CENTRAL LABORERS' WELFARE FUND SUMMARY PLAN DESCRIPTION

EFFECTIVE 10-01-2023

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Central Laborers' Welfare Fund

Summary Plan Description
Amended October 1, 2023

Prepared By
The Segal Company

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INTRODUCTION

The Board of Trustees of the Central Laborers' Welfare Fund is proud to provide you and your Dependents with a comprehensive and quality benefit plan. As your Board of Trustees, we continually evaluate the benefits provided and look for opportunities to enhance them while maintaining a financially sound Fund.

We are pleased to present you with this booklet that describes the eligibility rules and benefits available to active and retired Participants of the Central Laborers' Welfare Fund effective January 1, 2003 or as of the date amended, as noted. For the most part, active and retired Participants are eligible for the same benefits. However, there are some differences in benefit availability as noted in the table of contents and at the beginning of each section.

The Welfare Fund offers various health care options designed to provide you with the flexibility to choose the coverage that best meets your health care needs. During each annual Open Enrollment Period you elect your covered plan for the upcoming year. A *Schedule of Benefits*, summarizing the level at which benefits are paid, can be found in the back pocket of this booklet. From time to time, the Fund may make changes to Plan benefits. If this occurs, you will receive benefit updates that you can insert into the back pocket of this booklet. That way, you will have all your benefit information in one place.

Please contact the Fund Office at (217) 243-8521 or toll-free at (800) 252-6571 if you have questions about your benefits or any information contained in this booklet.

Sincerely,
Board of Trustees

This booklet contains only highlights of certain features of the Central Laborers' Welfare Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify or terminate the Plan at any time. You and your eligible Dependents do not acquire any vested right to Plan benefits either before or after you retire.

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Important Phone Numbers

If You Have Questions About:	Call:	At:
Your welfare benefits in general or specific questions about vision, hearing, dental, or accidental death and dismemberment (AD&D) benefits	Central Laborers' Welfare Fund Office	(217) 243-8521 or (800) 252-6571
Medical benefits	Your specific medical plan:	
	❖ Blue Cross HMO Illinois (for Retirees only)	(800) 772-6897
	❖ BlueCross BlueShield of Illinois PPO	(800)252-6571
	❖ Health Alliance	(800) 322-7451
	❖ HealthLink	(800) 252-6571
Medical Providers	Your specific medical plan:	
	❖ Blue Cross HMO Illinois	(800) 772-6897
	❖ Blue Cross Blue Shield of Illinois PPO	(800) 571-1043
	❖ Health Alliance	(800) 322-7451
	❖ HealthLink	(800) 624-2680
Mental health and substance abuse referrals	Family Assistance Services Program	(217) 243-8521 or (800) 252-6571
Retail prescription drug benefits and participating pharmacies	CVS/Caremark	(866)818-6911
Mail order prescription drug benefits	Mail Order Service – CVS/Caremark	(866)818-6911

Life Events

At some point in your life, you may experience a life event that impacts your health care coverage. Your benefits are designed to adapt to your needs at different stages of your life. Life events that can affect your benefit coverage include:

- marriage;
- birth of a child;
- adoption of a child;
- divorce or legal separation;
- your child reaches the maximum age for coverage;
- your spouse loses a job or takes a new job;
- medical leave;
- military duty;
- you become disabled;
- your death;
- death of a Dependent;
- leaving work;
- retirement; or
- eligibility under Medicare.

This section describes how life events affect your coverage.

Getting Married

When you get married, your spouse may become eligible for medical, prescription drug, vision, hearing care and dental care benefits. If your spouse has comparable coverage under his or her employer's plan, your spouse should enroll for that coverage and must do so before this Plan will provide or coordinate benefits for your spouse.

You need to notify the Fund Office of your marriage and provide the necessary documentation within 31 days of the date of your marriage to have your spouse covered from that date. If you notify the Fund Office after 31 days, your spouse's coverage will be effective on the first day of the month following receipt of the documentation by the Fund Office.

(Please note – If your spouse works full time and has medical coverage offered through his or her employer, he or she **must enroll in that employer's comparable plan before any medical benefits can be paid under this Plan. This provision does not apply to the spouse of a Retiree who becomes independently eligible for Retiree benefits.

Marriage. If you get married, provide the Fund Office with:

- ❖ Enrollment/Change Form;
- ❖ copy of your marriage certificate;
- ❖ your spouse's date of birth; and
- ❖ your spouse's medical insurance information (if your spouse is covered under another group health insurance plan). **

Adding an Adult Dependent or Dependent Child by Birth, Adoption or Open Enrollment (Effective November 2, 2018)

Generally, the Plan covers natural born children, adopted children (including placement for adoption), stepchildren and children for whom you are the legal guardian subject to the following requirements:

- For initial enrollment of ***natural born, adopted children (including placement for adoption), stepchildren and children for whom you are the legal guardian***, you must notify the Fund Office and provide the required documentation within 31 days of the qualifying event (i.e., adoption, placement for adoption, legal guardianship or marriage for addition of stepchildren) for coverage to begin as of the date of the qualifying event.

- For initial enrollment of ***natural born children, being added due to birth***, you must notify the Fund Office and provide the required documentation within 90 days of the qualifying event (i.e., the birth) for coverage to begin as of the date of birth. If you notify the Fund Office or delay providing required documentation for a period greater than 90 days, in the case of a natural born child being added due to birth, coverage will begin on the first day of the month following the month in which the Fund Office receives notification and all required documentation.

When adding a child, provide the following information to the Fund Office:

- ❖ Enrollment/Change Form;
- ❖ birth date, effective date of adoption or placement or marriage date (for purposes of adding stepchildren);
- ❖ copy of the birth certificate, adoption papers or other legal documents as required.
- ❖ copy of the birth certificate, marriage certificate, dependent confirmation forms and legal documents; and/or
- ❖ copy of your child's other medical insurance information, if covered under another group health insurance plan.

If you adopt a child or have a child placed with you for legal guardianship or adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage. Stepchildren are eligible for coverage on the date of your marriage, provided your spouse is required to

maintain medical and/or dental coverage. All children need to meet the Plan's definition of a Dependent described in the definitions section of this Summary Plan Description.

You may add a Dependent without a qualifying event during the Plan's annual Open Enrollment process. If adding your Dependent during Open Enrollment and that enrollment is not due to a qualifying event, your Dependent's eligibility will be effective, the first day of the plan year for which you are enrolling, the first day of the participant's eligibility, if after the start of a plan year, or the first day of the month following receipt of the Open Enrollment form and all required documents if they are submitted after the Open Enrollment deadline date, whichever is later.

Please remember that your Dependent(s)' eligibility may be subject to verification and may require additional documentation such as a birth certificate(s), divorce decree(s), marriage license, death certificate(s) or other information necessary to confirm a Dependent's relationship and eligibility for benefits. Some of the documentation can be completed by you or your Dependent. However, some forms must be completed by a Dependent's insurance carrier or Dependent's employer, if applicable. If the required documentation is not received on a timely basis, then your Dependent's eligibility may be delayed as provided above.

Divorce or Legal Separation

If you and your spouse obtain a legal separation or divorce, your spouse will no longer be eligible for coverage as a Dependent under the Plan. However, your spouse may elect to continue coverage under COBRA for up to 36 months. Please review the section related to electing COBRA Continuation Coverage for more detailed information.

Divorce or legal separation may affect coverage for Dependent children. Please notify the Fund Office immediately to avoid denial of benefits or unnecessary delays in claim payments.

Also, contact the Fund Office if a Qualified Medical Child Support Order (QMCSO) or a Qualified Domestic Relations Order (QDRO) has been issued as a result of your divorce or legal separation. These orders may affect your benefit coverage or elections.

Divorce or legal separation. If you become legally separated or divorced, provide the Fund Office with:

- Enrollment/Change Form;
- copy of your separation or divorce decree; and
- copy of QMCSO or QDRO (if applicable).

If your ex-spouse wants to continue coverage, he or she should contact the Fund Office within 60 days of the divorce or legal separation to enroll for COBRA Continuation Coverage.

Dependent Child or Adult Dependent Losing Eligibility (Effective November 2, 2018)

In general, your dependent child or adult dependent is no longer eligible for coverage when he or she no longer meets the definition of Dependent as described in this Summary Plan Description. You should notify the Fund Office immediately when your dependent child or adult dependent is no longer eligible for coverage. See the definition of Dependent in the Definitions section of the Summary Plan Description.

Your Dependent may consider applying for COBRA Continuation Coverage as he or she nears the age of 26 or otherwise loses eligibility as a result of no longer being a Dependent under the Plan. Generally, your Dependent may elect COBRA Continuation Coverage for up to 36 months when his or her Plan coverage ends provided you notify the Fund Office within 60 days of your Dependent losing eligibility for Plan coverage.

Your Spouse or Dependent Loses a Job or Takes a New Job

When your spouse or Dependent children loses employer-provided insurance due to the loss of his or her job, you should contact the Fund Office to add your spouse or children to your coverage.

If your spouse takes a new job and your spouse's new employer offers comparable coverage to this Plan or comprehensive insurance, your spouse must enroll in that coverage before this Plan will provide or coordinate benefits for your spouse. Please contact the Fund Office if your spouse accepts a new job. This provision does not apply to the spouse of a Retiree who becomes independently eligible for Retiree benefits.

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

When your spouse or Dependent loses a job, you may:

- ❖ add your spouse to your coverage; and
- ❖ add your Dependent children to your coverage.

When your spouse or Dependent child takes a new job, you should provide information about the new plan to the Fund Office.

Please note: If your spouse's employer offers comparable coverage to this Plan or comprehensive insurance, your spouse must enroll in that coverage before this Plan will coordinate benefits. This provision does not apply to the spouse of a Retiree who becomes independently eligible for Retiree benefits.

Family and Medical Leave of Absence

Under the Family and Medical Leave Act of 1993 (FMLA) in certain circumstances you may be able to take up to 12 weeks of unpaid leave from your employment during any 12-month period due to:

- ϖ the birth of a child or placement of a child with you for adoption or foster care;
- ϖ the care of a seriously ill spouse, parent or child; or
- ϖ your serious Illness.

Under FMLA, eligibility for benefits must be extended to you and your Dependents if:

- ϖ you are an eligible active Participant;
- ϖ you have been granted leave by your employer under FMLA; and
- ϖ your employer makes the required contributions to the Welfare Fund.

FMLA leave is generally granted for the following reasons:

- ❖ birth, adoption or placement of a child with you for adoption;
- ❖ care of a seriously ill spouse, parent or child; or
- ❖ your serious Illness.

The FMLA requires your employer to inform you of your rights and obligations under this law. You should ask your employer if you have any questions.

If you have been granted FMLA leave, your employer must notify the Fund Office to prevent you from losing eligibility. You may wish to notify the Fund Office yourself, but you are not required to do so. Your employer must verify your eligibility for benefits while on leave, and must pay for your extended eligibility before the Welfare Fund can provide benefits.

Your eligibility for a FMLA leave is determined by your employer.

You may be eligible for a leave under the Family and Medical Leave Act if you:

- ❖ have worked for one Contributing Employer for at least 12 months;
- ❖ have worked for one Contributing Employer for at least 1,250 hours over the previous 12 months; and
- ❖ work at a location where your employer employs at least 50 employees within a 75-mile radius.

Military Leave

Your health care coverage will continue if you serve in the Uniformed Services of the United States (active or inactive duty training) for up to 31 days. If you serve for 31 days or more, you may continue your coverage at your own expense for up to 18 months from the first day of your leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you continue your coverage at your own expense, it will stop at the *earliest* of the following:

- ϖ the date you or your Dependents do not make the required payments within 30 days of the due date;
- ϖ the date the Fund no longer provides any group health benefits;
- ϖ the date you reinstate your eligibility for coverage under the Plan;
- ϖ the end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- ϖ the last day of the month after 18 consecutive months.

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

- ❖ notify your Contributing Employer and the Fund Office; and
- ❖ make any required self-payments to the Fund Office to continue your coverage if you wish to continue your health coverage with the Plan in addition to your military insurance coverage.

Upon your discharge from military service, you may apply for reemployment with your former employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any health coverage offered by that employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service. Please refer to the following chart, which outlines the deadlines applicable to your rights to reemployment and reinstatement of health care coverage.

Length of Military Service	Reemployment/Reinstatement Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

For more information about self-payments under USERRA, contact the Fund Office at (217) 243-8521 or (800) 252-6571.

In the Event of Your Disability

If you become Totally and Permanently Disabled, your attending Physician will need to submit proof of your disability to the Fund Office. When you are disabled, you may receive up to a maximum of 12 months of coverage without charge for your disabling condition. However, if you wish to continue full coverage under the Plan, you may make self-payments for coverage or you may elect COBRA Continuation Coverage. The 12-month continuation of coverage for a disabling condition is not automatic. You must submit proof of your disability to the Fund Office and inform them of your election for this coverage option.

In the Event of Your Death

At the time of your death, your spouse or beneficiary should notify the Fund Office and provide a copy of your death certificate. Your spouse or beneficiary should complete a Death Benefit application from the Plan. If your spouse and Dependents are covered under the Plan on the date of your death, they may continue health care coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary self-payments. If you are retired at the time of your death, you will not be eligible for a Death Benefit; however, your spouse and Dependents may be eligible for continuation of your Retiree coverage. To determine if your spouse and Dependents are eligible to continue coverage under the Retiree plan, please contact the Fund Office.

At your death, your spouse or beneficiary should notify the Fund Office and:

- ❖ provide an Enrollment/Change Form;
- ❖ provide a copy of the death certificate;
- ❖ apply for Death Benefit, if eligible; and
- ❖ enroll and pay for COBRA to continue Plan coverage, or
- ❖ enroll and pay for Retiree coverage, if eligible.

In the Event of Your Dependent's Death

If a Dependent dies, you should notify the Fund Office within 31 days and provide a copy of the death certificate.

When You Stop Working

If you are eligible for benefits under the provision of a collective bargaining agreement, coverage for you and your Dependents will end on the last day of any three-month period for which the required hours of contributions were not made on your behalf. If you are eligible for benefits under a non-construction agreement, your coverage will end on the last day of the month for which contributions have been made on your behalf. If you are covered as a bargained employee, you may elect to continue coverage under the Central Laborers' Welfare Fund's self-payment option or COBRA Continuation Coverage. If you are a non-construction Participant, you may elect to continue coverage under the COBRA Continuation Coverage only. You would only be eligible for COBRA Continuation Coverage after you make the necessary self-payments for the coverage. For more information and the rules related to electing COBRA Continuation Coverage review that section of this document.

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

- ❖ notify the Fund Office; and
- ❖ enroll for COBRA Continuation Coverage.

When You Retire

If you are eligible for Retiree coverage, you may elect to participate in the Plan as a Retiree until you become eligible for Medicare. You will be required to make self-payments for your coverage after your retirement.

When you retire, you may be able to elect Retiree coverage.

Be sure to complete any forms necessary for continuation of coverage.

Eligibility Rules

Bargained Employees

Initial Eligibility

The eligibility rules described in this booklet are effective as of April 1, 2017. You become eligible for coverage as long as you are not receiving a pension from Central Laborers' Pension Fund or similar craft and when:

- you perform work that is under the jurisdiction of any local union participating in this Welfare Fund; and
- sufficient contributions are made on your behalf by Contributing Employers.

- ***Contribution hours*** are your hours of work for which your employer contributes to this Fund under the terms of a collective bargaining agreement.

Seasonal bad weather or a temporary work shortage will not necessarily cause you to lose eligibility because all contribution hours over a 12-month period are counted in determining your eligibility.

You first become eligible for Welfare Plan benefits when you have completed 500 hours of work for which employer contributions or contribution hours have been made on your behalf to the Welfare Plan within a six-consecutive month period. When you have met this requirement, your eligibility for Welfare Plan benefits begins on the first day of the second calendar month following the 500th contribution hour. Once you become eligible for Welfare Plan benefits, your eligibility will continue for at least three months. (See the first example below)

If, however, you have completed 500 contribution hours before the completion of a six-consecutive month period, your eligibility will begin on the first day of the second calendar month that follows the month you completed your 500th contribution hour. Your eligibility for Welfare Plan benefits will continue for at least three months. (See the second example below)

Example 1:
Ryan is not receiving a pension from Central Laborers' Pension Fund or similar craft.

Ryan begins working on March 1. He works 85 hours in each of the six months (March, April, May, June, July and August) and his employer reports and pays contributions to the Plan for all hours worked. Because Ryan has worked

510 contribution hours by the end of August, he becomes eligible for benefits on October 1, which is the first day of the second month following his completion of 500 or more contribution hours.

Example 2:
Ryan is not receiving a pension from Central Laborers' Pension Fund or similar craft.
If Ryan worked 160 hours per month beginning in March, he would complete over 500 contribution hours by the end of June and his eligibility would begin on August 1.

Continued Eligibility and Termination of Eligibility (EFFECTIVE 04/01/2017)

After you satisfy the initial eligibility rules, your eligibility will continue for each succeeding three-month period if contributions are made on your behalf that satisfy one of the requirements for that three-month eligibility period according to the following schedule.

Schedule Instructions:

1) Find the three-month period which you are wanting to identify contribution requirements. (Three-month periods are located in the right-hand column.
2) Move to the left-hand column and see what hours must be contributed on your behalf.

(Please note: You do not need to meet all contribution hour requirements listed to be eligible for benefits. The Fund Office calculates eligibility by looking to see if you have the necessary contribution hours during the 3 months listed. If you do not, the Fund Office calculates eligibility by looking to see if you have the necessary contributions hours during the 6 months listed. If you do not satisfy the contribution hour requirement for the 6-month period, the Fund Office looks at contribution hours for the 9-month period and finally by looking at contribution hours for the 12-month period listed.

Once the Fund Office determines you have satisfied the required contribution hours for any one of the four possible scenarios, your eligibility will be updated for the three-month period listed in the right-hand column.

If You Work:	Your Coverage Continues During:
250 contribution hours in September, October, November; or 500 contribution hours in June through November; or 750 contribution hours in March through November; or 1,000 contribution hours in December through November	January, February and March
250 contribution hours in December, January, February; or 500 contribution hours in September through February; or 750 contribution hours in June through February; or 1,000 contribution hours in March through February	April, May and June

250 contribution hours in March, April, May; or 500 contribution hours in December through May; or 750 contribution hours in September through May; or 1,000 contribution hours in June through May	July, August and September
250 contribution hours in June, July, August; or 500 contribution hours in March through August; or 750 contribution hours in December through August; or 1,000 contribution hours in September through August	October, November and December

Your eligibility terminates at the end of the last day of any of the above three-month eligibility periods if the required contributions have not been made on your behalf for the 250, 500, 750 or 1,000 hour work requirement.

The rules that cover your continuing eligibility have been designed to enable you to "look-back" during any designated 12-month period to take advantage of the contribution hours you earned during periods of high employment and avoid losing health insurance coverage during seasonal work slowdowns or periods of low employment.

For Example:

Angelo becomes eligible for Plan benefits on January 1, 2017. Angelo's benefits continue for the three months of January, February and March. To determine his eligibility for April through June, Angelo looks back to his hours of work during the previous December, January and February. If his hours for that period total 250, then he continues to be covered during April through June. If his hours do not total at least 250 for that period, Angelo looks back to the 6-, 9- or 12-month period to see if he meets the hour requirement for that period.

To determine whether he is eligible for coverage during April, May and June 2017 Angelo looks back to December, January and February. If his hours for that period total 250, then he continues to be covered during April, May and June 2017. If his hours do not total 250 for that period, Angelo looks back to the 6-, 9- or 12-month period shown in the table above for the April, May and June coverage period. If Angelo does not meet the hour-requirement for the April, May and June 2017 period, his coverage will terminate at the end of the day on March 31, 2017.

Contributing Employers must report and remit the contributions required by the collective bargaining agreement to the Welfare Fund on a monthly basis. Some Contributing Employers submit their monthly reports based on actual hours worked during the full calendar month. Other Contributing Employers submit their monthly report based on their payroll periods for the reported month. The Welfare Fund's records used to determine eligibility are based on the monthly hours reported on each Contributing Employer's monthly remittance report.

Contribution hours from all of your Contributing Employers are counted. If you move from one Contributing Employer to another, your eligibility will continue if the combined contribution hours received on your behalf from all Contributing Employers meet one of the continued eligibility rules.

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

If a local union or district council stops participating in the Central Laborers' Welfare Fund with respect to one or more bargaining units, continued eligibility of employees in that

bargaining unit or units will be determined by the Board of Trustees. For this purpose, coverage for a bargaining unit will be considered terminated as of the last day that the collective bargaining agreement requires employer contributions to be paid to the Central Laborers' Welfare Fund.

