WELFARE BENEFIT PLAN SPONSORED BY THE BUILDING MATERIAL CHAUFFEURS, TEAMSTERS AND HELPERS WELFARE FUND OF CHICAGO

Plan Document

As Amended and Restated through September 1, 2022

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BUILDING MATERIAL CHAUFFEURS, TEAMSTERS AND HELPERS WELFARE FUND OF CHICAGO

ARTICLE I
ESTABLISHMENT AND NAME OF THE PLAN

Section 1.01 Establishment, Name, and Funding of the Plan

The Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago (hereinafter also referred to as the "Fund") established a welfare benefit plan for the Eligible Participants hereunder, which Plan will be known as the "Welfare Benefit Plan Sponsored by the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago" (hereinafter also referred to as the "Plan"). The Plan was established as of June 27, 1950, and is maintained in accordance with the provisions of the Agreement and Declaration of Trust effective January 1, 1976, as amended. For purposes of the Employee Retirement Income Security Act of 1974, as amended, this Plan is deemed to be a "Welfare Plan."

The Plan is funded through Employer Contributions. In order to preserve the Plan's "grandfathered status" under the Affordable Care Act of 2010, as of the date of this restatement, the Board of Trustees currently is not accepting Employer contributions pursuant to a Collective Bargaining Agreement that requires Employees to contribute to the Plan unless such Collective Bargaining Agreement was approved by the Board of Trustees previously. Accordingly, the only circumstances when Employee contributions are permitted would be when an Employee is in a self-payment extension period as described in Section 3.17 or receiving COBRA continuation coverage.

Section 1.02 Purpose

This Plan document is adopted by the Board of Trustees of the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago under the terms of the Agreement and Declaration of Trust in order to establish provisions which determine the Eligibility of Employees for the benefits provided by the Plan and to prescribe the amount, extent, condition and method of payment under the Plan.

ARTICLE II
DEFINITIONS

Section 2.01 Definitions

(a) Whenever used in this Plan and any Supplements and Amendments hereto, the following capitalized terms will have the respective meanings set forth below unless defined otherwise in the text of the Plan document. If a capitalized term is not defined below, it will have the meaning given to it where it appears.

(1) **"Brand Name Drug"** means a prescription drug that is or was at one time under patent protection.

(2) **"Calendar Year"** means the 12-month period starting on January 1 of any year and ending on December 31 of that year.

(3) **"Case Manager"** means one of the professional staff members of the utilization management company who reviews the treatment, procedures, medical equipment and supplies for which prior authorization is required pursuant to Section 4.10 of the Plan and who determines whether such treatment, procedures, equipment or supplies are Medically Necessary and covered under the terms of the Plan.

(4) **"Chiropractic Care"** means 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.

(5) **"Code"** means the Internal Revenue Code and the regulations thereunder, as amended from time to time.

(6) **"Collective Bargaining Agreement"** means 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.

(7) **"Contributions"** means payments made or due to the Fund by 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.

(8) **"Covered Employment"** means 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.

(9) **"Covered Medical Expenses"** means 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 non-occupational accidental bodily Injury or Illness and for which benefits are payable by the Plan in accordance with the provisions of this document.

(10) **"Covered Under the Plan"** means 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 document governing the provision of benefits.

(11) **"Dental Hygienist"** means 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.

(12) **"Dentist"** means a person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DDM) who:

(A) 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,

(B) Acts within the scope of his or her license, and

(C) Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

(13) **"Dependent"** means the following categories of individuals:

(A) Eligible Participant's spouse (if not legally separated or divorced) (for purposes of the Plan, the term "spouse" includes a spouse of the same or opposite sex resulting from a marriage that was valid in the jurisdiction in which it occurred);

(B) Children from birth who are less than 26 years of age;

(C) Unmarried Children age 26 or older who are permanently and totally disabled due to physical handicap or mental disability and incapable of self-support. 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 subsection, "Child(ren)" means:

(A) Natural children, or

(B) Children who are legally adopted by the Employee or Placed for Adoption in the Employee's home, or

(C) 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"), or

(D) 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

(E) 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 to the extent described above.

(14) **"Eligible Participant"** means an Employee who has met and continues to meet the eligibility or continuation requirements of the Plan as set forth in ARTICLE III or the eligible Dependent of such Employee.

(15) **"Employee"** means any of the following:

(A) 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

(B) 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 described in subsection 2.01(a)(16) below (whether such employment is pursuant to a Collective Bargaining Agreement or not).

(16) **"Employer"** means any of the following:

(A) 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.

(B) The Union.

(C) 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.

(D) 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.

(E) The Northern Illinois Ready Mix and Material Association which enters into a written Participation Agreement with the Fund, by which is bound to make Employer Contributions to the Trust Fund on behalf of its own Employees who meet the definition of Employee.

(F) Any other employer or owner-operator that has entered into a Participation Agreement.

(17) **"Employer Contributions"** means those payments required to be made by Employers to the Trust Fund on behalf of their Employees in accordance with applicable Collective Bargaining Agreements or Participation Agreements requiring such payments.

(18) **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended, and the regulations thereunder.

(19) **"Essential Health Benefits"** means 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."

(20) **"Experimental" or "Investigative"** refers to 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, equipment, 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 has prescribed, ordered, recommended or approved the treatment, service or supply does not in itself make it eligible for payment.

(21) **"Fund," "Trust Fund," "Health and Welfare Fund"** means the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago created pursuant to the Trust Agreement, administered by the

Board of Trustees and consisting generally of all the monies, property and other things of value held by the Board of Trustees under the provisions of the Trust Agreement and which comprise corpus and additions, without distinction as to principal and income.

(22) **"Generic Drug"** means a prescription drug that is a multi-source drug that has never been under patent protection.

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

(A) It meets one of the following requirements:

(i) 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, or

(ii) It qualifies as a "Hospital", a "psychiatric Hospital" or a "tuberculosis Hospital", and is a provider of services under Medicare, if such institution is accredited as a Hospital by the JCAHO, or

(iii) It specializes in treatment of Mental Illness, Substance Abuse, or other related Illnesses, provides residential treatment programs, and is licensed in accordance with the laws of the appropriate legally authorized agency, and

(B) 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

(C) It is not a place for rest or for the aged and is not a nursing or convalescent home.

(24) **"Illness" or "Sickness"** means 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, for the purposes of this Plan, includes the pregnancy of an eligible Employee or eligible spouse.

(25) **"Infertility"** means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy, as certified by a Physician.

(26) **"Injury"** means any damage to a body part resulting from trauma from an external source.

(27) **"Medically Necessary"** means only those services, treatments or supplies provided by a Hospital, a Physician, or other qualified provider of medical services and supplies, that are required, in the judgment of the Board of 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:

(A) Must be consistent with the symptoms or diagnosis and treatment of the Eligible Participant's condition, Sickness, Injury, disease, or ailment,

(B) Must be appropriate according to standards of good medical practice,

(C) Must not be solely for the convenience of the Eligible Participant, a Physician, or a Hospital, and

(D) Must be the most appropriate that can safely be provided to the Eligible Participant.

(28) **"Mental Illness"** means 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").

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

(30) **"Nurse Anesthetist"** means 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.

(31) **"Participating Pharmacy"** means 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.

(32) **"Participation Agreement"** means a written agreement whereby an employer agrees to contribute to the Fund on behalf of its employees whose employment is not subject to a Collective Bargaining Agreement.

(33) **"Physical Therapy"** means 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. To be payable, 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.

(34) **"Physician"** means a legally qualified medical practitioner who is practicing within the scope of his or her license and who is licensed to prescribe and administer drugs or perform surgery.

(35) **"Placed" or "Placement for Adoption"** means the time when the eligible Employee becomes legally obligated to provide full or partial support for a child whom the eligible Employee plans to adopt.

(36) **"Plan"** means 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.

(37) **"Plan Year"** means the Plan's fiscal year, which runs from September 1 through August 31.

(38) **"Preexisting Condition"** is defined at Section 4.11 (b).

(39) **"Preferred Provider Organization" or "PPO"** means a network of Physicians, Hospitals or other medical care providers who have agreed to provide services at certain negotiated rates.

(40) **"Prosthetic Device"** means 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.

(41) **"Radiation Therapy"** means services including x-ray examinations, radium, radon, cobalt therapy, ultrasound testing, radioisotopes and computerized transaxial tomography (CAT) scans.

(42) **"Reasonable and Customary Charge"** means for PPO providers the amount of covered expenses that does not exceed the negotiated fee, and for non-PPO providers who have a contract with the Preferred Provider Organization to provide services at contracted rates, the amount of covered expenses that does not exceed the contracted rate. For non-PPO,

non-contracted providers, the "Reasonable and Customary Charge" means 135% of the base Medicare rate. With respect only to coverage for COVID-19 testing occurring on or after March 18, 2020, and prior to the expiration of the national public health emergency, the "R&C Charge" for non-PPO providers will be the cash price for such service as listed by the provider on a public internet website, unless the Plan has negotiated a lower charge with the provider.

(43) **"Room and Board Charges"** means all charges made by a Hospital, a Skilled Nursing Facility, or a Treatment Facility for Substance Abuse, on 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.

(44) **"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 the Summary Plan Description.

(45) **"Skilled Nursing Facility"** means a nursing facility, by whatever name called, that meets all of the following criteria:

(A) It is an institution, or a distinct part of an institution, that has in effect a transfer agreement with one or more Hospitals,

(B) It is primarily engaged in providing in-patient skilled nursing care and related services for individuals who require medical or nursing care,

(C) It is duly licensed by the appropriate governmental authorities,

(D) It has one or more Physicians and one or more registered professional nurses responsible for the care of inpatients,

(E) It requires that every patient must be under the supervision of a Physician,

(F) It maintains clinical records on all patients,

(G) It provides 24-hour-a-day nursing services,

(H) It provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals,

(I) It has in effect a utilization review plan,

(J) It is eligible to participate under Medicare, and

(K) It is not an institution that is primarily for the care and treatment of Mental Illness or tuberculosis.

(46) **"Substance Abuse"** means 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 DSM.

(47) **"Summary Plan Description"** means the summary of the Plan distributed to Eligible Participants as required under ERISA.

(48) **"Total Disability, Totally Disabled"** means that the Employee is completely unable to perform the duties pertaining to the Employee's occupation or employment as a result of a non-occupational accidental bodily Injury or Sickness.

(49) **"Treatment Facility for Substance Abuse"** means 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 JCAHO, licensed in the state in which it is located.

(50) **"Trust Agreement"** or **"Trust"** means the Agreement and Declaration of Trust establishing the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago, as amended.

(51) **"Trustee"** means 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.

(52) **"Union"** means 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.

(b) Any terms not defined above shall have the meaning attributed to them in the text of the document below.

ARTICLE III
ELIGIBILITY

Section 3.01 General

Employees will be eligible for benefits if they work in Covered Employment and Contributions are made to the Fund on their behalf in accordance with the provisions of this Article. In certain instances, eligibility may be based on self-payments as specified in this Article. Eligibility also may be contingent upon the Employee providing timely and adequate information in connection with enrollment as reasonably requested by the Plan. In addition, a Trustee on whose behalf contributions are made by the Welfare Fund and/or The Building Material Chauffeurs, Teamsters and Helpers Pension Fund of Chicago, and who the Board of Trustees determine is eligible in its discretion, will be eligible for benefits.

Section 3.02 Initial Employee Eligibility

(a) An Employee will become eligible on the first day of the month following the two or three consecutive month period in which the Employee has worked 6 weeks in Covered Employment and the required contributions have been received by the Fund.

(b) If an Employee declines enrollment for the Employee or for the Employee's Dependents because of other health insurance coverage, the Employee may in the future enroll the Employee and the Employee's Dependents in the Plan, provided that the Employee requests enrollment within 30 days after such other coverage ends. In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the Employee may enroll the Employee and the Employee's Dependents, provided that the Employee requests enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If the enrollment request in either case is made more than 30 days after the respective event, the Dependents still may be added, but coverage will be prospective only.

Section 3.03 Special Eligibility: The Children's Health Insurance Program Reauthorization Act

If the Employee or his/her Dependent experiences (1) a loss of eligibility for Medicaid or a state children's health insurance program ("SCHIP"), or (2) becomes eligible to participate in a premium assistance program under Medicaid or an SCHIP, the Employee and/or his/her Dependent will be entitled to receive coverage under the Plan. Such enrollment must be requested within 60 days of the loss of such eligibility or becoming eligible for such premium assistance.

If an Employee or the Employee's Dependent lost other coverage as a result of the failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), then a special enrollment right will not exist.

Section 3.04 Continuing Eligibility

Once an Employee becomes Eligible, the Employee will remain Eligible until the end of the month following the month for which the Employer last makes Contributions to the Fund on the Employee's behalf. As long as one week of contributions is received for a month, the Employee's coverage will continue through the end of the following month.

Section 3.05 Eligibility during Periods of Disability

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

(a) The Employee becomes disabled after the Employee has met the initial eligibility requirements and while the Employee continues to be eligible, and

(b) The Employee is unable to work due to a disability for which the Employee is eligible for, receives, and continues to receive workers' compensation benefits, Illinois Occupational Disease benefits or the Disability Benefits set forth in ARTICLE IX.

Section 3.06 Eligibility during Lay-Off or Leave of Absence

An Employee who is not working because of lay-off or because of an approved leave of absence (for example, a military leave) 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 an Employee no longer meets the Continuing Eligibility requirements of Section 3.04 , the Employee must have 25 weeks of contributions in the last nine months. Otherwise, the Employee's 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 with respect to the Employee, his 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.

Section 3.07 Reinstatement of Eligibility

(a) **Reinstatement Upon Return to Work**

An Employee whose eligibility was terminated will be reinstated on the first day of the month following the Employee's return to work in Covered Employment with a Covered Employer, provided Contributions by the Contributing Employer to maintain coverage under the Plan have not lapsed for twelve months or more. If

Employer Contributions have lapsed for twelve months or more, the Employee must meet the initial eligibility requirement in Section 3.02 .

(b) **Reinstatement after Military Leave**

An Employee who returns to work following a military leave of absence under the Uniformed Services Employment and Reemployment Rights Act ("USERRA") will have coverage reinstated on the day the Employee returns to work, provided:

(1) The Employee returns to Covered Employment within the period during which reinstatement rights are guaranteed by law under USERRA, and

(2) The required Contributions are made on behalf of the Employee after his return from military service.

Section 3.08 Trustee Eligibility

If a Trustee is not employed by the Union or by a contributing Employer, a Trustee will become eligible to participate in the Plan on the date that a participation agreement is fully executed between the Fund and such Trustee. The scope of such coverage shall be determined by such participation agreement.

