabetes Self-Management Training and Education	PPO	Non-PPO
Outpatient self-management training and education, equipment and supplies for the treatment of type 1, type 2 and gestational diabetes. Coverage includes the following: ♦ Prescription Drug Benefits • Blood glucose monitors • Blood glucose monitors and cartridges for the legally blind • Lancets and lancing devices • Insulin ($5/$25 Copayment for generic/brand, subject to a maximum Copayment of $100 per 30 days supply) • Syringes and needles • Test strips for glucose monitors ($5/$25 Copayment for generic/brand subject to a maximum Copayment of $50 per 30 days supply) • FDA approved oral agents used to control blood sugar • Glucagon emergency kits ♦ Regular foot care exams ♦ Diabetes self-management training as part of an office visit, group setting or home visit: • Up to 3 Medically Necessary visits following initial diagnosis of diabetes. • Up to 2 Medically Necessary visits following a significant change in the patient's symptoms or medical condition.	90%	80%

Family Planning and Care	PPO	Non-PPO
Annual preventive care "well woman" visits with any health care professional that has special training in providing care for women (such as an OB/GYN, midwife or nurse practitioner) including cervical cancer screening (i.e., a pap smear and HPV testing). (Other screening/tests are not covered.)	100%; deductible doesn't apply.	
Physician's charges for prenatal care, delivery and postnatal care. See page 32 for information about the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)	90%	80%
Well baby care, including routine nursery care in a Hospital and routine pediatric care during the first year of life.	100%	
Childhood immunizations for children under age 19 (office visits not covered) as recommended by the American Academy of Pediatrics.	100%; deductible doesn't apply.	
Well child care visit for children under age 19 once per year.	100%; deductible doesn't apply.	
Certain Adult Immunizations including flu shots, immunizations recommended by the Centers for Disease Control, and immunizations required for travel if certified as Medically Necessary by Sav-Rx	100%; deductible doesn't apply.	
Birthing Center	90%	80%
Treatment of Infertility Note that in vitro fertilization and other costly procedures are covered only when less costly Infertility treatments have not been successful. There are other limits on these benefits. Call the Fund Office for details. Lifetime maximum benefit per couple includes, but is not limited to, egg retrievals, in vitro fertilization, gamete intrafallopian tube transfer and zygote intrafallopian tube transfer. The diagnosis of and other treatments of Infertility, including the treatment of physical and hormonal conditions underlying Infertility are not counted against the $20,000 lifetime maximum Infertility benefit limit, but, instead, are subject to the annual maximum applicable to Essential Health Benefits. (See "Additional Information on Coverage for Infertility" on page 32 for more information.)	90% up to $20,000 per couple lifetime	80% up to $20,000 per couple lifetime

Other	PPO	Non-PPO
Hearing aids that are prescribed by a legally qualified otologist, audiologist or otolaryngologist.	100% with no deductible up to $750 lifetime maximum	
Rental of equipment such as wheelchairs, Hospital beds and other durable equipment for therapeutic treatment. Reduced by 20% if precertification is not obtained.	90%	80%
Lasik surgery (once per eye per lifetime).	90%	80% up to $1,600 per eye
Prosthetic devices for initial replacement of natural limbs or eyes.	90%	80%
Blood and blood plasma that is not donated or replaced.	90%	80%
Sterilization services.	90%	80%
Orthotic devices.	90%	80%
Casts, splints, trusses, braces and crutches.	90%	80%
Nursing services by a registered nurse or certified nurse midwife.	90%	80%
Hospice.	90%	80%
Dental care for treatment of natural teeth within 90 days after an accident, including the initial replacement of teeth and the setting of a jaw fractured or dislocated in the accident.	90%	80%
Bra (prosthetic) ordered after treatment for breast cancer.	90%	80%
Acupuncture, when recommended by a Physician, except that acupuncture administered to aid in overcoming eating disorders is not covered.	90%	80%
Ambulatory outpatient center.	90%	No coverage (for all services other than LASIK)
Ambulance services provided by a professional ambulance service for necessary transportation to the nearest hospital equipped to furnish treatment for an injury or disease.	90%	80%
Oxygen and its administration.	90%	80%
Smoking Cessation Benefits	90%	80%
Organ donation where the recipient is an Eligible Participant, regardless of whether the donor is covered by the Plan or not (includes expenses to harvest the organ, but not expenses related to pre-harvest match testing and post-harvest complications).	90%	80%

Mental Health and Substance Abuse Treatment	PPO	Non-PPO
The following benefits are available to you and your family in addition to the Member Assistance Program (MAP) benefits. See page 39 for more information about the MAP. Benefits are paid after you meet the annual deductible, and are subject to the Plan's annual maximum benefit for Essential Health Benefits.		
Diagnosis and treatment by a licensed psychiatrist, clinical psychologist, licensed clinical professional counselor, licensed clinical social worker, M.D., or any other professional provider appropriately licensed or certified as required by applicable law and acting within the scope of such license or certification. Inpatient benefits as follows when treatment is pre-certified by HCS (pre-certification is not required for outpatient mental health and Substance Abuse benefits).		
Mental Health and Substance Abuse Treatment:		
♦ Outpatient:		
• Doctor visits	90%	80%
• Psychiatric/psychological testing.	90%	80%
♦ Inpatient/Intensive Outpatient:		
• Hospital charges	90%	80%
• Doctor visits	90%	80%
Wellness Benefits		
Coverage for participation in the wellness benefit program (including blood analysis, urinalysis, cancer screening, and a lung function test) offered by the Fund's wellness provider or for a comparable physical examination provided that you submit the results to Health Care Strategies. (No coverage for wellness benefits if results are not submitted, unless otherwise covered under "Family Planning and Care" above.)	100% with no Deductible $250 Visa Gift Card incentive for participation in program offered by wellness provider (total of $500 if both Employee and spouse participate) OR $125 HRA credit for submission of physical exam results	

Newborns' And Mothers' Health Protection Act Of 1996 (NMHPA)

The Plan does not restrict a mother's or a newborn child's benefits for any Hospital length of stay related to childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In addition, a provider will not be required to obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

Women's Health And Cancer Rights Act Of 1998

The Plan covers reconstruction of the breast on which a mastectomy was performed, surgery on the other breast to produce a symmetrical appearance and prostheses, and physical complications of all stages of mastectomy, including lymphedemas. This coverage is subject to the Plan's deductible and Coinsurance provisions.

Additional Information on Coverage for Infertility

Infertility treatment, includes, but is not limited to the following procedures:

- In vitro fertilization,
- Uterine embryo lavage,
- Embryo transfer,
- Artificial insemination,
- Gamete intrafallopian tube transfer,
- Zygote intrafallopian tube transfer,
- Low tubal ovum transfer.

Benefits for in vitro fertilization, gamete intrafallopian tube transfers and zygote intrafallopian tube transfers are payable only if:

- The Eligible Participant has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments for which coverage is available under this Plan, and
- The procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Expenses for donor eggs and sperm donations are excluded from Infertility treatment.

Coverage for Emergency Services

The Plan covers Emergency Services provided by both PPO and non-PPO providers at 90%. Your Coinsurance responsibility with respect to Emergency Services received from a non-PPO provider or at a non-PPO Hospital (or other facility) will be based on the Recognized Amount.

Coverage for Certain Non-Emergency Services Received from Non-PPO Providers at PPO Facilities

If you receive non-Emergency items or services that are otherwise covered by the Plan from a non-PPO Provider who is working at a PPO facility, those non-Emergency items or services will be covered by the Plan as follows:

- The non-Emergency items or services received from a non-PPO Provider working at a PPO facility will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that

would apply if the items or services had been furnished by a PPO Provider (generally, this is 10%). In other words, the Coinsurance percentage and any co-payments applicable to such services will be the same as if the services were furnished by a PPO Provider.

- Your Coinsurance responsibility will be based on the Recognized Amount (as defined above).
- An exception applies with respect to certain non-PPO Providers who have provided notice to the patient and received informed consent with respect to the non-network billing practices in compliance with applicable law.
- If the exception applies, the applicable non-PPO Coinsurance to be paid by the Plan will be based on the Reasonable and Customary Charge.
- No exception is available with respect to providers of Ancillary Services, however, or with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or services is furnished, regardless of whether the notice and consent requirements have been satisfied.

Coverage for Air Ambulance Services

The Coinsurance rate that you pay for air ambulance (medial transport by fixed wing airplane or rotary wing helicopter) will be the same (10%) whether the provider is a PPO or non-PPO provider, and your Coinsurance responsibility will be calculated based on the lesser of the billed amount for the services or the median of the PPO network's contracted rates with participating providers in the geographic region for the respective services as of January 31, 2019, indexed for inflation thereafter.

Services or Supplies Obtained from Non-Network Provider Believed to be a Network Provider

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number listed on your ID card. The PPO network consists of providers, including Hospitals, of varied specialties as well as general practice, who are contracted with the Plan's Preferred Provider Organization (PPO).

If you obtain from the Plan or the Preferred Provider Organization and rely upon incorrect information about whether a provider is a PPO provider, the Plan will apply PPO cost-sharing to your claim, even if the provider is a non-PPO Provider. In other words, benefits will be paid as if the provider were, in fact, a PPO provider, subject to application of the PPO coinsurance rates.

Continuing Coverage with a Network Provider who Leaves the Plan's PPO Network

If you are a Continuing Care Patient and the Plan's PPO terminates its contract with your PPO provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will:

- Notify you in a timely manner of the Plan's termination of its contracts with the former PPO provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and
- Allow you ninety (90) days of continued coverage with benefits paid on the same terms and conditions under the Plan as if the provider or facility had remained in the PPO in order to allow time for you to transition your care to a PPO provider.

Important!
For your spouse and/or eligible Dependent children to receive prescription drug program benefits, they must be listed on your enrollment card. To update your enrollment card, contact the Fund Office.

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits are an important part of your health care package and offer convenient, cost-effective ways to get your prescriptions filled.

You and your covered Dependents receive comprehensive prescription drug benefits through the following two programs:

- The Sav-Rx Prescription Drug Card Program for short-term prescriptions (a 30-day supply or less and up to two refills); and
- The Sav-Rx Mail Service Pharmacy Program for long-term prescriptions (over a 30-day supply).

The Sav-Rx Prescription Drug Card Program

The Welfare Fund provides coverage for your short-term prescriptions through the Sav-Rx Prescription Drug Card Program. When you have your short-term prescription filled at a Participating Pharmacy and present your Sav-Rx identification (ID) card, you'll pay only a small portion of the prescription's cost at the time you receive your medication. There are no claim forms to file, and you don't have to satisfy the annual deductible before benefits begin.

Participating Pharmacies

There are thousands of pharmacies that participate in the Sav-Rx Program, including several national chain stores (Walgreen's, Osco, and CVS, just to name a few). If you need help finding a Participating Pharmacy near you, call Sav-Rx at (800) 228-3108.

Please note that Wal-Mart and Sam's Club do not participate in the Sav-Rx Program.

How The Sav-Rx Prescription Drug Card Program Works

When you fill a short-term prescription at a Participating Pharmacy and present your Sav-Rx ID card to the pharmacist, you'll automatically receive a discount on your prescription. Of that discounted price, you'll pay:

- 10% of the cost of a generic prescription (minimum $5); or
- 25% of the cost of a brand name prescription (minimum $25) or, if a generic is available, 30% of the cost (minimum $30) plus the difference in the cost between the generic prescription and the brand name prescription).

Notwithstanding the preceding, note that effective April 1, 2021, your payments towards the cost of insulin and diabetes test strips will be limited to a maximum of $100 and $50, respectively, for a 30-day supply.

You just pay your share of the cost at the time you fill your prescription. You can receive up to a 30-day supply (and up to two refills) of a short-term medication. Benefits for *long-term* (or maintenance) medications are available to you through the Sav-Rx Mail Service Pharmacy Program.

Please note that if your doctor indicates that a generic equivalent can be used to fill your prescription and you choose to receive a Brand Name Drug instead, you will pay more for your prescription. You will have to pay the difference in cost between the Brand Name Drug and its generic equivalent in addition to your Copayment. See page 36 for more information about generic versus Brand Name Drugs.

When you fill prescriptions through the Sav-Rx Prescription Drug Card Program or through the Sav-Rx Mail Service Pharmacy Program, the costs do not apply toward the Plan's annual deductible.

If you request a brand name medication when your doctor indicates your prescription can be filled with a generic, you should call Sav-Rx to find out the cost of your prescription in order to determine the cost difference between the generic and brand name.

If You Fill Your Prescription At A Non-Participating Pharmacy

If you fill your prescription at a non-Participating Pharmacy, it will not be Covered Under the Plan.

The Sav-Rx Mail Service Pharmacy Program

The Sav-Rx Mail Service Pharmacy Program provides coverage for your long-term prescriptions. Long-term (or maintenance) prescriptions are those that you take on an ongoing basis, and are used to treat conditions such as high blood pressure, ulcers, high cholesterol, arthritis and diabetes. There are no claim forms to file, and benefits are not subject to the annual deductible.

How The Sav-Rx Mail Service Pharmacy Program Works

You receive the highest level of coverage for your long-term prescriptions when you order your prescription through the Sav-Rx Mail Service Pharmacy Program. For up to a 90-day supply, you pay:

- 10% of the cost of a generic prescription (minimum $5); or
- 25% of the cost of a brand name prescription (minimum $25) or, if a generic is available, 30% of the cost (minimum $30) plus the difference in the cost between the generic prescription and the brand name prescription.

Please note that if your doctor indicates that your prescription can be filled with a generic equivalent and you choose to receive a Brand Name Drug instead, you'll pay more for your prescription. You will have to pay the difference in cost between the Brand Name Drug and its generic equivalent in addition to your Copayment. See page 36 for more information about generic versus Brand Name Drugs.

How To Order A Long-Term Prescription

If you are currently taking a long-term prescription, or if your doctor prescribes one for you, just follow the steps below to have your prescription filled through the Sav-Rx Mail Service Pharmacy Program:

Step 1: Ask your doctor for a new prescription for up to a 90-day supply. If you need the prescription filled immediately, ask your doctor to write two prescriptions: one for a 14-day supply to be filled at a Sav-Rx retail Participating Pharmacy, and one for up to a 90-day supply, you can use the 14-day supply while ordering your prescription by mail.

Step 2: Call Sav-Rx at (800) 228-3108 to ask for the price of the prescription.

Step 3: Send your written prescription and payment to Sav-Rx. You can pay by check or money order (payable to Sav-Rx) or you may charge your payment to your HRA debit card or to your VISA, MasterCard or Discover Card account.

In general, your long-term prescription will be delivered to your home within 14 days from the date you mail in your prescription. Sav-Rx pays all postage and shipping costs.

Prescription Refills

If your written prescription indicates that refills are available, the Sav-Rx Mail Service Pharmacy will send you a refill label with your prescription order. The refill label indicates the number of times that the prescription can be refilled and the earliest date at which the prescription can be refilled. Be sure to check your refill ticket to make sure that the prescription hasn't expired and that there are refills remaining. Otherwise, you may need to get a new prescription from your doctor.

If you are paying for your refill by check or money order, attach the refill label to a Prescription Order Form and send it to Sav-Rx along with your payment.

If you are paying for your refill by HRA Card, VISA, MasterCard or Discover Card, all you have to do is call (800) 228-3108 to order your refill by telephone. When you call, please have your prescription label and credit card information in front of you.

If There Are No Refills Remaining

If there are no refills remaining on your prescription, you can:

- Call your doctor for a new written prescription to submit to Sav-Rx;
- Have your doctor call Sav-Rx at (800) 228-3108 to order additional refills on your behalf; or
- Fax your prescription to (888) 810-1394.

