Local No. 1 Health Fund
2018 Summary Plan Description
Plan C (Supplemental Plan A) and Plan D (Supplemental Plan B)

Effective January 1, 2019

This booklet has been prepared for active Participants of the Local No. 1 Health Fund and describes the benefits in effect as of January 1, 2018. This edition replaces and supersedes any previous Summary Plan Description ("SPD"). Full details are contained in the legal Plan Document. If there is a discrepancy between this booklet and the Plan document, the Plan document will govern. The Trustees reserve the right and have the authority to amend, modify, eliminate benefits, or terminate the Plan at any time. However, oral modifications are not permitted. (In particular, a quote for benefits does not serve to modify the terms of the Plan, and, if a quote is inconsistent with the Plan or SPD, the Plan and SPD govern.) In addition, the Trustees, or such other persons as delegated by the Trustees, have the discretion to interpret and construe the rules of the Plan.

This booklet contains a summary in English of the Local No. 1 Health Fund Plan A and Plan B. If you have any difficulty understanding any part of this booklet, contact Wilson-McShane, the Plan Administrator by:

- Calling 630-288-6868; or
- Writing to or visiting their office at Wilson-McShane, 1431 Opus Place, Suite 350, Downers Grove, IL 60515.

Wilson-McShane's office hours are 8:00 AM to 5:00 PM, Monday through Friday.

Este folleto contiene un resumen en inglés del Local No. 1 Health Fund Plan A y Plan B. Si tiene dificultad en entender cualquier parte de este folleto, contacte Wilson-McShane, el Administrador del Plan:

- Llamando al 630-288-6868; o
- Escribiendo o visitando su oficina en el Wilson-McShane, 1431 Opus Place, Suite 350, Downers Grove, IL 60515.

Las horas de trabajo de la oficina de Wilson-McShane son de 8:30 AM a 5:00 PM, de lunes a viernes.

W niniejszej broszurze znajdą Państwo informacje dotyczące Planu A i Planu B Miejscowego Funduszu Zdrowia nr 1. W przypadku jakichkolwiek dodatkowych pytań dotyczących treści broszury, prosimy o kontakt z Wilson-McShane, Administratorem Planu, w następujący sposób:

- Kontakt telefoniczny pod numerem 630-288-6868; lub
- Przesłanie korespondencji na adres siedziby bądź zgłoszenie się osobiście: Wilson-McShane, 1431 Opus Place, Suite 350, Downers Grove, IL 60515.

Godziny pracy Wilson-McShane: 8.30-17.00, Pn. – Pt.

INTRODUCTION

As a Participant in the Local No. 1 Health Fund, you are eligible for:

- Comprehensive Major Medical Benefits (Plan A or Plan B);
- Prescription Drug Benefits;
- Dental Benefits;
- Vision Benefits; and
- Member Assistance Program ("MAP") Benefits.

When you are initially eligible, you have a choice between two medical programs – Plan A and Plan B. In addition, the Plan currently has an annual open enrollment period during which time you may change medical programs. (Changes from one medical program to the other are not permitted except during the open enrollment period.) However, there is no guarantee that open enrollment will be offered every year. Open enrollment is offered only at the discretion of the Trustees and may not be offered in the future. This means that you should choose carefully between the two Plans – the choice that you make during the current open enrollment period will be in effect for at least one year and may be in effect indefinitely thereafter, depending on if and when the Trustees decide to offer another open enrollment opportunity. Indeed, it is possible that you will not have the opportunity to make a change again.

Regardless of the medical program you choose, you receive the same prescription drug, dental, vision, and MAP benefits. For more information on your medical plan choices, see page 21.

This booklet is designed to help you understand the benefits available to you. We urge you to read the booklet and share it with your family. In addition, we recommend that you keep this booklet with your important papers so you can refer to it when needed.

About This Booklet

In this booklet, we have tried to describe your benefits as completely as possible and in everyday language. We have also tried to organize the booklet and inserts in a way that will be useful to you. This booklet includes:

- A Schedule of Benefits provided by the Plan (included in the pocket of this booklet's folder);
- A listing of important contact information (included in the pocket of this booklet's folder);
- Information about when you and your Dependents can participate in the Plan;

- A life events section designed to show you how your benefits work and how they fit into the different stages of your life;
- An explanation of your coverage under each benefit program;
- Information about how to file claims and appeals;
- General Plan administrative information; and
- A glossary of important definitions.

Your Responsibility

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

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BECOMING A PARTICIPANT

Initial Eligibility

Employees of Contributing Employers may be eligible to participate in the Plan. Generally, you are eligible for benefits as of the first day of the month following three full months of Contribution obligation from your Employer to the Fund on your behalf. For example, if you are hired April 18, and your employer makes contributions to the Fund on your behalf for all of May, June, and July you will be eligible for coverage under the Plan as of August 1. You cannot decline coverage for yourself or your eligible Dependents, even if you have other coverage.

Dependent Eligibility

Your Dependent(s) becomes eligible for Plan benefits on the date that you become eligible or, if later, on the date you acquire a Dependent.

In general, your Dependents include your Spouse and your children.

However, you must notify the Fund Office of any Dependents, and provide any requested materials, before the Plan will pay benefits for your Dependents.

For a detailed definition of Dependent and a definition of Spouse and child, see the Glossary starting on page 99.

Please note that the Plan requires certain documentation as to whether a person actually qualifies as a Dependent as defined under the Plan.

Any Dependent that is not added to the Plan on the date of your eligibility or the date that the person first satisfies the Plan's definition of Dependent may be added to the Plan as of the first day of any month following the month in which you notify the Plan that you want to add this Dependent and provide the required documentation.

Enrolling For Coverage

In limited circumstances, the Plan covers domestic partners. Throughout this booklet, unless otherwise noted, the term Spouse is used to refer to a Participant's opposite or same sex spouse or same sex domestic partner or same or opposite sex civil union partner.

While your and your Dependents' eligibility for coverage is automatic when you meet the eligibility requirements, to be covered you must:

- Enroll for coverage (including providing all required documentation);
- Choose a medical plan; and
- Pay any required premiums for coverage.

When you are initially eligible, you will be provided with enrollment materials. These materials will inform you of your medical plan options (Plan A or Plan B) and provide the necessary forms you will need to complete for your medical coverage. It is important that you read these materials carefully and return the necessary forms.

When you are initially eligible, you have a choice between Plan A and Plan B. If you do not elect a plan when you are initially eligible, you will automatically be enrolled in Plan A.

Each year, during open enrollment, you will be given the opportunity to choose which medical plan option best suits you and your family (see page 21 for more information on your medical plan options).