Section 3.09 Dependent Eligibility

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. Notwithstanding the preceding, the Employee may elect to waive coverage for a Dependent. Such Dependent may be enrolled in the Plan at a later time pursuant to the procedures established by the Plan Administrator and set forth in the Summary Plan Description. If a request for enrollment at a later time is made within thirty days of the loss of other coverage, then such enrollment will be retroactive to the date of loss of the other coverage; otherwise, such enrollment will take effect as soon as practicable following the Plan Administrator's receipt of an enrollment request.

Section 3.10 Termination of Employee's Eligibility

An Employee's eligibility will terminate:

(a) At the end of the month following the month for which Contributions were last received on behalf of the Employee if termination of employment is due to retirement, voluntary termination, or dismissal from employment,

(b) At the end of the month following the month for which Contributions were last received on behalf of the Employee 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),

(c) the date determined by the Fund if the Employee commits an act of fraud or a material misrepresentation with respect to Plan benefits or coverage, in which case coverage may be terminated retroactively;

(d) At the end of the three-month extension if the Employee was on lay-off or leave of absence, or

(e) The date the Plan is terminated.

Section 3.11 Termination of Dependent's Eligibility

An eligible Dependent's eligibility will terminate on the earliest of the following dates:

(a) The last day of the month that contains the date that the Dependent child stops being an eligible Dependent;

(b) The date that a Dependent spouse ceases to be an eligible Dependent spouse.

(c) The date the Employee's coverage ends;

(d) The date the Dependent spouse enters the armed forces on full-time active duty;

(e) An administratively practicable date following the Employee's request to waive coverage for the Dependent;

(f) 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; or

(g) The date the Plan is discontinued or no longer covers Dependents.

Section 3.12 Extension of Dependent Coverage if Employee Dies.

If an Employee dies while he and his Dependent(s) are covered under the Plan, such Dependent(s) shall remain eligible for coverage under the Plan for three months beyond the date coverage would otherwise terminate due to the Employee's coverage ending.

Section 3.13 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 coverage of Employees and their Dependents retroactively if benefits were provided due to fraud or intentional misrepresentation of material fact. Thirty day advance notice will be provided 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.

Section 3.14 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.

Section 3.15 Uniformed Services Employment and Reemployment Rights (USERRA)

Eligible Employees may be able to continue Health Coverage benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

(a) **Definitions**

(1) Health Coverage means medical, prescription drug, dental and vision benefits provided under the Plan. Health Coverage is subject to change as a result of Plan modifications.

(2) USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).

(3) Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty, and a period for which a person is absent from employment to perform funeral honors duty as authorized by law.

(4) Uniformed services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

(b) **Continuation of Group Health Coverage under USERRA**

(1) For an Employee and the Employee's eligible Dependents: If Health Coverage ends because of an Employee's service in the uniformed services, an Employee may elect to continue such Health Coverage, if required by USERRA, until the earlier of:

(A) The period ending on the day after the date on which the Employee fails to apply for or return to a position of employment with the Employer on a timely basis, as determined in accordance with USERRA, or

(B) The date which is 24 consecutive months after the beginning date of the Employee's absence from employment for performing service in the uniformed services in accordance with USERRA.

(2) To continue coverage, an Employee or the Employee's Dependent must pay the required premium, unless service in the uniformed service is for fewer than 31 days, in which case the Employee is not required to pay anything. The Fund Office will inform an Employee or the Employee's Dependent of procedures to pay premiums.

(3) End of Continuation. A covered person's continued Health Coverage will end at midnight on the earliest of:

(A) The day an Employee's former Employer ceases to provide any group health plan to any Employee,

(B) The day a premium is due and unpaid,

(C) The day a covered person again becomes Covered Under the Plan, or

(D) The day Health Coverage has been continued for the period of time provided in part (l)(A) or (B) above (or any longer period provided in the Plan).

(4) Other Continuation Provisions. In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which the premium is paid in whole or in part by an Employer, then the premium an Employee is required to pay may increase for the remainder of the period provided above.

(c) **Reemployment and Reinstatement (Following Service in the Uniformed Services)**

Following discharge from such uniformed service, an Employee may be eligible to apply for reemployment with the Employee's former Employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any then existing health coverage provided by the Employer.

(d) **Important Notice Regarding USERRA**

In the event of a conflict between this provision and USERRA, the provisions of USERRA will apply.

Section 3.16 COBRA Continuation of Coverage

(a) Description of COBRA Continuation Coverage Requirements

The Fund will provide health care continuation coverage as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 and the regulations thereunder ("COBRA") for certain Employees and their Dependents whose coverage under the Plan would otherwise ordinarily end because of the Employee's termination of employment, death or certain other "qualifying events," as defined under COBRA. Covered Employees and their Dependents will receive additional information about their rights under COBRA. in the Plan's Summary Plan Description and also in the COBRA notices that the Fund provides.

Section 3.17 Extension of Coverage Beyond the COBRA Continuation Period

(a) Self-Payment Period Extension

If an Employee meets the requirements of subsection (b) below when the Employee's maximum COBRA continuation coverage period ends, the Employee may extend health care coverage for an additional period. This extension is called the self-payment period extension. The length of the period is dependent on the Employee's length of participation in the Plan prior to the beginning of COBRA continuation coverage.

(1) If the Employee was a Participant in the Plan for fewer than five years before the Participant's COBRA continuation coverage began, the Employee may make self-payments for a maximum of 18 months after the COBRA continuation coverage period ends.

(2) If the Employee was a Participant in the Plan for five years or more before the Participant's COBRA continuation coverage began, the Employee may make self-payments for a maximum of 42 months after the COBRA continuation coverage period ends.

(3) For Employees who were eligible for the 11-month disability extension under COBRA, the maximum number of months the Employee may make self-payments under (1) above is seven months and under (2) above is 31 months.

For purposes of (1) and (2) above, participation in the Plan is counted from the Employee's initial effective date of coverage and for each of the next five years in which the Employee is covered under the Plan for some part of each of those years. The Employee's coverage under COBRA will not be counted toward this requirement.

(b) **Eligibility for Self-Payment Period Extension**

An Employee is eligible to elect this extended coverage if the Employee meets all of the following requirements:

(1) The Employee initially loses coverage due to a layoff, reduction in hours of employment or termination of employment (other than for gross misconduct).

(2) The Employee elects and pays for COBRA continuation coverage through the maximum COBRA continuation coverage period.

(3) The Employee elects the self-payment period extension at the time the Employee initially elects COBRA continuation coverage.

(4) The Employee is not eligible for Medicare at the time the self-payment period extension begins.

(c) **Dependents' Eligibility for Self-Payment Extension Period**

If the Employee is eligible for and elects the self-payment period extension, the Employee's Dependents may also be covered if they elected COBRA coverage and continued and paid for such coverage for the maximum period permitted under COBRA and are not eligible for Medicare

(d) **Termination of Self-Payment Period Extension**

(1) An Employee's coverage under this extension will end on the earlier of the date the Employee:

(A) Becomes eligible for Medicare or any other group health plan coverage,

(B) Fails to make a timely self-payment, or

(C) Reaches the end of the maximum extension period applicable to the Employee.

(2) Coverage under this extension for an Employee's Dependent will end on the earlier of:

(A) The date a timely self-payment is not received by the Fund for the Dependent coverage,

(B) The date the person no longer meets the definition of Dependent under Section 2.01 (a)(13),

(C) The date the Dependent becomes eligible for Medicare or any other group health plan coverage, or

(D) The date that the Dependent reaches the end of the maximum extension period with respect to the Employee, or

(E) With respect to a Dependent child only, the later of the date that the Employee's coverage ends or the date that the Employee's spouse's coverage ends. (If the Employee does not have a spouse covered under this extension, this extension for the Employee's Dependent child will end on the date the Employee's coverage ends.)

(e) **Amount of Self-Payment**

The Employee's self-payment amount is determined by the Board of Trustees in its sole discretion. The amount is reviewed periodically and is subject to change.

Section 3.18 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 federal law, promptly provides written notification to the Fund that an application for a FMLA leave has been granted, and makes the required Employer Contributions to the Fund.

Section 3.19 Qualified Medical Child Support Orders

If a copy of a Medical Child Support Order, as defined in ERISA Section 609(a), is filed with the Fund Office, the Fund Office will promptly notify the eligible Employee and each alternate recipient of the receipt of such order and the Plan's procedures for determining whether the order is a Qualified Medical Child Support Order ("QMCSO"), as further defined in ERISA Section 609(a). The Fund Office will then determine whether the order is a QMCSO pursuant to the Plan's procedures and will notify the eligible Employee and each alternate recipient of the determination. The Plan will provide benefits in accordance with the applicable requirements of any QMCSO. Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial parent or legal guardian will be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

Section 3.20 Certificate of Coverage

When an eligible Employee's coverage under this Plan ends, the Fund will provide such Employee and the Employee's eligible Dependents with a certificate of creditable coverage that indicates the period of time that the Eligible Participant was Covered Under the Plan and certain additional information as required by Federal law. The certificate will be sent by first class mail within a reasonable period of time after the Eligible Participant's coverage under this Plan ends. If the Eligible Participant elects COBRA continuation coverage, another certificate will be provided within a reasonable period of time after the COBRA continuation coverage ends. In addition, a certificate will be provided within a reasonable period of time after receipt of a

request for such certificate if the request is received by the Fund within two years after the later of the date coverage under this Plan ended or the date COBRA continuation coverage ended.

ARTICLE IV
MEDICAL EXPENSE BENEFIT

Section 4.01 The Deductible

(a) The Deductible is the portion of Covered Medical Expenses that the Eligible Participant pays each Calendar Year before the Plan begins to pay benefits.

(b) Before most benefits begin, the Eligible Participant must first pay a Calendar Year Deductible. The individual Calendar Year Deductible will be set forth in the Schedule of Benefits in the Summary Plan Description. Covered medical charges for several different Illnesses or injuries during the Calendar Year may be added together to meet the Eligible Participant's individual Deductible.

(c) Each covered Eligible Participant is subject to the individual Deductible until the family deductible (also set forth in the Schedule of Benefits in the Summary Plan Description) is met by any or all family members.

(d) In determining whether the Deductible has been met, for the following adjustments will be made:

(1) The Deductible does not apply to certain charges (listed in the Schedule of Benefits in the Summary Plan Description) for which a Deductible is not required,

(2) Health care expenses incurred during the last three months of the Calendar Year that are used to meet the Deductible will also count toward the next Calendar Year's Deductible, and

(3) When 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 Calendar Year and the following Calendar Year.

Section 4.02 Coinsurance

Coinsurance refers to the fact that the Plan and the Eligible Participant are each responsible for paying a certain, specified portion of the Reasonable and Customary charges for health care services or supplies. In the Schedule of Benefits in the Plan's Summary Plan Description, coinsurance is expressed as a percentage of the charges paid by the Plan. The amount of coinsurance the Plan pays usually depends on whether the Eligible Participant uses providers who are part of the PPO network or providers outside of the PPO network, as listed in the Schedule of Benefits in the Summary Plan Description. As detailed in the Summary Plan Description, there are certain circumstances in which services received from non-PPO providers will be paid as if received from PPO providers.

Section 4.03 Annual Out-of-Pocket Maximum

The Plan limits the amount of money the Eligible Participant or his family pays out-of-pocket in a Calendar Year for the Eligible Participant's or family's share of covered expenses to an amount identified in the Schedule of Benefits in the Plan's Summary Plan Description per Eligible Participant or family, as applicable. If the Eligible Participant or his family reaches the applicable out-of-pocket maximum, the Plan will pay 100% of most covered expenses for the rest of the year, subject to all applicable limitations and provisions of the Plan.

(a) The following charges will not count toward the out-of-pocket maximum;

(1) Any amounts that apply to the Deductible.

(2) Any additional charges the Eligible Participant pays for a Brand Name Drug when a generic equivalent is available and the Eligible Participant's doctor would allow the generic drug to be substituted for the Brand Name Drug.

(3) Any additional charges the Eligible Participant pays for not following the second surgical opinion procedures or Pre-admission Review Procedures outlined in Section 4.10 .

(4) Any charges that exceed Reasonable and Customary amounts or any other Plan limits or otherwise are not covered by the Plan.

Section 4.04 Lifetime Maximum Benefit

(a) The Plan does not apply a lifetime maximum limit to Essential Health Benefits. Other non-essential benefits are subject to lifetime limits and other limits as listed in the Schedule of Benefits in the Plan's Summary Plan Description.

Section 4.05 Annual Maximum Benefit

(a) The Plan does not apply an annual limit to Essential Health Benefits.

(b) The Plan covers non-essential health benefits subject to separate annual limits and other limits as listed in the Schedule of Benefits in the Plan's Summary Plan Description. Non-essential health benefits are not counted for purposes of determining whether the overall annual limit with respect to Essential Health Benefits has been reached.

Section 4.06 Reasonable and Customary Limit

The Plan pays benefits up to Reasonable and Customary limits (as defined in the Definitions Article).

Section 4.07 Definition of Maximum Benefit

For purposes of this benefit, the term "Maximum Benefit" will mean the maximum amount of such benefits payable or allowable by the Plan, whether the amount be a dollar amount, a number of days, a period of time, or any other limitation of any kind as specified in the Schedule of Benefits in the Plan's Summary Plan Description. For each Eligible Participant, whether or not there has been an interruption in the continuity of eligibility, the maximum amount of benefits available during any specified period of time will be equal to the amount by which the Maximum Benefit specified for that period of time exceeds the sum of the benefits previously paid or provided on account of that Eligible Participant during that period of time.

Section 4.08 Medical Expense Benefit Payment Provisions

(a) Payment of benefits will be governed by any and all applicable provisions to which such payment is subject, including but not limited to the Maximum Benefits (shown on the Schedule of Benefits in the Plan's Summary Plan Description), Maximum Out-of-Pocket Expense amounts, Deductible Amounts, and all exclusions and limitations.

(b) The eligible Employee will be responsible for paying, on behalf of the Employee and the Employee's eligible 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.

(c) An expense will be deemed to be incurred as of the date the service was rendered or the purchase was made from which the expense or charge arises.

(d) 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, as specified on the Schedule of Benefits in the Plan's Summary Plan Description, once an Eligible Participant 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 individual as a result of such type of cause, condition, care, or treatment for the remainder of that Calendar Year.

Section 4.09 The Preferred Provider Organization (PPO) Network

(a) The Plan has an arrangement with a PPO network. The PPO network includes preferred Physicians, Hospitals and other health care providers. The providers have agreed to charge lower amounts for health care services provided to Fund members and their families. The Eligible Participant may receive a list of PPO providers by accessing the Provider website.

(b) The coinsurance percentage the Plan pays for PPO providers and providers outside the PPO network is listed in the Schedule of Benefits in the Plan's Summary Plan Description.