Eligibility Reserve Bank

If you are a bargained employee, and not receiving a pension from Central Laborers' Pension Fund or similar craft, contributions paid to the Welfare Fund on your behalf for hours of work beyond 1,875 per calendar year will be credited to your Eligibility Reserve Bank. The value of the hours is determined by multiplying each banked hour by the current contribution rate to determine a dollar amount that may be used only for continued Plan coverage.

ϖ As long as you are not receiving a pension from Central Laborers' Pension Fund or similar craft, you earn a dollar amount in an ***Eligibility Reserve Bank*** when your contribution hours exceed 1,875 in a calendar year. The balance in your Eligibility Reserve Bank may be used for self-payments or to offset self-payments under the active coverage plan.

You may accumulate a maximum of two quarterly self-payments and use the money in your Eligibility Reserve Bank when you have insufficient hours to continue your eligibility. This money can only be used as a credit to offset or reduce the self-payment you must make to continue coverage. Your coverage will terminate as explained in the *Continued Eligibility and Termination of Eligibility* section if the amount in your Eligibility Reserve Bank is not sufficient to cover the self-payment and you do not pay the difference.

Continued Eligibility During Disability Periods

If you become Ill or Injured and are unable to work because of a certified disability, you will be credited with 20 disability hours for each full week of the disability for the purpose of maintaining eligibility. Your credit may not exceed 260 hours during any continuous 12-month period or period of disability due to the same or related causes.

A certified disability is one in which you are determined to be totally disabled by a licensed medical practitioner as a result of a non-occupational or occupational Injury or Illness or by which you are receiving the Loss of Time Benefit from this Welfare Fund. Sufficient proof of the certified disability must be provided to the Fund Office for disability hours to be credited.

Self-Payment Rules for Active Bargained Employees

Under certain circumstances when your coverage would otherwise end, you may be eligible to make self-payments to continue eligibility and coverage under the Plan. To participate under the self-payment provision, you must have become eligible for coverage as required under the *Initial Eligibility* section of these eligibility rules. Once you become eligible and your coverage later terminates, you can make self-payments, as explained in the following rules or you can choose to make self-payment for COBRA continuation Coverage.

Notice. The Fund Office will send a letter to those employees whose eligibility has terminated showing the termination date, the amount that must be paid to continue eligibility under the self-payment rules and the date any self-payment is due.

The letter will be sent to your most current address on file at the Fund Office. Therefore, it is important – and your responsibility – to maintain a current mailing address with the Fund Office at all times and notify the Fund Office of any change of address. Participating local unions and district councils are not responsible to keep your address information current at the Fund Office.

You are responsible to make self-payments if you wish to continue eligibility. The self-payment for the specified three-month period must be postmarked no later than 25 days from the date of the letter of termination mailed by the Fund Office.

For Example:
Jim's eligibility terminates on December 31, 2007. Jim's termination notice is dated January 5, 2008. Jim wishes to continue his eligibility for the three-month period beginning January 1, 2008, so his self-payment must be postmarked no later than January 30, 2008.

If you make self-payments for three months of eligibility and your eligibility reinstates during that period by you working and receiving the required contribution hours for reinstated eligibility, you will receive a refund for the months of coverage you paid for and that are now covered through contribution hours and reinstatement.

You may continue to make self-payments for up to four consecutive three-month periods beyond the time your coverage would have ended under the Welfare Fund's regular termination rules. Each subsequent self-payment must be postmarked no later than 25 days after the date of the termination letter mailed by the Fund Office.

All checks or money orders should be made payable to "Central Laborers' Welfare Fund" and sent to the following address:

Central Laborers' Welfare Fund
P. O. Box 1267
Jacksonville, Illinois 62651-1267

The Trustees will determine, from time to time, the self-payment amount that Participants will be required to make to continue eligibility. You will not be allowed to make self-payments to qualify under a Plan of benefits that is no longer in effect.

Your self-payment will not be accepted (and no further self-payments will be accepted) and you must re-qualify for coverage based on employer contributions as described in these eligibility rules if:

- you fail to make the required self-payment within the specified time;
- your self-payment check is returned by your bank because of insufficient funds in the account to cover the amount of the check; or
- the self-payment is less than the required amount specified in the termination letter, in which case it will be considered the same as failure to have made the required self-payment.

Self-Payment Rules for Disabled Bargained Employees

If you are a Totally and Permanently Disabled Participant who makes self-payments under these rules, you may continue to make self-payments for up to eight quarters or until the date you become eligible for Medicare, whichever occurs first. You will be considered Totally and Permanently Disabled if you are receiving a Disability Pension from the Central Laborers' Pension Plan.

The Trustees may require medical evidence of Total and Permanent Disability and reserve the right to require a medical examination by a Physician of their choice. If you are a disabled Participant and fail to make the required self-payment within the specified time, you will not be allowed to make any further self-payments. The benefits you qualify for as a disabled Participant will be the same as for active Participants, excluding the Loss of Time, Death and AD&D Benefits or other benefit as noted in the Schedule of Benefits on Addendum A of this booklet.

Reinstatement of Eligibility

If your eligibility ends because the necessary contributions were not made on your behalf, you may re-qualify for coverage if 250 or more hours of contributions are received on your behalf in a three consecutive month period within the six-month reinstatement period as described below. Eligibility will be reinstated on the first day of the second calendar month that follows the date you meet the 250-hour requirement.

After reinstatement, you will remain eligible for at least three consecutive calendar months. You must meet the requirements for continued eligibility as explained in the *Continued Eligibility and Termination of Eligibility* section.

If you are receiving a pension from Central Laborers' Pension Fund or similar craft, you are not eligible for reinstatement.

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

Six-Month Reinstatement Period. For purposes of this reinstatement rule, hours will be counted for work you performed in the months immediately before the month your coverage terminated and the next five months. This is your six consecutive month reinstatement period. Suppose, for example, that your eligibility terminates as of January 1, 2015 because you do not have the required contribution hours through November 30, 2014. You must reinstate eligibility no later than July 1, 2015 based on 250 hours or more of work performed in a three (or less) consecutive month period between December 1, 2014 and May 31, 2015. If you do not meet the requirements of this reinstatement rule, you must again meet the 500-hour requirements in the *Initial Eligibility*.

For Example:

Harry's coverage terminates on March 31, 2015. Harry did not work during March, April or May 2015. Harry works 105 hours each month during June, July and August 2015 and his employer contributes to the Plan on his behalf. Because Harry has worked more than 250 hours in three consecutive months by the end of a six-month period (March through

August 2015) his coverage is reinstated on October 1, 2015, which is the first day of the second month following his completion of 250 hours of work.

If Harry worked 155 hours each month during May and June 2015, he would complete more than 250 hours of work by the end of June 2015. Harry's eligibility reinstatement would begin on August 1, 2015, the first day of the second month following his completion of at least 250 hours of work within a six-month reinstatement period.

If your eligibility ends and a period of six consecutive months elapses, you must again satisfy the 500-hour requirement in the *Initial Eligibility* section.

Non-Construction Participants

Initial Eligibility

To be eligible for this Plan, your employer must be making contributions to the Welfare Fund's Non-Construction Plan on your behalf. You must be working full-time, which is 40 hours per week (total contributions of 2,080 hours per year).

Your eligibility begins on the first day of the second calendar month following the month in which you work the required hours for which contributions are made to the Welfare Fund on your behalf. Your employer may request that your coverage start on a particular date, but must make contributions on the basis of the hours you work during the two months before the requested start date.

For Example:

Your employer begins paying contributions to the Non-Construction Plan on your behalf for hours worked in January 2003. If the Welfare Fund receives the contributions by February 15, 2003, your coverage begins on March 1, 2003. Coverage continues as long as your employer continues to pay contributions on your behalf on the 15th of the month before the month that your coverage is to continue.

If your employer requests that your coverage begins on January 1, 2003, your employer must pay contributions based on your hours worked in November 2002. Your employer would also be required to make contributions by January 15th, 2003 for your hours worked in December for your coverage to continue during February 2003. You would continue to be eligible for benefits as long as your employer continued to pay contributions on your behalf by the 15th of the month before the month that your coverage is to continue.

Continued Eligibility and Termination of Eligibility

Once you are initially eligible, you will continue to be eligible for each succeeding month if contributions are received by the 15th day of the current month. Your eligibility will end on the last day of the month, two months after the last month for which contributions were made on the Employee's behalf.

As a Non-Construction Participant, you are not eligible to make self-payments to extend your eligibility after coverage terminates, except through COBRA Continuation Coverage.

Dependents' Eligibility

Typically, your Dependents are eligible for coverage when you are eligible if they meet the definition of Dependent. You need to identify Dependents on your enrollment form and provide the required eligibility documentation.

If you marry and/or acquire a child while you are eligible, your Dependent may become eligible on the date you marry or the date a child is born, adopted or placed with you for adoption or legal guardianship. You must complete an enrollment form and provide the required eligibility documentation for your Dependent within 31 days of the qualifying event (e.g., marriage, birth, adoption). If you do not enroll your Dependent within 31 days of the qualifying event, your Dependent's coverage effective date will be postponed until the first day of the month following the date you apply to cover your Dependent.

Please Note: If your spouse's employer offers comparable medical coverage to this Plan or offers comprehensive insurance, your spouse must enroll in that coverage before this Plan will cover your spouse or coordinate benefits.

Delinquent Contributions

To be considered eligible for benefits, the required contributions must be received by the Fund Office. If your Contributing Employer does not pay the required contributions and as a result, your eligibility does not become effective or is terminated, the Trustees will make every effort to collect the required contributions from that Contributing Employer.

However, you will be required to make a self-payment if you wish to continue your eligibility due to termination as the result of delinquent hours. If the contributions are collected, you will be credited with the appropriate hours for the period that you actually worked and notified of any change in your eligibility that may result. Any self-payments that you have made will be reviewed and you may receive a full or partial refund of your self-payment.

Retirees

The Plan provides welfare benefits for you and your eligible Dependents if you retire with a pension or you become disabled and retire with a disability pension from the Central Laborers' Pension Fund or another Fund that has entered into an agreement with the Central Laborers' Welfare Fund. Eligibility requirements are shown below.

Retiree Eligibility

You and your Dependents are eligible for Retiree benefits if you:

- meet the definition of Retiree;

- have been eligible for at least 5 consecutive years under the Central Laborers' Welfare Fund immediately before the effective date of your eligibility for a service pension, OR, if you received workers' compensation benefits, in lieu of receiving an Occupational Disability Benefit, continuously

from your date of disability through the date your service pension starts or until resumption of laborer's (or covered) work during said 5 years immediately before the date of your retirement;

- are not eligible for Medicare; and
- make proper and timely self-payments to the Welfare Fund for your coverage.

Should you retire and not meet the eligibility requirements because you are eligible for Medicare, your spouse may be eligible for your Retiree benefits if you:

- meet the definition of Retiree;

And your spouse:

- is not eligible for Medicare; and
- makes proper and timely self-payments to the Welfare Fund for his or her coverage.

You, or your spouse if he or she become independently eligible for Retiree coverage, must provide an Open Enrollment Application for Retiree benefits and make the required self-payment on or before the deadline date printed on your self-payment notice.

Pease note, if your spouse works full-time, but becomes independently eligible for Retiree coverage under the above example, he or she would not be required to enroll in an employer's comparable medical coverage plan before any medical benefits can be paid under this plan.

The Trustees determine, from time to time, the number of self-payments for single/family coverage. You are required to make self-payments on a quarterly basis for Retiree benefits. To maintain coverage, you must make quarterly payments on or before the first day of the quarter (January 1, April 1, July 1, and October 1).

For Example:

Bob retires from 20 years of active employment at age 57, and begins receiving his pension from the Central Laborers' Pension Fund. After using his Eligibility Reserve Bank to maintain coverage, Bob's coverage under the active Participants' Plan ends on June 30, 2003. Bob must provide an Open Enrollment Application for Retiree Benefits and make his first self-payment for Retiree Benefits by the deadline date printed on his self-payment notice.

To maintain his Retiree benefit coverage, Bob must make timely quarterly payments on or before October 1, 2003, January 1, 2004, April 1, 2004, July 1, 2004 and on or before the first day of each following quarter until he is no longer eligible for Retiree benefits.

Retiree Dependents' Eligibility

Generally, eligible Dependents under the Retiree plan are the same as eligible Dependents under the active plan. In addition, your spouse is eligible for Retiree benefits if you are no longer eligible for Retiree benefits because you have become eligible for Medicare or in the event of your death. If your spouse becomes independently eligible for Retiree benefits because you become eligible for Medicare or in the event of your death, then the plan provision requiring a spouse who works full time to enroll in the employer's comparable medical plan, will no longer apply.

If your spouse is covered for Retiree benefits, your eligible Dependent children are also eligible for Retiree benefits. If your spouse is not eligible for Retiree benefits, or if you have no spouse, your Dependent children are not eligible for Retiree benefits, but may continue coverage through COBRA Continuation Coverage.

Retiree Benefit Exclusions

The following benefits, available to active Participants, are not available to Retirees:

- Loss of Time Benefit;
- Death Benefit; and
- Accidental Death and Dismemberment Benefit.

Termination of Retiree Benefits

Your Retiree benefits will terminate when the first of the following occurs:

- you become eligible for Medicare for any reason, including age;
- the Plan is discontinued;
- you are no longer entitled to receive a pension from the Central Laborers' Pension Fund; or
- you do not make the required self-payment.

Your Dependents' Retiree benefits end when the first of the following occurs:

- they no longer meet the definition of a Dependent;
- the Plan is discontinued;
- you are no longer entitled to receive a pension from the Central Laborers' Pension Fund;
- the required self-payment is not made; or
- your Dependent becomes eligible for Medicare.

Retiree coverage for your Dependent children ends when your Dependent spouse is no longer eligible for Retiree coverage.

Return to Work by Retiree

If you are receiving an early, regular or service pension, and making self-payments for Retiree benefits and suspend your pension to return to work, you must continue to make self-payments to the Welfare Fund for Retiree benefits during the period while you are working until you have met the eligibility requirements for Active participation in the Welfare Fund. If you do not continue your self-payments, you permanently lose your right to receive Retiree benefits. When you re-retire you will not be eligible for Retiree benefits.

ϖ ***Return to work.*** You must continue self-payments for Retiree benefits when you return to work after receiving a pension to maintain the right to Retiree benefits when you retire again. But you will not need to continue self-payments when you return to work after receiving a disability pension, once you qualify again for active Participants' benefits.

If you suspend your disability pension and return to work and were making self-payments for Retiree benefits, you are not required to continue to make self-payments for Retiree benefits after the date you earn regular eligibility under the Plan for active Participants. You will be allowed to make self-payments for Retiree benefits when you retire again.

Retiree Pre-Funded Subsidy Allowance Program

Eligibility

You may receive a Retiree Pre-Funded Subsidy Allowance to offset your self-payments for Retiree benefits if you:

ϖ A ***Retiree Pre-Funded Subsidy Allowance*** is earned during your working years and will help offset the cost of your Retiree benefits when you are retired.

- initially retire on or after March 1, 2002;
- are at least 53 years of age at the time of your initial retirement; and
- have at least 5 years of uninterrupted active participation in the Central Laborers' Welfare Fund immediately before the date of your initial retirement, OR, if you received workers' compensation benefits, in lieu of receiving an Occupational Disability Benefit, continuously from your date of disability through the date your initial retirement starts or until resumption of laborer's (or covered) work during said 5 years immediately before the date of your retirement.
- You are also considered eligible for the Retiree Pre-Funded Subsidy Allowance if you:
    - retire due to a Total and Permanent Disability (as defined by the Central Laborer's Pension Plan), on or after march 1, 2002 and you are not eligible for Medicare or other government-sponsored insurance;
    - are a spouse of a Participant who became Totally and Permanently Disabled on or after March 1, 2002 who is eligible for Medicare or other government-sponsored insurance;
    - are a spouse (at the time of death) of a Plan Participant who dies while eligible for the Retiree Pre-Funded Subsidy Allowance.

Termination of Retiree Pre-Fund Subsidy Allowance

The Retiree Pre-Funded Subsidy Allowance ends on the earliest of the date you:

ϖ become eligible for Medicare;

ϖ become eligible for Medicare because of a Total and Permanent Disability;

ϖ choose not to make a premium payment for Retiree benefits;

ϖ return to work for a Contributing Employer and become eligible for active Participants' benefits; or

ϖ return to work in disqualifying employment as defined in the Central Laborers' Pension Plan.

If you become eligible for Medicare because of age or a Total and Permanent Disability, your spouse will continue to receive the Retiree Pre-Funded Subsidy Allowance if your spouse is age 53 or older. Your spouse's coverage continues until he or she:

ϖ remarries;

ϖ becomes eligible for Medicare because of age or Total and Permanent Disability; or

ϖ does not pay the required self-payment.

If you initially retire on or after March 1, 2002, are age 53 or older, and suspend your pension to return to active employment, you must complete three years with active contributions of 1,000 hours each fiscal year to be considered eligible for the Central Laborers' Welfare Fund Retiree Pre-Funded Subsidy Allowance.

Calculating Your Retiree Pre-Funded Subsidy Allowance

If you are eligible for the Retiree Pre-Funded Subsidy Allowance, your Retiree self-payment amount will be automatically reduced by the amount of the subsidy.

You may accumulate a maximum of 30 Retiree Subsidy Credits in your lifetime. You begin earning Retiree Subsidy Credits after 500 hours have been reported on your behalf during a calendar year. You are credited with a maximum of one Retiree Subsidy Credit for 1,000 or more hours for which contributions have been paid on your behalf in a fiscal year. Retiree Subsidy Credits are calculated as shown below:

If You Work:	Retiree Subsidy Credits You Earn Are:
Less than 500 contribution hours	0.0
500 – 599 contribution hours	0.5
600 – 699 contribution hours	0.6
700 – 799 contribution hours	0.7
800 – 899 contribution hours	0.8
900 – 999 contribution hours	0.9
1,000 or more contribution hours	1.0

Your Retiree Subsidy Credits are multiplied by the amount of the monthly subsidy to determine the dollar amount that will be subtracted from your quarterly Retiree self-payment amount. If the self-payment amount is lower than the Retiree Pre-Funded Subsidy, you or your spouse will have the self-payment reduced by the lesser amount.

For Example:

Ned's initial retirement began April 1, 2002 and he accumulated 22.8 Retiree Subsidy Credits before he retired. For 2002, the amount of the Retiree Pre-Funded Subsidy Allowance is $11.54 per Retiree Subsidy Credit. Ned's monthly Retiree Pre-Funded Subsidy Allowance is $263.11 ($11.54 x 22.8 Retiree Subsidy Credits). The monthly Retiree Pre-Funded Subsidy Allowance amount is multiplied by three months and then subtracted from Ned's quarterly self-payment to determine the amount of his self-payment. If Ned chose a POS Plan that costs $1,800 per quarter for family coverage, his self-payment would be $1,010.67 each quarter ($1,800 – (3 x $263.11)).

COBRA Continuation Coverage

A federal law requires Welfare Funds like Central Laborers' Welfare Fund, to offer a temporary extension of health coverage (called "COBRA Continuation Coverage") at group rates in certain instances when you and/or your Dependents' coverage under the Plan would otherwise end. Following are your rights and obligations under the COBRA Continuation Coverage provisions.

If you are covered by the Central Laborers' Welfare Fund, you have a right to choose COBRA Continuation Coverage if you lose your health coverage because:

- you have insufficient banked hours (Bargained Employees);

- your employment is terminated (for reasons other than gross misconduct); or
- you have a reduction in hours so that you have insufficient hours of work to qualify for benefits.

When you or your Dependents lose coverage, the Fund Office will notify you of your COBRA rights and the cost to continue coverage under this option.

Your spouse has the right to choose COBRA Continuation Coverage if he or she loses health coverage for any of the following reasons:

- your death;
- termination of your eligibility because of insufficient hours of employment (and not enough Eligibility Reserve Bank hours for Bargained Employees); or
- divorce or legal separation from your spouse.

In the case of your Dependent child, he or she has the right to COBRA Continuation Coverage if health coverage under the Welfare Fund is lost for any of the following reasons:

- your death;
- termination of your eligibility because of insufficient hours of employment (or not enough Eligibility Reserve Bank hours for Bargained Employees);
- divorce or legal separation from your spouse; or
- the Dependent stops meeting the definition of a "Dependent" under this Plan.

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

If you have a newborn child, adopt a child or have a child placed with you for adoption or legal guardianship (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement and provide a completed enrollment form and other necessary documentation (e.g., birth certificates or legal documents) to have this child added to your coverage.