How To Transfer A Prescription From Another Pharmacy

If you want to transfer an existing prescription from another pharmacy to the Sav-Rx Mail Service Pharmacy, just send the following items to Sav-Rx:

- The pharmacy's name and phone number; and
- The prescription number or your doctor's name and phone number.

Sav-Rx will make the phone calls necessary to transfer your prescription to the Sav-Rx Mail Service Pharmacy.

General Information About Prescription Drug Benefits

The following information applies to the benefits available through the Sav-Rx Prescription Drug Card Program and the Sav-Rx Mail Service Pharmacy Program.

Expenses That Don't Apply To Provisions Of The Medical Plan

When your prescriptions are filled through the Sav-Rx Prescription Drug Card Program or the Mail Service Pharmacy Program, your costs do not apply toward annual deductible.

Generic Versus Brand Name Drugs

Generic drugs have the same active ingredients, potency and effectiveness as Brand Name Drugs. So why do they cost less? When a company develops a new drug, it has to pay for researching, developing and marketing the new drug. In return, it receives a "patent" and has exclusive rights to make and sell that drug — under a brand name — for a number of years. When the patent expires, other companies can make and sell the drug.

The drug can then be marketed as a Generic Drug or as a Brand Name Drug, even though it is essentially the same medication. However, the Generic Drug almost always costs less. If your doctor prescribes a Brand Name Drug, you may want to ask if a generic equivalent is available.

The prescription drug program limits payment for a prescription to the cost of the Generic Drug when a generic equivalent is available and your doctor allows the Generic Drug to be substituted for the Brand Name Drug. If you choose to receive a Brand Name Drug when a generic equivalent is available, you'll pay the difference in cost PLUS a higher co-payment amount.

Step Therapy Program

In many instances there are a number of drugs available to treat a particular long-term Sickness (like arthritis, asthma, high cholesterol, or high blood pressure, depression, osteoporosis, and migraines) or Injury.

Under the Step Therapy Program, the Plan will require that you first try an available generic medication or a lower cost brand medication in the therapeutic class. These are referred to as "first-line" or "step one" medications. If you elect to purchase a higher cost medication (a "second-line" or "step two" medication) without trying an appropriate generic or lower cost brand name medication, you will pay the full cost of the drug. If you try the generic or lower cost brand medication, and your Physician finds that the step one medication is not effective in treating your condition, you will be able to receive the higher cost step two brand medication at the applicable Copayment/Coinsurance rate. This does not apply to those brand name prescriptions for which there is a direct generic equivalent available. In those instances, if you decide to take the brand when there is a direct generic equivalent available, you will be required to pay the difference in cost plus the higher Brand Name Coinsurance amount.

Sav-Rx or the pharmacist will communicate with you and/or your Physician about any drugs that you are taking for which there is an available first-line medication to treat your condition.

Prior Authorization

Certain medications will be covered only subject to prior authorization by Sav-Rx. These include Specialty Drugs such as the medications administered in home infusion therapy, in a physician's office, or at an outpatient infusion center. You will be notified if a medication is subject to prior authorization. For a list of medications subject to prior authorization, please contact Sav-Rx.

Covered Medications

Covered charges are those Reasonable and Customary Charges incurred for the following prescription drugs and supplies that are Medically Necessary for treatment of an Injury or Sickness, subject to the conditions and limitations set forth in the Schedule of Benefits.

- All medications which, by federal law, can be dispensed only pursuant to a prescription, and which are required to bear the legend, "Caution, Federal Law Prohibits Dispensing Without Prescription," unless otherwise excluded below,
- Compounded medication of which at least one ingredient is a prescription legend drug,
- Insulin,
- Insulin syringes/needles,
- Non-insulin syringes,
- Swabs, blood test strips, blood glucose calibration solutions, urine tests, blood glucose monitors and kits, blood glucose monitors and cartridges for the legally blind, test strips for glucose monitors, lancets and lancet devices,
- FDA-approved oral agents used to control blood sugar,
- Glucagon emergency kits,
- Retin A for Eligible Participants with a letter from the Physician stating that the drug is Medically Necessary,
- Injectable drugs (subject to prior authorization),
- Contraceptive devices,
- Generic oral contraceptives, and
- Over-the-counter proton pump inhibitors with a prescription.

No prior authorization is needed to obtain coverage for these drugs unless specified otherwise above.

Medications Not Covered

Some types of medications are excluded from coverage under the Plan. These are:

- Prescriptions filled at a nonparticipating Pharmacy,
- Vitamins,
- Brand name oral contraceptives,
- Weight-loss medications, devices and appliances,
- Cosmetic drugs and medications,
- Retin A, if the patient does not have a letter from the Physician stating that the drug is Medically Necessary,
- Drugs that are considered Experimental or Investigative or are not approved by the Federal Drug Administration for the condition being treated,
- Existing and new drugs that are not uniformly and professionally endorsed by the general medical community for prescription in the course of standard medical care,
- Medications and supplies that may be purchased over-the-counter (except over-the-counter proton pump inhibitors with a prescription), and
- Drugs that are obtained through a non-participating pharmacy.

As new drugs become available, they are normally covered. However, the Board of Trustees reserves the right to review industry practices and consult with medical advisors before determining how a new drug will be covered by the Plan.

As new drugs become available, they are normally covered. However, the Board of Trustees reserves the right to review industry practices and consult with medical advisors before determining how a new drug will be covered by the Plan.

The Fund coordinates prescription drug benefits with your spouse's insurance. See Coordination Of Prescription Drug Benefits on page 74 for more information.

MEMBER ASSISTANCE PROGRAM (MAP)

Sometimes it can be hard to know where to turn for help with a personal concern. That's why the Fund provides a Member Assistance Program (MAP) to you and your immediate family members. Call the MAP at the phone number provided in the Important Phone Numbers section at the beginning of this booklet at any time, night or day, to speak confidentially with a MAP counselor. The counselors can help with problems such as:

- Marital problems;
- Family or parenting issues;
- Financial worries;
- Legal concerns;
- Drug or alcohol dependency; or
- Psychiatric or psychological concerns.

No problem is too big or too small, and any contact you have with the MAP is ***strictly confidential.***

When You Call

When you call the MAP, a counselor will schedule an appointment to meet with you. Depending on the issue at hand, the MAP will provide short-term counseling or refer you to specialized treatment. Problems that generally require referrals include long-term personal problems, alcoholism and drug abuse.

All services provided by the MAP are *free of charge to you*. If a counselor refers you to specialized treatment, the medical Plan may provide benefits for that treatment. MAP benefits are *in addition* to the mental health and Substance Abuse benefits provided by your medical coverage.

If a personal concern is interfering with your work or family life, call the MAP at the number listed in the Important Phone Numbers section at the beginning of this booklet. MAP counselors are available 24 hours a day, seven days a week, to help you with your problem -- no matter how big or how small. ***All contact with the MAP is strictly confidential.***

PRE-ADMISSION REVIEW PROGRAM

You must precertify your Hospital, Skilled Nursing Facility, or other facility stay (whether for surgery or otherwise) by calling the Utilization Review Service at the number listed in the Important Phone Numbers section at the beginning of this booklet to receive full benefits from the Plan.

Note: Precertification of an inpatient stay does not guarantee coverage. Rather, precertification is merely a determination as to whether services are Medically Necessary. For information as to Plan coverage, please contact the Fund Office.

In the face of rising health care costs, we want you to get the best care available in the most cost-effective manner. To help manage our Hospital and other facility expenses, the Utilization Review Service provides preadmission review for Hospital, Skilled Nursing Facility, Treatment Facility for Substance Abuse, and any other facility admissions (including, but not limited to, inpatient admissions for rehabilitative services).

If your Physician recommends an inpatient Hospital, Skilled Nursing Facility, Treatment Facility for Substance Abuse, or other facility stay, you, your Physician or the facility generally must call the Utilization Review Service before you are admitted.

- If the admission is not urgent: Call at least 10 business days before admission.
- If the admission is an Emergency: Advance review is not required. Call within 24 hours following confinement, or on the next business day if the confinement starts on a Friday, Saturday, or holiday.
- For pregnancy, you may precertify your admission any time after the pregnancy is confirmed. Then, you, a family member or your Physician should call the Utilization Review Service again when you enter the Hospital.

Here is how benefits are paid:

Situation	Benefits
You call the Utilization Review Service before admission and the representative certifies the Hospital, Skilled Nursing Facility or other facility stay.	The Plan pays 90% (80% if you use non-PPO providers) of most covered Reasonable and Customary Charges after you satisfy the annual deductible.
You call the Utilization Review Service before admission, and the representative does not certify the Hospital, Skilled Nursing Facility or other facility stay.	No benefits are paid.
You do not call the Utilization Review Service before admission, and the representative certifies the Hospital, Skilled Nursing Facility or other facility stay after admission.	Benefits are reduced by 20%.
You do not call the Utilization Review Service before admission, and the representative does not certify the Hospital, Skilled Nursing Facility or other facility stay after admission.	No benefits are paid.

You must call the Utilization Review Service at the number listed in the Important Phone Numbers section at the beginning of this booklet before your Hospital admission. (While the Hospital or Physician may call the Utilization Review Service on your behalf, it is your responsibility to make sure treatment is precertified.)

PRIOR AUTHORIZATION PROGRAM

Certain treatments, procedures and supplies require prior authorization in non-Emergency situations. For Emergencies, prior authorization is not required; however, you must report the treatment to the Utilization Review Service within 24 hours following treatment or on the next business day if the treatment begins on a Friday, Saturday, or holiday. If you do not follow these procedures for prior authorization/Emergency authorization, the Plan will reduce the amount of benefits that would otherwise be payable by 20%. Prior authorization from the Utilization Review Service is required for these treatments, procedures and supplies:

- Outpatient surgery or other invasive procedures (whether coded as surgeries or not), including, but not limited to surgical treatment of obesity, such as gastric bypass surgery or lap band procedures,
- Intensive outpatient treatment,
- Treatment at a freestanding ambulatory outpatient center (note: no coverage at all for treatment at non-PPO outpatient surgical center).
- Surgical services provided by a Physician's assistant,
- Durable medical equipment if the purchase price is greater than $1,500,
- Orthotic devices in excess of $1,500,
- Prosthetic Devices in excess of $1,500,
- Speech, occupational, physical, and ABA therapy after the first 18 visits,
- Services rendered outside of the U.S. unless on an Emergency basis,
- Colonoscopies,
- Injectable Specialty Drugs (Note: The Utilization Service must authorize the administration of the drug, and, if the drug is provided outside of a facility, SavRx must approve the use of the drug itself.),
- Infertility treatment,
- Rehabilitative services provided at a nursing home (note: no coverage for nursing home itself),
- Midwife services,
- Home birth,
- Birthing center,
- Treatment of sleep apnea,
- Sleep studies,
- Stress test,
- Treatment for pregnancy and child birth (may be authorized any time after pregnancy is confirmed and before delivery),
- Home health care,
- Hospice Care,
- Chemotherapy,
- Radiation,
- CT/CAT scans, MRA, MRI, PET scans, and nuclear scans,
- Cardiogram/echocardiogram/EKG,
- Tubal ligation,
- EGD,
- Vein stripping,
- Home infusion therapy,
- Skilled Nursing services,
- Observation in excess of 23 hours,
- Biopsy in excess of $2,000,
- Nutrition counseling after the first 18 visits,
- Charges for office procedures in excess of $2000,
- Anesthesia for dental services,
- Electroconvulsive therapy (ECT)/ Electric shock therapy,
- TMS (Transcranial Magnetic Stimulation),
- Enteral feeding

Note: Prior authorization does not guarantee coverage. Rather, prior authorization is merely a determination as to whether services are Medically Necessary. For information as to Plan coverage, please contact the Fund Office.

MEDICAL EXPENSES THAT ARE NOT COVERED

The Plan covers many services and supplies but, like all plans, it doesn't cover everything. If you have questions about whether an expense is covered, please call the Fund Office.

The following is a list of services, supplies and expenses that your Plan does not cover. Additional exclusions not listed below are listed in the "General Plan Exclusions" section beginning on page 59.

- Acupuncture administered to aid in overcoming eating disorders;
- Bedwetting corrective device;
- Bereavement counseling (unless provided through the MAP);
- At-home colon cancer screening tests (such as Cologuard), due to their lower rate of accuracy than colonoscopies;
- Dental care, except as specifically mentioned above for treating an accident;
- Exercise programs for the treatment of any condition;
- Gene and cell therapy drugs, products, and services (including therapies that genetically modify member's cells in vitro such as CAR-T, cellular immunotherapies, genetically modified oncolytic viral therapy, products derived from gene editing technologies, and oligonucleotide-based therapies);
- Genetic testing charges or expenses incurred for preventive surgery resulting from genetic testing (the Plan does cover treatment of a diagnosed Illness, but does not cover service provided merely as a result of a genetic propensity for Illness);
- Growth hormones;
- Home construction charges (to accommodate a disabled person);
- Charges for or relating to marriage counseling, mind expansion or elective psychotherapy, except as provided through MAP benefits or for the treatment of Mental Illness;
- Treatment provided by an ambulatory outpatient center or other outpatient treatment facility that is outside of the PPO network (unless treatment is or is related to LASIK surgery);
- Charges incurred in connection with confinement in a nursing home, rest home, convalescent home or a place for the aged;
- Orthopedic shoes;
- Reversal of surgical sterilization;
- Charges for routine physical exams or tests that are not related to an Illness or Injury, except as specifically described earlier in this Summary Plan Description;
- Sexual reassignment;
- Services or supplies related to temporomandibular joint dysfunction (TMJ), including surgery performed on the temporomandibular joint;
- Any charges related to a surrogate pregnancy, including medical expenses for the surrogate mother, child, and any complications resulting from the surrogate pregnancy;
- Travel charges and travel accommodations, whether or not recommended by a Physician (except for ambulance charges as defined in Covered Medical Expenses);
- Routine vision care, including eye exams, eyeglasses, contact lenses or their fitting. (For covered vision expenses, see page 46);
- Non-Emergency Hospital weekend admissions when the condition is not actively treated until the following Monday;
- Wellness care and preventive care (except as provided in the Schedule of Benefits or as provided by the Fund's Wellness Provider); and
- Wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician, except that the initial purchase of a wig will be covered following radiation or chemotherapy treatment, provided the change does not exceed the Reasonable and Customary Charge.

DENTAL COVERAGE

HOW YOUR DENTAL COVERAGE WORKS

For most covered dental services, the Plan pays 80%/70% (PPO/NonPPO, respectively) of covered charges once you satisfy a $25 annual deductible. The Plan pays up to $3,500 per person in dental benefits each year .

The Dental Network of America (DNOA) PPO network is offered under the Plan. DNOA is a nationwide dental PPO network with over 75,000 providers (3,200 in Illinois). The network provides an average savings of 33% as compared to what most dental providers charge. If you utilize a PPO provider, the Fund will pay 80% of the charges compared to 70% of the charges for a NonPPO provider.

The Plan is designed to help cover the costs of dental care for you and your family:

1. Each Calendar Year, each covered person pays the first $25 of covered charges—the deductible. (To encourage regular dental care, you do not have to satisfy the deductible before benefits are payable for preventive and diagnostic care.)
2. Then, the Plan pays 80%/70% (PPO/NonPPO, respectively) of remaining covered dental expenses up to a maximum benefit of $3,500 per person each Calendar Year.

Covered dental expenses fall into these three categories:

Type of Service	Preventive and Diagnostic	Basic Dental	Denture Replacement
Deductible	None	$25 per person each Calendar Year	
Coinsurance	80%/70% (PPO/NonPPO, respectively)	80%/70% (PPO/NonPPO, respectively)	80%/70% (PPO/NonPPO, respectively)
Annual Maximum	$3,500 per person each Calendar Year		

The deductible, Coinsurance and annual maximum are explained in more detail below.

The Deductible

Before benefits are payable for basic dental care and denture replacement services, you must first meet the $25 annual deductible. There is no deductible for preventive and diagnostic services.