Section 4.10 Hospital Pre-admission Review Program and Prior Authorization Program

(a) **Hospital Pre-admission Review Program.** The Plan has adopted a Hospital Pre-admission Review program to review all hospitalizations, admissions to a Skilled Nursing Facility or Treatment Facility for Substance Abuse, and all other inpatient admissions to any facility and determine the length of stay that is reasonably necessary for an Eligible Participant's care and treatment in an effort to control the increasing cost of Hospital Confinement. Emergency confinements are not subject to Pre-admission Review. However, the Eligible Participant must report the emergency admission to the Hospital Pre-admission Review Program within 24 hours following confinement or on the next business day if the confinement begins on a Friday, Saturday or Sunday in order to receive benefits for the hospitalization.

(1) Hospital Confinement means an Eligible Participant's confinement in a Hospital, Skilled Nursing Facility, Treatment Facility for Substance Abuse, or any other facility for which the Eligible Participant is charged Room and Board Charges by the Hospital, Skilled Nursing Facility, Treatment Facility for Substance Abuse, or other facility.

(2) Emergency Confinement means an Eligible Participant's Hospital Confinement or confinement in a Treatment Facility for Substance Abuse for a condition that, unless immediately treated on an inpatient basis, would endanger the Eligible Participant's life or cause serious impairment to bodily functions of the Eligible Participant.

(3) Under the Hospital Pre-admission Review Program:

(A) The Eligible Participant's Physician must submit a request for a Hospital Pre-admission Review to the Plan:

(i) Within 10 days before any non-Emergency Confinement begins,

(ii) With regard to an Emergency Confinement:

a. Within 24 hours from the beginning of such confinement, or

b. By the next business day following a confinement on Friday, Saturday or Sunday,

(iii) For pregnancy, the Eligible Participant may, but is not required to, submit a request for a Hospital Pre-admission

Review at any time after the pregnancy is confirmed and again when the Eligible Participant enters the Hospital.

(4) The Plan will notify the Eligible Participant, the Physician and the Hospital, in writing, as to the number of days of Hospital confinement being authorized by the Plan for the Eligible Participant's treatment.

(5) The Physician in charge of the Eligible Participant's treatment may, at any time, request that the Plan reevaluate and/or extend the number of days of Hospital Confinement that was originally authorized for the treatment.

(6) The amount of benefits otherwise payable for hospitalization will be reduced as set forth in the Summary Plan Description if a Hospital Pre-admission Review is not obtained before admission in connection with a non-Emergency Confinement or within the required time after an Emergency Confinement and the Hospital Pre-admission Review representative later certifies the Hospital or other facility stay. There is no reduction in benefits if an Eligible Participant does not obtain a Hospital Pre-admission Review in connection with a hospitalization in connection with childbirth that does not exceed 48 hours after a vaginal delivery or 96 hours after a Cesarean section.

(7) Obtaining a Hospital Pre-admission Review does not guarantee the amount or payment of any benefit. The Participant's eligibility for these benefits, as well as their payment, are subject to all the terms and conditions of Plan coverage. If the Hospital Pre-admission Review representative does not certify the Hospital stay, no benefits will be paid.

(b) **Prior Authorization Program.** The Plan has adopted a review program that requires prior authorization for certain treatment, procedures or supplies. Emergencies are not subject to the prior authorization program. However, the Eligible Participant must report the Emergency treatment to the utilization management company within 24 hours following treatment or on the next business day if the treatment begins on a Friday, Saturday, or holiday in order to receive benefits for the treatment.

An Emergency is a condition that, unless immediately treated, would endanger the Eligible Participant's life or cause serious impairment to bodily functions.

The amount of benefits otherwise payable for treatment, procedures or supplies that are subject to the prior authorization program will be reduced as set forth in the Summary Plan Description if prior authorization is not obtained before a non-Emergency treatment or procedure is performed or a non-Emergency supply is obtained or within the required time after an Emergency treatment or procedure is performed or an Emergency supply is obtained.

The Plan requires prior authorization for the following:

(1) 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;

(2) Intensive outpatient treatment.

(3) Treatment at a freestanding outpatient surgical center (note: no coverage at all for treatment at non-PPO outpatient surgical center);

(4) Surgical services provided by a Physician's assistant;

(5) Durable medical equipment purchase if the purchase price is greater than $1,500;

(6) Hospice care;

(7) Orthotic devices in excess of $1,500;

(8) Prosthetic devices in excess of $1,500;

(9) Speech, occupational, physical, and ABA therapy after the first 18 visits;

(10) Colonoscopies;

(11) Injectable drugs;

(12) Infertility treatment;

(13) Rehabilitative services provided at a nursing home (note: no coverage for nursing home itself);

(14) Midwife services;

(15) Home birth;

(16) Birthing center;

(17) Treatment of sleep apnea;

(18) Sleep studies;

(19) Stress test;

(20) Treatment for pregnancy and child birth (may be authorized any time after pregnancy is confirmed and before delivery);

(21) Home health care;

(22) Hospice Care;

(23) Chemotherapy;

(24) Radiation;

(25) CT/CAT scans, MRA, MRI, PET scans, and nuclear scans;

(26) Cardiogram/echocardiogram;

(27) Tubal ligation;

(28) EGD;

(29) Vein stripping;

(30) Home infusion therapy;

(31) Skilled nursing services;

(32) Services provided in a Treatment Facility for Substance Abuse

(33) Observation in excess of 23 hours;

(34) Biopsy in excess of $2,000;

(35) Nutrition counseling; and

(36) Charges for office procedures in excess of $2000.

Section 4.11 Preexisting Condition Exclusion

(a) If an Eligible Participant has a Preexisting Condition prior to being covered by this Plan, the Plan will pay up to $500 for treatment of that condition during the 12-month period following the Eligible Participant's "enrollment date" (as defined below).

(b) A Preexisting Condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the enrollment date. The enrollment date, for purposes of the Preexisting Condition Exclusion, means the day coverage begins or, if earlier, the beginning of the Employee's applicable waiting period during which the Employee was earning credit toward eligibility. For a late enrollee or special enrollee, the enrollment date is the date coverage actually begins.

(c) Only treatment directly related to the Preexisting Condition will be excluded from coverage above $500.

(d) The exclusion referred to in Section 4.11 (a) will be reduced by the aggregate period of creditable coverage. "Creditable coverage" is health care coverage that the Eligible Participant had under applicable prior plans. The coverage is only

creditable if there was no significant break in the prior coverage. A significant break in coverage is defined as 63 consecutive days without health coverage. If the Eligible Participant had creditable coverage under a prior plan, the Eligible Participant must submit a Certificate of Creditable Coverage to the Fund.

(e) No Preexisting Condition limitations will apply with respect to:

(1) Pregnancy,

(2) Individuals under the age of 19,

(3) Children who are totally and permanently disabled from birth and who are Dependents of the Participant, or

(4) Genetic information alone (without a diagnosis of a related condition).

Section 4.12 Schedule of Medical Benefits - Employees and Dependents

The Schedule of Benefits, including medical benefits, will be set forth in the Plan's Summary Plan Description. Any material updates thereto will be communicated to Eligible Participants as required via distribution of Summaries of Material Modification.

Section 4.13 Covered Medical Expenses

(a) Covered Medical Expenses are 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:

(1) Medically Necessary as defined at Section 2.01 (a)(27), and

(2) Required for treatment of the Eligible Participant as a result of a non-occupational accidental bodily Injury or Sickness or for prevention of Injury or Sickness and for which benefits are payable under this Plan in accordance with all applicable limitations and exclusions.

(b) Benefits for Covered Medical Expenses listed below, subject to any limitations stated in the Schedule of Benefits in the Plan's Summary Plan Description and other limitations contained in this Plan of Benefits, include:

(1) **Acupuncture**, when recommended by a Physician, except that acupuncture administered to aid in overcoming eating disorders is not covered.

(2) **Ambulance** services for necessary transportation to the nearest health care facility equipped to furnish treatment for the condition.

(3) **Applied Behavioral Analysis (ABA) Therapy** performed by a licensed professional acting within the scope of such license in order to treat

developmental delays/differences including autism spectrum disorders (ASDs).

(4) **Outpatient surgical center** (except as provided in Section 4.16 (a)(1)).

(5) **Anesthesia** and its administration.

(6) **Birthing center.**

(7) **Blood** and plasma that is not donated or replaced.

(8) **Bra** (prosthetic) ordered after treatment for breast cancer.

(9) **Breast reconstruction** as required under Women's Health and Cancer Rights Act of 1998, as explained at Section 4.15 of the Plan.

(10) **Chemotherapy** treatment, services and supplies.

(11) **Chiropractic Care** (with any services that are considered Essential Health Benefits subject only to the annual maximum for Essential Health Benefits).

(12) **Colorectal screening** comprised of a colonoscopy once every five years for persons over age 45, if approved by Case Manager pursuant to Section 4.10 (b) of the Plan (no coverage for at-home colon cancer screening tests).

(13) **Dental care**. Under the Medical Benefit, dental care is covered 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. Information about additional coverage for dental care is contained in the section of the Schedule of Benefits in the Summary Plan Description regarding the Dental Benefit.

(14) **Diabetes** self-management program, including training, education, equipment and supplies for the treatment of Type 1, Type 2 and Gestational diabetes, including:

(A) Regular foot care exams,

(B) Diabetes self-management training as part of an office visit, group setting or home visit,

(C) Up to three visits following initial diagnosis of diabetes, and

(D) Up to two visits following a significant change in the patient's symptoms or medical condition.

(15) **Diagnostic procedures and tests** (i.e., x-ray and laboratory examinations) including interpretation.

(16) **Durable medical equipment rental or purchase**, (purchase may be required, but may need to be authorized in advance by Case Manager pursuant to Section 4.10 (b) of the Plan, if the purchase price is less than the cumulative rental price).

(17) **Hearing aids**, subject to the following provisions:

(A) The Eligible Participant is not required to pay the Deductible toward the hearing aid expense, and

(B) The hearing aid must be prescribed by a legally qualified otologist, audiologist or otolaryngologist.

(18) **Hospice** care, subject to Case Manager approval pursuant to Section 4.10 (b) of the Plan.

(19) **Hospital** charges for services and supplies provided during emergency room treatment, surgical services, obstetrical care, during a period of confinement including the charges for a semi-private room or intensive care unit, as well as the charges for a private room in an in-network Hospital that only offers private rooms, subject to the Hospital Pre-admission Review Program at Section 4.10 (a) of the Plan.

(20) **Immunization for children and adults** as described in the Schedule of Benefits in the Plan's Summary Plan Description.

(21) **Infertility treatment**, including, but not limited to the following procedures:

(A) In vitro fertilization,

(B) Uterine embryo lavage,

(C) Embryo transfer,

(D) Artificial insemination,

(E) Gamete intrafallopian tube transfer,

(F) Zygote intrafallopian tube transfer,

(G) Low tubal ovum transfer,

(H) Benefits for procedures described in (A), (E) and (F) are payable only if:

(i) 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

(ii) 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.

(I) Benefits for in vitro fertilization (including related injectables), gamete intrafallopian tube transfer and zygote intrafallopian tube transfer are applied towards the lifetime maximum Infertility benefit limit set forth in the Schedule of Benefits in the Summary Plan Description. The diagnosis of and other treatments of Infertility, including the treatment of physical and hormonal conditions underlying Infertility are not counted against the lifetime maximum Infertility benefit limit, but, instead, are subject to the annual maximum applicable to Essential Health Benefits.

(J) Expenses for donor eggs are excluded from Infertility treatment.

(22) **Lasik surgery** (once per eye per lifetime)

(23) **Mammography** screening covered once a year for women age 35 and older (subject to deductible and coinsurance).

(24) **Mastectomy and post-mastectomy** reconstructive surgery as required by the law and outlined at Section 4.15 of the Plan.

(25) **Maternity** care, as outlined at Section 4.14 of the Plan Document.

(26) **Mental health** treatment, subject to the limitations in the Schedule of Benefits in the Summary Plan Description, including charges for diagnosis and treatment of Mental Illness or psychiatric disorders performed by a licensed psychiatrist, clinical-psychologist, licensed clinical professional counselor, licensed clinical social worker, or Physician, including telehealth/virtual visits with such providers.

(27) **Certified nurse midwife** services.

(28) **Newborn care** while in the Hospital (Hospital charges only).

(29) **Nursing** services rendered by a Registered Nurse or a Licensed Practical Nurse for non-custodial services.

(30) **Occupational therapy** charges provided by a licensed occupational therapist to improve bodily function (a treatment plan is required).

(31) **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).

(32) **Orthotic** devices, such as braces, splints or other appliances for initial purchase, fitting, and repair that are required to support a weak or deformed part of the body.

(33) **Oxygen** services and supplies.

(34) **Pap smear**, provided as routinely recommended, subject to deductible and coinsurance.

(35) **Physical therapy** charges provided by a licensed physical therapist to improve bodily function (a treatment plan is required).

(36) **Physician** charges for professional medical or surgical services.

(37) **Certified physician assistant** services.

(38) **Prescription drugs** ordered by the Physician are covered by the Prescription drug program only, except as described in Section 6.06 of the Plan Document regarding exclusions.

(39) **Prostate cancer screening** for men over age 50 once a Calendar Year or over age 40 or men at risk for prostate cancer (subject to deductible and coinsurance).

(40) **Prosthetic** Devices for initial purchase, fitting and repair to replace natural limbs with the prior approval of the Utilization Management service pursuant to Section 4.10 (b) of the Plan.

(41) **Radiotherapy**, treatment and supplies, including x-ray, radium and radiation therapy.

(42) **Second surgical opinions** as follows:

(A) The Plan will pay for a voluntary second surgical opinion whenever an Eligible Participant's Physician recommends surgery.

(B) To receive full benefits, Eligible Participants must obtain a second opinion if the Physician recommends a surgical procedure and the Plan requires a second opinion.

(C) Benefits are reduced as set forth in the Summary Plan Description if the Eligible Participant does not obtain a required second surgical opinion if so required and communicated to the Eligible Participant as part of the pre-certification process.

(D) If the second surgical opinion does not confirm the need for surgery, the Plan will cover a third surgical opinion.

(E) Second surgical opinions must be obtained by a specialist who is (i) not associated with the Physician who recommended surgery and (ii) will not perform or assist in the proposed surgery.

(43) **Smoking cessation** benefits.

(44) **Speech therapy** services provided by a licensed speech therapist .

(45) **Sterilization** services.

(46) **Substance abuse** treatment, subject to the limitations in the Schedule of Benefits in the Plan's Summary Plan Description, including charges for diagnosis and treatment performed by a licensed psychiatrist, clinical psychologist, licensed clinical professional counselor, licensed clinical social worker, or Physician (but not including any charges for services provided by an unlicensed practitioner of any kind).