Children born, adopted or placed for adoption or legal guardianship as described above have the same COBRA rights as a spouse or Dependents who were covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, their continued coverage depends on timely and uninterrupted payments on their behalf.

If you and your Dependents lose eligibility for Plan benefits for one of the reasons noted above within 18 months before or after your entitlement to Medicare, your Dependents have the right to continue health coverage on a self-payment basis under the COBRA rules for up to 36 months from your entitlement to Medicare. If your eligibility under this Plan would otherwise end more than 18 months after your entitlement to Medicare, your Dependents have the right to continue health care coverage under the COBRA rules on a self-payment basis for up to 18 months from the time your coverage would otherwise have terminated.

You or your eligible Dependents must inform the Fund Office of a divorce, legal separation or a child losing Dependent status. Your surviving spouse or Dependent child must notify the Fund Office of your death.

When the Fund Office is notified that one of these events has occurred, it will notify the appropriate persons of their right to choose COBRA Continuation Coverage. Under the law, eligible persons have at least 60 days from the date coverage would be lost to inform the Fund Office that they want COBRA Continuation Coverage due to one of the events described above. The notification sent by the Fund Office will be mailed to the last address on file at the Fund Office for that eligible person(s). If the eligible person's address is different than what is on file at the Fund Office, it is the responsibility of the eligible person to notify the Fund Office of a differently mailing address.

If COBRA Continuation Coverage is not elected, health coverage will end unless you or an eligible Dependent elects to continue coverage under the preceding rules regarding continuing coverage by making self-payments (if eligible) as outlined.

If you or your Dependents choose COBRA Continuation Coverage the Welfare Fund is required to provide health care coverage that is identical to the coverage provided to you and your Dependents under the Plan. However, COBRA Continuation Coverage does not include the Loss of Time, Death or Accidental Death and Dismemberment Benefits.

COBRA Continuation Coverage does not include Loss of Time, Death or Accidental Death and Dismemberment Benefits.

Your coverage (or your eligible Dependent's coverage) may continue for a total of 29 months (an additional 11 months) after your employment is terminated or you have a reduction in your hours. To qualify for this extension, the Social Security Administration must determine that you or your Dependents were totally disabled either:

- at the time of your termination or reduction in hours; or
- within the first 60 days of your COBRA Continuation Coverage period.

You must notify the Fund Office of your determination of disability by the Social Security Administration within the 18-month COBRA Continuation Coverage period.

You will have the opportunity to maintain COBRA Continuation Coverage for as long as 36 months after you use your Reserve Bank coverage unless you lost group health coverage due to termination of employment or insufficient hours of work. In that case, the required COBRA Continuation Coverage period is 18 months (or 29 months if you are disabled, as noted above). However, the law also provides that COBRA Continuation Coverage may be terminated for any of the following reasons:

- the Welfare Fund no longer provides group health coverage;
- the self-payment for your COBRA Continuation Coverage is not paid, or is not paid on time;
- you become eligible for Medicare;
- you become covered under a new group health plan; or
- your self-payment check is returned by your bank because of insufficient funds in the account to cover the amount of the check.

If you or one of your eligible Dependent(s) has a health problem that is excluded from or limited under a new group health plan, you or your eligible Dependent will be allowed to maintain COBRA Continuation Coverage under Central Laborers' Welfare Plan until you or your eligible Dependent has been covered for a total of 18, 29 or 36 months of coverage, whichever is applicable.

When your coverage ends, you will be provided with certification of your length of coverage under this Plan. This may help reduce or eliminate any pre-existing condition limitations under a new group medical plan.

Change in Eligibility Rules or Plan

The Board of Trustees, in its' discretion, are empowered to change or amend the preceding eligibility rules or the Plan of benefits described in this booklet or any other provision of the Plan in accordance with the Trust Agreement, as it, in its' sole discretion, determine to be necessary.

Certificate of Credible Coverage

When your coverage ends or when your Dependent's coverage ends, you (or your Dependent) will be provided with certification of the length of coverage under this Plan (called a "Certificate of Creditable Coverage"). This may help reduce or eliminate any pre-existing condition limitations under a new group medical plan. The Fund Office will automatically provide this certification when coverage ends (including COBRA Continuation Coverage) for you or your Dependent.

Non-Assignability Provision

The benefits in this Plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against Central Laborers' Welfare Fund. Central Laborers' Welfare Fund will not honor any such purported sale, assignment, pledge, transfer or grant. (May 23, 2017)

Medical Expense Benefit (For All Participants)

When you or your eligible Dependents incur expenses as a result of a non-occupational Illness or Injury, the Medical Expense Benefit Plan reimburses you or your provider for a portion of the Covered Charges. You or your eligible Dependent must first satisfy the deductible or make a required co-payment as shown in the *Schedule of Benefits* in the back pocket of this booklet. After the deductible is met, the Plan pays the percentage of the Usual and Customary Charges shown in the *Schedule of Benefits*. Once you have met the out-of-pocket maximum, the Plan may pay up to 100% of Covered Charges incurred for the remainder of the calendar year up to the calendar year benefit maximum.

- **Precertification is required for hospitalizations and partial hospitalization services, including those prescribed for medical, mental health and substance abuse treatment. Please ask your provider(s) to obtain precertification in advance, if possible. Failure to obtain precertification, when precertification is required, will result in a denial of benefits on the service(s) provided.**
- **The Fund recommends that you ask your provider to obtain precertification for any other service, expense, procedure, supply or device to verify such service, expense, procedure, supply or device is a Covered Charge.**

At the end of each calendar year, during the Open Enrollment Period, you will have the opportunity to choose your benefit coverage for the upcoming year through the:

- Participating Provider Option (PPO) Plan;
- Point of Service (POS) Plan; or
- Three-Tiered Plan.

For Retirees, you have the opportunity to choose your benefit coverage from the:

- Point of Service (POS) Plan;
- Health Maintenance Organization (HMO) Plan; or
- Three-Tiered Plan.

The benefit design of each of the Plans offered by the Welfare Fund is outlined in the *Schedule of Benefits* located in the back pocket of this booklet. Please call the Fund Office if you have questions about the coverage offered under any of the options. Health care coverage is a very personal decision, so you must decide which option is right for you and your eligible Dependents.

It is important to remember that the Medical Expense Benefit is not designed to cover every health care expense. The Plan pays Covered Charges for services and treatments that are allowed under this Plan to the limits and under the conditions established under the rules of the Plan. The decisions about how and when you receive medical care are up to you and your Physician – not the Plan. The Plan determines how much will be paid. You and your Physician must decide what medical care is best for you.

Preferred Provider Organization/Point of Service/HMO

The Welfare Fund has joined with several health care networks made up of Physicians, Hospitals and medical professionals that have agreed to provide discounted rates for some services that you or your eligible Dependents receive from them. After your deductible or a specified co-payment is satisfied, the Plan pays a higher percentage of Covered Charges when services are received from a network Hospital or Physician. Contact the plan network administrator to determine if your provider participates in the network.

Save money. You save money by using a network provider:

First, you save money because the cost of the services provided is discounted.

Second, the Plan pays a greater percentage of the cost of network services.

Deductible

The deductible is the dollar amount (shown in the *Schedule of Benefits* in the back pocket of this booklet) that you and your eligible Dependents are responsible to pay before the Medical Expense Benefit is payable. Only Covered Charges may be used to satisfy the deductible. The deductible applies only once in a calendar year.

If Covered Charges used to satisfy the deductible, in part or in full, are incurred during the last three months of a calendar year, then those charges will be used to satisfy the deductible for the following year as well.

Your deductible does not apply to:

- the Annual Physical Examination Benefit for eligible active Participants and their eligible spouses; or
- the well child benefit, provided at a physician's office or the Public Health Department, and associated with routine medical examinations for eligible Dependents under the age of 18, provided that the service is obtained at a network provider. See the *Schedule of Benefits* in the back pocket of this booklet.

Family Deductible

After eligible family members have collectively satisfied the family deductible (shown in the *Schedule of Benefits*) within a calendar year, no further deductible will be required for any family member for the remainder of that calendar year.

Co-Payment

Some Plan designs, specifically the Point of Service (POS) plans and the HMO, require the insured to pay a co-payment to a provider at the time services are rendered. Once the co-payment is made, as long as the medical provider participates with your health care network, and services are allowed benefits under the Plan rules, the remainder of the expense for the service will be covered at 100%.

Out-of-Pocket Maximum

Most plans have a designated out-of-pocket maximum that represents the maximum amount an individual or family will pay either as a percentage of benefits or as a co-payment. Please refer to the *Schedule of Benefits* in the back pocket of this booklet for specific amounts.

Please remember that an individual's satisfaction of his/her out-of-pocket maximum only occurs from allowable expenses. Expenses incurred that exceed a maximum benefit as defined by a plan will be the member's responsibility, regardless of whether the co-payment requirement has been previously satisfied.

For Example:

John is covered under the PPO plan. His annual out–of-pocket expenses are $2,100. In June, John meets his out-of-pocket maximum co-payment obligation and he knows that all expenses he now incurs at any network providers will be covered at 100%; however, in July, John exhausts his physical therapy benefits by attending more than 60 visits in a year. Since John has met a maximum under his physical therapy benefits, any expenses John incurs for physical therapy, from that point forward, will be his responsibility, even though he has satisfied his annual out-of-pocket maximum. This is because the Plan does not cover expenses beyond the allowable maximum for physical therapy benefits.

Maximum Benefits

The maximum amount payable with respect to all Illnesses or Injuries of any one individual during any calendar year will be the amount shown in the *Schedule of Benefits* in the back pocket of this booklet or specific areas within this booklet that describe particular benefits.

Mental Health Parity and Equity Act

This Plan is designed to be fully compliant with the parity requirements set forth under the Mental Health Parity and Addiction Equity Act ("MHPAEA"). Accordingly, all of the Plan's mental health and substance abuse dependency benefits, as written and in operation, including review and appeal components are designed and applied in full parity across each respective benefit classification under which medical-surgical benefits are provided for under the Plan.

The No Surprises Act

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

- **Emergency Services.** Emergency Services are covered:
  - Without the need for a prior authorization determination, even if the services are provided out-of-network;
  - Without regard to whether the health care provider furnishing the Emergency Services is a network provider or a network emergency facility, as applicable, with respect to the services;
  - Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from network providers and network emergency facilities;

- ❖ Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a network provider or a network emergency facility;
- ❖ By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- ❖ By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any network deductible or network out-of-pocket maximums applied under the plan (and the network deductible and network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by a network provider or a network emergency facility.

Cost sharing amount for Emergency Services from out-of-network providers is the lesser of billed charges from the provider, or the Qualified Payment Amount (QPA).

ϖ **Non-emergency services from an out-of-network provider at a network facility.** For non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by an out-of-network provider at a network facility, the items or services are covered by the plan:

- ❖ With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a network provider;
- ❖ By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such network provider were equal to the Recognized Amount for the items and services; and
- ❖ By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a network provider.

ϖ **When you may be billed for out-of-network providers who work at network facilities.**

In certain circumstances, you can be billed by an out-of-network provider who works at a network facility. This can occur if you are provided notice, as described below, that the provider is an out-of-network provider and you give your informed consent to be treated by the out-of-network provider. The out-of-network provider must give you notice that:

- ❖ is in writing;
- ❖ is provided to you at least 72 hours before the day of the appointment or at least 3 hours in advance of services rendered for a same-day appointment;
- ❖ states the provider is a out-of-network provider;
- ❖ includes the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment;
- ❖ includes the names of any network provider at the facility who are able to treat you;
- ❖ provides that you may elect to be referred to a network provider; and

- ❖ your costs may be greater if you consent to service or treatment from the out-of-network provider.

If you give informed consent to be treated by the out-of-network provider, then the Plan will pay for these services at the out-of-network rate, and the provider can bill you for the balance directly. You may revoke your consent prior to the receipt of services.

This rule does not apply to services provided by hospital-based providers, such as anesthesiologists and radiologists, also referred to as Ancillary Services, or items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished for which a out-of-network provider satisfied the notice and consent criteria described above. For Ancillary Services, your cost-sharing will be based on the Recognized Amount and any cost-sharing payments you make count toward your network deductible and network out-of-pocket maximum in the same manner as those received from a network provider.

- ϖ **Air Ambulance Services.** If you receive Air Ambulance services that are otherwise covered by the Plan from an out-of-network provider, those services will be covered by the Plan as follows:

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

- ϖ **Payments to out-of-network providers and facilities.** The Plan will make an initial payment or notice of denial of payment for Emergency Services, non-emergency services at network facilities by out-of-network providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the out-of-network provider. A "clean claim" is a claim that is accompanied by all information needed to decide, adjudicate or process the claim. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim relates to Emergency Services, Non-emergency services from an out-of-network provider at a network facility and Air Ambulance services from out-of-network provider, you cannot be required to pay more than the network cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the out-of-network provider that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount. The out-of-network rate means one of the following:

- ❖ the amount the parties negotiate;
- ❖ the amount approved under the independent dispute resolution (IDR) process; or

- ❖ if the state has an All-Payer Model Agreement, the amount that the state approves under that system.

- **Continuity of coverage.** If you are a Continuing Care Patient, and the contract with your network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

  - ❖ You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
  - ❖ You will be allowed up to ninety (90) days of continued coverage at network cost sharing to allow for a transition of care to a network provider.

  As used in this section, a termination does not include a termination of a contract for failure to meet applicable quality standards or for fraud.

- **External review.** If your initial claim for benefits related to an Emergency Service, non-emergency service provided by an out-of-network provider at a network facility, and/or Air Ambulances service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for external review of the determination. See the section of the SPD entitled "External Review of Emergency Service, applicable Non-Emergency Service and/or Air Ambulance Services as required by the No Surprises Act".

- **Incorrect network provider information.** A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

  If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply the network cost-sharing to your claim, even if the provider was an out-of-network provider at the time the service was rendered.

- **Complaint process.** Effective January 1, 2022, any Participant or covered Dependent, or their authorized representative, may make a complaint or raise a concern relating to the Fund's processing of any of the above-described types of claims. The complaint or concern should be directed to Christy Brake, Welfare Fund Director, who is the designated Fund office contact to review all such complaints and concerns and address them in accordance with the requirements of the No Surprises Act and any other applicable law or regulations. Participants and covered Dependents also have a separate and independent right under the No Surprises Act to submit a complaint to the Department of Health and Human Services relating to the processing of the above-described types of claims. Participants and covered Dependents may also contact the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

Covered Charges

Except in the case of Emergency Services, non-Emergency Services from an out-of-network provider at certain network facilities, and Air Ambulance services by out-of-network providers as described above,

benefits are payable for Usual and Customary Charges incurred for Medically Necessary treatment, services and supplies ordered by a Physician for the following services:

- ***Hospital services*** from the first day of inpatient treatment. Covered room and board charges may not exceed the Hospital's average rate for semiprivate rooms. If the Physician prescribes a private room, Covered Charges may not exceed the Hospital's average rate for semiprivate rooms.

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

- ***Hospital outpatient treatment.***

- ***Diagnosis, treatment and surgery*** made by a Physician or surgeon. Charges incurred ***on the day of surgery*** for outpatient surgical procedures performed by a Physician will be payable at the amount shown in the *Schedule of Benefits*. Such outpatient surgery can be performed in a Hospital's outpatient department, a licensed freestanding medical care facility or a Physician's office. All Covered Charges, including any follow-up treatment, are subject to the deductible and will be paid at the percentage shown in the *Schedule of Benefits*.

- ***Physiotherapy*** by a licensed physiotherapist, other than a physiotherapist who normally lives in your home or is a member of your family or your dependent's immediate family.

- ***Medical and surgical benefits for mastectomies,*** as required by federal law, including the following, when requested by the patient in consultation with her Physician:
  - reconstruction of the breast on which the mastectomy has been performed;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - prostheses and physical complications of all stages of mastectomy, including lymphedemas.

- ***Initial trusses, braces or supports, casts, splints and crutches.***

- ***Durable Medical Equipment and Home Health Care Services*** will be covered at a rate which is the lowest of the providers submitted charge, the Medicare fee schedule for the medical supply or equipment, or the amount determined as appropriate by use of the methodology set forth below:
  - If Medicare has not established a reimbursement amount for an item or services, the Plan payment will be based on the 50th percentile of the usual and customary charges submitted to the Plan for the items for the previous calendar year.
  - For any items for which there is not information about the usual and customary charges from the previous calendar year, payment will be based upon the manufacturer's suggested retail price minus 20%.
  - The rental benefit limit on any piece of equipment will not exceed the purchase cost.

- ***Oxygen*** and rental of equipment for its administration.

- ***Local ambulance service to the Hospital.*** Transportation or rail is considered a Covered Charge in an emergency when treatment is not available locally. Your Physician must order this treatment, and travel will only be covered to the nearest Hospital providing the necessary medical care or treatment.

- ***X-rays*** and ***laboratory tests.***
- Treatment by use of ***radium and radioactive isotopes.***
- ***Anesthesia*** and its administration.
- ***Blood*** and blood plasma.
- ***Pregnancy-related expenses,*** on the same basis as any other Injury or Illness.
- ***Dental work and oral surgery.*** Benefits are payable for expenses only if incurred for one of the following reasons:
  - the repair of natural teeth or other body tissues, required as a result of a non-occupational Injury, provided treatment is rendered within six months of the accident; or
  - the extraction of partially or completely un-erupted impacted teeth.

    BENEFIT COORDINATION RELATED TO THE ABOVE TREATMENTS:

    Medical benefits are coordinated with your dental benefits (your dental benefits will pay first and medical benefits will consider the remaining expenses related to the surgeon's fees and anesthesia charges only.)
  - When dental work is required to be performed under general anesthesia in a Hospital facility. (Medical necessity is required when any dental work is performed at a Hospital facility and is only payable if determined to be required due to medical conditions/safety reasons.

    BENEFIT COORDINATION RELATED TO THE ABOVE TREATMENTS:

    Medical benefits are coordinated with your dental benefits (your dental benefits will pay on all surgeon's fees and anesthesia. Your medical benefits will consider the expenses related to facility and anesthesia charges only.)
  - All Usual and Customary surgeon and anesthesia expenses are paid from your dental benefit and are subject to the annual dental maximum.
  - All Usual and Customary surgeon, anesthesia and/or facility charges considered under your medical benefits are subject to annual deductibles, co-payments, co-insurance rates, Plan maximums and exclusions.

For the purpose of the dental work or oral surgery recognized by this section, the term Physician includes a duly licensed dentist.

The benefits that are described in the following paragraphs are also Covered Charges under the Medical Expense Benefit and are subject to the calendar year deductible or co-payments and the rules and limitations explained under each item.

Home Health Care

You and your eligible Dependents are entitled to benefits for home health care services and supplies provided by a Home Health Care Agency up to the maximum of 40 visits per calendar year as shown in the *Schedule of Benefits*. This care must be Medically Necessary and ordered in writing by your Physician.

One home health care visit is either:

- four hours of home health aide services; or
- each visit by a member of a Home Health Care Agency team.

Covered home health care includes charges for the following services:

- part-time or intermittent home nursing care by or under the supervision of a registered graduate nurse;

- ϖ part-time or intermittent home health aide services that consist primarily of caring for the patient;
- ϖ physical, occupational or speech therapy if provided by the Home Health Care Agency (Speech therapy is only covered if it is required as the result of a head Injury or stroke or if used in the treatment of Paradoxical Vocal Cord Motion, which has been confirmed by two or more physicians who have evaluated the patient). The speech therapy would only be covered up to the restoration of the normal functions that were present prior to the Injury, disease or stroke.); (updated February 10, 2015)

  (Please note – when Physical/occupational therapy is provided in the home, it is limited to 40 visits per calendar year. In addition, the therapy received at home will also apply toward the 60 Rehabilitation Service visits allowed in a calendar year.
- ϖ medical supplies and laboratory services used in the treatment of the patient that are prescribed by a Physician; and
- ϖ allowable drugs and medications prescribed by a Physician if not provided under the Plan's prescription drug program.

Benefits are not payable for any expense incurred for:

1) Services or supplies not specified in the Home Health Care Plan.
2) Services provided by any individual who normally lives in your home or is a member of your family or your Dependent's family.
3) Services provided by any social workers.
4) Transportation services.