The individual deductible applies to each covered person once each Calendar Year.

Coinsurance

Your Coinsurance is the percentage of charges you pay for covered expenses. The Plan pays 80%/70% (PPO/NonPPO, respectively) of Reasonable and Customary Charges. Your Coinsurance is the remaining 20%/30% (PPO/NonPPO, respectively) of charges.

You can receive up to $3,500 each year in dental benefits.

Reasonable And Customary Limits

The Plan pays benefits up to the Reasonable and Customary Charge.

Alternative Procedures

There is often more than one way to treat a dental problem. For instance, in repairing a tooth, sometimes a silver (amalgam) filling can be just as effective as a gold one. The Plan will always base its determination of Reasonable and Customary Charges on the least costly procedure that gets the job done and meets acceptable dental standards.

Annual Maximum

You and each covered Dependent can receive up to $3,500 each Calendar Year in dental benefits from the Plan.

COVERED DENTAL EXPENSES

Among other things, the Plan covers exams, fillings, x-rays and dentures.

Note that the Plan does not cover orthodontia.

Preventive And Diagnostic Care

The Plan pays 80%/70% (PPO/NonPPO, respectively) of Reasonable and Customary Charges for the following services, with no deductible requirement:

- Dental examinations, including diagnosis performed by a Dentist, twice per Calendar Year.
- Prophylaxis (cleaning of the teeth) performed by a Dentist or Dental Hygienist, twice per Calendar Year.
- Topical application of fluoride, once every 12 months.
- Necessary dental x-rays and bite-wing x-rays once each Calendar Year. Benefits for full-mouth (panoramic) x-rays are payable once every three years.
- Sealants, once every 12 months.

Basic Dental Care

After you meet the deductible, the Plan pays 80%/70% (PPO/NonPPO, respectively) and you pay 20%/30% (PPO/NonPPO, respectively) of Reasonable and Customary Charges for the following:

- Extraction of teeth.
- Oral surgery.
- Periodontal treatment (treatment of the gums and tissues of the mouth).
- Fillings.
- Crowns.
- Initial installation of complete or partial removable dentures or fixed bridgework.

Denture Replacement

After you meet the deductible, the Plan pays 80%/70% (PPO/NonPPO, respectively) of Reasonable and Customary Charges for replacing an existing complete denture, but only if the denture or bridgework was installed five or more years before its replacement.

Bony Impacted Wisdom Teeth

Generally, dental coverage for individuals age 19 and over is subject to an annual maximum benefit of $3,500 per Calendar Year, as set forth above. However, if an individual has 100% bony impacted wisdom teeth, once the $3,500 maximum has been met, additional coverage will be available as a covered medical expense at 90% (PPO)/80% (non-PPO) once the $500 (individual)/$1,000 (family) medical deductible has been met. Further, individuals under age 19 will receive coverage that is no less in value than what they would have received prior to the elimination of the application of the $3,500 maximum to their dental care.

DENTAL EXPENSES THAT ARE NOT COVERED

The Plan does not cover all dental expenses. Here you will find a list of some of the expenses that are not covered by the Plan. Additional exclusions not listed below are listed in the "General Plan Exclusions" section beginning on page 59. If you have any questions about whether an expense is covered, call the Fund Office.

Here are some examples of charges that are not covered:

- Orthodontic treatment;
- Dental services provided solely for cosmetic reasons, except when needed because of an accidental Injury;
- Replacement of a lost or stolen denture; and
- Sterilization of equipment/infection control.

VISION COVERAGE

*Each year you are eligible to receive benefits for **either** eyeglass lenses **or** contact lenses.*

HOW YOUR VISION COVERAGE WORKS

Your vision care benefits can offset your costs for eye exams, and eyeglasses or contact lenses.

Here's how your vision benefits work:

- The Plan covers vision care services provided by a licensed ophthalmologist or optometrist. You can choose any doctor you wish. However, benefits generally will be highest for services and supplies received from in-network providers, with the highest benefits paid for providers in the "Plus" network.
- The Plan pays benefits as shown in the schedule below. Covered expenses include eye exams, frames, and eyeglass or contact lenses.
- You can receive benefits for either lenses for eyeglasses or contact lenses as shown in the following chart during any Plan Year.
- If you see an in-network provider, you will be responsible for paying any appliable copayment or any cost above the allowance shown in the schedule below, and the provider will file a claim with the Plan for the benefits available under the Plan. If you see a non-network provider, you must pay the provider for any services or supplies that you receive and then submit a claim for reimbursement up to the maximum dollar amount shown in

COVERED VISION EXPENSES

*As detailed in the chart below, the Plan pays up to a certain set dollar amount for certain services and supplies. For other services and supplies, you pay only the copayment shown, and the Plan will pay the rest of the cost.*The Plan pays the following amounts for covered expenses:

SCHEDULE OF BENEFITS

Service/Supply	Frequency
Vision Examination	Once every Plan Year
Vision Materials	
♦ Frame	Once every Plan Year
♦ Lenses and Lens Options	Once every Plan Year
♦ Contact Lenses	Once every Plan Year

Benefit	In-Network		Non-Network Provider *Reimbursement up to*
	Plus In-Network Provider	In-Network Provider	
Vision Examination			
Comprehensive Eye Exam	$0 Copayment	$20 Copayment	$40
Vision Materials			
Frame	$0 Copayment, up to $200 Allowance	$0 Copayment, up to $150 Allowance	$105
Contact Lenses *Only one of the following contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses and Lens Options.*			
♦ Conventional	$0 Copayment, up to $150 Allowance	$0 Copayment, up to $150 Allowance	$105
♦ Disposable	$0 Copayment, up to $150 Allowance	$0 Copayment, up to $150 Allowance	$105
♦ Medically Necessary	Paid in Full	Paid in Full	$300
Standard Plastic Lenses			
♦ Single Vision	$20 Copayment	$20 Copayment	$30
♦ Bifocal	$20 Copayment	$20 Copayment	$50
♦ Trifocal	$20 Copayment	$20 Copayment	$70
♦ Lenticular	$20 Copayment	$20 Copayment	$70
♦ Progressive-Standard	$75 Copayment	$75 Copayment	$50
♦ Progressive-Premium Tier 1	$105 Copayment	$105 Copayment	$50
♦ Progressive-Premium Tier 2	$115 Copayment	$115 Copayment	$50
♦ Progressive-Premium Tier 3	$130 Copayment	$130 Copayment	$50
♦ Progressive-Premium Tier 4	$195 Copayment	$195 Copayment	$50
Lens Options			
♦ Anti-Reflective Coating-Standard	$45 Copayment	$45 Copayment	$23
♦ Anti-Reflective Coating-Premium Tier 1	$57 Copayment	$57 Copayment	$23
♦ Anti-Reflective Coating-Premium Tier 2	$68 Copayment	$68 Copayment	$23
♦ Anti-Reflective Coating-Premium Tier 3	$85 Copayment	$85 Copayment	$23
♦ Polycarbonate Lenses-Standard Dependent Children under 19 years old	$0 Copayment	$0 Copayment	$0 Copayment

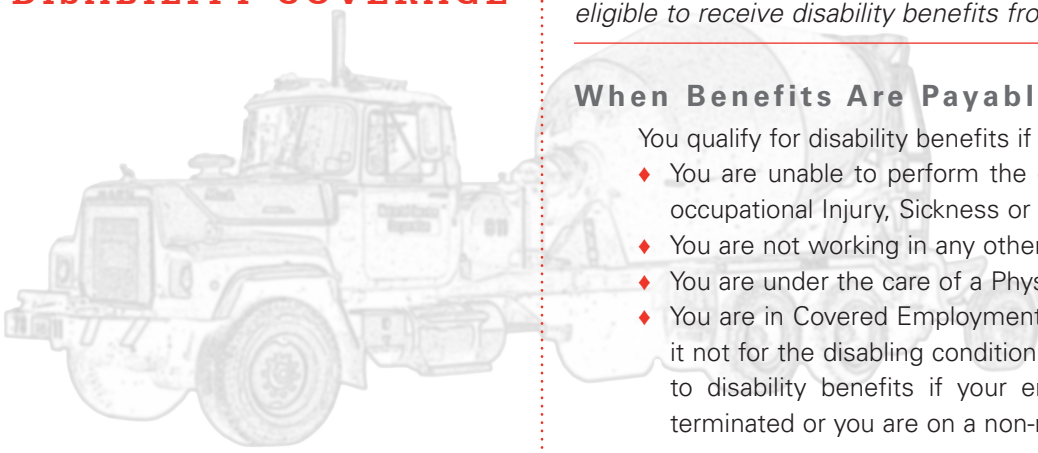
VISION EXPENSES THAT ARE NOT COVERED

Although the Plan covers many expenses, some services and supplies are not covered, including the following.

- Refraction except to the extent provided as part of your annual eye exam;
- Orthoptics or vision training, subnormal vision aids, and any associated supplemental testing;
- Aniseikonic lenses (lenses to correct a defect in which two retinal images of an object differ in size);
- Solutions, cleaning products, or frame cases;
- Two pairs of glasses instead of bifocals;
- Nonprescription/plano sunglasses, lenses, or contact lenses;
- Lost or broken lenses, frames, glasses or contact lenses unless replaced during a subsequent Plan Year;
- Medical or surgical treatment of the eyes or other related services or supplies (however, this may be covered under the medical benefits);
- Eye exams or corrective supplies required by an Employer as a condition of employmen;
- Benefits for eyeglass lenses during the same Plan Year in which you receive benefits for contact lenses;
- Safety eyewear;
- Services or materials provided as a result of any workers' compensation law or similar legislation, or required by any governmental agency or program; and
- Services rendered after the date you cease to be covered by the Plan except to the extent supplies have been ordered before coverage ended, and any related services are rendered within 31 days from the date

If you choose these services or features, the additional cost is your responsibility.

DISABILITY COVERAGE



The Plan pays a weekly $400 disability benefit for up to 26 weeks.

DISABILITY BENEFITS

If you're unable to work due to Sickness, Injury or pregnancy you may be eligible to receive disability benefits from the Plan.

When Benefits Are Payable

You qualify for disability benefits if you meet all of these requirements:

- You are unable to perform the duties of your job because of a non-occupational Injury, Sickness or childbirth;
- You are not working in any other occupation;
- You are under the care of a Physician; and
- You are in Covered Employment and would be actively working were it not for the disabling condition. (In other words, you are not entitled to disability benefits if your employment has been suspended or terminated or you are on a non-medical leave of absence.)

When Benefits Begin

The date benefits begin depends on the nature and timing of your disability.

- If the disability is due to an Injury, benefits begin on the first day of disability.
- If the disability is due to Sickness or pregnancy, benefits begin on the eighth day of continuous disability.
- Notwithstanding the above, if the disability begins while you are on lay-off, disability benefits will not begin until the later of the above date or the date that you would have been called back to work. You should contact the Fund Office if and when you are called back to work in this situation.

Amount Of Benefit

When you're disabled, the Plan pays a weekly benefit of $400. Benefits are paid until you recover, retire, or otherwise terminate employment, and start receiving pension benefits from the Teamsters Local Union 786 Building Material Pension Fund, up to a maximum of 26 weeks for each period of disability.

Two Or More Disabilities

Suppose you are disabled, recover and return to work for a day, and then become disabled again as a result of the same cause. If you work less than two weeks before becoming disabled again, you are eligible for one period of benefits (26 weeks total). If you work two weeks or longer before becoming disabled again, you are eligible for a new 26-week period of benefits, regardless of how long you work in between disabilities, so long as you have returned to work for at least one day.

When Benefits Are Not Paid

Benefits are not paid for an illness or Injury related to your work. However, you may be eligible for workers' compensation benefits. Contact your Employer or local Workers' Compensation office for more information.

Even if you are disabled as described above, disability benefits also are not paid or will end prior to the expiration of the 26-week period if you otherwise would not be able to work even if you were not so disabled – for example, due to your Employer going out of business or laying off all similarly situated Employees.

Additionally, on any day that you receive paid leave under any other applicable federal or state law, you will not be eligible to receive disability benefits on this basis, except with respect to Sickness due to having the virus yourself. Disability benefits (except when you yourself are sick) will only begin after expiration of any such paid leave.

LIFE AND AD&D INSURANCE

You have $75,000 of life insurance coverage through the Plan.

Life and AD&D insurance is made available through an insurance policy. If there are any conflicts between this booklet and the policy, the terms of the policy govern. You may request a copy of the policy from the Fund Office.

LIFE INSURANCE

Your beneficiary receives a life insurance benefit if you die.

Life Insurance Benefit

In the event you die while covered by the Plan, your beneficiary will receive a life insurance benefit of $75,000.

Repatriation Benefit

If you die more than 200 miles from your primary place of residence, the Plan also pays an additional repatriation benefit of up to $5,000 for the transportation of your body to a mortuary near your primary place of residence.

Eligibility

You will become eligible for life insurance benefits as of the first day of the month after completion of six (6) weeks of Covered Employment provided that you are actively at work or capable of active work (performing the material duties of your own occupation at your Employer's usual place of business) on the day before your eligibility date. If you are not actively at work or capable of active work, your coverage will not be effective until the day after you complete a full day of active work. You will no longer be eligible if you become a full-time member of the armed forces of any country.

Eligibility ends when your employment terminates or when you case to be eligible for coverage under the Plan. However, if you cease to be eligible under the Plan because you are working less than required, your life insurance will be continued as follows:

- While your Employer is paying you at least the same annual earnings as before loss of eligibility
- While you are unable to work because of sickness, injury, or pregnancy. (If you are totally disabled and not eligible for waiver of premium as set forth below, your life insurance will continue for six months, even if your employment terminates.)
- During the first 60 days of a temporary layoff or a strike, lockout, or other general work stoppage caused by a labor dispute between the Union and your Employer.
- During a leave of absence if continuation is required by applicable law (such as a law pertaining to family or medical leave).
- During any other scheduled leave of absence of up to 60 days if approved by your Employer in advance and in writing.

Designation of Beneficiaries

You may name anyone you wish as your beneficiary. **See Your Beneficiary Card** on page 7 for more information. You can change the beneficiary designation at any time by completing, dating, and signing a new Beneficiary Card and submitting it to the Fund Office. The card on file with the Fund Office or the insurance carrier takes precedence over a card that has not been received by either the Fund Office or carrier. In the unlikely

event that two cards remain on file with either the Fund Office or insurance carrier (or both), the card with the more recent date will be honored.

Unless provided otherwise, if a beneficiary dies before you, the deceased beneficiary's share of life insurance benefits will be divided equally among any remaining named beneficiaries. If no named beneficiary survives you, life insurance benefits will be paid to the following beneficiaries, if living in the following order: your spouse, natural or adopted children equally, father and mother equally, or your estate.

Continuation of Life Insurance Upon Disability

If you lose eligibility under the Plan due to being totally disabled prior to reaching age 60, your life insurance benefits may be extended, and you will be eligible for a premium waiver after you satisfy a waiting period if all required premiums have been paid and you provide satisfactory and timely proof of total disability to the insurance carrier.

The waiting period is the 180-day period beginning on the day you become totally disabled; your total disability must continue for the entirety of the waiting period. You must continue to pay premiums until the later of (i) the date you complete the waiting period or (ii) the date the insurance company approves your claim for waiver of premium. The insurance company may refund premiums paid for insurance after the date you provide satisfactory proof of being totally disabled. The waiting period is waived if you die during the waiting period.

You will be considered to be totally disabled for these purposes if, as a result of sickness, pregnancy, or accidental injury, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably suited by education, training, and experience.

The waiver of premium ends on the earliest of:

- The date you stop being totally disabled,
- The date you fail to attend an examination or cooperate with an insurance examiner,
- 90 days after the date a request for additional proof of disability is mailed to you if you do not provide the additional proof, and
- With respect to any amount of insurance you have converted, the effective date of the individual life insurance policy issued to you.