Required documentation for enrollment includes (but may not be limited to) the following:

- With respect to the employee, a form of government-issued identification.
- With respect to a spouse, a marriage certificate and one of the following documents:
  - ♦ Page 1 and signature page of the employee's most recent federal income tax return or e-mail confirmation of certificate of filing the federal income tax return listing the spouse.
  - ♦ A document dated within the past six months such as a mortgage statement, home equity loan, lease agreement, automobile registration, or credit card or account statement in the name of both the member and spouse.
- With respect to a biological Dependent child, a birth certificate or a court order of adoption or placement for adoption, as applicable.
- With respect to an adopted child or a child placed for adoption, court order or certificate of adoption or placement for adoption or a birth certificate listing the employee as the parent.
- With respect to a foster child, the order or decree pursuant to which the foster child has been placed with the employee or the employee's spouse.
- With respect to a child covered pursuant to a qualified medical child support order, a copy of such order.
- With respect to a stepchild, a marriage certificate or a certificate of civil union indicating that the child's biological, adopted or foster parent is married to or in a civil union with the employee, and one of the following:
  - ♦ Birth certificate of stepchild.
  - ♦ Certificate of adoption or order of adoption.
  - ♦ Order of decree pursuant to which the child has been placed with the spouse as a foster child.
- With respect to a disabled child, proof that the child is your biological, adopted, step or foster child (as described herein) and one of the following as proof of the child's disability:
  - ♦ Proof of receipt of Social Security Disability Income.
  - ♦ Social Security Income Award Letter.
  - ♦ Letter from a disability insurance carrier classifying the child as disabled.

- With respect to a civil union partner, a certificate of civil union and one of the following documents:
    - ♦ Page 1 and signature page of the employee's most recent federal income tax return or e-mail confirmation of certificate of filing the federal income tax return listing the partner.
    - ♦ A document dated within the past six months such as a mortgage statement, home equity loan, lease agreement, automobile registration, or credit card or account statement in the name of both the member and partner.

In any event, the Plan Administrator may exercise its discretion to accept alternative documentation depending on the circumstances.

Special Enrollment

The Plan complies with the special enrollment rules.

See also "Getting Married" and "Adding A Child" under Life Events on page 17 for information on enrolling a new Dependent.

Continued Eligibility

Once you meet the initial eligibility requirements, you will continue to be eligible for benefits on a month-by-month basis. If the amount of Employer Contributions required for your coverage is made on your behalf for a month, your coverage will continue for the next two following months. For example, if the required Employer Contribution is made on your behalf for you and your Dependents for May, coverage will continue through July 30 (except in cases of termination of eligibility; see below).

The required Employer Contribution is determined by the terms of your Collective Bargaining Agreement. These amounts are subject to change.

If the required Employer Contribution made on your behalf in a month is less than the amount required for you to remain covered, you may continue your eligibility for that month by making Self-Payments (see the following information), provided that your Employer(s) has made contributions equal to or greater than the minimum required Contribution, as established by the Board of Trustees (and subject to change from time to time) and provided that your employment has not terminated.

Continuing Coverage Through Regular Self-Payments

You are eligible to make regular Self-Payments to continue your coverage if your coverage would otherwise end because Employer Contributions made on your behalf are less than the required amount for that month. (Self-Payments are not allowed, however, for a month in which there are no Employer Contributions at all. Additionally, self-payments are not allowed for a month in which Employer contributions do not equal or exceed the minimum required contribution as determined by the Trustees.) You may make a Self-Payment for that month to continue coverage for

you and your eligible Dependents. (Self-Payments also are not allowed for purposes of establishing initial eligibility, only for the purpose of continuing eligibility.)

The amount of your regular Self-Payment for a month is the difference between:

- The amount of Employer Contributions made on your behalf; and
- The required Employer Contribution amount for your coverage.

The Fund Office will notify you when you are eligible to make regular Self-Payments to continue coverage. The notice will be sent to your last known address and will include the Self-Payment amount needed to continue coverage.

While the Fund Office will attempt to notify you when a regular Self-Payment is due, it is your responsibility to make any required payments on time. **It is very important the Fund Office have your correct address on file at all times to ensure that you receive important information.**

If you elect to make a regular Self-Payment to continue coverage, the Fund Office must receive your payment no later than the last day of the month preceding the month in which you otherwise would lose eligibility. You can personally take your regular Self-Payment to the Fund Office or you can mail it. However, if mailing it, be sure to allow sufficient time for delivery. If the Fund Office does not receive your payment by the due date, you will not be eligible to continue coverage by making regular Self-Payments.

If you are eligible to continue coverage as outlined above, but you do not make the required regular Self-Payment by the due date, you may be eligible for COBRA Continuation Coverage (see page 5).

When Eligibility Ends

For You

Your eligibility for coverage under the Plan will end on:

- The last day of the month in which you terminate employment;
- The last day of the month following the last month for which you made a Self-Payment for coverage;
- The date that you or a covered Dependent defrauds or attempts to defraud, or makes a material misrepresentation to the Plan;
- The date the Plan is discontinued;
- The date of your death; or
- The date you enter the armed forces on full-time active duty (subject to the conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA)).

For Your Dependent

Your Dependent's eligibility for coverage will end on:

- The date your eligibility ends (for reasons other than your death);
- In the event of your death, the last day of the month in which you die;
- The last day of the month in which your Dependent no longer meets the Plan's definition of an eligible Dependent (such as child reaching a certain age or your divorce or legal separation);
- The date that you or your Dependent defrauds or attempts to defraud or makes a material misrepresentation to the Plan;
- The date the Plan no longer offers Dependent benefits; or
- The date the Plan is discontinued.

Continuing Coverage Through COBRA Continuation Coverage

This section provides a general explanation of COBRA Continuation Coverage, when it may be available to you and your family, and what you need to do to protect your right to receive it.

COBRA Continuation Coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. COBRA (and the description of COBRA Continuation Coverage included here) applies only to the group health benefits (medical, prescription drug, dental, vision and MAP) offered under the Plan and not to any other benefits that may be offered under the Plan or another plan in which you participate (such as life insurance, disability benefits, or accidental death or dismemberment benefits).

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage becomes available to you when you would otherwise lose your group health coverage under the Plan. It also becomes available to your Spouse (not including your domestic partner or civil union partner/spouse to whom you are not legally married) and Dependent children (your Dependents) who are covered under the Plan when they would otherwise lose their coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator. The Plan provides no greater COBRA rights than what COBRA itself requires, and nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements.

When your eligibility for health care coverage under the Plan ends, there may be other, possibly more affordable, coverage options for you and your family other than COBRA continuation coverage. Under key parts of the Affordable Care Act (the "Act"), you will be able to buy coverage through

the Health Insurance Marketplace, as described under the Act. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late (or mid-year) enrollees, if you request enrollment within 30 days. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What Is COBRA Continuation Coverage?

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this section. After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA Continuation Coverage is offered to each person who is losing coverage due to the event (known as a qualified beneficiary). You and your Dependents become qualified beneficiaries and are entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. Certain newborns, newly adopted children, and alternate recipients under Qualified Medical Child Support Orders (QMCSOs) also may be qualified beneficiaries with the same rights as all other qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay the entire cost of the COBRA Continuation Coverage plus an administrative fee.