(47) **Surgery** charges, including:

(A) Physician's charges for surgery (except as provided in Section 4.16 (a)(1)).

(B) Hospital charges related to surgery, including pre-surgical laboratory examinations.

(C) Anesthesia and its administration.

(D) Charges for cosmetic surgery performed by a Physician, provided the services are rendered to treat:

(i) Injuries sustained in an accident (and services begin within 90 days after the accident),

(ii) A child's birth deformity, or

(iii) Reconstructive surgery following a mastectomy, pursuant to Section 4.15 of the Plan.

(48) **Surgical dressings**, casts, splints, trusses, braces and crutches used in the reduction of fractures and dislocations.

(49) **Telehealth visit** charges for one-on-one real-time consultations with qualified providers for Covered Medical Expenses that the Plan would have covered if the same services had been provided during a face-to-face consultation.

(50) **Well baby care**, including routine nursery care in a Hospital and routine pediatric care during their first seven days of life.

(51) **Well child care**

(52) **Wellness benefits for adults,** to the extent offered by the Fund's wellness provider and immunizations as recommended by the Centers for Disease Control and specified in the Summary Plan Description.

Section 4.14 Pregnancy, Childbirth and Related Conditions

(a) Benefits are payable for pregnancy, childbirth and related medical conditions. In addition, benefits are payable for routine nursery care (Hospital and Physician) prior to a newborn's release from the Hospital.

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

Section 4.15 Women's Health Act and Cancer Rights Act

(a) If an Eligible Participant is receiving benefits under the Plan in connection with a mastectomy and elects breast reconstruction, coverage will be provided to the Eligible Participant for:

(1) Reconstruction of the breast on which the mastectomy has been performed,

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(3) Prostheses and reconstruction for physical complications at all stages of mastectomy, including lymphedemas.

(b) This coverage is subject to the same co-payments, deductibles and coinsurance applicable to other physical conditions Covered Under the Plan.

Section 4.16 Medical Benefit Exclusions

(a) In addition to General Plan Exclusions listed in Section 13.01 , the Plan excludes coverage for charges and expenses related to medical care, treatments, services or supplies for the following:

(1) Treatment provided by an outpatient surgical center or other outpatient treatment facility that is outside of the PPO network (unless treatment is or is related to LASIK surgery).

(2) **Bereavement counseling** (unless provided through the Member Assistance Program).

(3) **Cosmetic surgery** charges, unless treatment is rendered for injuries sustained in an accident occurring within 90 days of the date of the accident, or treatment is for a congenital anomaly or unless treatment is for reconstructive surgery incidental to or following surgery covered by this Plan for any covered illness or pursuant to Section 4.15 of the Plan Document covering mastectomies.

(4) At-home **colon cancer screening tests.**

(5) **Dental care**, except as provided under the dental benefits portion of this Plan.

(6) **Exercise programs** for the treatment of any condition.

(7) **Experimental or Investigative** treatments, services, facilities, procedures, equipment, devices, drugs or supplies, including those used in manner which is not recognized as accepted, standard medical practice through established review mechanisms.

(8) **Genetic testing** charges or expenses incurred for prophylactic surgery resulting from genetic testing.

(9) **Growth hormones.**

(10) Charges in excess of the lifetime maximum per person as set forth in the Summary Plan Description for injuries received while the Eligible Participant was engaged in an activity or business that the Board of Trustees deems hazardous or unduly risky (such as, but not limited to, skydiving, scuba diving, motorcycling, or traveling in an aircraft piloted by someone other than a commercial pilot). Any benefits deemed to be Essential Health Benefits that an Eligible Participant receives as a result of incurring injuries due to an activity or business that the Board of Trustees deems hazardous or unduly risky will not be subject to the above referenced lifetime maximum.

(11) **Home construction** charges to accommodate a disabled person.

(12) **Non-emergency Hospital weekend admissions** when the condition is not actively treated until the following Monday.

(13) Charges for which the covered person has **no obligation** to pay.

(14) Charges incurred in connection with confinement in a **nursing home**, rest home, convalescent home or a place for the aged.

(15) **Nutritional supplements.**

(16) **Occupational** Sickness or Injury, that arises out of work for wage or profit that are covered by workers' compensation or that arise 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,

(17) **Orthopedic shoes.**

(18) Care, treatment, services or supplies which have not been recommended or approved by a **Physician** or for which the Eligible Participant is not under the care of **a Physician.**

(19) Benefits in excess of a certain amount as set forth in the Summary Plan Description for a **Pre-existing condition** during 12 months following an Eligible Participant's Enrollment date, pursuant to Section 4.11 of the Plan Document.

(20) **Reversal of surgical sterilization.**

(21) **Routine physical examinations** or tests that are not related to an Illness or Injury, unless specifically included in the Covered Expenses in Section 4.13 of the Plan or in the Schedule of Benefits in the Plan's Summary Plan Description.

(22) Charges with respect to injuries for which the Eligible Participant fails to sign a required Subrogation and Reimbursement Agreement or any other required document.

(23) **Temporomandibular Joint (TMJ)** dysfunction treatment or supplies, including surgery performed on the temporomandibular joint.

(24) **Travel** charges and travel accommodations, whether or not recommended by a Physician (except for ambulance charges as defined in Covered Medical Expenses).

(25) Routine **Vision care** (except as provided by the Fund's vision benefit at ARTICLE VIII of this document).

(26) **Wellness care and preventive care,** except as provided in the sections of the Schedule of Benefits in the Summary Plan Description relating to well baby, child, and adult care and as provided in Section 4.13 (b)(20) Section 4.13 (b)(49), Section 4.13 (b)(51), and Section 4.13 (b)(52).

(27) **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, subject to the usual, Reasonable and Customary Charge Guidelines.

ARTICLE V
MEMBER ASSISTANCE PROGRAM (MAP)

Section 5.01 Member Assistance Program (MAP) in General

(a) The Fund provides a Member Assistance Program ("MAP"), administered by a provider that contracts with the Fund to assist Employees and their immediate family members with personal problems.

(b) Through the MAP, Employees and their immediate family members may speak confidentially with a MAP counselor. The counselors can help with problems such as:

(1) Marital problems.

(2) Family or parenting issues.

(3) Financial worries.

(4) Legal concerns.

(5) Drug or alcohol dependency.

(6) Psychiatric or psychological concerns.

(c) The MAP program works as follows:

(1) When an Employee or an immediate family member of an Employee calls the MAP, a counselor will schedule an appointment to meet with the Employee or immediate family member. Depending on the issue at hand, the MAP will provide short-term counseling or refer the Employee or immediate family member to specialized treatment. Problems that generally require referrals for specialized treatment include long-term personal problems, alcoholism and drug abuse. Services are available 24 hours per day, seven days per week.

(2) All services are provided with confidentiality and are provided free of charge to the Employee or immediate family member. If a MAP counselor refers an Employee or immediate family member to specialized treatment, the medical Plan may provide benefits for that treatment.

(d) MAP benefits are in addition to the Mental Health and Substance Abuse benefits provided by the medical coverage outlined in ARTICLE IV.

ARTICLE VI
PRESCRIPTION DRUG BENEFIT

Section 6.01 Prescription Drug Benefits in General

(a) The prescription drug benefit is designed to cover a portion of prescription drug expenses incurred by Eligible Participants.

(b) When an Eligible Participant fills prescriptions through a retail pharmacy or through the mail order program, the costs do not apply toward any provisions of the Medical Plan so that they will not apply to the Plan's Annual Deductible or the Out-of-Pocket Maximum. However, benefits paid by the Plan for prescription drugs on behalf of Eligible Participants apply toward the annual maximum applicable to Essential Health Benefits.

Section 6.02 Retail Prescription Drug Benefits Payable

(a) If an Eligible Participant obtains any of the Covered Items listed in Section 6.05 through a retail Participating Pharmacy, the Eligible Participant will be responsible for the co-payment amounts as set forth in the Schedule of Benefits in the Summary Plan Description.

(b) If the prescription drug is obtained at a retail Participating Pharmacy, the Eligible Participant may obtain a maximum of a 30-day supply per prescription and up to two refills of a short-term medication.

Section 6.03 Mail-Order Prescription Drug Benefit Payable Per Calendar Year

If an Eligible Participant obtains any of the Covered Items listed in Section 6.05 through the Plan's mail-order program, the Eligible Participant will be responsible for the co-payment amounts as set forth in the Schedule of Benefits in the Summary Plan Description.

If the prescription drug is obtained through the mail order program, the Eligible Participant may obtain a maximum of a 90-day supply per prescription.

Section 6.04 Prescription Drug Generic Substitution

(a) When available, generic substitution will be made for all Brand Name Drugs or medications provided through the mail-order program, unless the Physician states on the prescription that the drug or medication must be dispensed as written.

(b) If a Brand Name Drug is dispensed when a generic substitute is available and the Physician does not state on the prescription that the drug or medication must be dispensed as written, the Eligible Participant will pay:

(1) The required co-payment (as identified in the Schedule of Benefits in the Summary Plan Description), plus

(2) The difference in cost between the Brand Name Drug and the generic substitute.

Section 6.05 Prescription Drug Covered Charges

(a) 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 in the Summary Plan Description, including the following prescription drugs for which no prior authorization is required:

(1) 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," except as excluded below,

(2) Compounded medication of which at least one ingredient is a prescription Legend Drug,

(3) Insulin,

(4) Insulin syringes/needles,

(5) Non-insulin syringes,

(6) 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,

(7) FDA-approved oral agents used to control blood sugar,

(8) Glucagon emergency kits,

(9) Retin A for Eligible Participants with a letter from the Physician stating that the drug is Medically Necessary,

(10) Injectable drugs,

(11) Generic oral contraceptives, and

(12) Contraceptive devices.

Section 6.06 Prescription Drug Exclusions

(a) In addition to the General Plan Exclusions listed in ARTICLE XIII, Prescription Drug Benefits will not be provided for any charges for the following:

(1) Vitamins,

(2) Brand name oral contraceptives,

(3) Weight-loss medications, devices and appliances,

(4) Cosmetic drugs and medications,

(5) Retin A, if Eligible Participant does not have a letter from the Physician stating that the drug is Medically Necessary,

(6) Drugs that are considered Experimental or Investigative or are not approved by the Federal Drug Administration for the condition being treated,

(7) 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,

(8) Medications and supplies that may be purchased over-the-counter (except over-the-counter proton pump inhibitors with a prescription and over-the-counter COVID-19 diagnostic tests through the duration of the COVID-19 national public health emergency).and

(9) Drugs that are obtained through a non-participating pharmacy.

Section 6.07 Prescription Drug Coordination of Benefits

(a) If the Dependent has other prescription drug insurance and uses the other insurance first towards prescription drug coverage, the Plan will pay 80% of the remainder of the balance that the Dependent has to pay for the prescription drugs with no deductible.

ARTICLE VII
DENTAL BENEFITS

Section 7.01 Dental Benefits

(a) The Dental Benefit is designed to cover a portion of the expenses incurred by an Eligible Participant for dental care or treatment given by a duly licensed Dentist or dental surgeon that are Reasonable and Customary as determined by the standards of generally accepted dental practice.

(b) Reasonable and Customary limits are the fees most commonly charged by providers in the geographic area where the Eligible Participant is being treated. Dental treatment includes examinations, fillings, x-rays and dentures.

(c) For most covered dental services, the Plan pays a certain percentage as set forth in the Schedule of Benefits in the Summary Plan Description of covered charges after the Eligible Participant satisfies the Calendar Year Deductible as set forth in the Schedule of Benefits. The Plan pays up to a certain maximum amount per Eligible Participant in dental benefits each Calendar Year. However, the maximum does not apply to services provided to individuals under age 19.

Section 7.02 Dental Deductible

(a) Before benefits are payable for basic dental care and denture replacement services, the Eligible Participant must first meet the annual Dental Deductible as set forth in the Schedule of Benefits. To encourage regular dental care, the Plan does not require the Eligible Participant to satisfy the Dental Deductible for preventive and diagnostic dental care services.

(b) The individual Dental Deductible applies to each Eligible Participant once each Calendar Year.

Section 7.03 Maximum Dental Benefits

The benefits paid by the Plan for Covered Dental Charges will not exceed the maximum Dental Benefit amount per Calendar Year per Eligible Participant as set forth in the Schedule of Benefits (except that the maximum does not apply to services provided to individuals under age 19).

Section 7.04 The Preferred Provider Organization (PPO) Network

(a) The Plan has an arrangement with a PPO network. The PPO network includes preferred Dentists and other dental care providers. The providers have agreed to charge lower amounts for services provided to Fund members and their families. The Eligible Participant may receive a list of PPO providers by accessing the Provider website.

(b) The coinsurance percentage the Plan pays for PPO providers and providers outside the PPO network is listed in the Schedule of Benefits in the Plan's Summary Plan Description.

Section 7.05 Preventive Dental Services

The Plan provides a dental program designed to pay a portion of the cost for routine dental service. The Eligible Participant does not pay a deductible before the Plan pays for these services. The Plan pays a certain percentage as set forth in the Schedule of Benefits in the Summary Plan Description of the Reasonable and Customary charges for the following services:

(a) Dental examinations, including diagnosis performed by a Dentist, twice per calendar year,

(b) Prophylaxis (cleaning of the teeth) performed by a Dentist or Dental Hygienist twice per calendar year,

(c) Topical application of fluoride once every 12 months,

(d) Necessary dental x-rays and bite-wing x-rays once per Calendar Year,

(e) Sealants once every 12 months, or

(f) Benefits for full-mouth (panoramic) x-rays are payable once every three years.

Section 7.06 Basic Dental Services

After an Eligible Participant meets the Dental Deductible, the Plan pays a certain percentage as set forth in the Schedule of Benefits in the Summary Plan Description of the Reasonable and Customary charges for the following:

(a) Extraction of teeth,

(b) Oral surgery,

(c) Periodontal treatment (treatment of the gums and tissues of the mouth),

(d) Fillings,

(e) Crowns, or

(f) Initial installation of complete or partial removable dentures or fixed bridgework.

Section 7.07 Denture Replacement

After the Eligible Participant meets the Dental Deductible, the Plan pays a certain percentage as set forth in the Schedule of Benefits in the Summary Plan Description of the 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.

Section 7.08 Alternative Dental Procedures

The Plan recognizes that there is often more than one way to treat a dental problem, such as using a silver (amalgam) filling in repairing a tooth that can be just as effective as using a gold filling. The Plan will always base its definition of Reasonable and Customary charges on the least costly procedure that addresses the problem and meets acceptable dental standards.

Section 7.09 Dental Exclusions

In addition to the General Plan Exclusions at ARTICLE XIII, the Plan does not pay for the following dental care services and supplies:

(a) Orthodontic treatment.

(b) Charges that exceed Reasonable and Customary limits.