Nutritional Counseling (Effective 10/15/2018)

Nutritional counseling includes the direct assessment by a registered dietician, licensed nutritionist or other qualified licensed health professional who has been formally trained in nutrition and whose assessment has been ordered by a licensed physician, or his or her designated and licensed Physician's Assistant or Advanced Practice Nurse, is medically necessary, involves the development of an individualized plan of care involving diet, counseling and/or other related nutritional therapies necessary to treat identifiable symptoms that are directly related to one or more of the following chronic conditions:

- Cardiovascular disease
- Diabetes Mellitus
- Hypertension
- Kidney disease
- Eating disorders
- Gastrointestinal disorders

- Seizures
- Childhood Obesity
- Growth delay
- Underweight
- Other conditions where diet and nutrition are determined to be having an effect on the disease state and that are considered medically necessary, are not provided for as a specific benefit under this Plan (i.e. – Services, supplies or surgical procedures for obesity – age 16-70) and are not otherwise excluded from benefits.

Organ Transplants

You and your eligible Dependents are entitled to benefits for Transplant Surgery. The Plan pays the Usual and Customary Charges you incur. All benefits are subject to the usual deductibles and/or co-payments/co-insurance rates as outlined in the *Schedule of Benefits* located in the back pocket of this booklet. Refer to your specific plan of coverage.

Organ transplant Covered Charges include the following:

- the use of temporary mechanical equipment, pending the acquisition of "matched" human Body Organ(s);
- multiple transplant(s) during one operative session;
- replacement(s) or subsequent transplant(s);
- follow-up expenses for Covered Charges (including immune-suppressant therapy) up to the follow-up expense maximum; and
- the following expenses incurred by a Donor(s), up to the lifetime maximum Donor(s) benefit:
  - testing to identify suitable Donor(s);
  - expenses for the acquisition of Body Organ(s) from a Donor(s);
  - expenses for life support of a Donor(s) pending the removal of a usable Body Organ(s); and
  - transportation of Body Organ(s) or a Donor(s) on life support.

Benefits under the lifetime maximum Donor(s) benefit are payable only when the Recipient is a covered employee or eligible Dependent under this Plan.

Benefits are not payable for charges for any of the following services:

1) Body Organ transplants, unless there is medical documentation that conventional treatment could be unsatisfactory, unavailable and/or more hazardous than a transplant.

2) Any animal organ or mechanical:
   a. equipment;
   b. device; or
   c. organ(s), except those listed in the *Schedule of Transplant Benefits* that do not exceed the lifetime maximum Recipient benefit.

3) Any financial consideration paid to the Donor for the performance of or in relation to Transplant Surgery, other than for Covered Charges.

4) Body Organ transplants for which the patient may not be legally required to pay.

5) Any Body Organ Transplant Surgery not shown in the *Schedule of Transplant Benefits*.

Hospice Care

You or your eligible Dependents are entitled to Hospice care benefits if Terminally Ill. The Plan pays the Usual and Customary Charges as shown below and at levels defined by each plan in the *Schedule of Benefits*.

Covered Hospice care includes charges for the following services:

- Hospice care facility, Hospital or convalescent facility inpatient charges for room and board, up to the facility's most common semi-private charges;
- services and supplies for pain control and other acute and chronic symptom management;
- part-time or intermittent nursing care by a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.) for up to eight hours per day;
- medical supplies, drugs and medicines prescribed by a Physician;
- medical social services under the direction of a Physician;
- part-time or intermittent home health aid services for up to eight hours per day; and
- services performed by other providers of care who are not part of or employed by a Hospice Care Agency or Home Health Care Agency, when that agency is responsible for patient care, such as a physical or occupational therapist or a Physician for consultation or case management services.

Benefits are ***not*** payable for the following services:

1) Bereavement counseling, pastoral counseling, financial or legal counseling, such as estate planning or drafting of a will and funeral arrangements.
2) Homemaker or caretaker services that are not solely related to the care of the patient such as sitter or companion services for the patient or other family members, transportation, house cleaning and house maintenance.
3) Respite care.
4) Services of any individual who normally lives in your home or is a member of your family or your Dependent's family.

Respite care is care furnished by a provider or facility during a period of time when the family or usual caretaker cannot, or chooses not to, attend to the covered family member's needs for any reason. Respite care is not a covered expense.

Substance Abuse Treatment

Substance abuse includes alcohol and drug abuse treatment as follows:

- ***inpatient*** treatment for confinement in a licensed Treatment Facility for Substance Abuse or Hospital for care.
- ***outpatient*** treatment for the treatment and care of alcohol and drug abuse in a licensed, non-residential Treatment Facility for Substance Abuse, a certified non-residential treatment program or Hospital.

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

Benefits for the Substance Abuse Treatment Benefits are *not* payable for the following services:

1) An admitting fee or deposit.
2) Treatment that is payable under any other benefit from the Plan.
3) Treatment involving the family of the person for whom a claim is submitted when they are part of the therapy.

Mental Health Treatment

You and your eligible Dependents are entitled to benefits for Covered Charges incurred for treatment of mental health, including mental and nervous disorders. Benefits for inpatient and outpatient treatment are paid at the levels shown in the *Schedule of Benefits*. Covered mental health treatment services include services furnished by a licensed or accredited Hospital and outpatient services.

Spinal Manipulation – Medical or Chiropractic

If you or your eligible Dependents incur expenses for detection, treatment or correction of a structural imbalance, subluxation or misalignment of your vertebral column, benefits are payable up to the maximum amount shown in the *Schedule of Benefits* under the spinal manipulation benefit. Covered services must be for the purpose of alleviating pressure on spinal nerves and its associated effects related to such structural imbalance, misalignment or distortion by physical or mechanical means.

Covered Charges include expenses for office visits to a Physician or a licensed chiropractor. Acupuncture must be prescribed by a Physician and is covered under the spinal manipulation benefit. Both spinal manipulation and acupuncture are subject to the calendar year maximum benefit amount shown in the *Schedule of Benefits*.

Therapy provided with spinal manipulations are subject to maximum benefits allowable in a calendar year. Please refer to the *Schedule of Benefits* located in the back pocket of this booklet. (Please note – in some cases, massage therapy may be ordered by a Licensed Chiropractor; however, Routine massage therapy is not a covered benefit under the Plan exclusions.

Rehabilitation Services

You and your eligible Dependents are entitled to benefits for Covered Charges incurred for outpatient Rehabilitation Services. This includes physical, occupational therapy and cardiac rehabilitation. Benefits are payable up to the maximum amount shown in the *Schedule of Benefits*. **Inpatient Rehabilitation Services are *not* covered.** (Speech therapy is only covered if it is required as the result of a head Injury or stroke or if used in the treatment of Paradoxical Vocal Cord Motion, which has been confirmed by two or more physicians who have evaluated the patient. The speech therapy is only covered up to the restoration of the normal functions that were present prior to the Injury or stroke. (Update February 10, 2015)

Prosthetic Appliances

You and your eligible Dependents are entitled to benefits for prosthetic appliances (artificial limbs or eyes) for the initial replacement of natural limbs or eyes. Subsequent expenses for such artificial limbs or eyes are subject to the following guidelines:

- Coverage is provided for a replacement prosthetic device for children up to age 18 when replacement is necessary due to growth of the child and is Medically Necessary as determined by the Physician.

- Coverage is provided for a total replacement of such prosthetic device for adults, provided that five years have elapsed since the previous device was purchased. This replacement also must be Medically Necessary as determined by the Physician.

The ***lifetime maximum*** for prosthetic appliances is $25,000.

- Replacement because of damage, as might occur in an accident, is covered when Medically Necessary as determined by the Physician. Payment for repair or replacement may be contingent upon any third-party insurance that is liable for payments.
- A lifetime maximum of $25,000 for the initial placement, subsequent repairs and replacement of all prosthetic devices will apply per individual.

Well Child Care (Routine Examinations and Required Immunizations)

Your eligible Dependents who are under the age of 18 are entitled to coverage for well child care benefits when a network provider renders services. However, Well Child Required Immunization charges will be reimbursed when the service is rendered by a local Public Health Department and only after proof of payment is submitted to the Fund Office. Well child care benefits include physical examinations and Well Child Required Immunizations. Well child benefits are defined in the *Schedule of Benefits* in the back pocket of this booklet.

Temporomandibular Joint (TMJ) Treatment

You or your eligible Dependents are entitled to treatment of jaw problems including temporomandibular joint (TMJ) dysfunction, disorder or syndrome and any other craniomandibular disorder or other conditions of the joint linking the jawbone and skull and muscles, and nerves and tissues relating to that joint. The TMJ benefit does not include orthodontic treatment. The percentage the Plan pays, after the deductible/co-payment is satisfied and the calendar year maximum is met, is shown in the *Schedule of Benefits*.

Podiatry Services ***(Revised January 1, 2006)***

You and your eligible Dependents are entitled to services provided by a podiatrist for foot care. The percentage the Plan pays, after the deductible/co-payment is satisfied, is shown in the *Schedule of Benefits* in the back pocket of this booklet.

Orthotic expenses are covered up to the calendar year maximum. Limitations to the orthotic benefit are as follows:

- Medical Necessity must be presented by the ordering Physician; and
- The orthotic must be specially molded for the recipient; and
- The patient has failed to respond to a course of appropriate conservative treatment (e.g., physical therapy, injections, strapping, anti-inflammatory medications). {Orthotics should not be considered first line therapy}

Second Surgical Opinion Benefit

You and your eligible Dependents are entitled to receive a second surgical opinion if your Physician recommends surgery while you are eligible for benefits under this Plan. The surgery must not be emergency in nature or caused by a job-related medical condition.

Benefits are payable for the Usual and Customary Charges for consultation fees and any necessary laboratory tests or X-rays up to the maximum amount shown in the *Schedule of Benefits* in the back pocket of this booklet.

The Plan pays the expense of a second (and third) surgical opinion.

If the second opinion does not confirm the need for surgery, you may consult another legally qualified Physician for a third opinion. Benefits for the third opinion are payable for the Usual and Customary Charges mentioned above up to the maximum amount payable in the *Schedule of Benefits*. Please refer to the *Schedule of Benefits* for your specific plan requirements.

Legally Qualified Physician. For the purpose of this benefit, a legally qualified Physician is one who is board certified in the field of the proposed surgery or a specialist in the field of medicine concerned with the condition involved.

Exclusions. No benefits are payable under the second surgical opinion benefit for any of the following:

1) A consultation by a Physician who is not a legally qualified Physician as defined above.

2) X-rays and tests not related to the proposed surgery.

3) An examination not made in person by the Physician rendering the opinion.

4) An examination where no written report is submitted by the examining Physician.

5) An examination by the same consulting Physician who also performs the surgery.

6) An examination by a Physician who has a financial interest in the outcome of his opinion.

7) A consultation regarding dental work or treatment.

8) A consultation about Illnesses or Injuries arising out of and in the course of any employment or self-employment.

Annual Physical Examination Benefit (For All Participants and their Eligible Spouses)

EFFECTIVE JANUARY 1, 2005

If you and your spouse incur covered expenses for a routine physical examination obtained while you are eligible under the Welfare Fund, reimbursement of those expenses will be paid up to the maximum amount stated in the *Schedule of Benefits*. You do not need to pay a deductible or co-payment before receiving reimbursement for these expenses.

The Plan provides an ***annual physical examination*** benefit for both you and your spouse with no deductible up to an annual maximum amount defined in the *Schedule of Benefits*.

Covered physical examination expenses for you and your spouse include a routine physical examination performed by a legally qualified Physician, or under a Physician's direct supervision, including the cost of X-ray and laboratory expenses connected with the examination. The Plan will pay for your or your spouse's Hepatitis B immunization if your Physician orders it at the time of the physical examination.

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

A Colonoscopy screening will be covered up to one time every 5 years and will not apply towards your Annual Physical Benefit maximum. However, payment for this procedure will be subject to deductibles, co-payments and co-insurance rates.

Exclusions. No benefits are payable under the annual physical examination benefit for any of the following:

1) Charges for services or supplies that are covered in whole or in part under any other portion of the Central Laborers' Welfare Fund Plan of Benefits.
2) Expenses for which benefits are payable under any Workers' Compensation Law.
3) Services received that are not performed by a Physician or under the direct supervision of a Physician.
4) Services received while confined in a Hospital, convalescent or extended care facility, nursing home, night care center or similar institution.
5) Medicines, drugs, appliances, equipment, materials or supplies.
6) Physical examinations to determine the existence or nonexistence of a pregnancy, during the term of the pregnancy or within 90 days after a pregnancy ends.
7) Psychiatric, psychological and personality or emotional testing or examination.
8) Examinations for the issuance of marriage licenses, employment requirements, insurance policies and maintenance of valid licenses.
9) Hepatitis B immunizations not prescribed or ordered by a Physician during or at the time of the physical examination.
10) Flu/pneumonia vaccines not administered at a session coordinated by the local union hall or district council.
11) Charges in excess of the specified maximum shown in the Schedule of Benefits or as described under a particular benefit in this booklet.

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

You do not need prior authorization from the Plan, BlueCross BlueShield of Illinois, HealthLink or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Fund Office.

Extension of Benefits

If you or your eligible Dependent is totally disabled at the time your coverage under this Plan terminates, benefits may be extended for Covered Charges incurred for the care and treatment of the condition that caused the disability if:

- the expense would have been covered if the coverage under this Plan had continued;
- you or your Dependent remains totally disabled to the date each such expense is incurred; and
- you or your Dependent are not entitled to similar benefits under any other group plan when such expense is incurred.

Benefits are extended and payable only for the treatment of the Injury or Illness that caused the total disability. The benefits payable will be subject to the same maximums, limitations and exclusions that were in effect under this Plan at the time coverage terminated.

Benefits will continue until the earliest of:

- the date you or your Dependent is no longer totally disabled;
- the date you or your Dependent becomes covered for benefits under another plan or policy that provides similar benefits; or
- 12 consecutive months following the date that the total disability began.

For this extension, totally disabled means:

- you are prevented from engaging in your regular or customary occupation due solely to an Injury or Illness that is not employment-related; or
- your Dependent is prevented from engaging in substantially all of the normal activities of a person of like age and gender who is in good health due solely to an Injury or Illness that is not employment-related.

Please Note: Extension of benefits is not automatic. You must notify the Fund Office of your election of this coverage and submit the necessary proof of disability documented by your Physician.

Medical Benefit Exclusions

The following services are **not** covered and benefits will not be paid for them under the Medical Expense Benefit:

1) Services that are not Medically Necessary as determined by the Plan or are not in accordance with accepted standards of medical practice as determined by the Plan.

2) Eye refractions, eyeglasses, lenses, hearing aids or the fitting thereof. (See benefits for Vision Care in this booklet).

3) Treatment of Injury sustained or Illness contracted resulting from war, declared or undeclared, or any act of war, including accidental Injury or Illness contracted while on duty with any military force of any country or international organization.

4) Treatment of Injuries you received while engaged in a criminal act or acts resulting in a felony conviction or for which felony charges are pending.

5) Treatment of Injuries resulting directly or indirectly from commission of an illegal act, except traffic offenses. However, treatment of Injuries sustained in a motor vehicle accident is excluded where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (B.A.C.) of 0.15 or more. A breathalyzer, blood or urine test result that the claimant had a B.A.C. of 0.15 or more or that the claimant was utilizing an illegal drug at the time of any Injury or Illness, will be considered objective evidence that alcohol or illegal drug use was a contributing cause of the Injury or Illness.

6) Charges for treatment of any intentional act unless caused by an underlying medical or mental health condition. (Effective September 1, 2022)

7) Any Injury, Illness or dental treatment for which the eligible person has received, or is arguably entitled to receive, benefits under a Workers' Compensation or Occupational Diseases Law, which arises out of or in the course of any occupation or employment for wage or profit. However, if a case is disallowed by the Industrial Commission, benefits may be payable.

8) Expenses for which you would not have been charged had there been no coverage.

9) Expenses for which there is no legal obligation or financial liability to pay.

10) Hospital charges and confinements not recommended or approved by the Physician.

11) Expenses for educational services (except for Nutritional Counseling as specifically provided for under Covered Charges), supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, auditory aids, speech aids, etc., even if they are required because of your Injury, Illness or disability. (effective 10-15-2018)

12) Treatment by acupressure, hydrotherapy, massage therapy, biofeedback or hypnotherapy.

13) Speech therapy unless required as the result of a head Injury or stroke or if used in the treatment of Paradoxical Vocal Cord Motion, which has been confirmed by two or more physicians who have evaluated the patient. The speech therapy would only be available up to the restoration of the normal functions that were present prior to the Injury or stroke. (Updated February 10, 2016)

14) Dental implants and/or charges related to orthodontic treatment.

15) Transportation other than local ambulance service.

16) Services or supplies that are furnished, paid for or otherwise provided by the U.S. Government or its agencies.

17) Elective abortions or for any charges related to the evaluation and treatment of complications resulting from the abortion unless:

    a) The life of the mother is endangered if the fetus was carried to term;

    b) In the case of intrauterine fetal demise; or

c) When a serious fetal disorder is detected by prenatal diagnosis and resulting in seriously adverse prognosis for the life or health of the child, including significant congenital deformity or defect, confirmed by two (2) independent physicians specializing in maternal-fetal medicine or a related field of expertise, and when no treatment is available to likely affect the adverse prognosis.

18) Services performed on or to the teeth, nerves of the teeth, gingivae or alveolar processes, except for tumors or cysts or unless resulting from an accidental Injury to sound natural teeth while eligible or covered under another group plan and within six months of the accident;

19) Cosmetic surgery unless resulting from accidental Injury or congenital disease or anomaly that results in a functional defect from trauma, infection or other disease of the involved portion of the body.

20) Reversal of voluntarily sterilization.

21) Well child care and immunizations that are received from an out-of-network provider; except when Well Child Required Immunizations are received at a local health department.

22) Any charges that exceed the Usual and Customary Charges, allowable charges as defined by the Plan of Benefits or charges that exceed network allowances.

23) Marriage, legal and/or financial counseling. The Central Laborers' Family Assistance Services Program may provide referrals for these services. For benefits provided by your health care network plan, contact your plan.

24) Personal hygiene, comfort or convenience items such as, but not limited to, air conditioners, humidifiers, purifiers, dehumidifiers, heating pads, pillows, hot water bottles and other non-medical equipment or supplies. Also, personal comfort or convenience items such as radio, television, telephone or guest meals.

25) Services, supplies or surgical procedures for the treatment of a condition of obesity, except that certain services for the treatment of a condition of obesity will be payable if the following criteria are met:
    a) The surgical candidate must be at least 75% overweight according to body habitus, age, sex and height.
    b) The patient must be unable to participant in activities related to gainful employment and/or normal activity due to limitations related to morbid obesity that would be resolved by weight reduction.
    c) Documentation that a reasonable medical management program has repeatedly failed to achieve significant weight loss over 2 years or longer.
    d) Documented incipient or actual complications that because of morbid obesity may be anticipated to be life threatening to the specific individual for whom the procedure is requested.
    e) No evidence of GI pathology, liver or renal disease which might be a contraindication to the proposed surgery.
    f) Extended follow-up plans for medical management following the procedure must be well documented.
    g) Age of the surgical candidate must be between 16-70 years.
    h) The surgical candidate should not be alcohol dependent.
    i) The psychological capacity of the patient to understand the procedure and post-operative care must be conducted by an appropriate provider, other than the surgeon.

26) Expenses related to sexual reassignment.

27) Services for the diagnosis and treatment of infertility, impotency or sexual dysfunction.

28) Charges for failure to keep a scheduled visit, completion of claim forms, phone calls, handling fees, venipunctures when billed by a freestanding lab or Hospital/office lab, medication administration fees, personal items, special reports and leaving or signing out against medical advice.

29) Radial keratotomy or any surgical procedure for the improvement of vision when vision can be corrected through the use of glasses or contact lenses.

30) Inpatient Rehabilitative Services, including care received in a skilled nursing facility, convalescent center or other facility, even if the treatment is determined by a Physician as Medically Necessary.

31) Drugs or medication, cosmetics, dietary supplements, vitamins, beauty aids and nutritional formulas; provided however, nutritional formulas shall not be excluded in the cases where no other means of nutrition is medically available except through a gastric feeding tube. **(Change effective 07/16/2013)**

32) Expenses related to prevention of pregnancy, including, but not limited to, condoms, drugs or medicines and devices. However, oral contraceptives purchased at both the mail order and retail pharmacy, as well as injectable contraceptives are allowed. **(Change effective 01/01/2013) In** addition, contraceptives, including IUDs and other devices, will be allowed. **(Change effective 01/01/2014)**

33) Genetically engineered drugs, except those that have been pre-approved by the Board of Trustees or their representative.

34) Charges for commercial medical waste disposal.

35) Any expenses beyond the maximum amounts listed in the *Schedule of Benefits* or as described under a particular benefit in this booklet.

36) Orthoptics or vision training.

37) Non-medical services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, psychological counseling or educational therapy for mental retardation.