Accelerated Life Insurance Benefits

If you give the insurance company satisfactory proof that you have a qualifying medical condition, you may have the right to receive during your lifetime a portion of the insurance amount as an accelerated benefit.

For purposes of the accelerated benefit, a qualifying medical condition means that you are terminally ill as a result of an illness that is reasonably expected to result in death within 12 months.

You may receive an accelerated benefit of 75% of the insurance amount, paid once in your lifetime in a lump sum. You are not required to repay the amount if you recover.

The accelerated benefit will not be paid if:

- All or part of your insurance benefit is payable to an irrevocable beneficiary such as a former spouse as part of a divorce decree or separation agreement,
- You made an assignment of all or part of the insurance (unless you provide a signed written consent from the assignee),
- You are married and live in a community property state (unless you provide a signed written consent from your spouse),
- You are required by a government agency to use the accelerated benefit to apply for, receive, or continue a government benefit or entitlement, or
- You have previously received an accelerated benefit under the Policy.

This benefit is paid in lieu of a portion of the life insurance benefit that would have been paid at your death. Once this benefit is paid, the amount of your life insurance benefit will be reduced by the accelerated benefit you received plus interest.

Conversion Rights

You may have the right to convert the life insurance benefit to an individual policy of life insurance pursuant to the terms of the life insurance policy. For more information, please consult the life insurance carrier as identified in the Plan Information section.

Life and AD&D insurance is made available through an insurance policy. If there are any conflicts between this booklet and the policy, the terms of the policy govern. You may request a copy of the policy from the Fund Office.

AD&D INSURANCE

Accidental death and dismemberment (AD&D) insurance pays a benefit if you die or suffer certain serious injuries in an accident.

Eligibility

You will become eligible for AD&D insurance benefits as of the first day of the month after completion of six (6) weeks of Covered Employment provided that you are actively at work or capable of active work (performing the material duties of your own occupation at your Employer's usual place of business) on the day before your eligibility date. If you are not actively at work or capable of active work, your coverage will not be effective until the day after you complete a full day of active work. You will no longer be eligible if you become a full-time member of the armed forces of any country.

For purposes of this benefit only:

- a "spouse" includes your lawful spouse, civil union partner, or domestic partner (provided you've completed and submitted an affidavit of declaration of domestic partnership) provided that none of these individuals are full-time members of the armed forces of any country, and
- a "child" means natural born and adopted children and stepchildren living in your home from live birth through age 25, except that the age limits will not apply with respect to children who are continuously incapable of self-sustaining employment because of physical or mental incapacity and chiefly dependent upon you for support and maintenance or institutionalized because of mental retardation or physical incapacity.

In the event you die or suffer one of the listed injuries in an accident, the Plan pays the benefits listed in the following chart. AD&D benefits are in addition to any life insurance benefits payable on your behalf.

Loss	Benefit Amount
Death Both hands or both feet Sight of both eyes One hand and one foot One hand and sight of one eye One foot and sight of one eye	$75,000
One hand One foot Sight of one eye	$37,500

No more than $75,000 will be paid for all losses resulting from any one accident.

Generally, all benefits are payable to you, the Employee. However, in the event that you die accidentally, or die before benefits have been distributed, benefits are payable to your beneficiary—the person you name to receive the insurance amount (the same beneficiary designated for purposes of life insurance). You name a beneficiary when you become eligible under the Plan, and you can change your beneficiary at any time by completing and signing a new beneficiary card and submitting it to the Fund Office. The card on file with the Fund Office or the insurance carrier takes precedence over a card that has not been received by either the Fund Office or carrier. In the unlikely event that two cards remain on file with either the Fund Office or insurance carrier (or both), the card with the more recent date will be honored. Unless provided otherwise, if a beneficiary dies before you, the deceased beneficiary's share of AD&D Benefits will be divided equally among any remaining named beneficiaries. If no named beneficiary survives you, AD&D Benefits will be paid to the following beneficiaries, if living in the following order: your spouse, natural or adopted children equally, father and mother equally, or your estate.

How A "Loss" Is Defined

A loss must be a direct and sole result of an accidental injury, be independent of all other causes, and the loss must occur within 365 days of the accident.

- Loss of a hand or foot means actual and permanent severance at or above the wrist or ankle joints.
- Loss of sight, means entire, uncorrectable and irrecoverable loss of sight.

When Benefits Are Not Paid

AD&D benefits are not paid for any loss resulting directly or indirectly from the following:

- Suicide or intentionally self-inflicted Injury, while sane or insane;
- Any sickness or pregnancy existing at the time of the accident;
- Heart attack or stroke;
- Committing or attempting to commit an assault or felony;
- Being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison, or any other controlled substance as defined in Title II of the comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by the person's Physician and used in the manner prescribed. (Criminal conviction is not necessary for a determination of being under the influence.)
- Active participation in a violent disorder or riot. (For purposes of this exclusion, "active participation" does not include being at the scene while performing official duties.)
- War or any act of war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
- Medical or surgical treatment for any of the above.

AD&D Career Adjustment Benefit

If the Employee dies as a result of an accident for which an AD&D insurance benefit is payable, the Plan also pays to the Employee's spouse a career adjustment benefit in the amount of $5,000 per year up to a maximum of $10,000 for expenses incurred within 36 months of the date of the Employee's death for tuition expenses (not including room and board, books, fees, supplies and other expenses) at an accredited institution of higher education or trades training program for the purposes of obtaining employment or increasing earnings.

AD&D Higher Education Benefit

The Plan also pays an education benefit in the amount of $5,000 per child per year (up to a total of $18,750) for tuition expenses (exclusive of room and board, books, fees, supplies, and other expenses) incurred at an accredited institution of higher education within four years after the date of the Employee's death as a result of an accident for which an AD&D insurance benefit is payable.

AD&D Child Care Benefit

The Plan also pays a child care benefit of up to $5,000 per year or $10,000 total to your spouse if you die as a result of an accident for which an AD&D insurance benefit is payable for expenses incurred within 36 months of your death for a licensed child care provider who is not a member of your family for child care provided to your children under age 13 in order for your spouse to work of obtain training for work to increase earnings.

AD&D Seat Belt Benefit

The Plan also pays an additional seat belt benefit of $10,000 if:

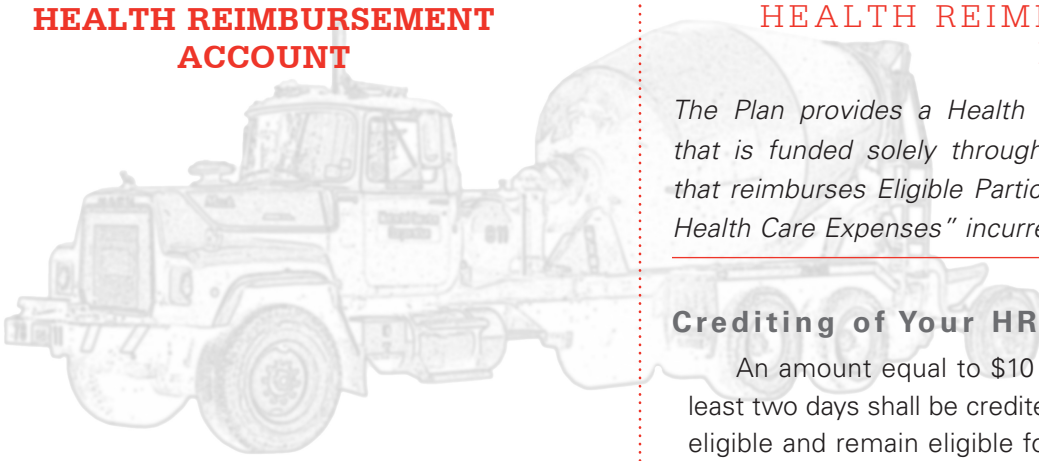
- The Employee dies as the result of an automobile accident for which an AD&D benefit is payable for loss of life, and
- The employee was wearing and properly using a seat belt system at the time of the accident, as evidenced by a police report.

AD&D Air Bag Benefit

The Plan also pays an additional air bag benefit of $5,000 if:

- The Employee dies as the result of an automobile accident for which a seat belt benefit is payable,
- The automobile was equipped with an air bag system that was installed as original equipment by the automobile manufacturer and has received regular maintenance or schedule replacement as recommended by the automobile or air bag manufacturer,
- The Employee was positioned in a seat that was equipped with the air bag system, and
- A police report establishes that the air bag deployed.

HEALTH REIMBURSEMENT ACCOUNT



HEALTH REIMBURSEMENT ACCOUNT BENEFIT

The Plan provides a Health Reimbursement Account ("HRA") Benefit that is funded solely through Employer contributions to the Fund and that reimburses Eligible Participants for certain out-of-pocket "Qualifying Health Care Expenses" incurred by you or your Dependent.

Crediting of Your HRA

An amount equal to $10 per week for every week that you work at least two days shall be credited to your HRA so long as you otherwise are eligible and remain eligible for Plan coverage. The amount credited shall be available to reimburse Qualifying Health Care Expenses. Debit cards reflecting your account balance will be issued to you. The amount available through your card will reflect credits to your HRA that accumulated since the inception of the HRA. However, you will not receive a card until you have earned initial eligibility under the Plan. Additionally, if you lose eligibility under the Plan, you generally will not be able to access allocations to the HRA made with respect to hours worked after your loss of eligibility until such time as you regain eligibility. (However, for a period of 12 months, you can continue to access HRA contributions allocated with respect to hours worked before you lost eligibility.) If you lose active eligibility and elect COBRA, you will continue to accrue additional contributions to the HRA and will have immediate access to those contributions. (Your rights, if any, to COBRA under the HRA will be explained in the COBRA Election Notice that is provided following a loss of eligibility.) However, if you continue coverage under the Plan beyond the COBRA continuation period, as part of a self-payment period extension as described on page 20, you neither will accrue HRA contributions nor have access to HRA contributions.

You will not be entitled to any earnings (such as interest) on the money credited to the HRA, nor will you be subject to losses.

HRA Wellness Credit

If you meet certain requirements (set forth below), you may receive an additional $125 credit to your HRA following satisfaction of the requirements. If your spouse also participates, you may receive another $125 credit to your HRA in the calendar year following your spouse's completion of participation.

Please note, however, that within any one twelve-month period, you cannot get both the $125 credit to your HRA and the $250 gift card for participation in the wellness benefit program offered by UIC Wellness (as described on page 23) – you are eligible to receive only one or the other. Also, you will not be eligible for the $125 credit to your HRA more frequently than once every twelve months.

In order to qualify for the $125 HRA credit, you and/or your spouse must receive a physical exam from either your regular Physician or another provider (for example, at an on-site wellness fair) and submit the results to Health Care Strategies. This is referred as the "Health Reach" program.

The $125 reward for participating in this wellness program is available to all participants and their spouses. The provider performing the physical exam must complete a form provided by the Fund Office, and then the form must be returned to Health Care Strategies after completion.

Eligible Expenses: Qualifying Health Care Expenses

Only those expenses that are "Qualifying Health Care Expenses" are eligible for reimbursement from the HRA. "Qualifying Health Care Expense" means certain medical expenses incurred and paid by you or your covered Dependents for medical care as defined in section 213(d) of the Internal Revenue Code (including amounts paid for health plan deductibles, co-payments, and Coinsurance, and amounts exceeding health plan maximums for certain types of expenses), but only to the extent that you are not otherwise reimbursed or entitled to reimbursement for the expense from the Fund, another health plan or insurance policy, or otherwise. "Qualifying Health Care Expense" includes expenses incurred for over-the-counter drugs such as antacids, allergy medicines, pain relievers and cold medicines, *provided that you or your Dependent has a prescription for such over-the-counter drugs* (except that no prescription is required for insulin). "Qualifying Health Care Expense" also includes over-the-counter medical devices and supplies, long-term care insurance premiums and COBRA premiums.

"Qualifying Health Care Expense" does not include any expense incurred for qualified long-term care services or charges for failure to pre-certify hospital admissions or receive prior authorization for other services as required.

Claims for Reimbursement

You may access funds in the HRA by paying for covered expenses utilizing the debit card, which is issued to you.

A second debit card will be provided if you have covered Dependents.

Please contact the Claim Administrator immediately if your debit card is lost or stolen.

If your debit card is not active or is rejected or if you are seeking reimbursement for claims incurred at a time when you had insufficient funds available through your debit card, you may apply in writing to the Claims Administrator, Elite Administration, for reimbursement of Qualifying Health Care Expenses. Written claim statements may be submitted to:

Elite Administration
1300 West Higgins Road, Suite 208
Park Ridge, Illinois 60068
(312) 243-1265; (800) 762-4166

Such statements must be in such form as the Plan Administrator may prescribe, and should set forth.

1. The amount, date, and nature of each expense with respect to which a benefit is requested;
2. The name of the person, organization, or entity to which the expense was paid and evidence of such payment, such as a receipt;
3. The name of the person for whom the expense was incurred and paid, and, if such person is not you, the relationship of such person to you;
4. The amount recovered from the Fund or from any other health plan or insurance arrangement, with respect to the expense; and
5. A statement that the claimed expense has been paid by you or your covered spouse or dependent child and has not been reimbursed and is not reimbursable under any other health plan or insurance.

You must include with any claims a written receipt or other documentation showing that the expense has been incurred and paid, the

date(s) of such treatment and the amount of the expense, and/or such other documents that the Fund Office may request. With respect to any claim paid directly by means of the debit card, you must maintain records of all of the above information and be prepared to submit it, together with supporting documentation, to the Fund Office for verification upon request.

In the event of your death, your spouse (or, if none, your estate's executor or administrator) may apply on your behalf for reimbursements.

Generally, any fees associated with the debit card will be borne by the Fund.

Note: You are encouraged to use your HRA to pay for out-of-pocket expenses as they arise rather than saving the money for use at a later time; there is no advantage to saving the money for later use, and this only increases the risk that you will forfeit the money as described below.

Rollover of HRA balance

If any balance remains in your HRA for a calendar year, such balance shall be carried over to reimburse you for Qualifying Health Care Expenses incurred during subsequent calendar years. Conversely, amounts credited to your HRA during a subsequent calendar year may be used to reimburse expenses incurred during the prior calendar year, provided that the expense was incurred on or after the date that you first were credited with an hour of work.

Termination and continuation of coverage

You may continue to be reimbursed for Qualifying Health Care Expenses from the HRA for up to 12 months following your loss of Plan eligibility, so long as there is money in the HRA. Additionally, if you die with a positive account balance, your spouse may continue to submit claims with respect to you, himself/herself and any dependent children for up to 12 months following your death. If you are not married at the time of death, the remaining balance in the HRA (if any, after expenses that were incurred prior to your death have been paid) will be split between any dependent children, and they may continue to submit claims for up to 12 months following your death. If you have no surviving spouse or dependent children, or if you or your survivors do not use up the available funds within the permitted timeframe, the remaining balance is forfeited and reverts back to the Plan to be used to fund other Plan benefits.

You will be offered COBRA continuation coverage with respect to the HRA to the extent required by applicable law.

HRA Opt-Out

Upon your loss of active eligibility, you will be entitled to permanently opt out of and waive future reimbursements under the HRA. This right to opt out of HRA benefits is intended to facilitate an application for subsidized coverage through the Affordable Care Act "Marketplace" (also known as the "Exchange"), should you choose to apply for such coverage (however, there is no need for you to apply for such coverage so long as you remain eligible for Plan benefits).

Amendment or Termination of HRA benefits

As is the case with any other Fund benefit, the HRA is not a vested benefit and the Board of Trustees reserves the right to modify or terminate the benefits provided under the HRA at any time for any reason. Any portion of your HRA that is not used prior to such modification or termination of benefits will remain available to reimburse Qualifying Health Care Expenses as described above.