(c) Services that are not Medically Necessary.

(d) Dental services provided solely for cosmetic reasons, except when needed because of an accidental Injury.

(e) Replacement of a lost or stolen denture.

(f) Services or supplies received or ordered before the Eligible Participant's coverage began or after the Eligible Participant's coverage ends.

(g) Care for Injury or Sickness 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.

(h) Treatment of a condition caused by war, insurrection, international armed conflict or riot.

(i) Sterilization of equipment/infection control.

ARTICLE VIII
VISION BENEFITS

Section 8.01 Vision Benefits

The Plan pays for Vision Benefits to offset the cost of eye exams, and eyeglasses or contact lenses for Eligible Participants, as follows:

(a) The Plan covers vision care services provided by a licensed ophthalmologist or optometrist. The Eligible Participant may choose to be treated by any licensed ophthalmologist or optometrist.

(b) The Plan pays up to a specific dollar amount toward the cost of covered vision expenses, including eye examinations, eyeglasses (lenses and frames) or contact lenses as provided in the Schedule of Benefits in the Summary Plan Description. However, the maximum does not apply to eye exams and diagnostic testing services provided to individuals under age 19.

(c) The Eligible Participant pays the provider for any services or supplies that the Eligible Participant receives and then submits a claim for reimbursement.

Section 8.02 Schedule of Covered Vision Benefits

The Plan pays for eye examinations and eyeglasses (lenses and frames) or contacts as set forth in the Summary Plan Description.

Section 8.03 Vision Benefit Exclusions

In addition to the General Plan Exclusions listed in ARTICLE XIII, the Plan does not pay for the following vision expenses:

(a) Procedures that are considered special or unusual in nature, such as:

(1) Orthoptics or vision training, Subnormal vision aids,

(2) Aniseikonic lenses (lenses to correct a defect in which two retinal images of an object differ in size),

(3) Multifocal plastic lenses,

(4) Coating of lenses,

(5) No-line bifocals (blended type), and

(6) Two pairs of glasses instead of bifocals.

If the Eligible Participant chooses the services or features in items 1 through 7 above, the additional cost is the responsibility of the Eligible Participant.

(b) Non-prescription lenses,

(c) Lost or stolen lenses or frames (unless a Calendar Year has passed since the Eligible Participant last had an eye examination or pair of lenses, or two Calendar Years have passed since the Eligible Participant last received frames),

(d) Damaged or broken lenses or frames (unless a Calendar Year has passed since the Eligible Participant last had an eye examination or pair of lenses, or two Calendar Years have passed since the Eligible Participant last received frames),

(e) Medical or surgical treatment of the eyes (however, this may be covered under the medical benefits),

(f) Services or materials provided by workers' compensation or a similar law or government agency,

(g) Care for Injury or Sickness 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.

(h) Eye exams required by an Employer as a condition of employment,

(i) Eyeglass lenses during the same Calendar Year in which the Eligible Participant receives benefits for contact lenses, or

(j) Contact lenses during the same Calendar Year in which the Eligible Participant receives benefits for eyeglass lenses.

ARTICLE IX
DISABILITY BENEFITS

Section 9.01 Disability Benefits in General

The Plan provides Disability Benefits for Employees who are unable to work due to Sickness, Injury or childbirth.

Section 9.02 Eligibility for Disability Benefits

An eligible Employee qualifies for Disability Benefits if the eligible Employee meets all of the following requirements:

(a) The eligible Employee is unable to perform the duties of the job because of a non-occupational Injury, Sickness or pregnancy, ,

(b) The eligible Employee is not working in any other occupation,

(c) The eligible Employee is under the care of a Physician, and

(d) The eligible Employee is in Covered Employment and would be actively working were it not for the disabling condition. (In other words, an individual is not entitled to disability benefits if his/her employment has been suspended or terminated and s/he is not on a non-medical leave of absence),

Eligibility for Disability Benefits ends if the Employee retires and begins collecting pension benefits from the Teamsters Local Union 786 Building Material Pension Fund.

Section 9.03 Timing of Disability Benefits

The date benefits begin depends on the nature of the eligible Employee's disability, as follows:

(a) If the disability is due to an accident or related to coronavirus as set forth in Section 10.02(a) above, Disability Benefits begin on the first day of disability, and

(b) If the disability is due to Sickness or pregnancy, Disability Benefits begin on the eighth day of continuous disability.

Unless the Employee is unable to perform the duties of the job due to having coronavirus himself, the Plan will not pay Disability Benefits on any day that the Employee receives paid leave under any other applicable federal or state law.

Section 9.04 Amount of Disability Benefits

The Plan pays a weekly benefit as set forth in the Summary Plan Description to eligible Employees who meet the requirements of Section 9.02 . Benefits are paid until the eligible Employee recovers), up to a maximum of 26 weeks for each period of disability.

(a) If an eligible Employee is disabled, then recovers and returns to work and then becomes disabled again from the same cause before the eligible Employee works a full two-week period, the eligible Employee is eligible to continue the balance of the original 26-week period of benefits.

(b) If an eligible Employee is disabled, then recovers and returns to work and then becomes disabled again from the same cause and the eligible Employee works two weeks or longer before becoming disabled again, then the eligible Employee is eligible for a new 26-week period of benefits.

(c) If, after returning to work for at least one day, the eligible Employee experiences a second disability that is due to a different cause, the eligible Employee is eligible for a new 26-week period of benefits.

Section 9.05 Disability Benefit Exclusions

(a) The Plan will not pay Disability Benefits for an Illness or Injury that is related to any employment for wages or profit or that is covered under workers' compensation.

(b) Even if the Employee is disabled as described above, the Plan will not pay Disability Benefits or will cease paying such benefits prior to the expiration of the 26-week period if the Employee otherwise would not be able to work even if the Employee were not so disabled – for example, due to the Employer going out of business or laying off all similarly situated Employees.

ARTICLE X
LIFE INSURANCE BENEFITS

Section 10.01 Life Insurance Benefits in General

The Plan will pay the designated beneficiary of an eligible Employee a life insurance benefit if the eligible Employee dies.

Section 10.02 Eligibility for Life Insurance Benefits

To be an eligible Employee for purposes of life insurance benefits, the employee must have completed 10 weeks of Covered Employment as of the time of death.

Section 10.03 Amount of Life Insurance Benefits

In the event the eligible Employee dies while covered by the Plan, the Plan will pay an amount set forth in the Schedule of Benefits in the Plan's Summary Plan Description.

Section 10.04 Life Insurance Payment Options

Section 10.05 The Plan will pay the Life Insurance Benefit in a lump sum. In addition, the eligible Employee's beneficiary may choose to assign all or a portion of Life Insurance Benefits to a funeral home.

Section 10.06 Designation of Life Insurance Beneficiary

(a) The eligible Employee may name anyone as the designated beneficiary of Life Insurance Benefits. The Fund Office will provide the eligible Employee with a Beneficiary Designation Card on which the eligible Employee may designate a beneficiary. The Employee can change the beneficiary designation at any time by completing and signing a new Beneficiary Designation 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.

(b) Unless provided otherwise, if a beneficiary dies before an eligible Employee, the deceased beneficiary's share of Life Insurance Benefits will be divided equally among any remaining named beneficiaries. If no named beneficiary survives the eligible Employee, Life Insurance Benefits will be paid to the following beneficiaries, if living in the following order: spouse, natural or adopted children equally, father and mother equally, or the estate of the eligible Employee.

Section 10.07 Continuation of Life Insurance Benefits upon Disability

(a) If an eligible Employee loses eligibility under the Plan due to being Totally Disabled prior to reaching age 60, the eligible Employee's Life Insurance may be extended, and the Employee will be eligible for a premium waiver after the Employee satisfies a waiting period if all required premiums have been paid and the Employee provides proof of Total Disability within 12 months of becoming Totally Disabled.

(b) The waiting period is the six consecutive month period beginning on the day the eligible Employee becomes Totally Disabled. Premiums must continue to be paid by the Employee until the later of (i) the date the eligible Employee completes the waiting period or (ii) the date the insurance company approves the eligible Employee's claim for waiver of premium. The insurance company may refund premiums paid for insurance after the date the eligible Employee has provided satisfactory proof of being Totally Disabled. The waiting period is waived if the eligible Employee dies during the waiting period.

(c) An eligible Employee will be considered to be Totally Disabled for these purposes if, as a result of sickness, accidental injury, the eligible Employee is completely unable to engage in any occupation for wage or profit. The waiver of premium ends on the earliest of:

(1) The date the eligible Employee stops being Totally Disabled or reaches age 99, whichever occurs first,

(2) The date the eligible Employee fails to attend an examination or cooperate with an insurance examiner, and

(3) With respect to the amount of insurance the eligible Employee has converted, the effective date of the individual life insurance policy issued to the eligible Employee

Section 10.08 Accelerated Benefits under the Life Insurance Benefit

(a) If an eligible Employee qualifies for waiver of premium and gives the insurance company satisfactory proof that the eligible Employee has a qualifying medical condition, the eligible Employee may have the right to receive during the eligible Employee's lifetime, a portion of the insurance amount as an accelerated benefit.

(b) For purposes of the accelerated benefit, a qualifying medical condition means that the eligible Employee is terminally ill as a result of an illness or physical condition that is reasonably expected to result in death within 12 months.

(c) An eligible Employee may receive an accelerated benefit of up to 75% of the insurance amount, with a minimum benefit of $5,000, paid once in the eligible Employee's lifetime in a lump sum. The eligible Employee is not required to repay the amount if the eligible Employee recovers.

(d) The accelerated benefit will not be paid if:

(1) All or part of the eligible Employee's insurance must be paid to an irrevocable beneficiary, such as the eligible Employee's children, spouse or former spouse as part of a court-approved divorce decree, separate maintenance agreement or property settlement agreement,

(2) The eligible Employee lives in a community property state, unless the eligible Employee provides a signed written consent from the eligible Employee's spouse,

(3) The eligible Employee made an assignment of all or part of the insurance, unless the eligible Employee provides a written consent from the assignee,

(4) The eligible Employee is required by a government agency to use the accelerated benefit to apply for, receive or continue a government benefit or entitlement, or

(5) The eligible Employee previously received an accelerated benefit under the policy, or

Section 10.09 The eligible Employee's qualifying medical condition is a result of an attempted suicide (while sane or insane), or a self-inflicted injury

Section 10.10 Right to Convert the Life Insurance Benefit to an Individual Policy

(a) The eligible Employee has the right to convert the life insurance benefit to an individual policy of life insurance without evidence of insurability if:

(1) The eligible Employee's insurance ends or is reduced due to a termination of employment or because such eligible Employee is no longer eligible for the life insurance benefits, or

(2) The life insurance benefits under the insurance policy cease or the life insurance policy is amended in such a way as to make the eligible Employee ineligible for such benefits.

(3) The eligible Employee must have been insured for a minimum of five years in order to have the right to convert under (2) above.

(4) In order to convert policies, the eligible Employee must apply in writing and pay the insurance company the first premium during the 31-day period after the insurance under the policy ceases.

(b) The eligible Employee may convert life insurance in an amount as determined under the life insurance contract.

(c) If the eligible Employee dies during the 31-day period in which the eligible Employee may exercise the right to convert, the insurance company will pay a death benefit equal to the maximum amount the eligible Employee had a right to convert if proof of death is received within two years from the date of death.

ARTICLE XI
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS

Section 11.01 Accidental Death and Dismemberment (AD&D) Insurance Benefits in General

The Plan provides eligible Employees and their dependents with Accidental Death and Dismemberment ("AD&D") insurance that pays a benefit if the Eligible Participant dies or is seriously injured in an accident.

Section 11.02 Eligibility for AD&D Insurance Benefits

To be an eligible Employee for purposes of AD&D insurance benefits, the employee must have completed 10 weeks of Covered Employment as of the time of the occurrence.

For purposes of this benefit only, "dependent" means the eligible Employee's lawful spouse and/or any unmarried child (whether natural or adopted) who is not in active military service and under age 19, or, if a full-time student, under age 23, except that the age limits will not apply with respect to children who are primarily dependent upon the Employee for support and who cannot work to support themselves due to a physical or mental incapacity that began before the age limit was reached

Section 11.03 A person cannot be insured for this benefit as both an Employee and a dependent.

Section 11.04 Amount of AD&D Insurance Benefits

In the event the eligible Employee or Dependent dies or is seriously injured in an accident, the Plan pays the benefits as set forth in the Summary Plan Description. AD&D benefits are in addition to any Life Insurance Benefits payable on behalf of the Employee pursuant to ARTICLE X.

Section 11.05 Restrictions on Payment of AD&D Insurance Benefits

(a) Only one benefit is payable as a result of all losses sustained in anyone accident. If an Eligible Participant suffers multiple losses, the Eligible Participant will receive the highest benefit.

(b) Generally, all benefits are payable to the Employee. However, in the event that the Employee dies accidentally **or dies before benefits have been distributed,** benefits are payable to the Employee's beneficiary who is the person the Employee designates on the Beneficiary Designation Form provided by the Fund Office to receive the insurance amount when the Employee becomes eligible under the Plan. The Employee can change the beneficiary designation at any time by completing and signing a new Beneficiary Designation 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 an eligible Employee, the deceased beneficiary's share of AD&D Benefits will be divided equally among any remaining named beneficiaries. If no named beneficiary survives the eligible Employee, AD&D Benefits will be paid to the following beneficiaries, if living in the following order: spouse, natural or adopted children equally, father and mother equally, or the estate of the eligible Employee.

Section 11.06 Definition of AD&D "Loss"

(a) 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.

(b) Loss of a hand or foot means severance at or above the wrist or ankle joints.

(c) Loss of eyes, speech, and hearing means total and irrecoverable loss of sight, speech, and hearing.

(d) Loss of eyes, speech, and hearing means total and irrecoverable loss of sight, speech and hearing.

(e) Loss of thumb and index finger means the entire digit at or above the joints.

(f) Loss includes quadriplegia which means the total and permanent paralysis of both upper and lower limbs.

Section 11.07 Loss includes hemiplegia which means the total and permanent paralysis of both upper and lower limbs of one side of the body.

Section 11.08 AD&D Seat Belt Benefit

(a) The Plan also pays an additional seat belt benefit if:

(1) The eligible Employee or dependent dies as the result of an automobile accident for which an AD&D benefit is payable, and

(2) The eligible Employee or dependent was wearing a seat belt at the time of the accident, as evidenced by a police report.

(b) For purposes of this benefit, a seat belt means a properly installed seat belt, lap and shoulder restraint or other restraint approved by the National Highway Traffic Safety Administration. Automobile means a motor vehicle licensed for use on public highways.

(c) The amount of the additional seat belt benefit is set forth in the Summary Plan Description.