38) Preparation of reports, evaluations, physical examinations, immunizations or Hospitalizations not required for health reasons such as securing insurance, meeting employment requirements, obtaining government licenses, participating in sports, traveling to foreign countries or complying with a court order.

39) Private Hospital rooms and/or private duty nursing except when Medically Necessary as determined by the Plan, and then only up to the normal semiprivate room rate.

40) Custodial Care or assisted care with the activities of daily living including, eating, bathing, dressing or Custodial Care or self-care activities, homemaker services or services primarily for rest or domiciliary care.

41) Any charge, expense, service, supply or device that is deemed to be Experimental and/or Investigational and/or Unproven as defined on Page 99.

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

43) Any services, supplies or treatment not specifically provided as a benefit under the Plan.

Family Assistance Services Program (For All Participants)

The Family Assistance Services Program offers referrals and information for the treatment of mental health and substance abuse treatment. The program provides you with professional and confidential assistance to help you resolve personal and work problems before they get out of control.

For mental health and substance abuse treatment referrals, call the Family Assistance Program at (217) 243-8521 or (800) 252-6571.

Confidentiality is key when you use the Family Assistance Services Program. Your privacy is guaranteed; whatever is discussed with representatives is considered confidential.

The Family Assistance Services Program can provide referrals for many issues, including:

- ***work-related problems*** such as job site conflicts, drug testing, sexual harassment and retirement concerns;
- ***marital problems*** such as separation, divorce, conflicts or domestic violence;
- ***substance abuse problems*** such as problem drinking, citations for Driving Under the Influence (DUIs), illegal drug use, smoking cessation and misuse of prescription drugs;
- ***family issues*** such as parent-child conflicts, eldercare, single-parenting and childcare;
- ***emotional and mental health issues*** such as stress and anxiety, depression, anger management and loss of a loved one;
- ***financial problems*** such as gambling problems, household finances or over-extended credit.

Prescription Drug Benefits – July 19, 2022

If you or your eligible Dependents incur covered prescription drug expenses while eligible for benefits, CVS/Caremark will reimburse those expenses. The CVS/Caremark program was chosen by the Trustees to allow you and your family a more cost-effective program for prescription services.

If an FDA approved generic medication is available, it **must** be issued instead of the brand name or non-formulary prescription. The *Schedule of Benefits* located in the back pocket of this booklet shows the co-payment amounts for the retail and mail order programs. Prescription drug co-payments do not apply to the individual/family medical out-of-pocket maximum.

If you do not go to a CVS/Caremark participating retail pharmacy or use the mail order program, your prescription will not be covered under the Plan.

Save money!

ϖ Generic and Formulary brand medications cost less than non-formulary, brand name medications. Ask your Physician if a generic or formulary brand is available to avoid additional prescription drug costs.

ϖ For maintenance medications (medications you take on a long-term basis), you are encouraged to use the mail order program or purchase at a CVS retail location to receive a larger supply of your prescription medication at a lower cost than if you had filled it at a retail pharmacy other than CVS.

Retail Program

When filling or refilling a prescription at participating retail pharmacies, you must show your CVS/Caremark identification card to your pharmacist. The original prescription will be dispensed as written by the Physician for up to a 30-day supply or a 90-day supply if the purchase is made at a CVS retail pharmacy.

Mail Order Program

If you are taking a maintenance or long-term medication, you may use the Plan's mail order program. The mail order service can provide you with a 90-day supply delivered directly to your home for a co-payment specified in the *Schedule of Benefits* located in the back pocket of this booklet. Please see the terms of the mail order program regarding whether postage costs are covered or paid by the Plan.

To begin using the program a new Physician's prescription must be submitted to the mail order program. For more information, to obtain mail order envelopes or to receive a formulary listing for your ordering Physician(s) contact the Mail Order Service directly at (866) 818-6911 or contact the Fund Office at (800) 252-6571.

Covered Prescriptions and Supplies

The following items are covered by the Plan:

ϖ Prescription drugs approved by the Food and Drug Administration that are:
- purchased from a licensed participating pharmacy;
- dispensed in accordance with the prescription of the treating Physician; and,
- prescribed for a Medically Necessary and covered treatment of an Illness or an Injury.

ϖ Diabetic supplies. The Plan provides coverage for diabetic supplies such as insulin syringes and needles, sugar test tablets, sugar test tape, diabetic test strips and acetone test tablets. If

insulin and needles/syringes are dispensed at the same time, only one co-payment will be applicable, even if the insulin and needles/syringes are on separate prescriptions.

- Tobacco cessation products with a Physician's prescription.

Prescription Drug Exclusions

Prescription drug benefits are not payable under the Plan for the charges described below:

1) Over-the-counter medications not requiring a prescription.
2) Medications lawfully obtainable without a prescription.
3) Devices or appliances, support garments or other non-medicinal substances.
4) Administration fees for drugs or insulin.
5) Any charge, expense, service, supply, drug or device that is deemed to be Experimental and/or Investigational and/or Unproven as defined on Page 99.
6) Unauthorized refills.
7) Prescription drugs covered under federal, state or local programs for which there is no charge.
8) Medications used for cosmetic purposes, such as Rogaine.
9) Medications when confined to a rest home, nursing home, sanitarium, extended care facility, Hospital or similar entity.
10) Retin-A except for the treatment of acne vulgaris.
11) Charges for erectile dysfunction medications, except for purchases of Viagra, Levitra and Cialis, or their generic equivalent. However, purchases of Viagra and Levitra, or their generic equivalents, will be limited to a quantity not to exceed 12 pills per month. Purchases of Cialis, or its generic equivalent, other than Cialis 2.5 mg or Cialis 5mg, will be limited to a quantity not to exceed 12 pills per month. Cialis, or its generic equivalent 2.5 mg or Cialis 5mg, will be limited to a quantity not to exceed 30 pills per month or 90 pills in a 90-day period when purchased at a CVS retail store or through CVS/Caremark mail order, for the diagnoses of benign prostatic hypertrophy and erectile dysfunction. (Change effective July 1, 2021)
12) Charges for tobacco cessation products obtainable without a Physician's prescription
13) Any injectable medication without prior approval of the Fund Office.
14) Drugs required for a specific test, monitoring service, or procedure performed in an outpatient or inpatient setting, which would otherwise be considered under the Medical Benefit Plan of this Summary Plan Description. (updated May 19, 2015)

Coordination of Benefits under the Prescription Benefit Plan is not intended to allow a greater benefit than your actual health care expense, so the benefit payable under the Plan will be coordinated with the benefits of other prescription benefit plans. The amount of the benefit payable under this Plan may be affected when you are covered by any other plan.

When Central Laborers' Welfare Fund is the secondary plan it will make payments based on the balance left, if any, after the primary prescription benefit or health care plan has paid. Central Laborers' Welfare Fund will pay no more than that balance up to the amount it would have paid had it been primary.

Central Laborers' Welfare Fund will pay only for prescription drug expenses that are covered under this contract and will pay no more than the “allowable expense” for the prescription drug expense involved.

The allowable expenses and exclusions listed under the Prescription Drug Benefits, as well as the allowances, exclusions and order of payment rules listed under the Coordination of Benefits section of your Summary Plan Description will apply as they relate to the Prescription Drug Benefit Administration.

Vision Care Benefit (For All Participants)

If you or your eligible Dependents incur covered vision care expenses while you are eligible under the Welfare Fund, you will be reimbursed for those expenses up to the maximum benefit specified in the benefit grids located in the back of this booklet.

Covered vision care expenses include charges for:

- an eye examination performed by a legally qualified ophthalmologist or optometrist;
- contact lenses or lenses within frames prescribed by the ophthalmologist or optometrist, including contact lenses obtained through mail order; and
- frames.

Maximum vision care benefits are payable for you or your eligible dependent(s) each calendar year as follows:

- Child (age 0-up to age 19) Eye Examinations costs are paid under the Well Child Benefit. Exams are not subject to the annual deductible and paid at 100% up to the Well Child Benefit 100% max of $200 per calendar year and then payments are made at 80% for vision exam allowable expenses.

- Child (age 0-up to age 19) glasses, contacts and related hardware purchases are available annually. There is a maximum of $300 per purchases for lenses, frames and/or contact lenses. (Prescription is required for each purchase and all purchases are subject to a medical necessity determination.)

- Adult (19 years and older) Eye Examinations, glasses, contacts and related hardware costs are not subject to a deductible or co-pay, but are subject to a $300 per calendar year maximum.

Vision Care Exclusions

No benefits are payable under the Vision Care Benefit for any of the following:

1) Charges for services or supplies that are covered in whole or in part under any other portion of the Central Laborers' Welfare Fund.

2) Services and supplies that exceed the maximum.

3) Expenses for which benefits are payable under any Workers' Compensation law, or is arguably entitled to receive benefits under a Workers' Compensation or Occupational Disease Law.

4) Special procedures such as orthoptics or vision training and special supplies or non-prescription sunglasses and subnormal vision aids.

5) Visual analysis that does not include refraction.

6) Services or supplies not listed above as covered expenses above. Vision care expenses connected with Illness or Injury are covered under the Welfare Fund's Medical Expense Benefit.

7) Non-prescription safety glasses.

8) Replacement of lost or stolen items not covered.

Opt Out of Vision Benefits

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

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

Hearing Care Benefit (For All Participants)

If you or your eligible Dependents incur covered hearing care expenses while eligible for benefits, those expenses will be reimbursed up to the specified maximum benefit.

A legally qualified otologist, audiologist or otolaryngologist must perform the hearing examination. The qualified specialist must prescribe the hearing aid instrument. The maximum benefits that apply to you and each of your eligible Dependents can be found on the benefit grids located in the back of this booklet.

Hearing Care Exclusions

Benefits will *not* be paid under the Hearing Care Benefits for any of the following:

1) Charges for services or supplies that are covered in whole or in part under any other portion of the Central Laborers' Welfare Fund.

2) Expenses for which benefits are payable under any Workers' Compensation law, or is arguably entitled to receive benefits under a Workers' Compensation or Occupational Disease Law.

3) Examinations that are not made by a licensed otologist, audiologist or otolaryngologist or a hearing aid instrument specifically prescribed by a licensed otologist, audiologist or otolaryngologist.

4) Speech therapy related to any hearing disorder.

Dental Benefits (For All Participants)

EFFECTIVE January 1, 2016

Most types of dental services are covered under the Dental Plan and are grouped into three categories: preventative care, primary care and major care. Orthodontic benefits are explained later in this section

The Plan pays 80% of Covered Dental expenses up to a maximum of $2,500 per person per year. The Plan pays 50% of Covered orthodontic expenses up to the dental expense maximum of $2,500 per child per year and up to a ***lifetime*** maximum of $1,500 per Dependent child.

The Plan pays a ***maximum of $2,500 per person*** each year for dental and orthodontic expenses. Orthodontic expenses are further limited to a lifetime maximum of $1,500.

Date of Service

The date of service is the date that services are actually rendered. In the case of a prosthesis, the date of service is the date the final impression is performed. The date of service for endodontic treatment is the date the treatment is started.

Preventative Care Dental Services – Coverage A

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

Routine dental exams and cleanings are limited to ***once every six months.***

- **Oral Examinations.** Includes initial oral examination and periodic routine oral examinations. Benefits are payable for one examination every six months.
- **Prophylaxis.** Includes cleaning, scaling and polishing of your teeth. A dental hygienist may perform this service. Benefits are payable for one cleaning every six months.
- **Topical Fluoride Application.** Benefits for this procedure are available to eligible persons under age 19 and are payable for one application every six months.
- **Protective Sealants.** Benefits for protective sealants are available to persons under age 17 and are payable for one application during a 36-month period.
- **Dental X-rays.** Benefits are payable for a set of full mouth X-rays once during a 36-month period, when Medically Necessary as determined by your dentist.
- **Space Maintainers.** Benefits for space maintainers are available to eligible persons under age 19 when they are not part of an orthodontic treatment.
- **Emergency Treatment.** Benefits are payable for emergency oral examinations and treatment for the relief of pain.

Primary Care Dental Services – Coverage B

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

- **Restorative Services.** Includes treatment requiring use of amalgam, synthetic porcelain and plastic restorations (fillings) or stainless-steel crowns.
- **Periodontics.** Includes treatment for diseases of the gums.
- **Oral Surgery.** Provides benefits for extractions and other types of oral surgery related to the teeth or gums, including pre- and post-operative care.
- **Endodontics.** Includes pulpal therapy and root canal filling.

If you expect that the charges for your Primary Care dental services may total more than $100, it is wise to ask your dentist to prepare a written report describing the proposed treatment and the cost for the services. This procedure is called "Pre-Estimation of Benefits."

Major Care Dental Services – Coverage C

Major Care dental services cover charges for dental repair on your natural teeth or dentures. Coverage includes:

- ***Gold restorations*** when the teeth cannot be restored with another filling material. (If possible, a synthetic or less expensive filling material should be used).
- ***Inlays, onlays or crowns*** when the teeth cannot be restored with a filling material.
- ***Repairing or recementing*** of crowns, inlays, bridgework or dentures.
- ***The initial installation of full or partial removable dentures*** or fixed bridge work, provided the Participant's or Dependent's natural teeth, accidentally Injured or diseased, were removed or extracted on or after the effective date of the Participant's or Dependent's eligibility under this provision, except in cases where the Participant or Dependent's dentist is convicted of a criminal act and his license to practice dentistry is revoked between the time of the removal or extraction of the teeth and the fabrication and/or distribution of the permanent denture. Coverage will only be extended when a denture or bridgework includes the replacement of teeth so removed, extracted or missing.
- ***The replacement of a crown***, provided the original crown was installed more than five years prior to the replacement. The Plan treats a temporary crown and permanent crown as a combined benefit, payable up to the Usual and Customary Charges.
- ***Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework*** by a new denture or new bridgework, but only if the existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable.

  Replacement of an existing fixed bridgework that is less than five years from the initial placement will be covered only if the abutment tooth used in the original bridgework fails and must be extracted. In such cases, prior authorization is required and must include the Plan of treatment, proof of failure of the abutment tooth and, in the case of replacement, documentation as to why the existing fixed bridgework cannot be made serviceable. **EFFECTIVE 1/23/2007**

Limitations on Full and Partial Dentures

The Plan will pay benefits toward the replacement for crowns, inlays, bridges, full or partial dentures *only* if five years have elapsed since the prior placement of the crown, inlay, bridge or denture with the following exception:

- Replacement of an existing fixed bridgework that is less than five years from the initial placement will be covered only if the abutment tooth used in the original bridgework fails and must be extracted. In such cases, prior authorization is required and must include the Plan of treatment, proof of failure of the abutment tooth and, in the case of replacement, documentation as to why the existing fixed bridgework cannot be made serviceable.

- The Plan will not pay for the replacement of a bridge or denture that could have been made serviceable or that was lost or stolen.

Also, the Plan will not cover any "personalized restorations" or "specialized techniques" that you and your dentist may agree upon during the construction of a full or partial denture. The Plan's payment of benefits for denture construction is limited to the appropriate amount for a standard denture.

Denture relines are limited to once per Calendar Year.

Pre-Estimation of Benefits

Pre-Estimation of Benefits allows you to know in advance what services are covered and how much will be paid by the Plan for the treatment that your dentist recommends. If you or one of your eligible Dependents know that you will have dental expenses over $100 (such as for primary care or major care services), you should ask your dentist to file a Pre-Estimation of Benefits form.

Avoid surprises. Have your dentist file a Pre-Estimation of Benefits form so that you and your dentist will know how much the Plan will pay for the work.

Here's how it works:

- Your dentist completes a treatment plan describing the proposed course of treatment by itemizing the services and charges on the claim form that is provided by your dental office.
- You or your dentist submits the written report to the Fund Office.
- The Welfare Fund determines the amount payable under the Plan and informs you and the dentist.
- You and your dentist should discuss the Fund's estimated payment before the work is done.

Pre-Estimation of Benefits will help you avoid surprises and could save you money (see "Alternate Procedures"). Please note that a Pre-Estimation of Benefits that is issued by the Fund Office is valid for a six-month period, provided that you are eligible for Dental Plan benefits at the time the expenses are actually incurred.

Alternate Procedures

> The Plan covers the ***least costly treatment.*** Be sure to choose the most cost-effective treatment to avoid paying the difference from your own pocket.

Often there is more than one way to treat a particular dental problem. For example, either a crown or filling could be used to restore a tooth. You also have choices regarding the materials to be used – for example, precious metal or porcelain; composite or amalgams. Benefits are payable for the least expensive course of treatment. If you and your dentist decide upon a more costly treatment or your dentist chooses to bill expenses that are not Usual and Customary Charges for the service provided, you will be responsible for the additional charges above or the difference in the amount allowable for a service that is approved by the Welfare Fund.

Extension of Dental Expense Benefits

If your eligibility for dental benefits terminates, you may continue to receive dental services under the Plan for up to 30 days following termination if you were receiving treatment for major care (coverage C) and your treatment is completed within the 30-day period. The Fund Office will determine extension of benefits based on the final impression date that is given by your dentist. The final impression date must have occurred while your dental coverage was still active.

Dental Exclusions

Dental benefits are *not* payable under the Plan for the charges described below. The amount of any charges for the following will be deducted from your dental expenses **before** the benefits of the Dental Plan are determined.

1) Charges for services that are more than the calendar year maximum benefit described in the *Schedule of Benefits*.

2) Work done for appearance (cosmetic) purposes, except for conditions resulting from accidental Injuries, scars, tumors or diseases.

3) Work done while you are not covered under this Plan, except as provided under the Extension of Dental Expense Benefits provision.

4) Charges for mouth rehabilitation will be paid only as related to replacing missing teeth or for necessary treatment of oral disease. The balance of the treatment charges, including charges related to the appliances or restorations intended to increase vertical dimensions or restore the occlusion, will remain your responsibility to pay.

5) Extra sets of dentures or other appliances.

6) Treatment that is otherwise free of charge to you.

7) Treatment that is furnished or payable by the armed forces or any civil unit of any government that you do not have to pay.

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

9) Any Injury, Illness or dental treatment for which the eligible person has received, or is arguably entitled to receive, benefits under a Workers' Compensation or Occupational Diseases Law, which

arises out of or in the course of any occupation or employment for wage or profit. However, if a case is disallowed by the Industrial Commission, benefits may be payable.

10) Charges related to orthodontic treatment regardless of the reason that such treatment is being rendered, including extractions done in conjunction with orthodontic treatment, unless provided to an eligible Dependent child as described under the Orthodontic Services described below or in the case of an eligible adult covered on the policy who requires adult orthodontia attendant and medically essential in successful jaw repair or reconstruction related to a jaw injury as a result of trauma and only up to the maximum benefit level allowed by the Plan. (Change effective March 28, 2006)

11) Services or supplies for any condition that was caused by an act of war.

12) Any charge, expense, service, supply or device that is deemed to be Experimental and/or Investigational and/or Unproven as defined on Page 99.

13) Treatment of temporomandibular joint dysfunction with intra-oral prosthetic devices, or any other method to alter vertical dimension.

14) Charges for medications.

15) Charges for denture adjustments for the first six months after the dentures are initially received.

16) Charges for bases, liners, anesthetics and local anesthesia used in conjunction with permanent restorations.

17) Charges for treatment by anyone other than a dentist or licensed dental hygienist.

18) Charges for temporary partials, bridges and dentures.

19) Charges for infection control and medical waste disposal.

20) Charges for more than one denture reline per calendar year.

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

22) Treatment of Injuries resulting directly or indirectly from commission of an illegal act, except traffic offenses. However, treatment of Injuries sustained in a motor vehicle accident is excluded where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (B.A.C.) of 0.15 or more. A Breathalyzer, blood or urine test result that the claimant had a B.A.C. of 0.15 or more or that the claimant was utilizing an illegal drug at the time of any Injury or Illness, will be considered objective evidence that alcohol or illegal drug use was a contributing cause of the Injury or Illness.

23) Treatment of Injuries you received while engaged in a criminal act or acts resulting in a felony conviction or for which felony charges are pending.

Opt Out of Dental Benefits

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

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

Orthodontic Services – Effective July 1, 2021

Orthodontic treatment is allowable for Eligible Dependent Children and only for services or charges incurred on or after January 1, 2001.

Orthodontic treatment is allowable for Eligible Participants and Spouses and only for services or charges incurred on or after January 1, 2007.

Orthodontic services are covered up to 50%, with a lifetime maximum of $1,500. Orthodontic expenses are also subject to the calendar year maximum of $2,500 for Dental Benefits. This means that if you, your spouse or eligible Dependent child reaches the $2,500 maximum for dental expenses in a calendar year, you, your spouse or Dependent child's orthodontic services will not be covered that year and vice versa.