COBRA Continuation Coverage is the same coverage that the Plan gives to other similarly situated persons under the Plan who are not receiving COBRA Continuation Coverage. This means, for example, that, if the Plan changes benefits for active Employees, your COBRA Continuation Coverage will change accordingly. Each qualified beneficiary who elects COBRA Continuation Coverage will have the same rights under the Plan as other persons covered under the Plan.

Qualifying Events And Entitlement To COBRA

If you are an Employee, you are entitled to elect COBRA Continuation Coverage if you would otherwise lose your group health coverage under the Plan because your:

- Hours of employment are reduced; or
- Employment ends for any reason other than gross misconduct.

If you are the Spouse (not including your domestic partner or civil union partner/spouse to whom you are not legally married) of an Employee, you

are entitled to elect COBRA Continuation Coverage if you would otherwise lose your group health coverage under the Plan because:

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse dies;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both) (not likely to cause a loss of coverage, however);
- You become divorced or legally separated from your spouse.

An Employee's Medicare entitlement is only a qualifying event for a Dependent if the Employee's Dependent actually loses coverage under the Plan as a result, which generally occurs only if the Employee voluntarily decides to drop coverage under the Plan.

If an Employee reduces or eliminates a Spouse's group health coverage in anticipation of a divorce or legal separation, and the divorce or legal separation occurs, the divorce or legal separation may be considered a qualifying event for the Spouse even though the coverage was reduced or eliminated before the divorce or separation.

Your Dependent children are entitled to elect COBRA Continuation Coverage if they would otherwise lose group health coverage under the Plan because the:

- Parent-Employee's hours of employment are reduced;
- Parent-Employee's employment ends for any reason other than gross misconduct;
- Parent-Employee dies;
- Parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- Parents divorce or legally separate; or
- Child no longer meets the Plan's definition of a Dependent.

You do not have to show that you are insurable to elect COBRA Continuation Coverage. However, COBRA Continuation Coverage is provided subject to your eligibility for such coverage. In particular, you must have been both eligible for coverage and actually covered by the Plan on the day before the date of the qualifying event. The Plan Administrator reserves the right to terminate your COBRA Continuation Coverage retroactively if you are determined to have been ineligible.

When COBRA Coverage Is Available

The Plan offers COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the

Employee's entitlement to Medicare benefits, the Employer must notify the Plan Administrator of the qualifying event. However, because Employers contributing to multiemployer funds may not be aware of all qualifying events, the Fund Office may rely on its records for determining whether eligibility is lost under certain circumstances.

When Notice Is Required

For other qualifying events (divorce, legal separation, or a dependent no longer meeting the Plan's definition of a Dependent), you are not entitled to COBRA Continuation Coverage unless you notify the Plan Administrator, in writing, within 60 days after the later of the date:

- Of the qualifying event; or
- On which the qualified beneficiary would otherwise lose coverage under the terms of the Plan because of the qualifying event.

The notice must be mailed or hand-delivered. For written notice that is:

- Mailed, by U.S. Mail or some other express delivery, the notice must be postmarked or sent no later than the deadline; or
- Hand-delivered, the notice must be received no later than the deadline.
- Notice is not acceptable if provided:
- Orally, including notice by telephone; or
- Electronically, including notice that is sent via e-mail or facsimile.

The notice may be provided by the covered Employee, another qualified beneficiary who would otherwise lose coverage due to the qualifying event, or a representative acting on behalf of either one.

The notice must contain the:

- Plan name;
- Name of the contributing Employer;
- Employee's name, address, birth date, and social security (or other identification) number;
- Name and address of any impacted spouse or Dependent;
- Description of the qualifying event;
- Date of the event; and
- Adequate documentation of the event (such as divorce decree or decree of legal separation or a copy of the dependent's birth certificate. A form for providing this notice may be available from the Plan Administrator but need not be used as long as all the relevant information is included in the written notice.

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

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

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

Electing COBRA Continuation Coverage

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees (and Spouses if the Spouse is a qualified beneficiary) may elect COBRA Continuation Coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA Continuation Coverage on behalf of their children.

Any qualified beneficiary for whom COBRA Continuation Coverage is not elected within the 60-day election period described in the Plan's COBRA Election Notice will lose his or her right to elect COBRA Continuation Coverage. However, if an Employee qualifies for federal trade adjustment assistance (TAA) under the Trade Act of 2002, as amended, then the Employee and his or her qualified beneficiaries will be provided an additional 60-day enrollment period with continuation coverage beginning on the date of such TAA approval. Further information is available at http://webapps.dol.gov/elaws/ebsa/health/employer/C19.htm.

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

Newborns And Adopted Children

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if a child is born to or placed for adoption with the covered Employee during a period of COBRA Continuation Coverage, that child will be eligible for COBRA Continuation Coverage. The newborn or child placed for adoption can be added to COBRA Continuation Coverage and become a qualified beneficiary under COBRA upon proper notification to the Plan Administrator, within 60 days of the birth and within 30 days of the adoption or during open enrollment, if the Plan offers open enrollment, provided payment of any required additional premium is made and required documentation is submitted by the applicable deadline. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Paying For COBRA Continuation Coverage

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

When And How COBRA Continuation Coverage Payments Must Be Made

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

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

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

Example

Sara's coverage ended on September 30. She elects COBRA Continuation Coverage on November 15 and makes her initial premium payment on December 15 (15 days before the December 30 deadline, which is 45 days after the date of the COBRA election). Sara's minimum required initial payment is the premium amount for coverage for October and November. Her December premium is due December 1, so, it too should be included, but because of the grace period, she has until January 15 to pay the December premium.

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

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

Monthly COBRA Continuation Coverage Payments

After you make your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent month of coverage. Under the Plan, each of these monthly payments for COBRA Continuation Coverage is due on the 1st of the month for that month's COBRA Continuation Coverage. If you make a monthly payment on or before the 1st day of the month for which it applies, your coverage under the Plan will continue for that coverage period without any break. If you do not make a monthly payment on or before the 1st day of the month, your coverage may be suspended pending payment. The Plan is not required to send monthly notices of payments due for these coverage periods. It is your responsibility to pay your COBRA premiums on time, regardless of whether you receive a monthly bill.

Although monthly payments are due on the 1st day of each month, there is a grace period until the 15th of the following month to make each monthly payment. Your COBRA Continuation Coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

If you do not make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan.

COBRA Continuation Coverage Periods

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee becoming entitled to Medicare benefits, the covered Employee's divorce or legal separation, or a Dependent child losing eligibility, COBRA Continuation Coverage may last for a total of up to 36 months. When the qualifying event is the end of employment or reduction of the Employee's

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

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

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

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA Continuation Coverage, under another group health plan (;
- A qualified beneficiary becomes entitled to Medicare benefits (Part A, Part B, or both) after electing COBRA Continuation Coverage; or
- During a disability extension period (as explained below), the disabled qualified beneficiary is no longer determined by the Social Security Administration to be disabled.