Section 11.09 AD&D Air Bag Benefit

(a) The Plan also pays an additional air bag benefit if:

(1) The eligible Employee or dependent dies as the result of an automobile accident for which an AD&D benefit is payable, and

(2) The eligible Employee or dependent was positioned in a seat that was equipped with a factory-installed air bag; and

(3) The eligible Employee or dependent was properly strapped in the seat belt when the air bag inflated; andThe police report establishes that the air bag inflated properly upon impact.

Section 11.10 For purposes of this benefit, an air bag means an inflatable supplemental passive restraint system installed by the manufacturer of the automobile, or proper replacement parts as required by the automobile manufacturer's

specifications, that inflates upon collision to protect an individual from injury and death. An air bag is not considered a seat belt.

Section 11.11 AD&D Repatriation Benefit

Section 11.12 The Plan also pays an additional repatriation benefit for the preparation and transportation of an eligible Employee or dependent's body to a mortuary if:

Section 11.13 the total AD&D Benefit is payable for loss of the eligible Employee's life; and

Section 11.14 the death occurs at least 75 miles away from the decedent's residence.

Section 11.15 AD&D Education Benefit

The Plan also pays an additional education benefit to the eligible Employee's dependent student if the total AD&D Benefit is payable for loss of the eligible Employee's life.

(a) For purposes of this AD&D education benefit only, the following definitions apply:

(1) Student means a dependent child who, on the date of the eligible Employee's death, is:

(A) A full-time post-high school student in a school of higher education; or

(B) A student in the 12th grade but who becomes a full-time post-high school student in a school of higher education within 365 days after the eligible Employee's death.

(2) School of higher education means an institution which:

(A) is legally authorized by the state in which it is located; and

(B) provides either a program for:

(i) Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or

(ii) Gainful employment as long as such program is at least one year of training; and

(C) is accredited by an agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time.

(3) Dependent child(ren) means any unmarried child of the eligible Employee (whether natural, step, foster or adopted) who is:

(A) at least 15 days but less than 18 years of age and dependent on the Employee for support and maintenance; and

(B) not in active military service.

(b) Eligibility will continue to age 23 for dependent children who are not employed full-time and are enrolled as full-time students in a recognized school and dependent on the eligible Employee for support and maintenance.

(c) Eligibility will continue past the age limit for dependent children who are primarily dependent upon the eligible Employee for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Proof of such incapacity must be provided upon request.

(d) No eligible person may be covered more than once under this policy. If a person is covered as an eligible Employee, he cannot be covered as a spouse or dependent child of another eligible Employee.

(e) The AD&D education benefit will be paid in four equal annual installments.

(f) A dependent student will no longer be eligible to receive the AD&D education benefit upon the earlier of the following:

(1) The fourth installment payment of the AD&D education benefit on behalf of or to the dependent student; or

(2) At the end of the period during which proof must be submitted if no proof is submitted.

(g) Special Child Education Benefit: If the eligible Employee's dependent child does not qualify as a student, but is enrolled in an elementary or high school, a child education benefit in an amount specified in the Schedule of Benefits in the Summary Plan Description will be paid. This benefit is payable once upon proof that the eligible Employee has died as a result of an accident for which the AD&D benefit is payable and that, within 12 months after the eligible Employee's death, such child is a full-time student in an elementary or high school.

Section 11.16 AD&D Benefit Exclusions

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

(a) Suicide or intentionally self-inflicted Injury, while sane or insane.

(b) Any disease or infirmity of mind or body, and any medical or surgical treatment of such disease or infirmity.Any infection, except a pus-forming infection of an accidental cut or wound.

(c) Travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft.

(d) Committing or attempting to commit an assault or felony or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing official duties.

(e) 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.

(f) Active participation in a riot. For purposes of this exclusion, "riot" means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, with a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

(g) War or any act of war, if the cause of death occurs while the person is serving in the military, naval or air forces of any country, combination of countries or international organization, provided such death occurs while in such forces or within six months after termination of service in such forces.

ARTICLE XII
HEALTH REIMBURSEMENT ACCOUNT BENEFIT

Section 12.01 General.

Effective January 1, 2015, the Plan offers a Health Reimbursement Account benefit. This benefit is intended to qualify for tax treatment as medical reimbursement plan benefits under section 105(b) of the Code. The purpose of this benefit is to provide Eligible Participants with reimbursements of Qualifying Health Care Expenses (as hereinafter defined) that are excludable from the Employee's gross income under section 105(b) of the Code.

Section 12.02 Eligible Expenses.

Only those expenses that are "Qualifying Health Care Expenses" are eligible for reimbursement. "Qualifying Health Care Expense" means an expense incurred and paid by an Eligible Participant, for medical care as defined in section 213(d) of the Code, but only to the extent that the Eligible Participant incurring the expense is not reimbursed or entitled to reimbursement for the expense from the Fund, another health plan, insurance policy, or otherwise (other than under the Health Reimbursement Account feature of the Plan).

Qualifying Health Care Expenses (if any) shall be deemed to be incurred at the time the services to which the expenses related are rendered. Only expenses incurred on or after January 1, 2015, may be considered Qualifying Health Care Expenses.

Section 12.03 Crediting of Accounts.

An amount, which is to be determined by the Board of Trustees based on a particular unit of work (e.g., per week) (as determined by an applicable Collective Bargaining Agreement) worked by an Employee on or after May 1, 2014, shall be credited to the Health Reimbursement Account of each Employee following receipt of the required contribution from the Employer. The amount credited shall be available to reimburse Qualifying Health Care Expenses incurred on or after January 1, 2015. However, each Employee shall be entitled, on an annual basis, to opt out of the Health Reimbursement Account, and waive any future reimbursements from the Health Reimbursement Account.

The Trustees, in their discretion, may establish a minimum account balance that must be reached before reimbursements will be made. Additionally, no individual will be able to access amounts contributed to the Health Reimbursement Account until he becomes an Eligible Participant. If an Employee never becomes an Eligible Participant, all amounts contributed to a Health Reimbursement Account with respect to his hours worked will be forfeited.

Except as otherwise required by law, the amount credited to each such Health Reimbursement Account shall be the property of the Fund until and unless paid out to the Employee as set forth below. Accordingly, no interest, earnings, or losses of any kind will accrue to the Employee's Health Reimbursement Account.

Section 12.04 Debiting of Accounts.

An Eligible Participant's Health Reimbursement Account shall be debited from time to time in the amount of all payments to the Eligible Participant for Qualifying Health Care Expenses.

Section 12.05 Rollover of Health Reimbursement Account Balance.

If after all reimbursements hereunder, any balance remains in the Employee's Health Reimbursement Account for a calendar year, such balance shall be carried over to reimburse the Eligible Participant for Qualifying Health Care Expenses incurred during subsequent calendar years. Conversely, amounts credited to the Employee's Health Reimbursement Account 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 the Employee first was credited with an hour of work.

Section 12.06 Claims for Reimbursement.

Once the Health Reimbursement Account balance equals or exceeds for the first time the minimum established by the Board of Trustees (if any), an Eligible Participant may be reimbursed for Qualifying Health Care Expenses incurred by the Eligible Participant or his or her

Dependent while he or she was an Eligible Participant during the calendar year by following the procedures established by the Plan Administrator.

Section 12.07 Reimbursement or Payment of Expenses.

The Fund shall reimburse the Eligible Participant, at such time and in such manner as the Fund Office may prescribe, for Qualifying Health Care Expenses incurred during the calendar year for which the Eligible Participant makes written application and provides documentation in accordance with the provisions set forth above to the extent that such Eligible Participant has sufficient funds in his Health Reimbursement Account to cover such reimbursement.

Section 12.08 Termination and Continuation of Coverage.

An Eligible Participant may continue to be reimbursed for Qualifying Health Care Expenses from his or her Health Reimbursement Account for so long as there is money in the Account even after the Employee's eligibility to participate in the Plan otherwise terminates for up to 12 months. However, after an Employee's eligibility to participate in the Plan otherwise terminates, he will not be able to access amounts credited to his Health Reimbursement Account with respect to hours worked after his loss of eligibility until such time as he regains eligibility, unless he elects COBRA continuation coverage. If an Employee loses eligibility under the Plan and elect COBRA with respect to his or her Health Reimbursement Account benefit, he or she may continue to accrue additional contributions to the Health Reimbursement Account and will have immediate access to those contributions.

If an Eligible Participant's eligibility to participate in the Plan terminates, he shall be entitled to opt out of and waive any future reimbursements otherwise available under the Health Reimbursement Account.

Additionally, if the Employee dies with a positive account balance, his spouse may continue to submit claims with respect to the spouse and any Dependent children for up to twelve months following the Employee's death. If the Employee is not married at the time of death, the remaining balance in the Health Reimbursement Account (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 until their respective balances are exhausted for up to twelve months following the employee's death. If there is no surviving spouse or Dependent children, the remaining balance is forfeited and reverts back to the Plan to be used to fund other Plan benefits.

Section 12.09 Amendment or Termination of Health Reimbursement Account Benefits.

As is the case with any other Plan benefit, the Board of Trustees reserves the right to modify or terminate the benefits provided under this Article at any time for any reason. Any portion of an Employee's Health Reimbursement Account that is not used prior to such modification or termination of benefits will remain available to reimburse Qualifying Health Care Expenses as described herein.

ARTICLE XIII
GENERAL PLAN EXCLUSIONS

Section 13.01 Plan Exclusions

(a) If any services or supplies are not specifically addressed in this Plan Document, 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 in ARTICLE IV, ARTICLE VI, ARTICLE VII, ARTICLE VIII, ARTICLE IX and ARTICLE XI, the following services and supplies are excluded from coverage by the Plan:

(1) Services and treatment, including routine care and treatment, not considered Medically Necessary, except as specifically provided by the Plan.

(2) Charges in excess of what is considered usual, Reasonable and Customary.

(3) Bedwetting corrective devices.

(4) Food for sustaining life, food substitutes, food/nutritional supplements or vitamins outside of a Hospital.

(5) Sterilization reversals.

(6) 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 Insurance.

(7) 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.

(8) Confinement in any Hospital or treatment by any Physician when the Hospital or Physician makes no charge that the person is required to pay.

(9) Any loss caused by or resulting from insurrection, 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, or in the military service of any country.

(10) Services, treatment or supplies received from a dental or medical department, facility or clinic maintained by another employee benefit plan or labor union.

(11) Services, treatment or supplies that are payable or provided under any insurance policy or other medical benefit plan or service plan for which the Board of Trustees will, directly or indirectly, have paid for all or a portion of the cost.

(12) Services or treatment rendered or supplies furnished primarily for cosmetic purposes, unless the treatment is for:

(A) An Injury sustained in an accident provided treatment began within 90 days of the accident,

(B) A child's birth deformity, or

(C) Reconstructive surgery following a mastectomy, pursuant to Section 4.15 of the Plan.

(13) Services, treatment and supplies that are not recommended and approved by a Physician or Dentist.

(14) Services, treatment and supplies rendered or furnished before the Eligible Participant's eligibility date or after the Eligible Participant's coverage terminates.

(15) Services, treatments and supplies that are Experimental or Investigative.

(16) Non-medical equipment, including, but not limited to air conditioners, humidifiers, air purifiers, whirlpools, chairlifts, non-hospital beds, scales, and exercise equipment.

(17) Charges for failure to keep a scheduled appointment or charges for completion of a claim form.

(18) Charges for or relating to marriage counseling, mind expansion or elective psychotherapy, except as provided through MAP benefits or Mental Illness treatment as set forth in Section 4.13 .

(19) Charges for or relating to general maintenance or delivery of durable medical equipment.

(20) Any charges for custodial care or care in custodial or similar institutions or rest cures, except as specifically provided by the Plan.

(A) 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:

(i) Provision of Room and Board, preparation of special diets,

(ii) Supervision of administration of medications that can normally be self-administered, or

(iii) Helping the Eligible Participant walk, get in or out of bed, eat, dress, bathe, use the toilet and perform other personal hygiene functions.

(21) Services or supplies for which a person is eligible for reimbursement under "no-fault" automobile insurance, and when not eligible, if ineligibility for reimbursement is a result of a person's failure to purchase such "no-fault" insurance, to the extent state law mandates the purchase of such insurance.

(22) Services or supplies for which a person is eligible for reimbursement by a third party if the Eligible Participant does not provide a signed Repayment and Subrogation Agreement to the Fund Office as required under ARTICLE XVI regarding subrogation.

(23) Removal of an organ for donation purposes where the transplant recipient is not covered by this Plan.

(24) Non-Medically Necessary acupuncture, including acupuncture administered as an aid to cessation of overeating.

(25) Charges for treatment of injuries received while engaged in or attempting to commit a criminal act resulting in a conviction or for which felony charges are pending with respect to which the Board of Trustees has 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).

(26) Claims submitted more than 12 months after the expense was incurred.

(27) Any charges related to a surrogate pregnancy, including medical expenses for the surrogate mother, child, and any complications resulting from the surrogate pregnancy.

(28) Services rendered outside the U.S. to a person who is absent from the U.S. for a period of 60 continuous days or more.

(29) Services rendered outside the U.S. which are not pre-certified in advance subject to the Plan's preauthorization procedures as set forth in the Summary Plan Description, unless rendered in emergency circumstances.

(30) Services or supplies provided prior to the beginning of coverage or after coverage ends.

(31) Treatment or services rendered for self-inflicted injury unless such injury is the result of a medical condition (such as, but not limited to, depression, regardless of whether such condition previously had been diagnosed).

(32) Services or supplies provided by a relative (spouse, parent, child, sibling or by a person who regularly resides in the covered person's home).

(33) Expenses related to Sickness or Injury caused by war, insurrection, international armed conflict or riot.

(34) Services or supplies provided at no cost or for which the Eligible Participant is not required to pay.

(35) Gene therapy drugs, products, and services.

ARTICLE XIV
COORDINATION OF BENEFITS

Section 14.01 Applicability

(a) This Coordination of Benefits provision applies to This Plan when an Employee or the Employee's covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

(b) If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. This reduction is described in Section 14.04 "Effect on the Benefits of This Plan."

Section 14.02 Definitions Applicable to Coordination of Benefits

(a) The term "Plan," as used only in this Article, means any of the following types of coverage, whether insured or uninsured, that provides benefits or services for medical, dental or vision care treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.

(2) Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301 et seq.), as amended from time to time).

The term "Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services. The term "Plan" will also be construed separately with respect to that portion of any policy, contract or other arrangement that reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

(b) Plan does not include school accident type coverage.

(c) The term "This Plan," as used in this Article, means those portions of the Welfare Benefit Plan sponsored by the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago that provide the benefits for health care expenses.

(d) "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

(e) The term "Allowable Expense," as used in this Article, means any necessary, Reasonable and Customary charge or item of expense for health care, when the

item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

(1) The difference between the cost of a private Hospital room and cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the Plan, or unless the Hospital is in-network and only offers private rooms.