If you have arranged a payment plan with your orthodontist, you will need to provide the Plan with information confirming when orthodontic treatment will begin and whether payments are being made as scheduled. Payments are made directly to the orthodontist, so you should encourage the orthodontist to submit bills for services directly to the Fund Office. The Welfare Fund will not make payments on the basis of payment coupons, and reimbursements for orthodontic expenses will not be made directly to you.

Orthodontic benefits are limited by the calendar year and lifetime dollar maximums listed in the Schedule of Benefits.

Regarding any eligible treatment started prior to June 30, 2021, Orthodontic benefits are not payable under the Plan for the charges associated with any "Invisalign" or similar treatment that utilizes a removable aligner with the exception of a retainer used as a part of the plan of care associated with treatment that has utilized traditional orthodontic appliances which incorporate the use of brackets, bands, wires, springs and/or other related materials to correct the abnormal alignment of the teeth.

Regarding any treatment started on or after July 1, 2021, orthodontic benefits are payable under this Plan for charges associated with treatments such as *Invisalign* that utilize a Food and Drug

Administration (FDA) approved removable aligner, where the treatment is managed by a licensed dentist or orthodontist who determines whether and at what age the treatment is appropriate given the development of teeth and their arrangement in the mouth. No benefits are payable for "do-it-yourself" kits, including those ordered online or by mail, and/or where the treatment is not managed by a licensed dentist or orthodontist. Benefits are payable subject to the dental network contracted rate or, for services performed and not subject to network discounts, then the reasonable and customary charges for conventional orthodontics.

Regarding any treatment started on or after July 1, 2021, orthodontic benefits are payable under this Plan for charges associated with treatments such as traditional brackets, bands, wires, springs and/or other related materials to correct the abnormal alignment of the teeth, where treatment is managed by a licensed dentist or orthodontist.

Recovery Incentive Program (For All Participants) (Effective January 9. 2020)

Recovery Incentive Program. If you discover an overcharge for medical services and you arrange for a corrected bill, ***you may receive 25% of the overcharged amount*** from the Plan for your efforts.

This program provides a cash incentive to you and your Dependents if you discover and arrange for recovery of overcharges made on Hospital, Physician and outpatient clinic bills that in turn result in benefit dollars saved for the Welfare Fund. The program rules follow:

- The Welfare Fund will pay you a cash incentive of 25% of the actual amount of an overcharge when the Hospital, Physician or outpatient clinic that made the overcharge agrees that the overcharge is present on your bill and, after direct negotiations have taken place between you and the Hospital, Physician or outpatient clinic, that the overcharge will be removed from your bill.

- The maximum paid by the Welfare Fund in any calendar year under this program will not exceed $500 per person. Overcharges totaling less than $25 are not eligible for the Recovery Incentive Program.

- The Welfare Fund will consider only those expenses that the Plan covers in determining the amount payable under this program. Claims involving coordination of benefits will be eligible only if this Plan is primary.

- You must submit proof of eligibility for a cash incentive. That proof must include the following:

    - A copy of the initial itemized Hospital, Physician or outpatient clinic bill with the overcharge(s) circled.
    - A copy of all documentation that supports your claim that the Hospital, Physician or outpatient clinic overcharged for services rendered or charged for services not rendered.
    - A copy of the amended claim or corrected/adjusted billing invoice may service as proof of the overcharge(s).
    - You must submit this proof to the Welfare Fund within 12 months following the date of discharge or the date the charges were incurred from the Hospital, Physician or outpatient clinic.

- You are solely responsible for identifying any overcharges and collecting the supporting documentation substantiating your claim. The Trustees and Welfare Fund staff will not be involved in resolving any conflict between you and the Hospital, Physician or outpatient clinic with respect to disputed charges unless and until it becomes necessary to process refunds, process corrected claims or must otherwise perform activities required to facilitate a successful recovery on overpaid benefits.

- The Trustees have the sole right at any time to amend or modify these rules or terminate the Recovery Incentive Program.

- Following are specific suggestions for a careful and complete review of a bill:

    - List everything that happens while you are at the Hospital, Physician or outpatient clinic by reconstructing events daily or immediately upon discharge.
    - Before leaving the Hospital, clinic or Physician's office, make sure to have an itemized bill sent to you.

- Match your list against bills to detect any discrepancies.
- Check the bill carefully for any charges that represent any treatments, services or supplies that were not received. Use the following or similar checklist:

  - Were you billed for the correct number of days that you occupied the room?
  - If intensive care was required, were you billed for the correct number of days that you were confined to an intensive care unit?
  - Were you charged for the day that you were discharged, even though you left before the day's charges began?
  - Were you charged for the correct type of room that you occupied (private, semiprivate, ward, etc.)?
  - Were you billed only for tests or X-rays that you actually received?
  - Were you billed for medication, injections, dressings, supplies, etc. that you did not receive? For quantities in excess of what you received?
  - Do you recognize medication, injections, dressings, supplies, etc. that you did not receive that may have belonged to a roommate or other patient?
  - Were medications that your Physician ordered billed throughout your entire stay even though you took them only for a limited period of time?
  - If you received physical, radiation, inhalation and/or occupational therapy, were you charged for the correct type and number of hours of treatment?
  - If you received a blood transfusion, were you charged for blood that a donor, blood bank or a Red Cross family or community assurance program replaced?
  - If admitted to the maternity wing, were you billed for a labor room that may not have been used because of a swift delivery?
  - If permitted to keep your newborn child in your room, were you billed for improper nursery charges?
  - Were you billed for miscellaneous charges? Did you ask the Hospital to explain them in specific terms?
  - Did a Physician who did not visit you bill you for a visit?

❖ Circle any overcharges. Report all overcharges to the Hospital, Physician or outpatient clinic billing department and request a corrected bill. If you properly identify the specific discrepancies in the Hospital, Physician or outpatient clinic bill, the Hospital, Physician or outpatient clinic must drop unsubstantiated charges unless there is evidence in the medical file to the contrary. A copy of the adjusted bill will be used as proof that the Hospital, Physician or outpatient clinic removed the overcharge(s).

❖ You may receive payment of your cash incentive by sending the Welfare Fund a copy of the original bill with the overcharge(s) circled and a copy of the correct bill that the Hospital, Physician or outpatient clinic reissues; or

❖ If payment of benefits has already been made to the Hospital, Physician or outpatient clinic, a check will be issued to you for your assistance in the recovery of funds only after the overcharge amount(s) has been received as a refund from the Hospital, Physician or outpatient clinic.

❖ Within 30 days after receipt of proof and verification that the overcharge(s) has been removed and the refund has been received by the Fund, if payment of benefits has already been made to the Hospital, Physician or outpatient clinic, the Welfare Fund will disburse a check to you in the amount of the cash incentive.

You should note that these reimbursements are considered income to you and should be reported to the Internal Revenue Service.

Loss of Time Benefit (For Active Employees Only)

The Loss of Time Benefit is payable if you are unable to work because of a non-occupational accidental bodily Injury or a non-occupational Illness. The maximum weekly benefit and the maximum benefit period is 13 weeks in any given 12-month time period. The benefit will begin on the first day of a disability due to accidental bodily Injury or on the eighth day of a disability due to Illness. In accordance with federal regulations, Social Security (FICA) and Medicare taxes will be deducted from each payment you receive.

The Loss of Time Benefit is only payable for disabilities that occur while you are eligible for benefits under the Welfare Fund.

The Trustees may require that you submit, on a periodic basis, medical evidence that you are disabled. You may be required to submit to a physical examination by a Physician selected by the Trustees.

Proof of disability. You may be required to periodically submit medical evidence that you are disabled or be examined by a Physician chosen by the Trustees.

Continuous Periods of Disability

If you return to work or are available for work and then require additional time off due to the same or related condition, a new claim for benefits will be required to process the additional payments.

A maximum 13 weeks of disability payments is possible, subject to eligibility, within a 12-month time period.

Loss of Time Benefit Exclusions

Occupational Injury or disease means an Injury or disease for which you are entitled to or are pursuing entitlement to benefits under the applicable Workers' Compensation Law, Occupational Disease Law or similar laws.

No benefits will be payable under the Loss of Time Benefit for any:

1) Period of disability during which you are not under the direct care of a Physician.

2) Disability that is due to accidental bodily Injuries arising out of and in the course of your employment.

3) Disability that is due to an occupational Injury or Illness. For this purpose, occupational Injury or Illness means an Injury, Illness or disease for which you are entitled to or pursuing entitlement to benefits under the applicable Workers' Compensation Law, Occupational Disease Law or similar laws.

4) Disability that begins while you are not eligible or while the Central Laborers' Welfare Fund does not have primary responsibility for your coverage as defined under the *Coordination of Benefits* section.

5) Disability that is due to Injuries resulting directly or indirectly from the commission of an illegal act, except traffic offenses. However, treatment of Injuries sustained in a motor vehicle accident is

excluded where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (B.A.C.) of 0.15 or more. A Breathalyzer, blood or urine test result that the claimant had a B.A.C. of 0.15 or more or that the claimant was utilizing an illegal drug at the time of any Injury, will be considered objective evidence that alcohol or an illegal drug use was a contributing cause of the Injury.

6) Period of disability during which you are considered a Retiree under the Central Laborers' Pension Fund and are receiving a monthly pension benefit.

Death Benefit (For Active Employees Only)

If you die while you are eligible for Plan benefits, the Death Benefit may be paid to your beneficiary. The amount of the Death Benefit is $10,000 as shown in the *Schedule of Benefits* located in the back pocket of this booklet. This benefit is usually paid to your beneficiary in a lump sum.

Beneficiary

You may name anyone you wish as your beneficiary. Your beneficiary is the person you name to receive your death benefit and will be the most recent beneficiary named by you on the beneficiary designation form that must be on file with the Fund Office prior to your death. You may change your beneficiary at any time by completing the proper form and returning it to the Fund Office. The change will be effective when the Fund Office receives the completed form. If no beneficiary is named, the death benefit will be payable to your estate.

Continuation of Death Benefit During Total and Permanent Disability

If you become Totally and Permanently Disabled before age 60, your Death Benefit coverage will continue if:

- your Physician provides written proof of your disability to the Trustees no later than 12 months after the start of your disability; and
- the proof confirms that you were Totally and Permanently Disabled for at least nine months, and that your disability will continue indefinitely.

Totally and Permanently Disabled

For the purpose of this benefit, Totally and Permanently Disabled means that you are prevented from engaging in any business, occupation or employment for wages or profit due solely to an Illness or Injury.

To have your Death Benefit continue for each 12-month period after initial confirmation of your Total and Permanent Disability, you must submit proof of your continuing Total and Permanent Disability each year within three months of the anniversary date that your initial proof of disability was submitted. The Board of Trustees reserves the right to have you examined by a Physician of their choosing.

For Example:

Nick becomes Totally and Permanently Disabled on March 1, 2001. Nick sends proof to the Trustees on February 1, 2002 that he has been disabled for at least nine months and that his disability is expected to continue indefinitely. The Trustees accept Nick's proof of disability and Nick's Death Benefit coverage continues for a 12-month period from February 1, 2002 through January 31, 2003. Nick must submit proof of his continuing disability on or before October 31, 2003 to have his Death Benefit coverage continue for the 12-month period from February 1, 2003 through January 31, 2004. Nick must repeat this process each year that he remains disabled to keep his Death Benefit coverage in effect.

Amount of Coverage Continued

The amount of your Death Benefit coverage while you are Totally and Permanently Disabled will be the amount that was in force at the time you initially became disabled.

How Long Benefits Continue

Benefits will continue under this extension until the earliest of:

- 31 days after the date that you are no longer Totally and Permanently Disabled;
- the date you fail to furnish the Trustees with proof of your continued disability (that must be within three months of the anniversary date the initial proof of disability was submitted); or
- the date you fail to be examined by a Physician designated by the Trustees, if the Trustees request it. Such an examination will not be required more than once a year after your coverage has been continued under this extension for two full years.

Death Benefit Exclusions

No Death Benefit is payable if your death is caused directly or indirectly, wholly or partly, by:

1) Participation in the commission of a felony.

2) War or an act of war.

3) Disabilities or Injuries resulting directly or indirectly from the commission of an illegal act, except traffic offenses. However, Injuries sustained in a motor vehicle accident are excluded where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (B.A.C.) of 0.15 or more. A Breathalyzer, blood or urine test result that the claimant had a B.A.C. or 0.15 or more or that the claimant was utilizing an illegal drug at the time of the Injury, will be considered objective evidence that alcohol or illegal drug use was a contributing cause of the Injury.

Accidental Death and Dismemberment (AD&D) Benefit (For Active Employees Only)

If you suffer any of the losses listed below as the result of an accident, the Accidental Death and Dismemberment (AD&D) Benefit will be paid. Benefits are only payable for losses that occur within 90 days from the date of Injury. This benefit is in addition to any other benefits payable under the Plan.

Schedule of Accidental Death and Dismemberment Benefits

Loss Suffered	Amount of Benefit
Life	$10,000
Two hands, two feet or sight of two eyes	$10,000
One hand and one foot	$10,000
One hand and sight of one eye	$10,000
One foot and sight of one eye	$10,000
One hand or one foot or sight of one eye	$5,000

If you suffer more than one of these losses listed above in any one accident, you will be paid only for the loss for which the largest amount is payable.

Beneficiary

Benefits for loss of life are payable to the beneficiary you name. Benefits for any other loss are payable only to you. You may name anyone you wish as your beneficiary of your Accidental Death Benefit. Your beneficiary is the person you name to receive your death benefit and will be the most recent beneficiary named by you on the beneficiary designation form that must be on file with the Fund Office prior to your death. You may change your beneficiary at any time by completing the proper form and returning it to the Fund Office. The change will be effective when the Fund Office receives the completed form. If no beneficiary is named for your Accidental Death Benefit, the benefit will be paid to your estate.

Special Terms

- Loss of hand or foot means that the limb is severed at or above the wrist or ankle joint, respectively.
- Loss of sight means the total and irrecoverable loss of sight.

AD&D Exclusions

No benefit is payable under this Accidental Death and Dismemberment Benefit if your death or any loss is caused directly or indirectly, wholly or partly, by any of the following:

1) Infirmity or disease of any kind.

2) Ptomaine or bacterial infections (except infections caused by pyogenic organisms that occur with and through an accidental cut or wound) or hernia.

3) Participation in the commission of a felony.

4) War or an act of war.

5) Service in any military, naval or air force of any country.

6) Police duty as a member of any military, naval or air organization or community work.

7) Occurring from disabilities or Injuries resulting directly or indirectly from the commission of an illegal act, except traffic offenses. However, Injuries sustained in a motor vehicle accident are excluded where there is sufficient evidence that the accident was a result of the claimant's Blood Alcohol Content (B.A.C.) of 0.15 or more. A Breathalyzer, blood or urine test result that the claimant had a B.A.C. or 0.15 or more or that the claimant was utilizing an illegal drug at the time of the Injury, will be considered objective evidence that alcohol or illegal drug use was a contributing cause of the Injury.

Claim Filing and Appeal Information

Once you are eligible for coverage, the Trustees must ensure that you receive all the benefits to which you are entitled. Most health care providers will submit your claims for you. Be sure to show your ID card to your providers so they will know where to submit your claim. If your provider does not submit your claim for you, it is then your responsibility to do so.

Most providers will file claims for you. If your provider does not, follow the steps listed in this section. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed by the Trustees.

Important benefit information including claim filing information will be sent to the address the Fund Office has on file. Please ensure your current address is on file with the Fund Office at all times.

Procedure for Filing a Claim

If you need a claim form, please contact:

Central Laborers' Welfare Fund
201 North Main Street
P. O. Box 1267
Jacksonville, Illinois 62651-1267
Phone: (217) 243-8521 or (800) 252-6571
Electronic Mail Address: claims@central-laborers.com
Website: www.central-laborers.com

The Fund Office will check the records of your hours worked and will forward the claim forms to you immediately if you are eligible for benefits under the Plan or you may download a printable form by visiting the "Forms Gallery" on the Central Laborers' Web site: www.central-laborers.com.

Using the Claim Form

If you or an Eligible Dependent has coverage under more than one health care plan, benefits are coordinated.

- When you receive a ***medical*** claim form, complete the Member Section and Dependent Section, if applicable. In the event of an accident, please complete the accident information form.
- When you receive a **vision** claim form, follow the instructions carefully when completing it. You may have your vision provider submit a vision claim directly to the Fund Office or attach your vision care receipts to your claim form and mail them to the Fund Office.
- When you receive a ***dental*** claim form, called a Dental Service Report, follow the instructions carefully when completing it. You will need to complete and sign Part 1 – Insured Information of Dental Service Report. Be sure to answer all questions. Ask your dentist to complete and sign Parts 2 and 3 when treatment has been completed.

Return your claim form to the Fund Office at the above address as soon as possible.

When you enter a Hospital, the Hospital may require you to complete an assignment form that directs the Welfare Fund to pay whatever benefits are available under the Plan to the Hospital to satisfy your bill. The Welfare Fund follows the procedure of automatically paying benefits directly to the Hospital if you have an outstanding bill and have assigned benefits to the Hospital. You will receive notification of the payment made to the Hospital on your behalf.

Keep Important Information Current

It is important that you notify the Welfare Fund Office whenever you:

- ϖ change your home address;
- ϖ wish to change your beneficiary;
- ϖ receive Workers' Compensation Benefits;
- ϖ return to work after your disability ceases;
- ϖ enter the Armed Forces of the United States;
- ϖ get married or divorced; or
- ϖ gain a Dependent or your Dependent is no longer considered an eligible Dependent.

Information about your Plan of Benefits and other documents required to process your or your Dependent's claims will be mailed to the last address on file at the Fund Office. To ensure your timely receipt of these important mailings, your current address must be provided to the Fund Office. Failure to provide the Welfare Fund Office with current and/or accurate information may result in the suspension and/or loss of benefits to you and your dependents.

Time Limit for Submitting a Claim

Claim deadline. You have one year from the date of service to file your claim.

The Central Laborers' Welfare Fund will not accept a claim for any benefits that is received more than one year from the actual date the expense was incurred. This rule applies to all benefits payable under this Plan.

For Example:

If you incur a claim on February 1, 2002, you should submit your claim to the Welfare Fund Office by no later than February 1, 2003.

Claims received after the one-year grace period will be denied unless you can show that it was not possible to provide such notice of claim within the required time and that the claim was filed as soon as was reasonably possible.

Claim Procedures

Health Care Claims

Health care claims are typically filed after you have received services. Health care claims include medical, prescription drug, vision, hearing and dental claims.

Loss of Time Benefit Claims

Be sure to notify your employer and the Fund Office if you are sick or injured due to non-occupational causes and are unable to work. The Fund Office will send you a claim form. Have your Physician complete the form. Then send the completed form to the Fund Office as soon as possible. Benefits are not payable until you apply for and submit the required information.

Death and AD&D Benefit Claims

In the event of your death, your beneficiary should call the Fund Office for help in filing a claim. Your beneficiary will need to provide a certified copy of the death certificate. If you have an Injury covered under the AD&D program, you should file the claim and any benefits will be paid to you.

Claim Decisions and Benefit Payment

When you submit a claim for benefits to the Fund Office, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. Reimbursement for covered expenses will be made to you unless benefits have been assigned, in which case payment will be made to the provider of service.

Health Care Claims

Generally, all health care benefits will be paid within 30 days after acceptable proof is received. The Plan will notify you of its initial decision within certain timeframes. If a claim is approved, payment will be made and the payment will be considered notice that the claim was approved.

An initial determination will be made within 30 calendar days from receipt of your claim. If additional time is necessary, up to 15 additional calendar days, due to matters beyond the control of the Plan, you will be informed of the extension within this 30-day deadline. In addition, if additional information is needed to process your claim, you will be notified within 30 days of receipt of your claim and you then have up to 45 days to provide the requested information. The notice will state the special circumstances and the date the Plan expects to make a decision. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.

Loss of Time Benefit Claims

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

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

Death and AD&D Benefit Claims

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

Legal Proceedings

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

- ❖ before the expiration of 60 days after you filed your claim as required by the Plan; or
- ❖ after three years from the expiration of the time allowance within which you were required to file your claim with the Plan.

Examinations

The Welfare Fund has the right to have its own medical Physician examine you while your claim is pending, when and so often as is reasonable and necessary in order to process your claim.

Payment for a Person Who is Not Legally Capable

The Board of Trustees reserve the right to pay benefits to a person who is entitled to payment even though the person eligible for benefits is, in the opinion of the Trustees, legally incapable of giving valid receipt for any payment due him, in the absence of an appointment legal guardian to receive such payment. The obligation under the Plan to pay benefits will be discharged by such a payment.