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

You must notify the Plan Administrator in writing within 30 days if, after electing COBRA Continuation Coverage, you or one of your family members enrolls in another group health plan or becomes entitled to Medicare. This notice should include the:

- Name and address of the covered or former covered Employee;
- Type and date of the initial qualifying event;
- Name and address of the qualified beneficiary who became covered by Medicare or another group health plan; and
- Date that Medicare or other coverage began.

Documentation of the date of Medicare entitlement or other group health coverage should be included (for example, a copy of the Medicare card or health insurance card). The notice may be provided by the covered or former covered Employee, a qualified beneficiary, or a representative acting on behalf of either, and such notice will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries. A form for providing this notice may be available from the Plan Administrator. The Plan reserves the right to terminate COBRA Continuation Coverage retroactively and to require reimbursement of all benefits paid after the date of commencement of the other health coverage or Medicare, regardless of whether or when notice is provided.

Extension Of COBRA Continuation Coverage Period

The period of COBRA Continuation Coverage resulting from a termination of employment or a reduction of hours may be extended in two ways.

Disability Extension

If a qualified beneficiary is determined by the Social Security Administration to be disabled and notifies notify the Plan Administrator in a timely fashion, all of the qualified beneficiaries in the family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA Continuation Coverage because of a covered Employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered Employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA Continuation Coverage that would be available without the disability extension (generally 18 months). A final determination of disability status must be made by the Social Security Administration before the end of the 18-month COBRA Continuation Coverage period.

The disability extension is available only if the Plan Administrator is notified of the Social Security Administration's decision, in writing, within 60 days after the latest of the date:

- Of the Social Security Administration's determination;
- Of the covered Employee's termination of employment or reduction of hours; or
- On which the qualified beneficiary loses (or would otherwise lose) coverage under the terms of the Plan as result of the termination or reduction in hours;

and within 18 months of the termination of employment or reduction in hours.

There is no disability extension of COBRA Continuation Coverage unless notice is properly provided. See page 8 for more information on when notice is required.

If the disabled person is no longer determined by the Social Security Administration to be disabled, you must notify the Plan in writing of that fact within 30 days after the determination. This notice should include the:

- Name and address of the covered or former covered employee;
- Type and date of the initial qualifying event;
- Name and address of the qualified beneficiary whose disability has ended;
- Date that the disability ended; and
- Date of the determination regarding cessation of disability.

A copy of the determination regarding cessation of disability should be included. The notice may be provided by the covered or former covered employee, a qualified beneficiary, or a representative acting on behalf of either, and such notice will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries. A form for doing so may be available from the Plan Administrator. Provided that the original 18-month period has elapsed, COBRA Continuation Coverage for all qualified beneficiaries will end (retroactively, if applicable) as of the first day of the month that is more than 30 days after a final determination that the qualified beneficiary is no longer disabled, regardless of whether or when the notice is provided. The Plan will require repayment of all benefits paid after the termination date.

Second Qualifying Event Extension

If your Dependents experience another qualifying event while covered under COBRA Continuation Coverage due to the covered Employee's termination of employment or reduction of hours (including COBRA Continuation Coverage during a disability extension period as described above), the Dependents receiving COBRA Continuation Coverage can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, provided notice of the second qualifying event is properly provided to the Plan. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits, or divorces or legally separates, or if the Dependent child no longer qualifies as a Dependent, but only if the event would have caused the Dependent to lose coverage under the Plan had the first qualifying event not occurred.

You must notify the Plan Administrator in writing within 60 days after a second qualifying event occurs if you want to extend your COBRA

Continuation Coverage. See page 8 for more information on when notice is required. The notice must include the:

- Plan name,
- Employee's name, address, birth date, and social security (or other identification) number;
- Name and address of any impacted spouse or Dependent
- Description of the qualifying event
- Date of the initial qualifying event (the termination of employment or reduction in hours);
- Date of the second qualifying event; and
- Documentation of the event (such as a death certificate or published obituary, divorce or legal separation decree, a copy of the Employee's Medicare card, a copy of the dependent's birth certificate, or a transcript showing the last date of the dependent's enrollment in an educational institution, as applicable).

The notice may be provided by the Employee or former Employee who is or was covered under the Plan, another qualified beneficiary who lost coverage due to the covered Employee's termination or reduction in hours and is still receiving COBRA coverage, or a representative acting on behalf of either one. A form for providing this notice may be available from the Plan Administrator but need not be used so long as all the relevant information is included in the written notice. There is no extension of COBRA Continuation Coverage unless notice is properly provided.

If You Have Questions

Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the Plan Administrator.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA), see page 96. For more information about health insurance options available through a Health Insurance Marketplace and to locate an assister in your area who can talk to you about the different options, visit www.HealthCare.gov or call 1-800-318-2596.

Additional Information About Eligibility

Keep Plan Informed Of Address Changes And Keep Copies Of Notices

To protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses

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

Reinstating Eligibility

If your eligibility for coverage under the Plan ends, you will need to meet the Plan's initial eligibility requirements to reinstate your eligibility for coverage (see page 1).

Rescission of Coverage

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

1. The Plan terminates your coverage back to the date of your loss of coverage due to loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.

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

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

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

LIFE EVENTS

Your benefits are designed to adapt to your needs at different stages of your life. Since different events can affect your benefits coverage, this section describes how your coverage is affected and what you may need to do when different events occur. For more information, please contact the Plan Administrator.

Getting Married or Entering Into a Civil Union

When you marry or enter into a civil union, your Spouse or civil union partner is eligible for medical, prescription drug, dental, and vision coverage as of the date of your marriage or civil union. However, the Fund will not pay any benefits on behalf of your Spouse or partner until you enroll your Spouse or partner for coverage. If you notify the Fund Office, in writing, within 30 days of your marriage or civil union benefits will be paid retroactively to the date of your marriage or civil union. If you do not notify the Fund Office, in writing, within 30 days of your marriage or civil union, your Spouse or partner's coverage will not begin until the first day of the month following the month in which you notify the Fund Office. Any Spouse or partner that is not added to the Plan upon first becoming eligible (or within 30 days of becoming eligible) may be added to the Plan as of the first day of the month following the month in which you notify the Plan that you want to add your Spouse.

To enroll your Spouse or partner, call the Fund Office and request an enrollment form. Complete the necessary form and return it to the Fund Office.

Adding A Child

Your natural child will be eligible for coverage on the date of birth. If you adopt a child, have a child placed with you for adoption, or have a foster child placed with you, he or she will be eligible for coverage on the date of placement as long as the child meets the Plan's definition of a Dependent child. Stepchildren are eligible for coverage on the date of your marriage.