GENERAL PLAN EXCLUSIONS

GENERAL PLAN EXCLUSIONS

The following services, treatments and supplies are not covered by the Plan.

If any services or supplies are not specifically addressed in this Summary Plan Description, whether as covered expenses or exclusions, it is not to be assumed that such services or supplies are covered under this Plan. In addition to the exclusions listed above in the Sections entitled "Medical Coverage," "Dental Coverage," "Vision Coverage," "Disability Coverage," and "Life and AD&D Insurance," the following services, treatments and supplies are excluded from coverage by the Plan:

- Charges that exceed usual, Reasonable and Customary;
- Charges for services, treatment or supplies that are not considered Medically Necessary;
- Sterilization reversals;
- Disease, defect or accidental Injury that occurs during or arises out of any occupation for wage or profit for which the Eligible Participant with regard to whom the claim is submitted, is eligible to earn wages for a profit and is entitled to benefits under the applicable Illinois workers' compensation law, occupational disease law or similar legislation. If the Eligible Participant is a self-employed person, the Plan does not pay benefits for a disease, defect, or accidental Injury that occurs during or arises out of the Eligible Participant's self-employment if the Eligible Participant would have been entitled to workers' compensation type of benefits if an insurance policy was available in the state in which the Eligible Participant resides to provide coverage for such disease, defect or accidental Injury arising out of, or occurring in the course of, the type of economic activity the Eligible Participant was engaged in and the Eligible Participant had secured such a policy. This limitation does not apply to Life or AD&D Insurance;
- Care for an Injury or Sickness that is related to any employment for wage or profit or that is covered under Workers' Compensation or that arises out of work for wage or profit that is deemed to be prohibited employment under the terms of the Building Material Chauffeurs, Teamsters and Helpers Pension Fund of Chicago;
- Confinement in any Hospital or treatment by any Physician when the Hospital or Physician makes no charge that the person is required to pay;
- Any expense or loss related to a disease or Injury caused by or resulting from insurrection, riot, atomic explosion or other release of nuclear energy under any conditions (except when used solely as medical treatment), declared or undeclared war, or any act of war, international armed conflict, or any loss while in the military service of any country;
- Food for sustaining life, food substitutes, food/nutritional supplements or vitamins outside of a Hospital;

- Services, treatment or supplies received from a dental or medical department, facility or clinic maintained by another employee benefit plan or labor union.
- Services, treatment or supplies that are payable or provided under any insurance policy or other medical benefit plan or service plan for which the Trustees will, directly or indirectly, have paid for all or a portion of the cost;
- Charges for or relating to general maintenance or delivery of durable medical equipment;
- Removal of an organ for donation purposes where the transplant recipient is not an Eligible Participant in the Plan;
- Services, treatment and supplies that are not recommended and approved by a Physician or Dentist;
- Services, treatment and supplies rendered or furnished before the Eligible Participant's eligibility date or after the Eligible Participant's coverage terminates;
- Any charges for custodial care or care in custodial or similar institutions or rest cures, except as specifically provided by the Plan;
  - Custodial care means services and supplies that are mainly provided to help the Eligible Participant perform the activities and meet the needs of daily living, whether or not the Eligible Participant is disabled, and not rendered mainly for their therapeutic value in the treatment of a bodily Injury or disease, including, but not limited to:
  - Provision of Room and Board, preparation of special diets,
  - Supervision of administration of medications that can normally be self-administered, or
  - Helping the Eligible Participant walk, get in or out of bed, eat, dress, bathe, use the toilet and perform other personal hygiene functions.
- Claims submitted more than 12 months after the expense was incurred;
- Services or supplies for which a person is eligible for reimbursement by a third party if the Eligible Participant does not provide a signed Subrogation and Reimbursement Agreement to the Fund Office as set forth in the Section entitled "Subrogation and Reimbursement Agreement";
- Services or supplies for which a person is eligible for reimbursement by a third party if the Eligible Participant does not provide a signed Subrogation and Reimbursement agreement to the Fund Office as set forth in the Section entitled "Subrogation and Reimbursement Agreement";

- Treatment for cosmetic surgery, unless treatment is for:
  - An Injury sustained in an accident, provided treatment began within 90 days of the accident; or
  - A child's birth deformity; or
  - Reconstructive surgery incidental to or following surgery for any covered illness or for a mastectomy.
- Services or supplies provided at no cost or that you are not required to pay;
- Services or supplies that are furnished by or payable under any plan or law of any government other than Medicare/Medicaid (subject to applicable coordination of benefit rules);
- Services provided by a person who ordinarily resides in your home or who is an immediate family member;
- Expenses that are incurred outside of the United States and Canada, if you or your Dependent is outside of the United States and/or Canada for more than 60 days;
- Services rendered outside the U.S. which are not pre-certified in advance, unless rendered in Emergency circumstances;
- Services or supplies provided by a relative (spouse, parent, child, sibling or by a person who regularly resides in the covered person's home);
- Experimental or Investigative services, treatments, services, facilities procedures, equipment, devices, drugs or supplies, and supplies;
- Charges for the completion of claim forms;
- Charges for failure to keep a scheduled appointment;
- Charges incurred as a result of engaging in an illegal act by committing or attempting to commit any crime resulting in a conviction or for which felony charges are pending or with respect to which the Trustees have a good-faith belief that the basis for felony charges exists but the person dies prior to charges being brought (not applicable to injuries that result from domestic violence);
- Charges for which there would have been no charge if coverage had not been in force;
- Personal care items and equipment including (but not limited to) air conditioners, humidifiers, air purifiers, exercise equipment, whirlpools, chair lifts, non-Hospital beds, and scales;
- Services, treatment or supplies provided by the United States Government or any agency thereof, any state, territorial or commonwealth government or political subdivision thereof (other than Medicaid) or a foreign government or agency thereof if the person has no legal obligation to pay for the services, treatment or supplies.

APPLYING FOR BENEFITS

To File A Medical Claim
Fill out a claim form and send it, with an itemized bill, to BCBS:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680

HOW TO FILE A CLAIM

Filing a claim is easy if you follow the steps below.

Medical, Dental and Vision Claims

In general, you don't have to file claims for medical, dental, or vision services received from PPO providers. PPO providers will file claims for you.

To file a claim for medical benefits received from a non-PPO-provider, you need to complete a medical claim form and send it along with the itemized bill to Blue Cross/Blue Shield for processing. Claims must be submitted within one year of incurring the expense .

Be sure to get an *itemized* bill or statement from your Physician, Dentist, or other provider. If you want your benefits to be paid directly to the Hospital or Physician instead of to you, complete the "Authorization to Pay" section of the claim form. When you submit a claim, be sure to include:

- Provider's name, address, and tax identification number.
- Employee's name and unique identification number.
- Patient's full name and date of birth.
- Date of service, diagnosis, type of service, and charge.

To file a claim for dental benefits received from a non-PPO provider, you will need to obtain an itemized bill from the provider and submit the bill directly to the Claim Administrator as identified on page 81.

Claims for vision benefits should be filed with EyeMed. Generally speaking, if you receive services from an in-network provider, you should not have to file a claim; rather, the provider will file the claim on your behalf.

If you or your Dependent has primary coverage under Medicare or another group medical plan, please submit claims to both plans. If this Plan is secondary, be sure to send an explanation of benefits (EOB) from the other insurance company or plan. See **Coordination Of Benefits** on page 72 for information about primary coverage.

Claims must be submitted within one year of incurring the expense.

Explanation of Benefits (EOB) Form

When you file a medical, dental, or vision claim, an explanation of benefits (EOB) form is sent to you. This form tells you if a claim has been paid in part or in full. If the claim is not paid, it also gives you the reason for the decision.

Types Of Health Care Claims

There are four basic types of health care claims:

- **Urgent Care.** An urgent care claim is a pre-service claim for medical care or treatment that would:
  - Seriously jeopardize your life, 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 approval is sought, in the opinion of a Physician with knowledge of your condition.

- **Pre-service.** A pre-service claim is a claim for treatment where the Plan requires that you obtain preauthorization. The Plan will not deny benefits for these procedures or services if:
  - It is not possible for you to obtain preauthorization; or
  - The preauthorization process would jeopardize your life or health.
- **Post-service.** A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services for which you are seeking benefits.
- **Concurrent Care.** A concurrent care claim is a claim that is reconsidered after it is initially approved (such as recertification of the number of days of a Hospital stay) and the reconsideration results in:
  - Reduced benefits; or
  - A termination of benefits.

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, 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 you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment.

Generally, when network providers submit the claims, payment is made directly to the provider. Network 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 general, you don't have to file claims for prescription drugs.

Prescription Drug Claims

In general, you don't have to file claims for prescription drug benefits. See the section in the Plan pertaining to prescription drug benefits beginning on page 34 for information on how to order and pay for prescriptions through the Plan. Generally, participating pharmacies will submit claims for you. You will pay the pharmacy the Copayment and then the claim payment is made directly to the pharmacy.

Remember, prescription drugs purchased from non-participating pharmacies will not be covered under the Plan.

Life And AD&D Insurance Claims

When You File A Claim. You should notify the Fund Office as soon as possible after you or a Dependent sustains an Injury covered by AD&D insurance or in the event of a death. The Fund Office provides the forms necessary to process your claim. You should submit your claim within 90 days of the Injury or death.

When Your Beneficiary Files A Claim. Your beneficiary should contact the Fund Office for information as to the steps necessary to claim benefits. Those steps include providing the Fund Office with a certified copy of the death certificate. Your beneficiary must submit the claim within one year of your death. Payment will be made to your beneficiary or his or her legal guardian, if applicable.

Life and AD&D benefits are fully insured through Standard Insurance Company. Accordingly, Standard Insurance Company processes all claims and appeals with respect to life and AD&D benefits. While the Fund Office can supply forms necessary for submitting a claim for benefits, claims and appeals should be submitted to Standard Insurance Company.

Disability Claims

You will need to complete a form to apply for disability benefits. You can get a form from the Fund Office. Please be sure that your Employer completes his/her portion of the form. You will be required to turn in a doctor's statement with the completed form to the Fund office. You should submit your claim as soon as you are eligible for benefits. Payments will be made directly to you.

Health Care Claims (Medical (including MAP), Health Care Reimbursement Account, Prescription Drug, Dental And Vision)

All health care claims are processed promptly by the Fund Office or, in the case of vision benefits, by EyeMed, when complete claim information is received. The Plan will notify you of its initial decision within certain timeframes. If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, the Plan will give you written notice of its decision about your claim.

The deadlines differ for the different types of claims as shown in the following information:

- Urgent Care Claims. An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. The notice will state the special circumstances and the date the Plan expects to make a decision. You will then have up to 48 hours to respond. The initial 72-hour deadline is suspended for up to 48 hours or until the information is received if sooner.
- Pre-Service Claims. An initial determination will be made within 15 days from receipt of your claim. If additional time is necessary due to matters beyond the control of the Plan, you will be informed within the original 15-day period of the need for an additional 15 days, the special circumstances warranting the extension, and the date the Plan expects to make a decision. If additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim, and you then will have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.
- Post-Service Claims. An initial determination will be made within 30 days from receipt of your claim. If additional time is necessary due to matters beyond the control of the Plan, you will be informed within the original 15-day period of the need for an additional 15 days, the

special circumstances warranting the extension, and the date the Plan expects to make a decision. If additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim, and you then will have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.

Life And AD&D Insurance Claims

Generally you will receive written notice on a decision on your claim within 90 days after the Plan receives your claim. If circumstances require an extension of time for processing your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

Disability Claims

Generally, you will receive written notice of a decision on your initial claim within 45 days of receipt of your claim. If additional time is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this time. The Plan may extend this 45-day period up to an additional 60 days maximum. However, if a determination is not made within the first 75 days, you will be notified that an additional 30 days is necessary.

In some instances the Plan may require additional information to process and make a determination on your claim. If such information is required, the Plan will notify you within 45 days of receiving your request. You then have up to 45 days in which to submit the additional information. If you do not provide the information within this time, then your claim may be denied.

Reimbursement Provision (Subrogation)

Suppose you or your eligible Dependent has a claim for health care or weekly disability benefits that is due to an Injury caused by another person. The Plan has the right to impose a lien on the proceeds resulting from any such claim and be reimbursed from you for the full amount of any damages you collect from this person, up to the amount of medical or disability benefits paid to you by the insurance company. For benefits to be paid, you will be required to agree to this provision in writing. **Any attorney's fees incurred will not be paid by the Plan, and are the member's responsibility.** **See page 89 for more information.**

If you disagree with the initial decision on your claim, there's a process you can follow to request reconsideration of your claim.

IF A CLAIM IS DENIED

If a claim is denied, you're entitled to a full and fair review.

If a claim for benefits is denied, in whole or in part, the Plan will:

- Provide you with certain information about your claim; and
- Notify you of its denial of your claim within certain timeframes.

Information Requirements

When you are notified of an initial denial of your claim, the notice will include:

- The specific reason or reasons for the denial.
- Reference to the specific Plan provisions on which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- A description of any information or material needed to process the claim and an explanation of the reason it is needed.
- Instructions for appealing the claim, including the time periods to appeal your claim, and a description of your right to obtain information about such procedures.

In addition, for health care and disability claims the notice will include:

- A copy of any internal rule, guideline, protocol or similar criteria that was relied on in denying the claim, or a statement that a copy is available to you at no cost upon request, or in the case of disability claims, a copy of such criteria or a statement that such criteria do not exist.
- A copy of the scientific or clinical judgment, or statement that a copy is available to you at no cost upon request, if your claim is denied due to medical necessity, Experimental treatment or a similar exclusion or limit.If your request for a review relates to the denial of an urgent care claim, the notice will also include a description of the expedited review process.

And, with respect to disability claims the notice will also include n explanation of the basis for disagreeing with or not following:

- The views presented by you to the Plan of health care professionals treating the claimant and vocational professionals who evaluated you;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- A disability determination made by the Social Security Administration.

Appealing A Denied Claim

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Board of Trustees (to the attention of the Fund Administrator) as soon as possible. However, appeals with respect to vision benefits should be submitted to EyeMed. 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 a decision regarding **health care** or **disability** claims; or
- 60 days from the date of a decision regarding **life** or **AD&D insurance claims.**

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office (or to Eye Med with respect to vision claims) authorizing this representative. A healthcare professional that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

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 supporting comments, statements or documents; and
- Request to review all relevant information (free of charge).

In addition, if your claim is for health care or disability and is denied based on:

- An internal rule, guideline, protocol or other similar criteria, you have the right to request a free copy of such information; and
- A medical necessity, Experimental treatment or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment used for the determination.

Appeal Decisions

If you file your appeal on time and follow required procedures, a new, full and independent review of your claim will be made and the reviewers will not defer to the initial benefit decision. An appropriate fiduciary of the Plan, generally a review committee (comprised of an Employer Trustee and an Employee Trustee) will conduct the review and make a recommendation to the full Board of Trustees, who will make the final decision – except that vision benefit appeals will be reviewed by Eye Med. The decision will be based on all information used in the initial determination as well as any additional information submitted.

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

Appeal Timeframes

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

Health Care Claims:

- **Urgent Care Claims.** A determination will be made within 72 hours from receipt of your appeal.
- **Pre-Service Claims.** A determination will be made within 30 calendar days from receipt of your appeal.
- **Post-Service Claims.** A determination will be made by the Board of Trustees at its next quarterly meeting following receipt of the appeal unless the appeal is received 30 days or less prior to the meeting date, in which case a determination will be made at the meeting thereafter, and the Trustee's decision on appeal will be communicated to you within 5 days of the decision.
- **Concurrent Care Claims.** A determination will be made before the reduction or termination of your benefit.