If a Claim is Denied (Amended December 5, 2017)

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

If your claim is denied (in whole or in part), the Plan will:

- ϖ provide you with certain information about your claim; and
- ϖ notify you of its denial of your claim within certain timeframes.

Information Requirements

When the Plan notifies you of its initial denial on your claim (or Loss of Time Benefit claim files before January 1, 2018), it will provide:

- ϖ the specific reason or reasons for the decision;
- ϖ reference to the Plan provisions on which the decision was based;
- ϖ a description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed; and
- ϖ a copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim.
- ϖ a copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request; and
- ϖ a copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

In addition, for Loss of Time Benefit claim filed on and after January 1, 2018, the notice will also include:

- ϖ The specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

- An explanation of the clinical or scientific judgment for the determination, applying the terms of the plan to your medical circumstances, if the adverse benefit determination was based on medical necessity or other similar exclusions, or a statement that such explanation will be provided free of charge upon request;
- A discussion of the decision, including an explanation of the basis for (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable); (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable); and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
- A statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records, and other information to you claim for benefits;
- A statement of your right to present evidence and testimony in support of your claim during the appeal/review process;
- A statement that before the Plan can issue an adverse benefit determination or review of a disability claim, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim. The evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under the Plan to give you a reasonable opportunity to respond prior to that date; and
- A statement that before the Plan can issue an adverse benefit determination on review of a disability claim based on a new or additional rationale, the Plan shall provide you, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under the Plan to give you a reasonable opportunity to respond prior to that date;
- A statement of your rights under the Employee Retirement Income Security Act of 1974 ("ERISA) to bring a civil action; and
- If applicable, the notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

REFUNDS (Revised January 1, 2006)

Any benefit payment made in error due to misinformation or lack of information provided by you, your dependents, and/or your providers or due to an error in calculation, may require the Fund Office to request a refund. Central Laborers' Welfare Fund will attempt to recover refunds from providers before notifying you of any outstanding balances owed to the Fund. If the outstanding amount owed is not recovered, for any reason, from your providers or you, the Fund Office may reduce benefit payment from future claims for you or your policy beneficiaries until the Plan has recovered the benefit overpayment.

Appealing a Denied Claim

Appealing a Denied Claim (Effective April 1, 2018)

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

In general, you should send your written request for an appeal to the Trustees at the Fund Office as soon as possible. Deadlines for filing written appeals are as follows:

within 180 days from the date of a decision for ***health care*** or ***Loss of Time Benefit*** claims; or

within 60 days from the date of a decision for ***death*** or ***AD&D benefit*** claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal, you may:

submit additional materials, including comments, statements or documents; and

request to review all relevant information (free of charge).

In addition, if your claim is for health care or Loss of Time Benefits and is denied based on:

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

You may request a hearing (in person or by representative). If you don't request a hearing, this will be considered a waiver of your right to do so and the Trustees will proceed to consider your appeal based on the written information submitted.

If you do request a hearing, you will be notified in writing, of the date, time and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. You will have the right to present any additional information not previously submitted. If you request a hearing and do not appear at the hearing (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written information submitted.

Appeal Decisions

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

The Plan will notify you, in writing, within five calendar days after a decision on your appeal is made.

Appeal Timeframes

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

ϖ ***Health Care Claims.*** A determination will be made within 60 days from receipt of your appeal. However, the determination may be made at the Fund's next quarterly meeting if the appeal is received within 30 days of that meeting.

ϖ ***Loss of Time Benefit Claims.*** A determination will be made within 45 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 45 days), a decision will be made within 90 days after the date the Plan receives your request for review. However, the Plan may:

make its decision at the next quarterly meeting of the Board of Trustees; or

if your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

ϖ ***Death and AD&D Benefit Claims.*** A determination will be made within 60 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 60 days), a decision will be made within 120 days after the date the Plan receives your request for review. However, the Plan may:

- ♦ make its decision at the next quarterly meeting of the Board of Trustees; or
- ♦ if your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

Medical Judgements

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

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

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

Information Requirements

When the Plan notifies you of its determination on your appeal with respect to a health care claim (or Loss of Time Benefit claim filed before April 1, 2018), it will provide:

- ϖ the specific reason or reasons for the decision, including reference to the Plan provisions on which the decision was based;
- ϖ a statement notifying you that you have the right to request a free copy of all documents, records and relevant information;
- ϖ information relating to any additional voluntary appeal procedures offered by the Plan;

- a statement that you may bring a civil action suit under ERISA;
- a copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request; and
- a copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

In addition, for Loss of Time Benefit claims filed on an after April 1, 2018, the notice will include:

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

The Trustees' decision on an appeal is final and binding.

External Review of Emergency Services, applicable Non-Emergency Services and/or Air Ambulance Services as required by the No Surprises Act

I. External Review of Standard Claims

This External Review procedure is applicable claims eligible for External Review as required by the No Surprises Act. Generally, this will pertain to denials related Emergency Service,

applicable Non-Emergency Service and/or Air Ambulance Service claims as defined in the section of this SPD addressing the No Surprises Act. All other claims (*i.e., claims that are not covered by External Review requirements of the No Surprises Act*) are subject to the appeal procedures, which are defined in this SPD.

Your request for external review of claims subject to the No Surprises Act, must be made, in writing, within four (4) months of the date that you receive notice of an initial adverse benefit determination or adverse Appeal Claim benefit determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them differently.

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

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

A. *Preliminary Review*

1. Within five business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:
    a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Determination concerns a claim involving a claim eligible for External Review as required by the No Surprises Act.
    c. The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;
    d. You have exhausted the Plan's internal claims and appeals process (except in limited, exceptional circumstances); and
    e. You have provided all the information and forms required to process an external review.
2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:
    a. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
    b. If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

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

If the request is complete and eligible, the Plan will assign the request to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The IRO must be accredited by URAC or similar nationally-recognized accrediting organization. The Plan will rotate assignment among at least three (3) IROs with which it contracts.

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

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim. Such additional information must be submitted within 10 business days. Information submitted after 10 business days may not be considered by the IRO.
2. Within five business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.
3. If you submit additional information related to your claim, the assigned IRO must, within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if, upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
4. The IRO will review all the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it were new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer(s).
5. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.
6. The assigned IRO's decision notice will contain:
    a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount [if applicable]), and the reason for the previous denial);
    b. The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
    c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

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

e. A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;

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

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

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

II. Expedited External Review of Claims

You may request an expedited external review if:

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

A. *Preliminary Review*

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

B. *Review By Independent Review Organization*

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

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

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

III. After External Review

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

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

IV. Payment of Claims

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

Elimination of Conflict of Interest

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

Coordination of Benefits (Revised January 1, 2022)

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

The Plan has been designed to help you meet the cost of your health care expenses. It is not intended that you receive greater benefits than your actual health care expenses, so the benefits payable under the Plan will be coordinated with the benefits of other health care plans. The amount of benefits payable under this Plan may be affected when you are covered by any other plan (defined below), determined without regard to any coordination of benefits (COB) rules.

Specifically, in a calendar year, the Plan will pay either its regular benefits in full or a reduced amount that, when added to the benefits payable by the other plan or plans, will equal 100% of allowable expenses incurred by you or your Dependent. When a plan provides payment in the form of services, such as services received from a Health Maintenance Organization (HMO), rather than cash payments, the reasonable cash value of the services will be considered both an allowable expense and a benefit paid.

Allowable expense means a health care service or expense, reduced by this Plan's deductibles, coinsurance or co-payments that is covered in full or in part by the Central Laborers' Welfare Fund Plan of Benefits.

Allowable Expenses do not include:

- any of the exclusions under the Central Laborers' Welfare Fund;
- the difference between a semi-private room in the Hospital and a private room;
- any amount in excess of the lowest negotiated fees;
- in absence of negotiated rates, any amount in excess of this Plan's Usual and Customary Charges; or
- any amount reduced from a primary plan's allowable expenses when that reduction is related to the failure of the plan Participant to comply with the primary plan's utilization review procedures or the Participant's failure to obtain health care service from the primary plan's network providers.

Although payments by this Plan cannot be more than would normally be paid if the COB rules did not exist, your combined reimbursement may exceed the maximum under this Plan, but cumulative payments by this Plan will not exceed the maximum allowed for any benefit defined in this booklet.

"Plan" means any plan providing benefits or services for or by reason of medical, prescription drug, vision, hearing or dental or treatment or healing under:

- group insurance;
- group practice, group Blue Cross, group Blue Shield, individual practice offered on a group basis or other group prepayment coverage;
- labor-management trustee plans, union welfare plans, employer organization plans or employee benefit organization plans; or
- governmental programs or coverage required or provided by any statute.

Keep in mind that if your full-time working spouse has coverage offered through his or her employer, then your spouse must enroll in that coverage to have secondary coverage under this Plan. However, the COB rules will not apply and your spouse will have no coverage under this Plan if your spouse does not enroll in his or her employer's coverage. Note, this provision does not apply to the spouse of a Retiree who becomes independently eligible for Retiree benefits.

To administer the COB rules properly, and to determine whether this Plan will reduce its regular benefits, it is necessary to determine the order in which the various plans will pay benefits. The order in which the plans will be considered to pay benefits is determined by the first of the following rules that apply:

- When another plan does not have coordination of benefits rules (COB rules), that plan must pay benefits first.
- When another plan has COB rules, the first of the following rules that apply determine which plan will pay benefits first:
  - If a plan covers the claimant as an employee, then that plan will pay benefits first.
  - If a plan covers the claimant as a Dependent whose parents are not divorced or separated, the plan of the parent whose birthday anniversary is earlier in the calendar year will pay on allowable expenses incurred first; except if both parents' birthdays are on the same day, the plan covering

the parent for the longer period of time will pay first. If a plan does not adhere to the "birthday rule" in determining the order of benefits, then that plan must pay first.

- If a plan covers a Dependent whose parents are divorced or separated, then the following rules apply:
  - If a plan covers a Dependent of a parent who is ordered by court decree to provide health coverage, then that plan pays benefits first. If the parent with responsibility has no health care coverage for the Dependent's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan;
  - If a court decree charges each parent with equal responsibility to provide health coverage for a Dependent, then the birthday rule will apply so that the parent whose birthday anniversary is earlier in the calendar year pays first; except that if both parents' birthdays are on the same
  - when there is no court decree requiring a parent to provide health coverage for a Dependent, the following rules will apply:
    - when the parent who has custody of the child has not remarried, that parent's plan will pay first; or
    - when the parent who has custody of the child has remarried, benefits will be determined by that parent's plan first, by the stepparent's plan second and by the non-custodial parent's plan third.
  - If a Dependent is covered under this plan, a spouse's plan and/or his/her parents' plan, then the plan that has covered the Dependent for the longest duration will be primary. If two or more plans share the same effective date, the order of coverage will be determined by the policyholder or benefit plan holder's birth month, with the earliest plan holder with the earliest birth month being primary over all others. If a plan does not adhere to the "birthday rule" in determining the order of benefits, then that plan must pay first.
  - If a Participant's Spouse is covered under this plan and/or his/her parents' plan, then the plan that has covered the Spouse for the longest duration will be primary. (Keep in mind that if your full-time working spouse has coverage offered through his or her employer, your spouse must enroll in that coverage to have secondary coverage under this Plan. The COB rules will not apply and your spouse will have no coverage under this Plan if your spouse does not enroll in his or her employer's coverage.)
  - If a Participant, a Participant's Spouse or Dependent is a covered active employee under one plan and a covered retired or laid off employee under another plan, the plan that covers the person as an active employee or a dependent of an active employee is the primary plan. For purposes of this rule, a person continuing coverage through the use of an hour bank for continued eligibility is considered to be a laid off employee.
  - If a Participant, a Participant's Spouse or Dependent is covered under a right of continuation pursuant to federal or state law and is also covered under another plan, the plan that covers the person as an active employee is the primary plan and the plan providing continuation coverage is secondary.

Once the order of payment is determined, the Fund Office will calculate the regular benefits under each plan in the order in which the plans are considered to pay their benefits and compare the amount with the total allowable expenses under this Plan. If payment of regular benefits by the Welfare Fund would result

in payment of benefits that exceed allowable expenses, the Welfare Fund will reduce the regular benefit paid to eliminate the excess.

If this Plan is secondary and your primary plan does not pay benefits because you did not comply with that plan's rules, this Plan may deny your benefit claim.

Regardless of the order outlined above, in the event a covered person incurs claims and any no-fault, personal Injury protection ("PIP") and/or medical payments coverage(s) is found to be available, these "First Party" coverages (or Another source(s)) are primary and must be paid out (exhausted) in their entirety before a payment under the Welfare Fund is to be considered eligible.

The Welfare Fund has the right and does not need consent by you, your Dependent or any person to:

- release or obtain any information the Welfare Fund determines to be necessary to implement these rules (in accordance with any applicable legislation);
- make any payments necessary to satisfy the intent of these rules if payments have been made under any other plan that should have been made under the group policy; or
- recover any excess payments to satisfy the intent of these rules.

Medicare

So long as you and/or your dependent are covered under a benefit plan, other than a retiree plan or disability plan, your benefits are also coordinated with Medicare if you are eligible for Medical benefits, unless federal law requires the Plan to be the primary payer. If you are eligible for Medicare Part A and Part B or Medicare Part C, you are required to enroll in Parts A and B or Medicare Part C. If you do not enroll in Medicare Part A and Part B or Medicare Part C when you are eligible, your benefits will be calculated as if you were covered by Medicare Part A and B or Medicare Part C.

NOTE: It is important to enroll in Medicare Part A and Part B or Medicare Part C (Medicare+Choice – a Medicare HMO offering where available) when you are eligible. Your benefits will be calculated as though you are enrolled, if you are eligible, but choose not to enroll.

If you or your dependent are eligible under a retiree or disability benefit plan, benefits will not be coordinated with Medicare and eligibility, under this Plan, will be terminated for the Medicare eligible policy beneficiary.

Subrogation

Subrogation gives the Plan the right to recover all of the benefits it has paid to you, or to those who provided your medical treatment, from another payment source or from you if you have received the payment directly. The Plan has the right to recover those payments, whether or not you have been fully paid for your treatment or other expenses from the same Injury. Throughout this section, the term "you" refers to you or a covered Dependent.
For instance, if you are in an automobile accident, you may receive payment for your medical treatment from an automobile insurance company or from the person who was at fault for the accident. If the Plan paid for your expenses that the automobile insurance company is responsible for, the Plan has the right to recover those expenses from the automobile insurance company or from you if they were paid to you.

Definitions

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

- **Another person** or **entity** means any individual, corporation, municipality or other governmental entity, partnership, association, trust or any other organization, no matter how the person or entity has been identified.
- **Another source** means someone other than you or the Plan and includes:
    - an insurance company that must pay the claims that result from the acts of another person, such as accident coverage, "no fault" coverage, uninsured or underinsured motorist coverage, personal Injury protection, homeowners insurance or school or athletic insurance;
    - an employee health insurance plan or arrangement;
    - a medical and Hospital plan; or
    - another person or any other entity (such as a company, organization or corporation) that is responsible for the acts of the person that caused your expenses, such as a homeowner or other property owner.
- **Another source** does not include another employer group health plan that covers you, for example, through your spouse's employer, if that coverage is subject to the coordination of benefits provisions of this Plan.
- **Compensable Injury** means any Injury for which you or your Dependent may recover payment from another source.
- **Compensated Injury** means any Injury for which the expenses for you or your eligible Dependent has already been paid by another source before this Plan pays benefits toward the same claim.
- **Injury** means either an Illness or an Injury, if caused by the actions of another person or entity. It also includes conditions that you may develop over time, such as from continued exposure to a harmful agent or a prolonged misdiagnosis of your condition.
- **Recovery** means any payment from another source as a result of an Injury. It includes *any* judgment, award or settlement, whether or not the judgment, award or settlement specifically includes or excludes medical expenses or payments for disability. This definition applies no matter what the recovery is called. For example, "loss," "punitive damages," "pain and suffering," "medical expenses," "attorney's fees," "costs," etc. will all be defined as recoveries.
- **Subrogation** means that the Plan has the right to take your place to ensure that any person or entity responsible for your Injury pays for the expenses of your Injury or reimburses the Plan for the amount it has paid on your behalf for that Injury.
- **Third Party** means a person or organization other than the Participant or Dependent who suffers loss.

No benefits will be paid under any coverage of the plan with respect to any injury or sickness for which a Third Party may be liable or legally responsible. This exclusion will apply whether or not the injury or injuries occurred while the Participant was eligible under the plan. The Plan may, however, consider payment of benefits according to the terms of the Plan as follows:

1. Any claim arising, or arguably arising, from a work-related cause shall be first submitted by the claimant or his representative to, and administered through, the workers' compensation administration of the jurisdiction in which the claim occurred. The claimant and/or his representative shall execute and submit to the Fund a Subrogation Agreement in a form prescribed by the Fund. No benefits shall be paid regarding said claim unless, and to the extent, the workers' compensation claim is disproved and denied by the Industrial Commission. Any claims that fall under this definition will at no time be considered eligible for a Hardship or Extenuating Circumstances Appeal described below.

2. Any claim arising, or arguably arising, from circumstances for which a third party (including accident coverage, "no fault" coverage, uninsured and under insured motorist coverage, personal Injury protection, homeowners insurance or school or athletic insurance) may be liable, shall be

first submitted by the claimant and/or his representative to the insurance carrier responsible therefore or shall be first pursued by the claimant in an appropriate third-party action. The claimant and/or his representative shall execute and submit to the Fund a Subrogation Agreement in a form prescribed by the Fund. No benefits shall be paid regarding said claim unless, and to the extent, third-party liability is disproved and denied. Further, no benefits regarding said claim shall be paid until disposition of the third-party action; provided, however, that in cases of hardship or extenuating circumstances, the claimant and/or his representative may request relief from these guidelines through the Appeal Procedure of the Fund.

Should the claimant present to the Appeal Committee a hardship or extenuating circumstances which is subsequently granted by the Committee, any benefits paid will be paid according to the terms of the Plan as follows:

Failure to Comply with This Provision Will Result in the Denial of the Claim

You Must Agree to Reimburse the Plan for Other Payments

Whenever you or your Dependent has an Injury expense that may be paid for by another person or entity, you (and your Dependent if your Dependent is Injured) must complete a Reimbursement Agreement to receive benefits from the Plan. Signing a Reimbursement Agreement is not a guarantee of payments by the Plan. If your Dependent is a minor or is legally incompetent, you and/or the person who is legally authorized to act on his or her behalf must complete the Reimbursement Agreement. You and your Dependent must also comply with the following terms:

- You must agree to repay the Plan any benefits the Plan has paid because of your Injury. This provision applies even if the recovery does not fully pay you for the Injury expenses. The Plan does not recognize the "Make Whole Doctrine".
- You will only be required to repay the amount of the benefits the Plan paid on the claim, or the amount you have recovered, whichever is less, without regard to attorneys' fees and expenses you paid to obtain the recovery. The Plan will not be responsible for legal fees and expenses you pay to obtain a recovery from another source, unless the Plan has previously agreed to that in writing; the Plan does not recognize the "Fund Doctrine". The Plan may require your attorneys to sign an agreement that they will honor and enforce the terms of the Reimbursement Agreement before they disburse any money received as recovery from a compensable injury.
- Under ERISA section 503(a)(3), the Plan has an equitable lien upon any recovery received by the Participant, dependent(s), or their attorney (if the attorney is holding the monetary recovery) as a result of compromise or by way of judgment on the claim. The Plan's equitable lien is for the repayment of benefits advanced by the Plan to, or on behalf of, the Participant or dependent(s). The Reimbursement Agreement documents the Plan's equitable lien – or claim – on the money you recover from another source, both to the full extent of the Plan's reimbursement rights and to the full extent of its right to repayment under the Reimbursement Agreement. The equitable lien is valid whether or not the Reimbursement Agreement or the Plan's subrogation rights are enforceable.
- You must protect the Plan's right to reimbursement for benefits paid and do everything necessary for the Plan's recovery of benefits it paid. You must assist and cooperate with Plan representatives and sign all required documents to recover benefits paid by the Plan.
- If the Participant or dependent(s) recovers money from a third-party who is or may be liable for the illness or Injury that gave rise to the claim for benefits from the Plan, including an insurance company or a worker's compensation carrier, the Participant, dependent(s) and their attorney (if the attorney is holding monetary recovery) shall hold the money in constructive trust for repayment to the Plan, up to the amount of the recovery. *The Plan has the right to recover or*

subrogate 100% of the benefits paid or to be paid by the Plan on behalf of the Participant or Dependent(s) to the extent of any and all of the following payments: Any judgment, settlement or any payment made or to be made because of an accident, including but not limited to other insurance. The Plan has first priority with respect to its right to reduction, reimbursement and subrogation from the amount of the monetary recovery. (September 30, 2008). This repayment obligation applies to the recovery of any monies, regardless of whether the payment is characterized as compensation for pain and suffering or something else, and regardless of whether the Participant or dependent(s) has been made whole as a result of the recovery. The Participant or dependent(s) and his or their (if the attorney is holding the monetary recovery) shall be fiduciaries with respect to the monies held in constructive trust.