However, you must enroll your child for coverage before the Fund pays any benefits for that child. To enroll your child for coverage, call the Fund Office and request an enrollment form. Complete the necessary form and return it to the Fund Office. With respect to an adoption, placement for adoption, or placement of a foster child, if you notify the Fund office, in writing, within 30 days of your Dependent becoming eligible, benefits will be paid retroactively to the date your Dependent became eligible (i.e., the date of adoption or placement). If you do not notify the Fund Office, in writing, within 30 days of your Dependent becoming eligible, your Dependents coverage will not begin until the first day of the month following the month in which you notify the Fund Office. With respect to

a newborn child, if you notify the Fund office, in writing, within 60 days of the birth, benefits will be paid retroactively to the date of birth. If you do not notify the Fund Office, in writing, within 60 days of the birth, the child's coverage will not begin until the first day of the month following the month in which you notify the Fund Office. Any Dependent that is not added to the Plan upon first becoming eligible (or within 30 or 60 (as applicable) days of becoming eligible) may be added to the Plan as of the first day of the month following the month in which you notify the Plan that you want to add this Dependent.

A Qualified Medical Child Support Order (QMCSO) could have an effect on your benefit coverage or elections. Please notify the Fund Office if your situation involves a QMCSO. You or your Dependent may request a free copy of the Fund's procedures for handling such orders.

Getting Legally Separated Or Divorced

If you and your Spouse get a legal separation or divorce, your Spouse will no longer be eligible for coverage. However, a Spouse may elect to continue coverage under COBRA for up to 36 months. You or your Spouse must notify the Fund Office within 60 days of the divorce or legal separation date for your Spouse to obtain COBRA Continuation Coverage.

Child Losing Eligibility

Limiting Age

Under the Plan, the limiting age for your Dependent child is age 26.

In general, your child is no longer eligible for coverage as of the last date of the month containing the date on which he or she reaches age 26. You should notify the Fund Office when this occurs.

Your child may elect to continue coverage under COBRA for up to 36 months. You or your child must notify the Fund Office within 60 days of the date your child no longer meets the eligibility requirements to obtain COBRA Continuation Coverage.

If your child is not capable of engaging in any substantial gainful activity upon attaining age 26 by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, you may continue coverage for that child for as long as your own coverage continues and the child depends on you for the major portion of his or her support. To qualify, your child's disability must begin before his or her coverage would otherwise end.

Taking A Family And Medical Leave Of Absence

Your entitlement to a leave of absence from work pursuant to the Family and Medical Leave Act (FMLA) will be determined by your Employer. The Fund plays no role in determining entitlement to FMLA leave.

If you and your Spouse both work for the same Employer, you and your Spouse are eligible for a combined total of 12 weeks of leave

The Fund will maintain your eligibility and medical coverage until the end of the leave, provided your Employer properly grants the leave under the federal law and makes the required notification and payment to the Fund. If you do not return to work at the expiration of FMLA leave, you may qualify for COBRA Continuation Coverage (see page 5). Contact your Employer for more information relating to a leave under the FMLA.

Taking A Military Leave

If you are called into military service (active duty or inactive duty training) for up to 31 days, your health coverage will continue as long as you make the required Self-Payment (which will be the same amount you previously had been paying). If you are called into military service for more than 31 days, you may continue your coverage by paying the required Self-Payments for up to 24 months or, if sooner, the end of the period during which you are eligible to apply for reemployment in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The required self-payment in this case may be up to 102% of the full cost coverage (with no subsidy required from the Plan).

Reemployment

Following your discharge from service, you may be eligible to apply for reemployment with your former Employer in accordance with USERRA. Such reemployment includes your right to elect reinstatement in any existing health care coverage provided by your Employer.

Your coverage under USERRA will continue to the earliest of the following:

- The date you or your Dependents do not make the required Self-Payments;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment and report back to work in accordance with USERRA;
- The last day of the month after 24 consecutive months; or
- The date the Fund no longer provides any group health benefits.

You need to notify the Fund Office in writing when you enter the military. For more information about Self-Payments under USERRA, contact the Fund Office.

If You Do Not Continue Coverage Under USERRA

If you do not continue coverage from this Plan under USERRA, your coverage will end immediately when you enter active military service.

Your Dependents will have the opportunity to elect COBRA Continuation Coverage.

When you are discharged or released from military service, USERRA specifies the time you have to return to work for a Contributing Employer. If your Employer reports your return to work to the Fund Office within these timeframes, your eligibility and your Dependents' eligibility will be reinstated on the day you return to work. If you do not return to covered work within these timeframes, you will be considered a new Employee and you will need to satisfy the initial eligibility requirements (see page 1).

In The Event Of Death

In the event of your death, your Spouse and eligible Dependent children may continue coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary Self-Payments (see page 10).

When You Stop Working

Coverage for you and your Dependents will end if Contributions needed to maintain your eligibility are not made on your behalf (see page 3). You may be eligible to continue coverage by electing COBRA Continuation Coverage and making the necessary Self-Payments for such coverage by the due date (see page 10).

MEDICAL BENEFITS

Your medical benefits are designed to help protect you and your family against catastrophic medical expenses as well as to provide you with preventive care services. The medical program pays benefits for a wide range of services and supplies, including doctor charges, diagnostic testing, Hospital charges, and surgery. Medical programs available under the Plan include:

If you elect coverage under Plan A, you must use a Union Health Service (UHS) Physician to coordinate all of your medical coverage.

- Plan A; and
- Plan B.

Both programs cover the same range of services. However, certain Plan provisions may vary between the programs. The *Schedule Of Benefits* inserts in the pocket of this booklet's cover outlines the benefit coverage available under Plan A and Plan B.

Enrolling For Benefits: Selecting Plan A or B

When you are initially eligible, you have a choice between Plan A or Plan B. If you do not elect a plan when you are initially eligible, you will automatically be enrolled in Plan A. Regardless of the medical plan under which you are covered, you receive the same prescription drug, dental, vision, and MAP benefits.

You may elect to change from Plan A to Plan B or vice versa only during the Plan's open enrollment period. Generally, the open enrollment period occurs once each year. If you elect to change medical programs, the change will be effective as of January 1 of the next following year (unless specified otherwise).

While you always have the final say about the Physicians and Hospitals you and your family use, **it is important to note that under Plan A, benefits are only paid if your care is received from or coordinated by a Union Health Service (UHS) Provider**. In other words, if UHS does not either provide or approve the care, it will not be covered. If you are a Plan A Participant, you will be asked to choose a primary care Physician who will coordinate your care, including making referrals to specialists (including mental health and substance abuse professionals) in or outside the UHS network, or providers outside the UHS network, as determined by the primary care Provider. Therefore, it is very important that you consider your options carefully and choose the Plan that is best for you and your family. However, you will have the right to designate as your primary care provider any UHS primary care Physician who is available. Also, you may designate a Physician who specializes in pediatrics as the primary care provider for a child. You do not need prior authorization from Union Health Service 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 at Union Health Service 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 information on how to select a primary care Physician, and for a list of Union Health Service primary care Physicians, including health care professionals who specialize in pediatric, obstetrics or gynecology, contact Union Health Service at the number shown on the *Important Contact Information* insert in the pocket of this booklet's folder.