Disability Claims:

A determination will be made by the Board of Trustees at its next quarterly meeting following receipt of the appeal unless the appeal is received 30 days or less prior to the meeting date, in which case a determination will be made at the meeting thereafter, and the Trustee's decision on appeal will be communicated to you within 5 days of the decision. Life or AD&D Insurance Claims:

- A determination will be made within 60 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 60 days), a decision will be made within 120 days after the date the Plan receives your request for review.

Medical Judgments

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity of any medical experts consulted in making a determination of your appeal.

Information Requirements

When the Plan notifies you of its determination on your appeal, it will provide:

- The specific reason or reasons for the decision, including reference to the Plan provisions on which the decision was based;
- A statement notifying you that you have the right to request a free copy of all documents, records and relevant information; and
- A statement that you may bring a civil action suit under ERISA.

- A notice of any applicable contractual limitations period for bringing a civil action, and its expiration date.

In addition, for *health care* and *disability* claims the notice will include:

- A copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request, or in the case of disability claims , a copy of such criteria or a statement that such criteria do not exist, and an explanation that the Claimant also will be afforded a reasonable opportunity to respond to any new evidence or rationale relied upon on appeal; and

- A copy of the scientific or clinical judgment, or statement that a copy is available to you at no cost upon request, if your claim is denied due to medical necessity, Experimental treatment or a similar exclusion or limit.

Exhaustion of Administrative Remedies/ Limitation Period

You must follow the Plan's claims and appeals procedures completely before you bring an action in court under the Employee Retirement Income Security Act of 1974 (ERISA) to obtain your benefits. You may, at your own expense, have legal representation at any stage of the review process. No lawsuit may be brought more than one year after the final decision on review (or the expiration of the period in which the final decision is to be issued). Also, if you fail to include any theories or facts in your written appeal, they will be deemed waived. In other words, you will lose the right to raise factual arguments and theories that support your claim if you fail to include them in your written appeal.

Summary of Claims and Appeals Timing

	Pre-service Health	Urgent care Health	Post-service Health	Disability	Life Insurance and AD&D
Plan must make Initial Claim Benefit Determination (adverse or not) as soon as possible but not later than:	15 days	72 hours	30 days	45 days	The insurer makes initial decision within 90 days
Extension permitted during initial benefit determination:	15 days	No provision for extension of time	15 days	60 days	Up to 90 days
Appeal must be submitted to the Plan within:	180 days	180 days	180 days	180 days	Appeal must be submitted to the insurer 60 days
Appeal Review Committee makes recommendation to the Full Board of Trustees (as time permits) as soon as possible, and then full Board of Trustees makes decision on Appeal as soon as possible but not later than:	30 days	72 hours	Not later than the next quarterly meeting provided appeal received more than 30 days in advance of meeting; otherwise at the meeting thereafter	45 days	The insurer will make a decision within 60 days

EXTERNAL REVIEW

External Review

External review is available with respect to adverse benefit decisions that involve coverage for Emergency Services received at non-PPO facilities, services received from non-PPO Providers at PPO facilities, air ambulance services, services provided by non-PPO providers believed to be PPO providers (under certain circumstances), and services provided to Continuing Care Patients in order to determine compliance with the surprise billing and cost-sharing protections under the No Surprises provisions found in the Consolidated Appropriations Act of 2021.

You may submit a request for external review in writing to the Trustees within four (4) months of receipt of notification of the final internal denial of benefits. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. (Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.)

Within five (5) business days of receipt of your request, the Trustees or their delegate will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that:

1. The person incurring the claim was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
2. The final internal denial does not relate to the person's failure to meet applicable Plan eligibility requirements;
3. The covered person has exhausted the Plan's appeal process, to the extent required by law, and the Plan has denied in whole or in part coverage for the services;
4. The surprise billing and cost-sharing protections under the No Surprises Act are implicated; and
5. The covered person has provided all of the information and forms required to complete an external review.

The Trustees (or their designee) will provide you (or your authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. The Notice of Final External Review Decision from the IRO will be binding, except to the extent that other remedies may be available under state or federal law.

Expedited External Review

The Trustees shall provide you (or your authorized representative) the right to request an expedited external review if you have received:

- A denial or final internal denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal

appeal or a standard external review, respectively, would seriously jeopardize your health or life or ability to regain maximum function.

- A final internal denial of benefits that concerns an admission, availability of care, continued stay, or health care item or service for which you receive Emergency Services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan (or its designee) will perform a preliminary review to determine whether the request meets the same five requirements as stated above and will send notice of the Plan's decision.

Upon determination that a request is eligible for expedited external review, the Plan (or its designee) will assign an IRO, and provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the Participant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the Trustees (or their designee) and the Participant (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

PLAN INTERPRETATION AND AUTHORITY OF TRUSTEES

The Trustees or the person or committee to whom the Trustees have delegated responsibility will be the sole judges of the standard of proof required in any case and determine any and all questions arising in the administration, application and interpretation of this Plan, including questions regarding entitlement to benefits under the Plan. No benefits will be paid unless the Trustees (or their delegate) in their sole discretion determine that you are entitled to them. The decisions of the Trustees or their delegates will be final and binding. The Trustees also have the general right, in their sole discretion, to settle claims and waive Plan terms.

You are required to submit to the Trustees or their delegates all questions or controversies in connection with this Plan or its operation regarding:

- Any claim for benefits;
- The construction of Plan language;
- Any rules and regulations adopted by the Trustees; or
- Any writing, decision, instrument, or account in connection with the operation of the Plan.

The decision on review will be binding on all persons dealing with the Plan or claiming any benefit hereunder. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the Plan that such decision is to be upheld unless it is determined to be arbitrary and capricious.

All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement to change them. The Trustees have the authority to increase, decrease, or change the eligibility rules or other provisions of the Plan as they may determine to be in the best interest of Plan participants and beneficiaries.

COORDINATION OF BENEFITS

Your medical, dental and vision benefits are coordinated with other group plans covering you and your Dependents.

Benefits are coordinated if you or a Dependent has coverage under more than one plan.

The coordination of benefits feature eliminates duplicate payments for the same service when a patient is covered by more than one health care plan. Most health care plans have coordination of benefits provisions.

If you and your Dependents are covered by another group medical, dental or vision plan (such as through your spouse's employer), benefits from this Plan will be coordinated with those payable from other plans. Special rules apply for coordination with Medicare and Medicaid.

When benefits are coordinated, the plans must determine which plan pays benefits first (the primary plan), second (the secondary plan), etc.

If all plans have coordination of benefits provisions, the following rules apply:

- If an Eligible Participant elects membership in a Health Maintenance Organization (HMO) as an employee of another employer, benefits under this Plan are limited to co-payments and/or deductibles not covered under the HMO and eligible expenses that are specifically excluded under the HMO. There will be no coverage under this Plan for any item not covered by the HMO because the Eligible Participant chose not to receive services from an HMO participating provider
- A plan that covers the patient as an employee pays benefits before a plan that covers the patient as a dependent.
- A plan that covers the patient as an employee pays benefits before a plan that covers a patient who is laid off or retired.
- A plan that covers the patient as other than a person covered pursuant to COBRA (or pursuant to post-COBRA self-payments) pays benefits before a plan that covers a patient pursuant to COBRA (or pursuant to post-COBRA self-payments, as permitted under this Plan).
- A plan that covers the patient other than as a person whose coverage is continued due to use of an hours bank pays benefits before a plan that covers a patient pursuant to the use of an hours bank.
- When both parents have medical coverage for their children, the plan of the parent whose birthday is first during the year is the primary plan.

For example, if the mother's birthday is February 23 and the father's birthday is April 19, the mother's plan will pay benefits first. The age of the parent has no effect on whose plan pays benefits first. If these rules still do not establish an order of payment, the plan that has covered the parent the longest will pay benefits first.

- If the parents are separated or divorced, and both of their plans pay their children's medical expenses, then benefits for the child will follow the same order as the rules for a child where the parents are not divorced or separated.

- Depending on the circumstances, this Plan may be primary or secondary to Medicare. If you are eligible for Medicare coverage, call the Fund Office for details.
- If a plan provides the person's coverage under a right of continuation pursuant to federal or state law and the person is also covered under another plan, the following will be the order of benefit determination:
  - First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's Dependent).
  - Second, the benefits under the continuation coverage.

  If the other plan does not contain the order of benefits determination described in this booklet and if, as a result the plans do not agree on the order of benefits, this requirement is ignored.
- An Eligible Participant and the Eligible Participant's Dependent are both covered as Employees under this Plan and one of them has a claim. This Plan will pay primary benefits on the claim as the claim of an Employee and then pay secondary benefits on the claim as the claim of a Dependent.

If the above rules do not clearly show which plan should pay first, the plan that has covered the Eligible Participant (for whom the claim is filed) for the longest period of time will pay first, the plan that has covered the Eligible Participant for the next longest period of time will pay second, and so on.

If another Plan has coordination of benefits rules that conflict with this Plan's rules, this Plan will follow the rules established by the National Association of Insurance Commissioners.

Please note that a plan without coordination of benefits provisions is always the primary plan.

How Coordination Works

When our Plan is primary, it will pay benefits up to the limits described in this booklet. When our Plan is secondary, this Plan covers the expenses remaining after the primary plan's benefits have been paid, up to 100% of the expenses owed. However, the benefits paid by this Plan will never be more than the amount that would have been paid if this Plan were primary.

Certain facts are needed to apply these coordination of benefit rules. Subject to HIPAA Privacy rules, the Plan Administrator has the right to decide which facts it needs and may obtain those facts from or give them to any other organization or person and need not tell, or get the consent of any person to do this. An Eligible Participant who claims benefits under this Plan must give the Plan Administrator any facts needed to pay the claim.

If the amount of the payments made by the Plan is more than it should have paid under these coordination of benefit provisions, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid, insurance companies, or other plans or organizations. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination of Prescription Drug Benefits

If your Dependent (spouse or child) has other prescription drug insurance and uses the other insurance first towards prescription drug coverage, this Plan will pay 80% of the remainder of the balance that your Dependent has to pay for the prescription drugs with no deductible applied. For example, Lucy is covered by both this Plan and her mother's separate prescription drug insurance. Lucy's prescription cost $100 and was first paid by her mother's prescription drug insurance, which paid $70 (i.e., 70% of the cost). This Plan would then pay 80% of the remaining $30 owed by Lucy (i.e., $24).

Coordination with Medicare

If a person is eligible for benefits under the Plan and is also eligible for Hospital insurance under Medicare Part A, but not enrolled in Part A or the voluntary portion of Medicare Part B, the benefits provided to said person under this Plan will be paid as if the person has enrolled in both Medicare Parts A and B.

This Plan will have primary responsibility for eligible expenses incurred by an eligible Employee or the Employee's Dependent spouse who is Medicare eligible if:

- Eligibility for Medicare is due to the Eligible Participant being at least age 65 and the Employee is actively employed by an Employer subject to the Age Discrimination in Employment Act of 1967 (ADEA) which pays all or part of the required Contributions for eligibility,
- Eligibility for Medicare is due to the Eligible Participant being disabled and the Employee has "current employment status" with an Employer as defined by federal law, or
- Eligibility for Medicare is due to end-stage renal disease (ESRD). This Plan is primary only for a period of 30 months. If an Eligible Participant is Medicare eligible due to age or disability and then becomes entitled to Medicare due to ESRD, this Plan pays primary for the first 30 months of entitlement due to ESRD if this Plan had been primary to Medicare because of Medicare eligibility due to age or disability.

This Plan will have secondary responsibility for eligible expenses incurred by an eligible Employee or the Employee's Dependent spouse who is Medicare eligible if:

- Eligibility for Medicare is due to the Eligible Participant being age 65 and the Employee is not actively employed by an Employer subject to the ADEA that pays all or part of the required Contributions for eligibility,
- Eligibility for Medicare is due to the Eligible Participant being disabled and the Employee does not have "current employment status" with an Employer as defined by federal law, or
- Eligibility for Medicare is due to ESRD, but only after the first 30 months of either sole or dual entitlement to Medicare due to ESRD.

This section provides a summary of the coordination of benefit rules. For additional information about coordination of benefits, call the Fund Office.

SUBROGATION AND REIMBURSEMENT AGREEMENT

By accepting benefits under the Plan you agree to be subject to the terms and conditions of this Subrogation and Reimbursement Agreement.

To the extent the Plan makes or may be obligated to make payments for a claim related to a Third Party Incident (as defined below), the Plan shall be subrogated to any and all rights of recovery and causes of action that the Participant, his or her parent(s) and Dependent(s) or a representative, guardian or Trustee of the Participant, parent(s) or Dependent(s) (collectively referred to as "Claimant") may have relating to the Third Party Incident.

The Trustees intend that no person shall profit or be unjustly enriched from the payment of benefits or the payment of any compensation for injuries. The purpose of the Plan is to pay covered expenses if they are not paid or payable by anyone else, in accordance with the terms of the Plan. Therefore, expenses that are caused by, contributed to, or the responsibility of any Third Party or that are work-related are not Covered Medical Expenses under the terms of the Plan to the extent that any amounts are recovered by a Claimant from a third party related to such Third Party Incident, regardless of how the recovered amounts are characterized. If Claimant obtains a recovery with respect to the Third Party Incident, no further benefits will be payable from the Plan for any claims related to the Third Party Incident, until the total Covered Medical Expenses arising out of the Third Party Incident equals the gross amount of the recovery paid to or on behalf of the Claimant. The Plan will then consider only the amount of claims that exceeds the amount of the gross recovery. However, the Trustees, in their discretion, may choose to advance amounts as payment for expenses for medical care or disability in situations where or at a point in time when liability for such expenses has not been established, on the condition that the advance is reimbursed in full upon the settlement or adjudication of the Third Party Claim. No loan transaction is created by this advance.

"Third Party Incident" means any instance in which a third party is or may be responsible or liable for paying all or part of the expenses for which a claim is filed with the Plan.

A third party could be, but is not limited to:

- A third party tortfeasor (an individual or other entity of any kind who caused harm, such as the driver of another car in an automobile accident);
- An employee welfare plan or arrangement;
- A medical or hospital benefit plan;
- A no-fault or other car insurance policy;
- An uninsured or underinsured motorist provision or medical pay provision of your car insurance policy;
- A homeowners, school or athletic insurance policy;
- An employer or workers' compensation insurance carrier; or
- A liability insurance policy of any kind or nature.

"Subrogation" refers to the Plan's right to recover for benefits paid and advanced by the Plan on a claim if a Third Party is responsible for paying the expenses for which the claim is made, by transferring the Claimant's right to recover those benefits from a Third Party which may include pursuing a cause of action against a Third Party for benefits advanced on behalf of the Claimant.

"Reimbursement" refers to the Plan's contractual right to be reimbursed for expenses advanced on a claim if a Third Party is responsible for paying the expenses for which the claim is made.

Right to Subrogate

This Plan shall be fully subrogated to any and all rights of recovery and causes of action which the Claimant may have relating to the Third Party Incident. The Subrogation right applies on a priority, first dollar basis to any recovery, whether by suit, settlement or otherwise, whether a partial or full recovery and regardless of whether the Claimant is made whole, from any source liable for making a payment relating to the injury, illness or condition to which the claim relates. Thus, the Plan specifically rejects the "made whole doctrine" and any other equitable doctrine or law that requires an insured to be "made whole" before Subrogation rights are allowed. Furthermore, a Claimant is prohibited from settling a claim against a third party for certain elements of damages, while eliminating damages relating to medical expenses incurred.

Right to Reimbursement

The Claimant will first reimburse the Plan on a priority basis for all payments the Plan made or may be obligated to make for the claim from any recovery relating to a Third Party Incident, whether by suit, settlement or otherwise, including partial or full recoveries and regardless of whether the Claimant is made whole. Once the Plan makes or is obligated to make payments on behalf of the Claimant, the Plan is granted, and the Claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Claimant from any third party. Notice of a lien is sufficient to establish the Plan's lien against the third party.