- If you receive a judgment or settlement, you must repay the Plan the lesser of the full amount of benefits paid by the Plan, or the amount of the recovery. This provision applies whether or not the source of the recovery was legally responsible for paying those expenses. If you do not repay the Plan, the Plan may reduce future benefits for your claims until the Plan has recovered the benefits it paid. The Plan's right to reduce future benefits is in addition to any other legal rights the Plan may pursue to recover benefits.
- You, your Dependent or your Dependent's representative must:
    - not assign to any other person or entity your right to recover benefits from another source;
    - obtain the Plan's consent before releasing another person from liability for any Injury; and
    - not impair the Plan's claim and lien.

If you attempt to assign your right to recovery of benefits, the Plan may pursue legal action against you and the person or entity to which you assigned your rights, to cancel your assignment and recover the benefits paid by the Plan.

- As a condition for receipt of benefits arising from the treatment of injuries as a result of victimization from a crime or palpable crime, the claim or his/her representative must file a police report in the appropriate jurisdiction of the crime within a reasonable time of the commission of the crime, considering the totality of the circumstances. (November 13, 2012)

- The Plan is subrogated to your right to recover from another source.

Plan's Right of Subrogation

- Your agreement to repay in the Reimbursement Agreement and the Plan's right of subrogation are separate and distinct rights and obligations. If either the Agreement or the right of subrogation fails or is considered invalid in some way, it will not affect the validity of the other.
- The provisions in the previous section, *You Must Agree to Reimburse the Plan for Other Payments* also apply to the Plan's Right of Subrogation. If you fail or refuse to sign a Reimbursement Agreement, it does not affect the Plan's subrogation rights or the Plan's right to claim a lien against and collect benefits from any source of possible recovery.
- The Plan has the right to intervene and participate in any legal action you bring against another source.
- If you fail or refuse to take legal action against another source within a reasonable time, the Plan may do so in your name to recover amounts due under the subrogation provision. If the Plan takes legal action, the Plan has the right to deduct its expenses, costs and attorney's fees out of any recovery or settlement. The Plan is not required, by this provision, to pursue your claim against another person, however.
- If you recover benefits from another source and do not repay the Plan, the Plan may sue you to recover the amount of the benefits paid. The Plan may also reduce any of your future benefits until

the Plan is fully repaid, regardless of whether or not the future claim is related to the compensated Injury.

- If the Trustees determine that recovery from another source is not possible, the Plan may waive its rights to subrogation and reimbursement and pay its normal benefits for your claim.
- The Trustees or their authorized representative have the sole discretion to interpret the Plan's subrogation and reimbursement provisions and to settle any of the Plan's subrogation and reimbursement claims and liens.
- The Trustees have the sole discretion to make a determination regarding questions as to whether any benefit payment is related to a compensable Injury. The Trustees may condition your receipt of benefits on the requirement that you sign any and all necessary documents, releases and waivers that relate to their determination upon request.

Compensated Injuries

- If another source has already paid expenses toward treatment of your Injury, the Plan will not begin paying benefits until the total expenses for your compensable Injury exceed the total amount you have recovered from the other source.
- Any and all monetary recovery you receive will first be applied to benefits payable under this Plan.
- The Plan's subrogation and reimbursement rights are enforceable, regardless of:
    - who begins the legal action against the person or entity that is responsible for the Injury;
    - who pays the amount of the recovery;
    - whether the recovery is in the form of a judgment, settlement or otherwise; or
    - whether you receive the recovery as an employee, Dependent, legally competent or incompetent person or a representative of any such person.
- Nothing in this section will interfere with or limit the Fund's right to subrogation or reimbursement for health care expenses that were incurred and paid before you recovered the expenses from your Injury.

Important Information about the Plan

Name of Plan. This Plan is known as the Central Laborers' Welfare Fund.

Board of Trustees. A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of employer and union representatives, selected by the employers and the unions who have entered into collective bargaining agreements that relate to this Plan. If you wish to contact the Board of Trustees, you may use the address and phone number below:

Board of Trustees
Central Laborers' Welfare Fund
201 North Main
P. O. Box 1267
Jacksonville, Illinois 62651-1267
Telephone: (217) 243-8521 or toll free: (800) 252-6571
Electronic Mail Address: claims@central-laborers.com
Web site: www.central-laborers.com

The Trustees of the Plan are:

Board of Trustees

Union Trustees	*Employer Trustees*
Rusty Davenport	Adam Bruner
Robert McDonald	Ann Deedrich
Josh McElravy	Ed Doyle
Brad Schaive	Bob Dunn
Gregory Stimac	Roger Huebner
Brandon Royer	Donna Richter

You should send all correspondence to the Board of Trustees or any individual Trustee to the Central Laborers' Welfare Fund at the above address.

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

Identification Numbers. The Plan number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 37-6058345.

Agent for Service of Legal Process. Mr. Barry McAnarney is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any documents may be served upon Mr. McAnarney at the address shown in the front of this booklet. Service of legal process may also be made upon any of the Plan Trustees, individually.

Collective Bargaining Agreement. The relevant provisions in the collective bargaining agreement determine the hourly rate at which employers contribute to the Plan and the employees on whose behalf contributions are made. If you request it in writing, you and your Dependents may obtain:

- information about whether an employer is required to pay contributions to the Plan;
- the address of a particular Contributing Employer; and
- copies of the collective bargaining agreement.

You or your Dependents may also examine these documents and information at the Fund Office or your local union.

Source of Contribution. The benefits described in this booklet are provided through employer contributions. The amount of employer contributions is determined by the provisions of the collective bargaining agreement. Self-contributions from employees and surviving spouses are allowed under certain circumstances that are described in this booklet.

Trust Fund. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. The Welfare Fund's assets and reserves are invested primarily in short-term money market and government securities.

Type of Plan. This Plan is maintained for the purpose of providing death, disability and health care benefits in the event of death, Illness or Injury. The Plan benefits are shown in the *Schedule of Benefits* in the back pocket of this booklet.

Plan Year. The Plan Year is the calendar year (January 1 through December 31).

Eligibility. The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, denial or loss of any benefits are fully described in the Eligibility section of this booklet

Claim Procedure. The procedures to follow for filing a claim for benefits are set forth in this booklet. If all or any part of your claim is denied, you may appeal that decision.

Statement of Employee Retirement Income Security Act (ERISA) Rights

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

Receive Information about Your Plan and Benefits

You have the right to:

- examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration (PWBA);
- obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to furnish each Participant.

Continue Group Health Plan Coverage

You also have the right to:

- continue health care coverage for yourself, spouse or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event (you or your Dependents may have to pay for this coverage; review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA Continuation Coverage rights); and
- reduce or eliminate exclusionary periods of coverage for pre-existing condition limitations under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:
  - you lose coverage under the Plan;
  - you become entitled to elect COBRA Continuation Coverage; or
  - your COBRA Continuation Coverage ceases.

  You must request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition limitation for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty

to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Your Rights Regarding Claim Issues

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

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

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

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator at the Fund Office.

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

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the PWBA Brochure Request Line at (800) 998-7542 or contact the PWBA field office nearest you.

You may also find answers to your questions and a list of field offices using the PWBA's Web site at www.dol.gov/pwba.

Privacy Rules

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the rules issued by the U.S. Department of Health and Human Services. The privacy rules are effective as of April 14, 2003.

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

The Plan will distribute its Privacy Notice:

- before the privacy rules become effective;
- periodically, as required by the rules; and
- when changes are made in policies and procedures.

This Plan and the Plan Sponsor will not use or further disclose your protected health information except as necessary for the treatment, payment, health plan operations and Plan administration or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose your protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates," to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPPA with respect to your protected health information include the right to:

- see and copy your health information;
- receive an accounting of certain disclosures of your health information;
- amend your health information under certain circumstances; and
- file a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a Notice of Privacy Practices that provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Privacy Notice, questions about the privacy of your health information or to file a complaint about a privacy issue, please contact the Fund Office.

Definitions

Air Ambulance means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Allowable Charge for all claims except in the case of Emergency Services, non-emergency services from an out-of-network provider at certain network facilities, and Air Ambulance services from an out-of-network providers, means

- For a network provider, the negotiated fee/rate as stated in the agreement with the participating network provider; or
- For an out-of-network provider, the amount, as determined by the Board of Trustees, that this Plan will pay for a particular service or supply.
- The Board of Trustees has determined Allowable Charge to mean the amount most consistently charged by a licensed Physician or other professional provider for a given service. An Allowable Charge refers to a charge that is within the range of usual charges for a given service billed by most Physicians or other professional providers with similar training and experience in a given geographic area. When considering the range of usual charges, the Plan may consider discounted rates allowed by network providers as a basis for Allowable Charges.

The Allowable Charge or the amount paid by the Plan for any claim covered by the No Surprises Act shall be calculated as set forth in the Section of this SPD entitled "No Surprises Act."

Ancillary services are, with respect to a network facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by an out-of-network provider if there is no network provider who can furnish such item or service at such facility.

Body Organ means any of the following with respect to Transplant Surgery:

- kidney;
- heart;
- lung;
- liver;
- pancreas (when the condition is not treatable by use of insulin therapy);
- bone marrow; and
- cornea.

Continuing Care Patient means an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

A serious and complex condition means:

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

Cost sharing means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the Plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under the Plan.

Cost Sharing Amount means the Participant's cost-sharing for Emergency Services, Non-emergency Services performed by out-of-network providers at network facilities, and Air Ambulance services to be based on the Recognized Amount.

Covered Charges means the Usual and Customary Charges for services and treatments that are:

- ϖ covered under this Plan;
- ϖ for medical conditions covered under this Plan; and
- ϖ based on valid medical need according to accepted standards of medical practice.

Contributing Employer means an employer that, pursuant to the terms of a collective bargaining agreement, or other written agreement acceptable to the Trustees, agrees to contribute to the Central Laborers' Welfare Fund on behalf of individuals employed by the employer.

Custodial Care means the medical or non-skilled services that:

- ϖ do not seek to cure; or

ϖ are provided during periods when the medical condition of the patient is not changing or does not require the continuous administration of medical personnel.

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

Dependent means: (Effective November 2, 2018)

- Your lawful spouse; and
- Your child (including a natural child, legally adopted child, child formally placed for adoption, stepchild, and a child under legal guardianship) prior to the last day of the month of the child's 26th birthday.

- An unmarried child who is over age 26 who:

  - continues to be incapable of self-sustaining employment by reason of any handicap condition;
  - otherwise meets the criteria previously described;
  - is chiefly dependent upon you for lifetime care and supervision; and
  - who was considered to be handicapped upon reaching age 26.

  Upon request of the Plan, proof of such incapacity and dependency is to be furnished from time to time, but in no event more frequently than once a year. The child must maintain a principal residence with you for more than one-half of the calendar year and must be dependent on you for more than one-half of his or her support for the calendar year.

  - An unmarried disabled child who has reached age 26, is covered as a Dependent if the child does not live with you, provided that:

    - the child's parents:

      - are divorced or legally separated under a decree of divorce or separate maintenance;

      - live apart at all times during the last six (6) months of the calendar year;

      - provide over one-half of the child's support for the calendar year;

    - the child is in the custody of one or both of his or her parents for more than one-half of the calendar year; and

    - the child is the qualifying child or qualifying relative, as defined in the Tax Code, of one of the parents

- Your dependent child who is under age 26 and is named as an alternate recipient in a

Qualified Medical Child Support Order (QMCSO) approved by the Board of Trustees or a National Medical Support Notice issued by an authoritative agency within the state where the child, custodial parent or Participant resides.

- Notwithstanding anything contained in this Plan to the contrary, you or your Dependent has the affirmative duty to inform the Plan if and when an individual ceases to be a Dependent within sixty (60) days of such event.

Donor means a person who undergoes a surgical operation for the purpose of donating a Body Organ(s) for Transplant Surgery.

Durable Medical Equipment means equipment recognized as such by Medicare Part B and that:

- can stand repeated use;
- is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
- is usually not useful to a person in the absence of an Illness or Injury;
- is appropriate for home use;
- is related to the patient's physical disorder; and
- is approved in writing by a Physician as being Medically Necessary.

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

Emergency Services means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta). Emergency Services furnished by an Out-of-Network provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services

are furnished) also includes post-stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

- The provider or facility determines you are able to travel using nonmedical transportation or nonemergency medical transportation;
- You are supplied with a written notice, as required by federal law, that the provider is an Out-of-Network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any in-Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-Network providers listed; and

You give informed consent to continued treatment by the Out-of-Network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Out-of-Network provider may result in greater cost to the participant or beneficiary

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

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

Experimental and/or Investigational and/or Unproven means:

Any charge, expenses, service, supply or device that is deemed to be Experimental and/or Investigational and/or Unproven. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or Unproven.

The fact that an Experimental or Investigational or Unproven charge, expense, service, supply, or device regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

A charge, expense, service, supply or device will be deemed to be Experimental and/or Investigational or Unproven if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the charge, expense, service, supply or device was performed or provided or at the time the charge, expenses, service, supply or device was considered for Precertification, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the charge, expense, service, supply or device:**

1. The charge, expense, service, supply or device is described as an alternative to more conventional therapies in the protocols or consent document of the Physician, Hospital or health care provider that performs the service or prescribes the charge, expense, service, supply or device;
2. The prescribed charge, expense, service, supply or device may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or

scientific experts classify the charge, expense, service, supply or device as experimental and/or investigational or unproven or indicate that more research is required before the charge, expense, service, supply or device could be classified as equally or more effective than conventional therapies;

4. With respect to any charge, expense, service, supply or device regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the charge, expense, service, supply or device to be lawfully marketed and it has not been granted at the time the charge, expense, service, supply or device is prescribed or provided or a current investigational new drug or new device application has been submitted and filed with the FDA.

In determining if a charge, expense, service, supply or device is or should be classified as Experimental and/or Investigational or Unproven, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the charge, expense, service, supply or device was performed, provided or considered:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed charge, expense, service, supply or device;
3. Protocols of the Physician, Hospital or health care provider that renders, or if applicable, prescribes the charge, expense, service, supply or device;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed charge, expense, service, supply or device for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Centers for Disease Control & Prevention (CDC); or the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the U.S. such as Aetna, Anthem, CIGNA, or Unitedhealthcare (UHC), Tufts or MCG Care Guidelines, formerly Milliman Care Guidelines, or the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines or, the clinical decision support resource titled "UpToDate," McKesson Interqual criteria or Trilogy Claims Administrative Handbook, or the American Dental Association (ADA) with respect to a dental charge, expense, service, supply or device.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed charge, expense, service supply or device.
7. The latest edition of "The Medicare National Coverage Determinations Manual" or Medicare "Local Coverage Determinations" (LCDs).

Free-Standing or Ambulatory Treatment/Surgical Center means a licensed facility that:

Is recognized as an institution, place or building devoted primarily to the maintenance and operation of the performance of medical/surgical procedures. Such facility shall not provide beds or other accommodations for the overnight stay of patients; however, facilities devoted exclusively to the treatment of children may provide accommodations and beds for their patients for up to 23 hours following admission. Individual patients shall be discharged in an ambulatory condition without

danger to the continued wellbeing of the patients or shall be transferred to a hospital.

Home Health Care Agency means an agency or organization that:

- is primarily engaged in providing nursing and other therapeutic services;
- is federally certified and duly licensed, if such licensing is required;
- has policies established by a professional group associated with such agency, including at least one Physician and registered nurse, to govern the services provided;
- provides for full-time supervision of such services by a Physician or by a registered nurse;
- has its own administrator; and
- maintains a complete medical record on each patient.

Home Health Care Plan means a program:

- for you and your Dependent's continued care and treatment;
- established and approved in writing by the attending Physician; and
- certified by the attending Physician that proper treatment would require confinement in a Hospital in the absence of the services and supplies provided by the Home Health Care Plan.

Hospice is an organization licensed as a Hospice by the jurisdiction where it is located that focuses on comfort and pain relief rather than curative treatment for patients who have a prognosis of less than six months to live.

Hospice Care Agency means an agency or organization that provides or otherwise arranges for services to Terminally Ill patients on a 24-hour per day basis and:

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

Hospital means an institution that:

- is primarily engaged in providing, by or under the supervision of Physicians, inpatient diagnostic, surgical and therapeutic services for diagnosis, treatment and rehabilitation of Injured, disabled or sick persons;
- maintains clinical records on all patients;
- has by-laws in effect with respect to its staff of Physicians;
- has a requirement that every patient be under the care of a Physician;
- provides 24-hour nursing service rendered or supervised by a registered professional nurse;
- has a Hospital utilization review plan in effect;
- is licensed pursuant to any state or agency of the state responsible for licensing Hospitals; and

- has accreditation under one of the programs of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Unless specifically provided, the term Hospital does not include any institution, or part thereof, that is used principally as a rest facility, nursing facility, convalescent facility, facility for the aged, inpatient rehabilitation facility or for the care and treatment of alcoholism or drug abuse, except as mandated by state law. It does not mean any institution that makes a charge that you or your Dependent is not required to pay.

Illness means sickness, disorder or disease that is not employment-related. Pregnancy is treated the same as an Illness under this Plan for you or an eligible Dependent.

Independent Freestanding Emergency Department means a health-care facility (not limited to those described in the definition of Health Care Facility for non-emergency services) that is geographically separate and distinct from a hospital under applicable state law and provides Emergency Services.

Injury means physical damage to you or your Dependent's body caused by purely accidental means, independent of all other causes. Injuries that are not employment-related are considered for benefits under this Plan, except under the Life and Accidental Death and Dismemberment Benefits.

Medically Necessary or **Medical Necessity** means those services required to identify or treat a member's Illness or Injury, and that are determined by the Plan to be:

- consistent with the symptoms, diagnosis and treatment of the Participant's condition, Illness or Injury;
- in accordance with recognized standards of care for the Participant's condition, Illness or Injury;
- appropriate with regard to standards of good medical practice;
- not solely for the convenience of the Participant, Physician, Hospital or other health care provider; and
- the most appropriate level of service that can be safely provided to the Participant.

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

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Nutritional Counseling (effective 10/15/2018) means any charge, expense, service, supply or device that is ordered by a licensed physician, or his or her designated and licensed Physician's Assistant or Advanced Practice Nurse, and is provided by a registered dietician, licensed nutritionist or other qualified licensed health professional who has been formally trained in nutrition, is determined to be medical necessary and involves the direct assessment of a patient with the development of an individualized plan involving diet, counseling and/or other related nutritional therapies necessary to treat an acute or chronic condition.

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

Participant means an employee who becomes qualified for coverage upon satisfying the eligibility rules described in this booklet.

Physician means a duly licensed doctor of medicine authorized to perform a particular medical or surgical service within the lawful scope of his or her practice.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR 716-6(c).

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

Recognized Amount means, for items and services furnished by an out-of-network provider or out-of-network Emergency Facility, the Recognized Amount is one of the following:

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

Rehabilitation Services means the treatment modalities that are a part of a rehabilitation program that include physical therapy, occupational therapy and cardiac rehabilitation. The Plan does not cover inpatient rehabilitation.

Retiree means an Employee who was covered under the Central Laborers' Welfare Fund for at least 5 consecutive years immediately prior to his or her retirement and who qualifies for a pension under the Central Laborers' Pension Fund, or with proof of receipt of a pension from another Fund, either by reason of having attained retirement age or by reason of having attained disability pension status.

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

Transplant Surgery means the transfer of a Body Organ(s) from the Donor to the recipient.

Treatment Facility for Substance Abuse is a rehabilitation facility for the inpatient or outpatient 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 alcohol and/or drug abuse (substance abuse). To be considered an approved treatment facility for purposes of this Plan, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and must be approved by the Trustees or their administrative designees.

Usual and Customary Charges means the amount most consistently charged by a licensed Physician or other professional provider for a given service. A customary charge refers to a charge that is within the range of usual charges for a given service billed by most Physicians or other professional providers with

similar training and experience in a given geographic area. When considering the range of usual charges, the plans may consider discounted rates allowed by network providers as a basis for Usual and Customary Charges.

Well Child Required Immunization means any immunization that has been recognized and is required for school age and pre-school age children by the Department of Public Health.

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