How The Medical Program Works

Network And Non-Network Providers

To save you and the Fund money, the Fund has negotiated prices with two networks:

The Plan generally pays a higher percentage of Covered Expenses when you use a Network Provider.

- *For Plan A Participants,* UHS is the network administrator with respect to services it provides, as well as with respect to most Physicians to whom it refers you for services. With respect to any other services you receive (for example, services provided by Hospitals), Blue Cross Blue Shield of Illinois (BCBSIL) is the PPO Network administrator. You must have your care provided by or approved by a UHS Provider to receive coverage under the Plan.

- *For Plan B Participants,* BlueCross BlueShield of Illinois (BCBSIL) is the PPO Network administrator Each time you need health care, it is your decision whether to use a Network or Non-Network Provider.

Network Provider

Network Providers are health care providers who participate in the network and have agreed to charge negotiated rates.

When you or your family use a Network Provider (a provider that participates in one of the networks), you maximize the amount of health care benefits you receive. Since Network Providers have agreed to charge negotiated rates, your out-of-pocket expenses are less than if you use a Non-Network Provider (a provider that does not participate in the network under which you are covered). A Non-Network Provider has not agreed to accept discounted amounts for services and may bill you for the full amount of charges, which may be above the amount eligible for payment under the Plan. Also, the Plan pays a higher Coinsurance Percentage with respect to Network Providers as compared to Non-Network Providers.

Generally, the provider networks are large enough to provide most health care services that you and your family will need. However, since health care is a very personal issue, sometimes you might prefer to go to a provider that does not participate in the Plan's networks. The Network/Non-Network Provider feature of our Plan accommodates these

circumstances. Each time you receive medical care, you can choose whether to use a Network Provider. However, remember that to encourage you to use Network Providers whenever possible, the Plan pays a higher percentage of your health care expenses when you go to a Network Provider. **In addition, *for Plan A Participants*, your care must be provided by or coordinated by a UHS Provider to receive coverage under the Plan. This means that there will be no coverage for Non-Network Providers under Plan A unless approved by UHS**.

What provider you use is your decision. However, remember that the Plan and network administrator are not liable for any act or omission of any provider. The fact that a provider is a Network Provider is not a recommendation or referral, nor is it a statement as to the ability or quality of that provider by the Plan or network administrator. In addition, the fact that a provider is a Non-Network Provider is not a statement as to the provider's skill or quality by the Plan or network administrator.

To take advantage of the savings the network provides, you must check to see if your provider is in the network (providers participating in the network change periodically). In addition, you must show your ID card at the time that you receive services. To find a Network Provider in Plan A, contact UHS (and remember, all care must be approved by UHS). To find a Network Provider in Plan B, you can:

- Ask your provider if he/she participates in the network; or
- Contact the network directly–by phone or by visiting their Web site (see your identification card or the *Important Contact Information* insert in the pocket of this booklet's folder). Information about network providers is available free of charge upon request.

Remember that Network Providers have agreed with the network administrator to charge discounted rates for their services. As part of these agreements, the network administrator may receive payments or additional discounts, rebates, or allowances from the providers. These agreements between the network administrator and providers do not affect your entitlement to benefits under the Plan.

If you need to see a Physician:

- Call to make an appointment.
- Write down any questions you may have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- Make a list of any medications you are taking. Be sure to note how often you take the medications.
- Show your ID card when you go to your appointment.
- File a claim with the Fund Office if your provider does not file claims for you. It is a good idea to make a copy of any supporting materials for your records before submitting the claim.

Annual Deductible

An annual Deductible is the dollar amount you must pay each year before the Plan begins to pay benefits for covered services. You do not need to meet the annual Deductible before the Plan begins to pay benefits for certain medical services (see the *Schedule Of Benefits* inserts in the pocket of this booklet's cover).

Any amounts used to satisfy your annual Deductible applies to both your network and non-network annual Deductible.

In the event that two or more eligible family members are injured in the same accident, only one Deductible will apply to Covered Expenses that are a direct result of the accident.

Copayment

Copayment is the charge you are responsible for paying for certain covered health services (after you meet the annual Deductible, if applicable). Copayment amounts may be expressed as flat dollar amounts or percentages (see the *Schedule Of Benefits* inserts in the pocket of this booklet's cover).

Out-Of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount you pay out of your pocket in a Calendar Year for covered medical expenses. Once you reach the Out-of-Pocket Maximum in a Calendar Year, the Plan pays 100% of most covered medical expenses for the rest of the year, up to any specific benefit maximums (see the *Schedule Of Benefits* inserts in the pocket of this booklet's cover).

The Out-of-Pocket Maximum includes the annual Deductible (if applicable) and the percent the Plan does not pay (when the Plan pays less than 100%). However, the following charges do not apply toward your Out-of-Pocket Maximum:

- Expenses that are not covered under the Plan;
- Expenses that exceed the Reasonable and Customary Charge;
- Expenses that exceed any Plan maximum or limitation;
- Non-Precertification/Failure to Notify Deductibles;
- Expenses for services that are not Essential Health Benefits, such as, but not limited to chiropractic care expenses, acupuncture expenses, non-surgical TMJ treatment, and podiatry expenses (other than the removal of nail roots and care prescribed by a licensed physician treating a metabolic or peripheral vascular disease); and
- Expenses paid for prescription drugs (unless billed by the Hospital), dental care, and vision care.

Notwithstanding the preceding, a separate Out-of-Pocket Maximum applies to prescription drugs as set forth in the *Schedule Of Benefits* inserts in the pocket of this booklet's cover.

Benefit Maximums

While covered under the Plan, you and each covered Dependent can receive medical benefits up to any specific benefit maximums specified in the *Schedule Of Benefits*. There are no overall annual or lifetime maximums in the Plan. Also, annual benefit maximums are not applicable to benefits determined by the Plan to be "Essential Health Benefits" under the Affordable Care Act.

Your Responsibility

It is your responsibility to pay for any charges that are:

- Not considered Covered Medical Expenses;
- In excess of the Reasonable and Customary Charge;
- Used to satisfy any applicable Deductibles;
- Not paid by the Plan after the Plan has paid the Plan's portion; and
- In excess of any specific Plan maximum or limitation.

Medical Review And Precertification

The Plan offers a Medical Review and Precertification Program that specializes in helping you receive quality treatment, and at the same time, helping you maximize your Plan benefits. This program helps ensure that you get the right care at the right time because the program evaluates the necessity, appropriateness, and efficiency of the use of certain medical services, procedures, and facilities.

Generally, services and supplies that are Medically Necessary, efficiently provided in the most appropriate setting, and consistent with the way other providers would treat the same condition will be precertified.