Claimant will take such action as necessary or appropriate to recover any and all payments made or to be made by the Plan, regardless of whether or not the Claimant is made whole by any subsequent recovery. If the third party does not voluntarily pay Claimant for the incurred expenses and Claimant does not sue the Third Party for recovery of the expenses, the Plan has the right to sue the Third Party in Claimant's name to recover the amount it paid. In such a case, if there is a recovery or settlement, the Claimant further agrees that the Plan's expenses, costs and incurred attorney's fees will also be paid out of the recovery or settlement.

Enforcement of Rights

The Plan has the right to recover amounts representing the Plan's Subrogation and Reimbursement interest through any appropriate legal or equitable remedy, including but not limited to the initiation of a recognized cause of action under ERISA or other applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any Claimant for recovery from any third party, whether by settlement, judgment or otherwise. The Plan may participate in any legal action Claimant or anyone acting on Claimant's behalf may file against the third party to recover the expenses. The Plan's Subrogation and Reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity. The Claimant shall cooperate with the Plan and/or any and all representatives of the Plan, including Subrogation counsel, in completing discovery, attending depositions, and/or attending or cooperating at a trial in order to effect the Plan's Subrogation rights.

Further, where the Claimant or its agent receives a recovery from any third party but does not reimburse the Plan, the Plan shall have the right to offset the amount of future benefit payments on the claims submitted by the Claimant, the related Eligible Participant (if different from the Claimant) and any of the related Eligible Participant's Dependents covered under the terms of the Plan until the Plan has recovered the full amount allowed under this Section. Even if a lien is adjudicated by a court in favor of the Plan, if the Plan does not have reasonable notice of an opportunity to participate in the judicial proceeding, the Plan may seek reimbursement from the Claimant or its agent and may exercise this right of offset absent reimbursement by the Claimant or its agent.

The Plan's right of Subrogation and Reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Claimant, whether under the doctrines of imperative causation, comparative fault or contributory negligence, or any other similar doctrine in law. Accordingly, any so called "lien reduction statutes," which attempt to apply such laws and reduce a subrogating Plan's recovery for any reason, including contributory negligence, will not be applicable to the Plan and will not reduce the Plan's Subrogation recovery. The benefits provided under this Plan are secondary to any benefits or coverage provided under any no-fault law or similar legislation or no-fault-type insurance.

Also, these Subrogation rules do not apply to benefits you or your Dependent recovers under another employer-sponsored group health plan if that coverage is subject to Coordination of Benefits (COB) rules described on page 72.

Responsibilities of the Claimant

The Plan is not and will not be liable for, nor does it or will it have any obligation to pay, any benefit arising out of a Third-Party Incident. If a claim is submitted for expenses for which someone else is or may be legally responsible, the Claimant, or their agent, must execute a Subrogation and Reimbursement agreement and return it to the Plan Administrator as soon as possible. However, notwithstanding the preceding, as described above, simply by accepting benefits under the Plan, you and/or your Dependent agree to be subject to the terms and conditions of this Subrogation and Reimbursement Agreement Section of this document. Failure to comply with this section may result in offsets or other collective actions against the Employee and/or his/her Dependents. If Claimant is a minor or is otherwise legally incompetent, Claimant's parent, legal guardian or "next friend" must execute the Subrogation and Reimbursement agreement on his/her behalf.

The Subrogation and Reimbursement agreement will be binding upon the Claimant whether the payment received from the Third Party or its insurer results from a legal judgement, an arbitration award, a compromise settlement, or any other arrangement. The Subrogation and Reimbursement agreement also will be binding on any recovery made by the Claimant, even if the recovery does not include medical expenses.

Claimant agrees to instruct and cause any attorney(s) retained on their behalf to honor and enforce the terms of the Subrogation and Reimbursement agreement before disbursing the proceeds of any recovery arising out of the Third-Party Incident.

Separate Rights. The agreement to repay set forth in the Subrogation and Reimbursement agreement, and the Plan's right to Subrogation, are separate and distinct rights and obligations. The failure or invalidity, in

whole or in part, of one such right or obligation will not impair or otherwise adversely affect any such other right or obligation.

Attorneys' Fees. The Plan specifically disavows any claim the Claimant may make under the "Common Fund Doctrine." This means that the Plan shall not be responsible for any of the Claimant's court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses incurred in seeking a recovery, whether by suit, settlement or otherwise, unless the Trustees had agreed in writing to pay such fees or costs.

The Claimant is specifically prohibited from incurring any expenses, costs, or fees on behalf of the Plan in pursuit of his rights of recovery against a third-party or the Plan's Subrogation/Reimbursement rights as set forth herein.

Claimant agrees to indemnify the Plan for any cause of action brought by the Claimant's current or former attorney against the Fund seeking payment of fees or seeking to assert quantum meruit or the common fund doctrine.

Trustees Right to Waive. The Trustees of the Plan may waive the above Subrogation or Reimbursement rights, or any part thereof, if they decide such action is in the best interest of the Plan and its participants.

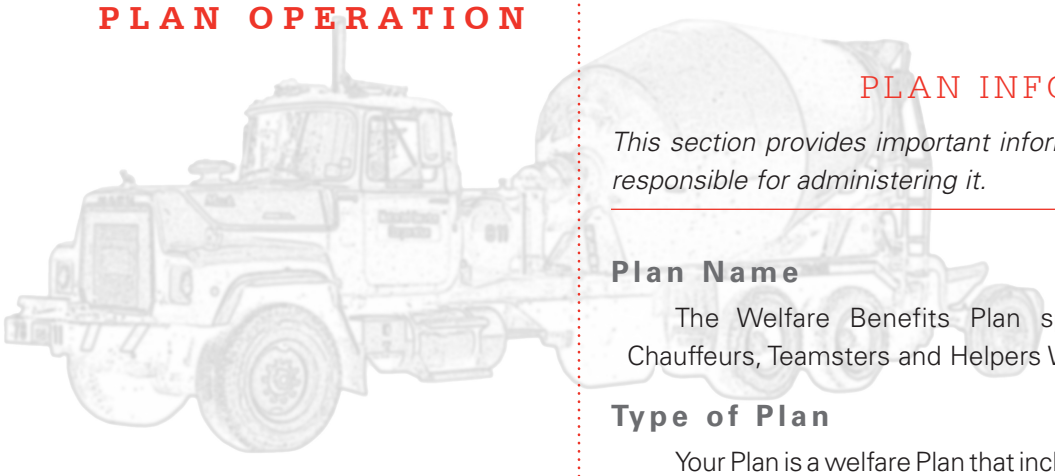
Anti-Assignment. By accepting benefits under the Plan, Claimants are prohibited from doing anything that will impair, release, discharge or prejudice the Plan's Subrogation or Reimbursement rights. Specifically, no Claimant may assign any rights or causes of action with respect to recovery of medical expenses or other damages that he or she might have against a third-party, without the express, prior written consent of the Plan. The Plan's Subrogation and Reimbursement rights apply even where a person has died as a result of his or her injuries and the Claimant is asserting a wrongful death or survivor claim against the third party under the laws of any state. The Plan's right to recover by Subrogation or Reimbursement shall apply to any settlements, recoveries, or causes of action owned or obtained by a decedent, minor, incompetent, or disabled person.

Maximum Amount of Recovery. Neither Claimant nor any other person will be required to reimburse the Plan more than the benefits the Plan pays on the claim, nor more than the gross amount the Claimant receives in recovery, whichever is less. Notwithstanding the preceding or anything herein to the contrary, Claimant shall be responsible for the repayment of any attorney's fees and expenses incurred by the Plan in a legal action to obtain such repayment from Claimant.

Fiduciary Status. Should any money subject to the terms of the Subrogation and Reimbursement agreement as set forth in this Subrogation and Reimbursement Agreement Section, be recovered by or on behalf of any Claimant, and such money is transferred to the Claimant, Claimant agrees that such money is a Plan asset and that Claimant is a fiduciary to the Plan with respect to that money, pursuant to ERISA § 3(21)(A)(i). As a fiduciary, Claimant is required to hold the money in trust on behalf of the Plan and not otherwise spend or distribute the money until the Plan has released its Subrogation lien in writing. If the Claimant is a fiduciary pursuant to the foregoing, a failure to comply with the Subrogation and Reimbursement agreement or this Section shall be considered a breach of fiduciary duty, and the Trustees may enforce the terms of the Subrogation and Reimbursement agreement or this Section through legal action, reduction of benefits, or any other available legal or equitable means.

This section provides a summary of the Subrogation rules. For additional information about Subrogation, call the Fund Office.

PLAN OPERATION



PLAN INFORMATION

This section provides important information about the Plan and the people responsible for administering it.

Plan Name

The Welfare Benefits Plan sponsored by the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago.

Type of Plan

Your Plan is a welfare Plan that includes medical, prescription drug, dental, vision, disability, life insurance, and accidental death and dismemberment insurance coverage.

Name and Address of the Plan's Fund Office

Building Material Chauffeurs, Teamsters and Helpers
Welfare Fund of Chicago
300 South Ashland Ave., Suite 500
Chicago, Illinois 60607
(312) 666-1875 or (877) 315-3758
www.teamsters786benefits.org

Plan Sponsor and Administrator

The Welfare Plan is administered by the Board of Trustees, consisting of Union and Employer Trustees who may be reached at the Fund Office. The present Trustees are listed below. However, with respect to Plan business, all can be reached in care of the Fund office.

Employee Trustees

Edward Rizzo
Teamsters Local 786
300 South Ashland Ave., Room 501
Chicago, Illinois 60607

Bryant Smith
Teamsters Local 786
300 South Ashland Ave., Room 501
Chicago, Illinois 60607

James Goddard
Teamsters Local 786
300 South Ashland Ave., Room 501
Chicago, Illinois 60607

Brandon Snow
Teamsters Local 786
300 South Ashland Ave., Room 501
Chicago, Illinois 60607

Employer Trustees

Steven Warnke, Chairman
300 South Ashland, Room 500
Chicago, Illinois 60607

Dave Mashek
VCNA Prairie Materials
7601 West 79th Street
Bridgeview, Illinois 60455

Kevin Jarchow
Wille Bros
11303 West Manhattan
Monee, Illinois 60449

Jeff Ozinga
Ozinga Illinois
18825 South Old LaGrange Road
Mokena, Illinois 60448

Determination of Eligibility and Benefits

The Trustees of the Plan are empowered to determine any and all questions arising in the administration, interpretation and application of the plan, including questions of eligibility of Employees, their Dependents and any other person.

If a decision of the Plan is challenged in court, the decision will be upheld unless the court finds it is arbitrary and capricious.

Right to Amend or Terminate

The Trustees reserve the right to amend, modify or discontinue all or part of this Plan, at any time. Upon termination of the Plan, the Trustees shall apply the monies of the Fund to provide benefits or otherwise carry out the purposes of the Plan in an equitable manner until the remainder of the Fund has been disbursed. You will be notified in writing of any changes to the Plan.

Plan Employer Identification Number

36-6057110

Plan Number

501

Plan Year

September 1–August 31

Agent for Service of Legal Process / Fund Administrator

Jeffrey W. Hoff
Building Material Chauffeurs, Teamsters and Helpers
Welfare Fund of Chicago
300 South Ashland Ave., Suite 500
Chicago, Illinois 60607
(312) 666-1875 or (877) 315-3758
Service may also be made on any Plan Trustee.

Legal Counsel

William T. Daniels and Monica B. Lasky
Laner Muchin, Ltd.
515 North State Street – Suite 2400
Chicago, Illinois 60654

Vince Pinelli
Burke, Burns & Pinelli, Ltd.
70 West Madison, Suite 4300
Chicago, Illinois 60602

Certified Public Accountant

Legacy Professionals, L.L.P.
4 Westbrook Corporate Center, Suite 700
Westchester, Illinois 60154

This booklet is provided for your convenience. You should note that if there is ever a disagreement between the Plan's legal document and this booklet, the legal document will be the final word. The Plan document is available for your inspection through the Plan administrator.

Claim Administrator

Elite Administration
1300 West Higgins Road, Suite 208
Park Ridge, Illinois 60068
(312) 243-1265 or (800) 762-4166

Utilization Review Service

HealthCare Strategies (HCS)
(800) 582-1535

Wellness Provider

UIC Wellness
(University of Illinois at Chicago)
835 South Wolcott – Room E144
Chicago, Illinois 60612
(312) 996-7429

Vision Insurance Carrier

Fidelity Security Life Insurance Company/EyeMed Vision Care LLC
(866) 800-5457
www.Eyemed.com

Life Insurance Carrier

Standard Insurance Company
1100 SW Sixth Avenue
Portland, Oregon 97204
(800) 628-8600

Contributing Employers

The most significant group of Employers making Contributions to the Welfare Plan includes members of the following Employer association:

Northern Illinois Ready Mix and Material Association
4415 West Harrison Street, Suite 502
Hillside, Illinois 60162

Upon written request, the Fund Office will provide you with information as to whether a particular Employer is contributing to the Plan.

Contributing Employer and Employee self-payments are used to pay insurance premiums, administrative expenses, and benefits.

Collective Bargaining Agreements

The Welfare Plan is maintained under collective bargaining agreements between the Union and various Employers—either individually or through an Employer association acting as the negotiating agent of its members. You can review your Collective Bargaining Agreement by requesting a copy in writing from the Local Union Office at 300 South Ashland, Suite 501, Chicago, Illinois 60607.

Plan Assets and Funding

The Board of Trustees holds all assets in Trust for the purposes of providing benefits to Eligible Participants, paying Life and AD&D Insurance premiums, and defraying reasonable administrative expenses. Medical, Dental, and Disability benefits are self-funded through the assets of the Trust which derive from Employer Contributions and Employee self-payments in certain circumstances as specified in this document.

Vision benefits are fully insured through:
Fidelity Security Life Insurance Company/EyeMed Vision Care LLC

Life and AD&D Insurance are fully insured through:
Standard Insurance Company

No Guarantee of Employment

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

Plan Benefits Do Not Vest

Benefits under the Plan do not vest. If you leave Covered Employment, benefits will cease except as explicitly provided under COBRA, USERRA, or the self-payment period extension, or under special layoff or leave circumstances such as FMLA, or under the certified disability continuance. If the Plan is terminated, benefits will cease.

Use and Disclosure of Protected Health Information

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

The Plan will use and disclose PHI as required by law and as permitted by authorization of the Eligible Participant. The Plan will disclose PHI to the Board of Trustees of the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago, the Plan sponsor, for the purpose of deciding health claim appeals.

YOUR ERISA RIGHTS

As a participant in the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan And Benefits

ERISA provides that all Plan participants are entitled 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. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or 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 Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate the Plan, called "fiduciaries", have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

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

Assistance With Your Questions

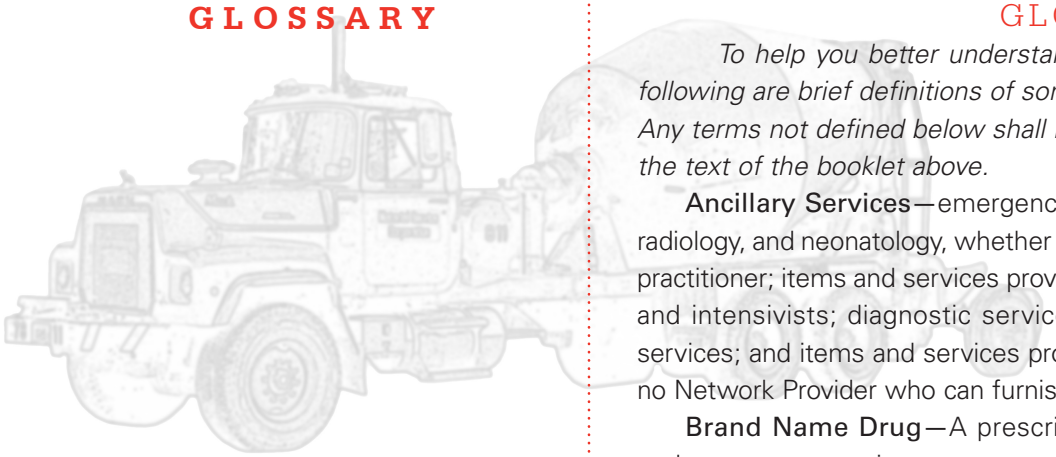
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits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

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

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices at the website of the EBSA:

- By calling (866) 444-3272; or
- Sending electronic inquiries to www.askebsa.dol.gov; or
- Visiting the website of the EBSA at www.dol.gov/ebsa.