(2) When a plan provides benefits in the form of furnishing services or supplies rather than cash payments, the reasonable cash value of each service or supply furnished will be deemed to be both an Allowable Expense and a benefit paid.

(3) When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense.

(f) The term "Claim Determination Period," as used in this Article, means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

Section 14.03 Order of Benefit Determination Rules

(a) In general, when there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of This Plan, and

(2) Both those rules and This Plan's rules, set forth below, require that This Plan's benefits be determined before those of the other plan.

(b) Rules: This Plan determines its order of benefits using the first of the following rules which applies:

(1) HMO: 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 avail himself or herself of the HMO participating provider.

(2) Non-Dependent/Dependent: The benefits of the plan that cover the person as an Employee or former Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the plan that covers the person as a Dependent.

(3) Employee/Laid off or Retired Employee: The benefits of the plan that covers the person as an Employee member or subscriber (that is, other than a laid off or retired Employee) are determined before those of the plan that covers the person as a laid off or retired Employee.

(4) COBRA: The benefits of the plan that covers the person as other than a person covered pursuant to COBRA (or pursuant to post-COBRA self-payments) are determined before those of a plan that covers the person pursuant to COBRA (or pursuant to post-COBRA self-payments, as permitted under This Plan).

(5) Hours Bank: The benefits of a plan that covers the person other than as a person whose coverage is continued due to use of an hours bank are determined before those of a plan that covers a person pursuant to the use of an hours bank.

(6) Dependent child (regardless of whether parents are married or were never married, or are separated or divorced): When This Plan and another plan cover the same child as a Dependent of different parents:

(A) The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in that year, but

(B) If both parents have the same birthday, the benefits of the plan that covered the parent for a longer period of time are determined before those of the plan that covered the other parent for a shorter period of time.

(7) Continuation coverage: 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:

(A) First, the benefits of a plan covering the person as an Employee, member or subscriber (or as that person's Dependent).

(B) 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.

(8) 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.

(c) 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.

(d) If the Dependent of an Employee has other prescription drug insurance and uses the other insurance first toward prescription drug coverage, the Plan will pay 80% of the amount that the Dependent has to pay for prescription drugs with no deductible.

(e) 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.

Section 14.04 Effect on the Benefits of This Plan

(a) This Section applies when This Plan is a Secondary Plan as to one or more other plans under the benefit determination rules of Section 14.03 . In that event, the benefits of This Plan may be reduced under this Section.

(b) The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the allowable expense under This Plan in the absence of this Coordination of Benefits provision, plus

(2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this Coordination of Benefits provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Section 14.05 Right to Receive and Release Needed Information

Certain facts are needed to apply these Coordination of Benefit rules. Subject to the Privacy rules of ARTICLE XVIII, 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.

Section 14.06 Facility of Payment

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, the Plan may pay that amount to the organization that made that payment. The amount will then be treated as though it was a benefit paid under This Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Section 14.07 Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under these Coordination of Benefits provisions, it 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.

ARTICLE XV
EFFECT OF MEDICARE

Section 15.01 General

The benefits payable to an Eligible Participant under this Plan will be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the amounts paid under Medicare Part A and Part B will not exceed the total of such "Allowable Expenses."

Section 15.02 Allowable Expenses

For purposes of this Article, "Allowable Expenses" means any Medically Necessary Reasonable and Customary Charges for medical cost or treatment that is covered by either this Plan or Medicare, up to Medicare's "limiting charge," as determined by law.

Section 15.03 Effect on Benefits

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.

Section 15.04 Order of Benefit Payment

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

(1) 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,

(2) 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

(3) 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.

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

(1) 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,

(2) 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

(3) 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.

Section 15.05 Definition of Medicare Benefits

"Medicare Benefits" means benefits for services and supplies which the Eligible Participant receives or is entitled to receive under Medicare Part A or B.

ARTICLE XVI
SUBROGATION AND REIMBURSEMENT

Section 16.01 General

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

(b) Definitions.

"Third Party Incident," for purposes of this Article, 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" for purposes of this Article could be, but is not limited to:

- A third party tortfeasor (an individual or other entity of any kind that 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; or
- A liability insurance policy of any kind or nature.

(c) The Trustees intend that no person shall profit 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 result from a Third Party Incident 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 Board of Trustees may choose to advance amounts as payment for expenses for medical care in situations where or at a point in time when liability for such expenses has not been established.

Section 16.02 Subrogation Rules

(a) 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, but eliminating damages relating to medical expenses incurred.

(b) 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 or advanced. 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. 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.

(c) 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.

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 fault, comparative negligence, or 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.

(d) Coordination of Benefits. These subrogation rules do not apply to benefits Claimant recovers under another employer-sponsored group health plan if that coverage is subject to Coordination of Benefits (COB) rules described in Section 14.02 .

(e) Responsibilities of 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 Repayment and Subrogation 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 Article XVI. 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 Repayment and Subrogation Agreement on his/her behalf.

The Repayment and Subrogation 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 Repayment and Subrogation 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 Repayment and Subrogation Agreement before disbursing the proceeds of any recovery arising out of the Third-Party Incident.

If Claimant is represented by an attorney, the attorney shall also execute the subrogation agreement or provide written acknowledgement that no claim shall be made against the Fund under the Common Fund Doctrine for any amount recovered by the Fund.

Section 16.03 Miscellaneous Rules

(a) Separate Rights. The Plan's rights to subrogation and reimbursement 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.

(b) Attorney's 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 Board of 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

(c) 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, unless determined to be acting in an arbitrary and capricious manner.

(d) 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, survivor, or similar 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.

(e) Maximum Amount of Recovery. Neither Claimant nor any other person will be required to repay to 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.

(f) Fiduciary Status. Should any money subject to the terms of the Repayment and Subrogation Agreement as set forth in this Article XVI 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 Repayment and Subrogation Agreement or this Article XVI shall be considered a breach of fiduciary duty, and the Board of Trustees may enforce the terms of the Repayment and Subrogation Agreement and this Article XVI through legal action, reduction of benefits, or any other available legal or equitable means.

ARTICLE XVII
CLAIMS DETERMINATIONS AND APPEALS

Section 17.01 Claim and Appeals Procedures

The Plan's claim and appeal procedures are set forth in the Summary Plan Description. All claims and appeals will be handled in accordance with ERISA and the applicable Claims Procedure Regulations issued by the Department of Labor.

ARTICLE XVIII
COMPLIANCE WITH THE HIPAA PRIVACY AND SECURITY RULES

Section 18.01 Purpose.

This Section, in compliance with the Privacy Rule and the Security Rule contained in the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations thereunder found at 45 C.F.R. Parts 160, 162 and 164 ("HIPAA"), is intended to allow disclosure of Protected Health Information ("PHI") including electronic PHI as defined under HIPAA, to the Board of Trustees of the Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago (the "Plan Sponsor") for the purposes specified below.

Generally, PHI, as defined under HIPAA, includes all individually identifiable information related to an individual's past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Plan in oral, written, or electronic form. PHI does not include information that has been de-identified. De-identified information is information that does not identify the individual and with respect to which there is no reasonable basis to believe that the information can be used to identify the individual.

Electronic PHI ("ePHI") refers to PHI that is transmitted by or maintained in electronic media including electronic storage media (such as hard drives, magnetic tapes or disks, optical disks, and digital memory cards) and electronic transmission media (such as the Internet, extranets, leased lines, dial-up lines, private networks, telephone voice response systems and faxback systems, but not paper-to-paper faxes or voicemail messages).

This Section applies only to the "health care components" of the Plan as that term is defined in 164 CFR §504 of the Privacy Rule contained in the Administrative Simplification

Provisions of HIPAA. In other words, this Section does not apply tothe disability, accidental death and dismemberment, and life insurance benefits.

To the extent that there is any conflict between this Section and any other Plan provisions, the terms of this Section as set forth below control. The Plan Administrator and its duly authorized representatives retain full discretion in interpreting and applying these rules.

Section 18.02 Disclosure of PHI to Plan Sponsor.

Plan may disclose PHI to the Board of Trustees in the following circumstances:

(a) Plan receives an authorization from the individual to disclose PHI to the Board of Trustees.

(b) Plan discloses information to the Board of Trustees on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance plan offered as part of the Plan.

(c) Plan provides summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from health insurers for providing health insurance coverage under the Plan, or so that the Trustees may evaluate whether to modify, amend or terminate the Plan. Summary health information is information that summarizes the claims history, claims expenses, or type of claims experienced by the individuals for whom the Fund has provided health benefits under the Plan, from which individual identifiers (other than certain limited geographical information), such as names and social security numbers, have been removed.

Otherwise, Plan shall disclose PHI to the Board of Trustees only to the extent necessary for the Board of Trustees to perform administrative functions on behalf of the Plan. (If the Board of Trustees does not perform such functions, Plan will not disclose PHI to the Board of Trustees other than as indicated above.) Administrative functions include activities that would meet the definition under the HIPAA Privacy Rule of treatment, payment, and health care operations activities. Such activities include, but are not limited to, the following:

(a) Review and resolution of claims for benefits and appeals.

(b) Determinations with respect to eligibility, coverage and cost sharing.

(c) Determining contribution rates.

(d) Exercise of subrogation rights.

(e) Coordination of benefits.

(f) Obtaining payment under a reinsurance contract (such as stop-loss insurance).

(g) Utilization review.

(h) Quality assessment.

(i) Solicitation of proposals for services to be provided to or on behalf of the Plan.

(j) Related computer and systems programming and development.

(k) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions.

(l) Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities.

(m) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance).

(n) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.

(o) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

(p) Business management and general administrative activities of the entity, including, but not limited to:

(1) Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, and

(2) Resolution of internal grievances, and

(3) Due diligence in connection with the transfer of Plan assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the transfer, will become a covered entity.

Notwithstanding anything to the contrary, in no event shall the Board of Trustees be permitted to use or disclose PHI in a manner that is inconsistent with HIPAA.

Section 18.03 Plan Sponsor Certification.

In adopting this Section 18.03, the Board of Trustees agrees to the following provisions:

(a) Prohibition on Unauthorized Use or Disclosure of PHI. The Trustees will not use or disclose any PHI received from the Plan, except as permitted in the Plan documents or as required by law.

(b) Agents (Including Subcontractors). The the Board of Trustees will require each of its agents, including subcontractors, to whom the Board of Trustees provides PHI that it received from the Plan, to agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information.

(c) Impermissible Purposes. The Board of Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any non-health care components.

(d) Reporting. The Trustees will report to the Plan any use or disclosure of PHI, of which they become aware, that is inconsistent with the uses and disclosures permitted by the Plan. Specifically, the Trustees will report to the Plan any Breach as defined by 45 CFR § 164.402.

(e) Access to PHI by Participants. The Board of Trustees will make PHI available to allow the Plan to provide Participants access to inspect and copy their PHI to the extent provided by 45 CFR § 164.524.

(f) Amendment of PHI. The Board of Trustees will make PHI available to Participants who request to amend or correct PHI that is inaccurate or incomplete and will incorporate any amendments to PHI to the extent required and/or permitted by 45 CFR § 164.526.

(g) Accounting of PHI. The Board of Trustees will make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

(h) Disclosure to the Secretary. The Board of Trustees will make the Fund's internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services or its designee for the purpose of determining the Plan's compliance with HIPAA.

(i) Breach Notification. The Board of Trustees will cooperate with Plan's efforts to comply with the Breach notification regulations set forth in 45 CFR §§ 164.404, 164.406 and 164.408.

(j) Return or Destruction of PHI. When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from the Plan, and retain no copies in any form. If return or destruction is not feasible, the Trustees agree to limit further uses and disclosures to the purposes that make the return or destruction infeasible.

(k) Adequate Separation. The Board of Trustees must ensure that adequate separation exists between the Plan and Trustees such that PHI will be used only for plan administration and not for employment-related actions or any other purpose. The following employees, classes of employees or persons under the control of the Board of Trustees may have access to and may use PHI, but only to the extent necessary to perform the administration functions that (i) are to be performed by the Board of Trustees as set forth under Section 18.02 and (ii) are assigned to such employees as a part of their job duties:

(1) All staff members of the Trustees to whom the Board of Trustees has delegated responsibility for Plan administration, and

(2) The Trustees.

In the event that any such persons do not comply with the requirements set forth herein, such persons shall be subject to disciplinary action by the Board of Trustees for noncompliance, pursuant to the Fund's discipline and termination or removal procedures. The Board of Trustees shall take whatever actions necessary to resolve such noncompliance. Regardless of whether a person is disciplined, terminated or removed pursuant to this paragraph, the Board of Trustees may modify or revoke any person's access to or use of PHI, and Board of Trustees shall take such action as warranted. Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Plan's Privacy Officer at the telephone number and address provided in the Plan's notice of privacy practices.

(l) Protection of Electronic PHI. If electronic PHI is created, received, maintained, or transmitted to or by the Board of Trustees on behalf of the Plan, the Board of Trustees will do the following:

(1) Ensure that the "adequate separation" described in subparagraph (k) above is supported by reasonable and appropriate security measures,

(2) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of such electronic PHI,

(3) Ensure that any agent (including a subcontractor) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information, and

(4) Report to the Plan any security incident of which it becomes aware. For purposes of this provision, "security incident" is defined as the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Notwithstanding the above, if the only ePHI that is disclosed to the Board of Trustees is disclosed pursuant to a HIPAA-compliant authorization or is limited to

Summary Health Information (as defined in the Privacy Rule) disclosed for the purpose either of obtaining premium bids for providing health insurance coverage under the Plan, or modifying, amending or terminating the plan, and information regarding an individual's participation, enrollment or disenrollment, the requirements of this Section 18.03 (l) do not apply.

ARTICLE XIX
GENERAL PROVISIONS

Section 19.01 Gender and Number

Any reference to the masculine gender in this document will be deemed also to apply to the feminine gender and vice versa, unless the context requires otherwise. Any reference to the singular also may apply to the plural and vice versa, unless the context requires otherwise or the result would be unreasonable.

Section 19.02 Exclusive Benefit

No part of the Plan or any assets of the Plan shall be used for purposes other than providing benefits for Eligible Participants under the Plan in accordance with the provisions of the Plan.

Section 19.03 Workers' Compensation Not Affected

This Plan is not in lieu of and does not affect any requirement for coverage under any workers' compensation act or occupational diseases act or similar law.

Section 19.04 Governing Law/Venue

(a) All questions pertaining to the validity and construction of the Trust Agreement, the Plan, and of the acts and transactions of the Trustees or of any matter affecting the Fund will be determined under federal law where applicable federal law exists. Where no applicable federal law exists, the laws of the state of Illinois will apply.