If you do not obtain precertification when required, you must pay the Plan's Non-Precertification Deductible before the Plan pays any benefits. (Merely receiving a quote for benefits from the Fund Office does not satisfy your obligation to obtain precertification.) In addition, if you do not obtain precertification and the services provided are determined not to have been medically necessary, or otherwise fail to comply with Plan requirements (for example, regarding bariatric surgery), then you run the risk that there will be no coverage at all. Precertification is required for:

- Inpatient Hospital admissions (excluding maternity admissions, but including Inpatient hospitalization to treat a Mental health or Nervous Disorder or a stay at a Chemical Dependency Treatment Facility);
- Hospice care;
- Outpatient surgery;

- Confinement in a Skilled Nursing Facility;
- Home health care (including occupational therapy that is provided as part of home health care);
- Purchase of Durable Medical Equipment over $500 and all rentals of Durable Medical Equipment;
- Gender reassignment surgery;
- Occupational, speech and physical therapy;
- Bariatric surgery;
- Prophylactic mastectomy and oophorectomy surgery;
- Nutritional supplements; and
- Genetic testing.

Precertification review is merely a process for making a decision regarding the Plan's coverage provisions. You, in consultation with your physician, are responsible for making decisions regarding appropriate treatment and care.

To get precertification, you, a family member or your Physician or Hospital must call the Medical Review Program provider (the "MRP provider," also referred to as the "Review Organization") (see the *Important Contact Information* insert) before receiving any non-Emergency care. If you are a Participant in Plan A, all services also must be authorized by Union Health Services ("UHS"), otherwise there will be no coverage at all.

In the event of an Emergency, you should follow the notification procedures set forth below.

Plan A: Emergency Services Notification Procedures

If you are a participant in Plan A, in the event of an Emergency, there are two different entities – Union Health Services ("UHS") and the Review Organization -- that each must be notified as follows. Failure to notify either UHS or the Review Organization will result in reduced or no coverage as described below:

1. You must notify UHS by calling 1-312-423-4200 within 48 hours of your admission for receipt of emergency care. Merely presenting your insurance card to the Hospital will not satisfy this requirement. **Failure to timely notify UHS will result in your claim being denied in its entirety.**

   Additionally, if at all possible, you should try to contact UHS before seeking Emergency care so that UHS can help you determine whether a true Emergency exists. (If an Emergency does not exist, the Plan will pay only 50%, so it is important to know whether UHS considers your situation to be an Emergency.)

2. In addition, Plan A has a Medical Review and Notification Program that helps you to receive quality treatment and maximize Plan benefits. **If you do not provide after-the-fact notification when required with respect to Emergency services, you must pay the Plan's "Non-precertification/Failure to Notify Deductible" before the Plan pays any benefits.** The amount of the Non-precertification/Failure to Notify Deductible is set forth in the Schedule of Benefits insert and must be paid in addition to the annual deductible required by the Plan if you fail to contact the Review Organization, as required.

   In the event of an Emergency, to satisfy this notification requirement, the Review Organization must be notified within 48 hours of your admission to the Hospital in connection with receipt of the Emergency care. Failure to so notify the Review Organization will result in you being required to pay the Non-precertification/Failure to Notify Deductible. Again, merely presenting your insurance card to the Hospital will not satisfy this requirement – you must confirm with the Hospital that it notified the Review Organization or you must do so yourself.

Where emergency services are sought for a medical condition that is not an Emergency, even if pre-authorization is obtained, the Plan will only cover 50% of such services, if any. Remember that if you are covered under Plan A, your medical care must be provided by, or referred or authorized by, a UHS doctor to be covered under the Plan.

If you are not sure whether your situation constitutes an "Emergency" as defined in this Summary Plan Description, you should contact UHS at 312-423-4200 x 3228 to discuss the situation. If UHS determines that it is, in fact, an Emergency, it will direct you to the appropriate Emergency Room facility.

Plan B: Emergency Services Notification Procedures

Plan B also has a Medical Review and Precertification Program that helps you to receive quality treatment and maximize Plan benefits. **If you do not provide notification when required with respect to Emergency services, you must pay the Plan's "Non-precertification/Failure to Notify Deductible" before the Plan pays any benefits.** The amount of the Non-precertification/Failure to Notify Deductible is set forth in the Schedule of Benefits insert and must be paid in addition to the annual deductible required by the Plan.

In the event of an Emergency, to satisfy the notification requirement, the Review Organization must be notified within 48 hours of your admission for receipt of the emergency care. Failure to so notify the Review Organization will result in you being required to pay the Non-precertification/Failure to Notify Deductible. Merely presenting your insurance card to the Hospital will not satisfy this requirement – you must confirm with the Hospital that it notified the Review Organization or you must do so yourself**. Additionally, if the Review Organization finds**

that an emergency did not exist at the time of services, the Plan will pay only 50%.

Covered Medical Expenses

The Plan pays eligible expenses based on the Reasonable and Customary Charge for a service, supply, care, treatment, or procedure. The Plan's medical benefits cover the following eligible expenses, up to the limits shown on the applicable *Schedule Of Benefits* in the pocket of this booklet's folder.

General Medical Coverage

- Room and Board Charges (up to the semi-private room rate) in a Hospital, Skilled Nursing Facility, or Chemical Dependency Treatment Facility, including general duty nursing care related charges, and charges incurred for Hospital intensive care units and nursery charges for healthy newborn infants (excluding charges for newborn children of Dependent children).

  This Plan will not restrict Hospital benefits for any length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require a Physician to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. However, the mother's or newborn child's Physician is not prohibited, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours).

- Miscellaneous services and supplies provided by a Hospital, Skilled Nursing Facility, Chemical Dependency Treatment Facility, network Outpatient Surgical Center (non-network Outpatient Surgical Centers are not covered), or Emergency Treatment Center on an inpatient or outpatient basis, including, but not limited to:

  The Plan does not cover expenses incurred at a **non-network** Outpatient Surgical Center.

  - ♦ Operating room, fracture room, and other rooms for surgical services;
  - ♦ Diagnostic X-rays and clinical and pathological laboratory examinations;
  - ♦ Anesthesia supplies and administration of anesthesia;
  - ♦ Physician services for anesthesia administration and for interpretation of X-rays, electrocardiograms, and laboratory and pathological tests, provided the Physician is not an employee of the facility where the services are provided;

- ♦ X-ray and radioisotope treatments and examinations, electrocardiograms, electroencephalograms, and basal metabolism determination;
- ♦ Restorative, development, and maintenance physical therapy, provided there are documented results and the services are provided by an individual appropriately licensed to provide such services and acting within the scope of such license, and provided that such services are precertified as Medically Necessary as by the Medical Review Program Provider;
- ♦ General nursing care; and
- ♦ Medications listed in the U.S. Pharmacopoeia (including, but not limited to, medications administered intravenously).

All of the above services and supplies are covered on the same basis as any other Hospital charge (as set forth in the *Schedule of Benefits*).