GLOSSARY



GLOSSARY

To help you better understand the terms used in this booklet, the following are brief definitions of some of the most commonly used terms. Any terms not defined below shall have the meaning attributed to them in the text of the booklet above.

Ancillary Services—emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by a non-PPO Provider if there is no Network Provider who can furnish such item or service at such facility.

Brand Name Drug—A prescription drug that is or was at one time under patent protection.

Calendar Year—The 12 month period starting on January 1 of any year and ending on December 31 of that year.

Case Manager—One of the professional staff members of the Utilization Review company who reviews the treatment, procedures, medical equipment and supplies for which prior authorization is required (see pages 40 and 41) and who determines whether such treatment, procedures, equipment or supplies are Medically Necessary and Covered Under the Plan.

Chiropractic Care—Any treatment, services, or supplies provided by a chiropractor, including, but not limited to manipulation of the spine, reduction of a spinal subluxation, office visits, physical therapy, and X-rays, regardless of how coded for billing purposes. All Chiropractic Care must be (i) prescribed by the Patient's Physician, and (ii) provided under the supervision of a Physician.

COBRA Continuation Coverage—Coverage provided pursuant to a federal law known as "COBRA" (Consolidated Omnibus Budget Reconciliation Act) which requires continuation of health Plan coverage beyond when it otherwise would end if a qualifying event occurs as described in the section entitled "COBRA Continuation Coverage."

Coinsurance—A designated portion of charges for health care services or supplies you receive for which you are responsible. Coinsurance may be expressed as a percentage.

Collective Bargaining Agreement—Any applicable Collective Bargaining Agreement now existing, or existing in the future, between an Employer and the Union providing for Contributions to the Trust Fund as well as any extensions, amendments or renewals thereof.

Continuing Care Patient—An individual is a Continuing Care Patient with respect to a provider or facility if the individual is:

- undergoing a course of treatment for a "serious and complex condition" from the provider or facility;
- undergoing a course of institutional or inpatient care from the provider or facility;
- scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- determined to be "terminally ill" and receiving treatment for such illness from such provider or facility.

An indvidual has a serious and complex condition if the individual has a condition that (a) in the case of an acute illness, is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time. An individual is terminally ill if the individual has a medical prognosis that the individual's life expectancy is six months or less.

Copayment—A designated portion of charges for health care services or supplies you receive for which you are responsible (usually paid at the time you receive one service or supply). The copayment may be expressed as a fixed flat dollar amount.

Contributions—Payments made or due to the Fund by/from Employers, pursuant to the terms of the Trust Agreement, a Collective Bargaining Agreement, or a Participation Agreement, on behalf of their Employees for work performed by such Employees.

Covered Employment— Employment of an Employee by an Employer (i) pursuant to a Collective Bargaining Agreement or (ii) where such employment is subject to a Participation Agreement between his/her Employer and the Fund, whereby the Employer makes contributions to the Fund on his/her behalf.

Covered Medical Expenses—The Reasonable and Customary Charges actually incurred by an Eligible Participant upon the recommendation or approval of the attending Physician for services and supplies that are Medically Necessary and that are required for treatment of the Eligible Participant as a result of a nonoccupational accidental bodily Injury or Sickness and for which benefits are payable by the Plan in accordance with the provisions of this booklet.

Covered Under the Plan—An individual is eligible, in accordance with the eligibility provisions of this Plan, to receive the Plan benefits that are applicable to the individual's eligibility status as an Employee or a Dependent of an Employee, subject to all applicable provisions of this booklet governing the provision of benefits.

Dental Hygienist—A person licensed to practice dental hygiene by the governmental authority having jurisdiction over the practice of dental hygiene and who works under the supervision of a Dentist.

Dentist—A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DDM) who:

- Is legally licensed and authorized to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered,
- Acts within the scope of his or her license, and
- Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dependent—The following categories of individuals:

- Eligible Participant's spouse (including a same-sex spouses) (if not legally separated or divorced),
- Children who are less than 26 years of age.
- Unmarried Children age 26 or older who are permanently and totally disabled due to physical handicap or mental disability and incapable of self-support. Coverage for a mentally or physically disabled child

may continue past the child's 26th birthday if the child remains dependent on you for support and maintenance. You will need to provide proof of the child's disability when requested. For purposes of this subparagraph, "totally disabled" means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

For purposes of this definition, "Child(ren)" means:

- Natural children,
- Children who are legally adopted by the Employee or Placed for Adoption in the Employee's home,
- Step-children, unless the step-children are required to be covered by another person under the terms of a Qualified Medical Child Support Order (QMCSO).
- Foster children who are placed with an Employee by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction, or
- Children for whom the Plan has received a QMCSO.

"Child(ren)" does not include children with respect to whom the Employee has been appointed to serve as a legal guardian, except as otherwise described above.

Eligible Participant—An individual employed by an Employer who has met and continues to meet the eligibility requirements of the Plan or the eligible Dependent of such Employee.

Emergency—A medical condition that is evidenced by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), seriously impair bodily functions, or result in serious dysfunction of any bodily organ or part. If symptoms exist that reasonable may be interpreted as an Emergency, that condition will be considered an Emergency even if the final diagnosis is of another condition. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an Emergency even if a final diagnosis of a heart attack is not made. Likewise, if you are taken for treatment to the nearest hospital or trauma center by the police, fire department, or ambulance under circumstances beyond your control, this too will be treated as an Emergency.

Emergency Services—Outpatient and inpatient services provided with respect to an Emergency, including treatment provided by and within the capabilities of the emergency department of a Hospital (including a Hospital outpatient department) or an independent, freestanding emergency department that is geographically separate and licensed separately from a Hospital under applicable state law, including an appropriate medical screening examination and ancillary services routinely available to the emergency department to evaluate such Emergency and medical treatment necessary to stabilize the person (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of

the person from the facility). Emergency Services include treatment of an Emergency by an urgent care facility if such urgent care facility is permitted by applicable state licensure laws to provide such services.

Employee—Any of the following:

- An individual employed by an Employer, on whose behalf the Employer, pursuant to a Collective Bargaining Agreement with the Union, is or has been required to make Contributions to the Trust Fund, or
- A person on whose behalf Employer Contributions are required to be made to the Plan pursuant to a written Participation Agreement, who are employed by and under the direction and control of an Employer (whether such employment is pursuant to a Collective Bargaining Agreement or not).

Employer—Any of the following:

- An employer who, by reason of a Collective Bargaining Agreement with the Union, is obligated to make Contributions on behalf of Employees to the Fund or to a welfare fund that has merged with the Fund or will hereafter do so,
- The Union,
- The Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago which has entered into a written Participation Agreement with the Union, by which it is bound to make Employer Contributions to the Trust Fund on behalf of its own Employees who meet the definition of Employee.
- The Building Material Chauffeurs, Teamsters and Helpers Pension Fund of Chicago, which has entered into a written Participation Agreement with the Fund, by which such fund is bound to make Employer Contributions to the Trust Fund on behalf of its own Employees who meet the definition of Employee.
- The Northern Illinois Ready Mix and Material Association which enters into a written Participation Agreement with the Fund, by which it is bound to make Employer Contributions to the Trust Fund on behalf of its own Employees who meet the definition of Employee.
- Any other employer or owner-operator that has entered into a Participation Agreement.

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

Essential Health Benefits—Those items and services covered within the following general categories: ambulatory patient services, Emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric services (meaning services provided to individuals under age 19), including oral and vision care. The Trustees have the sole discretion and responsibility to determine whether a benefit is deemed to be an "Essential Health Benefit."

Experimental or Investigative—The use of any treatment, procedure, facility, equipment, drug, device, or supply not yet generally recognized as accepted standard medical practice through established review

mechanisms, such as those established by the Federal Drug Administration or the American Medical Association. This would include any treatment, procedure, facility, equiptment, drug, device or supply provided as part of a clinical trial. This also includes 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. The Trustees have the authority to determine whether a treatment, service or supply is Experimental or Investigative. The fact that a Physician or Dentist has prescribed, ordered, recommended or approved the treatment, service or supply does not in itself make it eligible for payment.

Fund, Trust Fund, Health and Welfare Fund—The Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago created pursuant to the Trust Agreement and administered by the Trustees consisting generally of all the monies, property and other things of value held by the Trustees under the provisions of the Trust Agreement, which comprise corpus and additions, without distinction as to principal and income.

Generic Drug—A prescription drug that is a multi-source drug that has never been under patent protection.

Hospital—An institution accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), licensed in the state where it is located, and operating according to law, that meets the following requirements:

- It meets one of the following requirements:
  - It maintains on its premises all facilities necessary for medical and surgical treatment, provides such treatment on an inpatient basis for compensation under the supervision of Physicians, and provides 24-hour service by registered graduate nurses,
  - It qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and is a provider of services under Medicare, or
  - It specializes in treatment of Mental Illness, Substance Abuse, or other related Illnesses, and provides residential treatment programs
- It is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care (either on the premises or by formal arrangement with an acceptable institution) of injured and sick persons, and
- It is not a place for rest or for the aged and is not a nursing or convalescent home.

Illness or Sickness—Any bodily sickness or disease (including Mental Illness), including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition, and including the pregnancy of an eligible Employee or eligible spouse.

Infertility—The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy, as certified by a Physician.

Injury—Any damage to a body part resulting from trauma from an external source.

Maintenance Drug—Prescription drugs taken for periods of time of 30 days or longer for such chronic conditions as, but not limited to, high blood pressure, heart conditions, diabetes, ulcers, asthma or arthritis.

Medically Necessary—Only those services, treatments or supplies provided by a Hospital, a Physician, Dentist, 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 Participant'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 Participant's condition, Sickness, Injury, disease, or ailment,
- Must be appropriate according to standards of good medical practice,
- Must not be solely for the convenience of the Eligible Participant, a Physician, Dentist, or a Hospital, and
- Must be the most appropriate that can safely be provided to the Eligible Participant.

Note: The Plan may not consider certain services, treatments and supplies Medically Necessary unless and until you have tried certain other services, treatments or supplies first, and the Plan determines that such other services, treatments or supplies have not succeeded.

Mental Illness—A neurosis, psychoneurosis, psychopathy or psychosis or a mental or emotional disease or sickness of any kind that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Medicare—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.

Nurse Anesthetist—A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a Physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license, and is not the patient or the parent, spouse, sibling, spouse's sibling or child of the patient.

Participating Pharmacy—A retail prescription drug provider that has entered into an agreement with the Plan or the Plan's designee to provide prescribed drugs and supplies at agreed-upon, discounted rates.

Participation Agreement—A written agreement whereby an Employer agrees to contribute to the Fund on behalf of its employees whose employment may or may not also be subject to a Collective Bargaining Agreement.

Physical Therapy—Treatment that is intended to restore or improve a patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination or general mobility. Physical therapy must be (i) prescribed by the patient's Physician, (ii) given by or under the supervision of a Physician or a licensed physical therapist and (iii) given for a condition that is capable of significant improvement in a reasonable and generally predictable period of time.

Physician—A legally qualified medical practitioner who is practicing within the scope of his or her license, is licensed to prescribe and administer drugs or perform surgery, and has a doctorate of medicine (M.D.).

Placed for Adoption—The date the eligible Employee first becomes legally obligated to provide full or partial support of the child whom the eligible Employee plans to adopt.

Plan—The Welfare Benefit Plan sponsored by the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago and any Supplements or Amendments thereto, as described herein and as hereafter amended.

Plan Year—The Plan's fiscal year, which runs from September 1 through August 31.

Preferred Provider Organization or PPO— A network of Physicians, Hospitals or other medical care providers who have agreed to provide services at certain negotiated rates.

Prosthetic Device—An artificial device that replaces all or part of a body part or replaces all or part of the functions of a permanently disabled or poorly functioning body organ.

Radiation Therapy—Services including x-ray examinations, radium, radon, cobalt therapy, ultrasound testing, radioisotopes and computerized transaxial tomography (CAT) scans.

Reasonable and Customary (R&C) Charge—With respect to non-PPO, non-contracted providers, an amount that is 135% of the base Medicare rate. For non-PPO providers who have a contract with the Preferred Provider Organization to provide services at contracted rates, Reasonable and Customary is the amount of covered expenses that does not exceed the contracted rate. For Preferred Provider Organization (PPO) providers, Reasonable and Customary is the amount of covered expenses that does not exceed the negotiated fee.

Recognized Amount—An (i) amount determined by an applicable All-Payer Model Agreement under the Social Security Act, or, (ii) if there is no such applicable agreement, an amount determined by applicable state law, or (iii) if there is no such agreement and no amount determined by state law, the lesser of the billed amount or the median PPO network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter. Currently, there is no applicable All-Payer Model Agreement, nor any applicable state law, meaning that the Recognized Amount will be the lesser of the billed amount or the median PPO network rate.

Room and Board Charges—All charges made by a Hospital, a Skilled Nursing Facility, or a Treatment Facility for Substance Abuse, in its own behalf for room, board, general duty nursing and any other charges by whatever name called which 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.

Schedule of Benefits—means the schedule of annual and lifetime maximums, maximum out-of-pocket expense amounts, deductibles, co-payment percentages, and other benefit amounts and limitations set forth in this Summary Plan Description.

Skilled Nursing Facility—A nursing facility, by whatever name called, that meets all of the following criteria:

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

Specialty Drugs—injectable, infusion, and high-cost drugs used to treat complex or rare conditions, including conditions such as, but not limited to, anemia, immune deficiency, neutropenia, cancer, growth deficiency, multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Specialty Drugs also include high-cost pharmaceuticals with special administration requirements (such as complex dosing regimens), special handling (including temperature sensitive delivery), special clinical support, and/or special requirements for access to product.

Substance Abuse—A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Summary Plan Description— The summary of the Plan distributed to Eligible Participants as required under ERISA and contained in this booklet.

Treatment Facility for Substance Abuse—A rehabilitation facility for the treatment of individuals suffering from Substance Abuse. Such a facility may be a freestanding facility or may be a designated portion of a Hospital or other facility, provided such designated portion is solely for the purpose of providing rehabilitative treatment for individuals suffering from Substance Abuse. To be considered an approved treatment facility for purposes of this Plan, the facility must be licensed and operating according to law, accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and licensed in the state in which it is located.

Trust Agreement or Trust—The Agreement and Declaration of Trust establishing the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago, as amended.

Trustee—A member of the Board of Trustees that consists of Employee Trustees and Employer Trustees (as defined in the Trust) who are collectively appointed to act under the Trust.

Union—The Building Material, Lumber, Box, Shaving, Roofing and Insulating Chauffeurs, Teamsters, Warehousemen and Helpers, Local Union No. 786, I. B. of T., the Teamsters Local Union 786 Vending Employees and any other union or labor organization that has executed a Collective Bargaining Agreement with an Employer who, in accordance with such Collective Bargaining Agreement, participates in the Plan and contributes to the Trust Fund.

WELFARE BENEFITS

Teamsters Local 786
Building Material Welfare Plan

300 South Ashland Avenue, Suite 500
Chicago, Illinois 60607
(312) 666-1875
www.teamsters786benefits.org