(b) Any lawsuit arising under this Plan must be brought in the federal court for the Northern District of Illinois, Eastern Division, or if federal jurisdiction does not apply, then in the Circuit Court of Cook County, Illinois.

Section 19.05 Severability Clause and Conformity with the Law

(a) Whenever possible, each provision of the Plan shall be interpreted in such manner as to be effective and valid under applicable law (including the Code and ERISA). However, should any provision of the Plan or any amendment thereto be deemed or held to be unlawful or invalid, or unlawful or invalid as to any person or instance, (i) such determination will not adversely affect the other provisions herein or the application of those provisions to any other person or instance, unless such application will make impossible or impracticable the functioning of

the Plan, and (ii) such provision shall be deemed amended to, and to have contained from the outset such language as shall be necessary to, accomplish the objectives of the provision as originally written to the fullest extent permitted by law.

(b) To the extent permitted by law, the Board of Trustees will not be held liable for any act done or performed in pursuance of any provisions hereof prior to the time that such act or provision will be held unlawful by a court of competent jurisdiction.

(c) If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Section 19.06 Legal Proceedings

(a) No action at law or in equity or otherwise may be brought on any claim or other matter whatsoever against the Plan, the Administrator, the Trustees, or any of them, unless all of the required claim procedures and claim appeal procedures of the Plan have been followed and exhausted (to the extent applicable), nor will such action be brought at all unless brought within one year of the final decision on review (or the expiration of the period in which the final decision is to be issued) or within the maximum time permitted under the applicable provisions of ERISA, if shorter.

(b) If the claimant fails to include any theories or facts in his/her written appeal (to the extent a written appeal is required under the Plan's claims procedures), they will be deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories that support the claim if he/she fails to include them in any written appeal.

(c) This provision, permitting court action, will not be deemed to extend or reinstitute any claim or cause of action that has expired under the time limits set forth in the Trust Agreement, or in any Plan Document or regulations of the Board of Trustees or under any statute if such time limit already has expired.

Section 19.07 Release of Information

To the extent consistent with applicable state and federal law and subject to ARTICLE XVIII of the Plan and the provisions of HIPAA, an Eligible Participant making application for benefits will be required by the Plan to authorize any Physician, Hospital, Employer, government agency or any other person, corporation or organization having relevant health related information which may be required for a proper determination of the claim by the Plan to release such information to the Plan. Each Eligible Participant also will authorize the Plan to release relevant health related information to third parties, if necessary to facilitate the payment of benefit claims hereunder, provided, however, no authorization will be required if such authorization would violate applicable state and federal laws.

Section 19.08 Trustee Authority to Amend and Interpret

(a) The Trustees will have the power and authority in their sole discretion to increase, decrease, or change benefits, or change eligibility rules or other provisions of the Plan of Benefits at any time and for any reason, provided that such changes are not inconsistent with the law or with the provisions of the Trust Agreement.

(b) In carrying out their respective responsibilities under the Plan, the Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have the discretionary authority to construe and interpret the Trust Agreement, the Plan, the Plan documents and the procedures of this Fund, to construe and interpret any facts relevant to their determinations, and to determine eligibility and entitlement to Plan Benefits and otherwise operate the Plan in accordance with the terms of the Plan. Benefit payments under this Plan shall be made only if the Plan fiduciaries decide in their discretion that the applicant is entitled to them. The Trustees' interpretation will be binding on all involved parties hereto, including but not limited to eligible Employees, eligible Dependents of Employees, and beneficiaries of Employees. The decisions of the Board of Trustees will be given judicial deference in any court or other proceeding regarding benefits of this Plan, unless it can be shown by clear and convincing evidence that a decision was arbitrary and capricious.

(c) The Trustees in their sole discretion may amend this Plan at any time and for any reason, in accordance with the procedures set forth in the Trust Agreement, which amendment will be reduced to writing and may be effective prospectively or retrospectively, provided, however, no amendment to the Plan will retroactively reduce benefit entitlement or benefit levels then in effect. All amendments are subject to the limitations of the Trust Agreement and the applicable law and administrative regulations. Eligible Participants of the Plan will be notified in writing of any Plan amendments. No oral modifications to the Plan are permitted.

Section 19.09 Trustee Authority to Terminate the Plan

It is the intention of the Board of Trustees to continue the Plan indefinitely. However, the Board of Trustees reserve the right to terminate the Plan at any time and for any reason, either in whole or in part, by action of the Board of Trustees. For example, the Board of Trustees may terminate the Plan if future Collective Bargaining Agreements and participation agreements do not require Employer Contributions to the Plan. Eligible Participants are not vested in the benefits provided by this Plan.

Section 19.10 Payment of Benefits upon Plan Termination

(a) If it should happen that the Plan or a particular benefit is terminated, benefits for Covered Expenses incurred before the termination date fixed by the Board of Trustees will be paid to Eligible Participants as long as the Plan's assets are more

than the Plan's liabilities. Neither the Plan nor the Board of Trustees shall be liable for Covered Expenses incurred after the termination date.

(b) Full benefits may not be paid if the Plan's liabilities are more than its assets.

(c) If there are any excess assets remaining after the payment of all Plan liabilities (including administrative expenses), those excess assets will be used for purposes determined by the Board of Trustees in accordance with the provisions of the Trust Agreement and applicable law.

Section 19.11 Duties and Authority of the Plan Administrator

The Plan Administrator (as identified in the Summary Plan Description) shall be a fiduciary with respect to the Plan within the meaning of Sections 3(21)(A)(i) and (iii) of ERISA, and the named fiduciary under Section 402 of ERISA. As a fiduciary, the Plan Administrator shall discharge its duties under the Plan solely in the interest of the Participants in the Plan, and for the exclusive purpose of providing benefits to such persons and defraying the reasonable expenses of administering the Plan. In addition to any duties and authority otherwise conferred herein, the Plan Administrator shall have the discretionary authority and responsibility:

(a) To gather information necessary for administration of the Plan,

(b) To decide and settle disputes which may arise relative to a Plan Participant's rights,

(c) To waive enforcement of Plan terms,

(d) To prescribe procedures necessary for administration of the Plan, including procedures for filing a claim for benefits,

(e) To review and determine all claims for benefits and all appeals with respect to denied claims,

(f) To keep and maintain (or cause to be maintained) the Plan documents and all other records pertaining to the Plan,

(g) To perform all necessary reporting as required by ERISA and any other applicable law,

(h) To establish and communicate procedures to determine whether a medical child support order is qualified under Section 609 of ERISA,

(i) To delegate to any person or entity (such as, but not limited to, a third party administrator) such powers, duties and responsibilities (including fiduciary duties) as it deems appropriate,

(j) To make benefit payments and authorize all other disbursements by the Employer pursuant to this Plan, including the authority to sign checks on behalf of the Plan,

(k) To file claims with insurance companies providing stop-loss insurance to the Plan, if any, and

(l) To pay premiums to the insurance carriers (if any) that underwrite the benefits provided herein.

Section 19.12 Bonding.

Every fiduciary and other person who handles funds or other property of the Plan shall be bonded in accordance with Section 412 of ERISA.

Section 19.13 Precedence of Plan Document Provisions over a Summary

If any discrepancy exists between the provisions contained in the Summary Plan Description and the provisions contained in this document, the provisions of this document will take precedence.

Section 19.14 Free Choice of Physician

An Eligible Participant will have free choice of any legally qualified Physician, and the Physician-patient relationship will be maintained and in no way interfered with.

The fact that certain providers or facilities are part of the PPO Network as discussed herein or in the Summary Plan Description, 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 not part of the PPO Network should not be construed as a statement, negative or positive, as to the skill or quality of such provider or facility.

Section 19.15 Examination

The Trustees will have the right and opportunity, subject to ARTICLE XVIII:

(a) To employ a Physician to examine the person whose Injury or Sickness is the basis of a claim hereunder when and so often as they may reasonably require during pendency of a claim hereunder,

(b) To examine any and all Hospital or medical records relating to a claim under this Plan, and

(c) To make an autopsy in case of death, provided an autopsy is not forbidden by law.

Section 19.16 Payment of Benefits Generally

(a) Benefits are payable to the eligible Employee whose Injury or Sickness or whose eligible Dependent's Injury or Sickness is the basis for a claim under the Plan, except that:

(1) In the event of the eligible Employee's death, any applicable death benefits will be payable in accordance with the payment provisions specified in ARTICLE X and/or ARTICLE XI (as applicable) and any other benefits will be paid to the Employee's estate or to an entity or person which has financial responsibility for satisfying the debts of the estate (unless another provision below applies), and

(2) In the event that an unpaid Hospital bill, Physician's bill, or bill from any other provider providing services or supplies that are covered by this Plan is submitted to the Board of Trustees, the payment may be made directly to the Hospital, Physician, or provider, and

(3) To the extent that an eligible Employee or the Employee's Dependent spouse has filed a written assignment to make payment directly to a provider of medical services or supplies, payments will be made in accordance with the assignment.

(b) No assignment, alienation, sale, transfer, pledge, or other encumbrance of any present or future right, interest, or benefit under this Plan will bind the Board of Trustees without their written consent thereto. However, an Eligible Participant may direct that benefits due him be paid to any Hospital or medical service provider in consideration of medical or Hospital services given or supplies furnished or to be furnished.

(c) Benefits payable for any loss will be paid upon receipt of written proof covering the occurrence, character, and extent of the event for which claim is made, provided such proof is provided within the time limitations specified. The Plan's claims procedures are set forth in the Summary Plan Description.

(d) Subject to proof of loss, Disability Benefits will be paid each week during the continuance of the period for which benefits are payable.

(e) If any Eligible Participant is, in the opinion of the Board of Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed for that Eligible Participant, the Board of Trustees may, at their option, make such payment to the person or persons who, in the opinion of the Board of Trustees, has (have) assumed the care and principal support of such Eligible Participant.

(f) If the Eligible Participant should die before all amounts due and payable have been paid (other than death benefits, which are covered in subsection (a)(1) above), the Board of Trustees may, at their option, make such payment to the

executor, administrator or personal representative of the estate of the Eligible Participant or to the surviving spouse, parent-child or children of the Eligible Participant, or to an individual(s) who has provided principal support to the Eligible Participant, or to any other person or persons who, in the Board of Trustees' opinion, are entitled thereto.

(g) Any payments made by the Board of Trustees in accordance with these provisions will fully discharge the liability of the Board of Trustees to the extent of such payment.

Section 19.17 Provisions Governing Payment of Medical Benefits

(a) Benefits will be payable by the Plan up to but not to exceed any Maximum Benefit or other benefit limitation specified on the Schedule of Benefits in the Plan's Summary Plan Description For each Eligible Participant, whether or not there has been an interruption in the continuity of eligibility, the maximum amount of benefits available during any specified period of time will be equal to the amount by which the Maximum Benefit specified for that period of time exceeds the sum of the benefits previously paid or provided on account of the Eligible Participant during that period of time.

(b) Benefits will be payable only for expenses actually incurred by Eligible Participants.

(c) Benefits will be payable for expenses incurred by an Eligible Participant only if the expenses are incurred within any applicable time limitations specified on the Schedule of Benefits in the Plan's Summary Plan Description or in any other applicable provision of this document or the Summary Plan Description.

(d) Benefits will be payable only for expenses that are specified as Covered Medical Expenses or that are specified as payable in any applicable provision, subject to any applicable limitations or exclusions governing such expenses.

Section 19.18 Circumstances under which a Claim May Be Denied

The following list outlines some of the common reasons or circumstances under which all or part of a claim may be denied by the Board of Trustees:

(a) The Eligible Participant on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.

(b) The claim was not filed within the Plan time limits.

(c) The expenses that were denied are not considered Covered Expenses under the Plan.

(d) The expenses for which the claim was filed were not actually incurred.

(e) The Eligible Participant for whom the claim was filed had already received the Maximum Benefit allowed for that type of expense during a stated period of time.

(f) Another plan was primarily responsible for paying benefits for the expenses.

(g) No payment was made, or a reduced payment was made, because some or all of the expenses for which the claim was filed were applied against a particular deductible.

(h) A third party was responsible for paying the expenses, and the Eligible Participant on whose behalf the claim was filed did not submit the required subrogation agreement which would permit the Plan to process the claim and recover payment from the third party or the insurance company of the third party.

(i) The Plan of Benefits was terminated.

Section 19.19 Misrepresentation or Falsification of Claim or Other Matter

If any individual knowingly misrepresents or falsifies any information or matter in connection with a claim for Plan benefits or any other matter relating to the Plan, such as, but not limited to, eligibility, or otherwise commits fraud related to the Plan, the Board of Trustees may, in its sole discretion, deny all or part of the benefits which might otherwise be due in connection with that claim. Moreover, such misrepresentation, falsification, or fraud will be grounds for loss of eligibility for Plan benefits of the Eligible Participant through whom that individual receives coverage as well as all of the Eligible Participant's Dependents.

Section 19.20 Wrongfully Paid Benefits

Whenever the Board of Trustees pays benefits which exceed the amount of benefits that should be paid under the terms of this Plan, the Board of Trustees will have the right to recover the wrongfully paid benefits from any person(s), service provider or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of an Eligible Participant, the Plan, at its option, may require immediate repayment in full, set off the overpayment from current and/or future benefit payments that the related eligible Employee and the Employee's Dependents may be entitled to receive or institute legal action to collect the overpayment.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Plan also may obtain reimbursement of interest, professional fees incurred and other damages related to that overpayment.

Section 19.21 No Guarantee of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement to the effect that an Employee will be retained in the service of an Employer for any length of time, nor shall the Plan be construed as interfering with the right of an Employer to terminate any Employee or modify the terms of an Employee's employment at any

time. Also, nothing contained in the Plan will be construed to modify in any way the terms of employment or service of any Participant.

Section 19.22 Medical Loss Ratio Rebates

If any health benefits are ever offered under a policy of insurance, and amounts are received by the Plan or Employer, as the policyholder, from the insurer that are attributable to the medical loss ratio standards pursuant to Section 2718 of the Public Health Service Act, as amended, and the regulations thereunder, such amounts shall be allocated to, and be the sole property of the Employer and shall not be considered assets of the Plan under ERISA or the regulations thereunder.

EXECUTION

The WELFARE BENEFIT PLAN SPONSORED BY THE BUILDING MATERIAL CHAUFFEURS, TEAMSTERS AND HELPERS WELFARE FUND OF CHICAGO is restated and amended as set forth herein with respect to expenses incurred on and after September 1, 2022.

IN WITNESS WHEREOF, the undersigned have executed this restated Plan of Benefits as Trustees on behalf of the Board of Trustees of the BUILDING MATERIAL CHAUFFEURS, TEAMSTERS AND HELPERS WELFARE FUND OF CHICAGO this 13th day of March 2025.

Union Trustee

Employer Trustee