- Emergency medical care in an emergency, as follows:
  - ♦ *For Plan A Participants,* the Plan covers services and supplies provided for and in connection with UHS-approved treatment provided in a Hospital outpatient or Emergency Department or an Emergency Treatment Center.
  - ♦ *For Plan B Participants,* the Plan covers services and supplies provided for and in connection with treatment provided in a Hospital outpatient or Emergency Department or an Emergency Treatment Center.
  - ♦ *For both Plan A and Plan B Participants,* Non-Network Provider services will be paid at the Network Provider Coinsurance rate and subject to the Network Provider annual Deductible.
- Outpatient surgery services and supplies in a Hospital outpatient department or Network Outpatient Surgical Center.
  - ♦ *For Plan A Participants,* the surgery must be performed by a UHS Physician or a Physician to whom you have been referred by a UHS Physician to be covered.
  - ♦ For either Plan A or Plan B Participants, surgery performed in a Non-Network Outpatient Surgical Center is not covered.

- Reconstructive breast surgery following a mastectomy will be covered on the same basis as other surgical procedures covered by the Plan and includes:

  ♦ Reconstruction of the breast on which a mastectomy is performed;

  ♦ Reconstructive surgery on the other breast to produce a symmetrical appearance;

  ♦ Prostheses and surgical bras following a mastectomy; and

  ♦ Physical complications of any stage of mastectomy, including lymphedemas.

The Plan complies with the Women's Health and Cancer Rights Act of 1998 and provides medical and surgical benefits in connection with a mastectomy, as described to the left.

- Prophylactic mastectomies and oophorectomies for "high-risk" women with respect to their proclivity for breast cancer or ovarian cancer will be covered even without a prior cancer diagnosis on the same basis as other surgical procedures covered by the Plan provided that the Medical Review Program Provider precertifies such surgery as Medically Necessary.

Gender reassignment surgery for individual over age 18 will be covered on the same basis as other surgical procedures covered by the Plan, subject to the exclusion for cosmetic surgery and provided that the Medical Review Program Provider precertifies such surgery as Medically Necessary. Other services to treat gender dysphoria also will be covered subject to being Medically Necessary.

- Bariatric surgery for covered Employees and their covered spouses/civil union partners and domestic partners will be covered on the same basis as other surgical procedures covered by the Plan provided that the surgery is performed at a "center of excellence" for bariatric surgery (as identified by Plan B's PPO Network administrator) and provided that the Fund's Medical Review Program Provider precertifies the procedure as Medically Necessary. The Plan will not cover bariatric surgery for dependent children and will cover only one bariatric surgical procedure per person per lifetime.

  For purposes of determining Medical Necessity with respect to bariatric surgery, the Medical Review Program Provider may require, among other things, that the person meet the following criteria:

  ♦ The person must be at least 100 pounds over his/her medically desirable weight;

  ♦ The person must have a body mass index (BMI) of 45 or more;

  ♦ The obesity must be a threat to the person's life due to life threatening co-morbidities, such as diabetes, hypertension, heart disease, etc.;

- ♦ The person must have a documented history of unsuccessful weight loss attempts;
- ♦ The person must undergo a psychiatric evaluation and must have no significant psychiatric conditions that could reduce the chances that the surgery is successful and will continue to be successful in the future; and
- ♦ The person must enroll and participate in a weight management program through the Medical Review Program Provider for six months prior to being eligible for bariatric surgery.

  Note: Nutrition counseling generally is excluded from Plan coverage as a form of special education; however, nutrition counseling will be covered to the extent that it is part of the weight management program.

- Services and supplies provided for and in connection with administration of anesthesia (other than local infiltration anesthesia or topical anesthesia), including administration of the anesthesia, administration of fluids and/or blood incident to the anesthesia administration, and preoperative and post-operative visits, provided such visits are made by and the anesthesia is administered by a Physician other than the operating Physician.
- Services and supplies provided for and in connection with chemotherapy for cancer treatment.
- Services and supplies provided for and in connection with radiation therapy, including:
  - ♦ Physician services and supplies for providing X-ray, radium, radon, or radioisotope therapy to treat an Eligible Individual who has a cancerous condition;
  - ♦ Physician services and supplies for providing radioisotope therapy to treat an Eligible Individual who has a specific condition of hyperthyroidism, chronic angina pectoris, or chronic cardiac decompensation; and
  - ♦ Any necessary miscellaneous services and supplies provided by a Hospital outpatient department because of X-ray, radium, radon, or radioisotope therapy provided by a Physician, as described above.
- Rental, up to the purchase price, of Durable Medical Equipment (up to the maximums listed on the *Schedule Of Benefits* inserts in the pocket of this booklet's cover), Hospital-type equipment, such as a Hospital bed, wheelchair, or similar therapeutic equipment. If the total rental fee would be more than the purchase price, the Plan may approve purchase of the equipment.

- Physician, dentist, or oral surgeon services for treatment of a non-occupational Injury to the jaw or sound natural teeth, resulting from an accident, including Hospital expenses incurred while confined for such dental care and treatment, if such Hospital confinement is Medically Necessary.
- Private duty professional nursing care provided by an RN or an LPN in the Hospital or in the patient's home when the attending Physician certifies, in writing, that the nursing care is Medically Necessary and is not for the purpose of companionship. A nurse who is not an employee of the Hospital in which the person may be confined must provide the nursing care.
- Local professional ambulance service or transportation services as follows:
  - ♦ Emergency local transportation by a professional ambulance service, limited to the first trip to and from a Hospital for any one Sickness or for all Injuries sustained in one accident; and
  - ♦ If a Physician certifies that an Eligible Individual's disability requires specialized treatment that is not available in a local Hospital, transportation will be covered provided:
    - The transportation is by regularly scheduled airline or railroad, or if Medically Necessary, by air ambulance;
    - The transportation is from the city where the non-occupational Injury or Sickness occurred to the nearest Hospital qualified to provide the special treatment;
    - The transportation is limited to the continental limits of the United States, Canada, or within the geographical boundaries of Puerto Rico or Hawaii.
- X-ray and laboratory examinations, tests, or analyses made for diagnostic or treatment purposes.
- Whole blood, blood plasma or other human blood derivatives, on an inpatient or outpatient basis.
- Oxygen, oxygen administration, and rental of equipment for its administration, on an inpatient or outpatient basis.
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in surgical dressings, casts, splints, braces, and trusses, crutches, and surgical supplies, on an inpatient or outpatient basis.
- Initial charges for surgical supplies required to aid any impaired physical organ or part of an organ in its natural body function.
- Initial charges for appliances to replace physical organs or parts of organs that are lost, including such items as artificial limbs and eyes to replace natural limbs and eyes.

- Prosthesis, up to the maximums listed on the *Schedule Of Benefits* inserts in the pocket of this booklet's cover, once in any five-year period or, for a Dependent child under age 19, when necessary due to growth.
- Charges for non-Emergency care when travelling outside the United States are covered as out-of-network charges.
- *For Plan B Participants*, Physician services and X-ray and laboratory examinations performed to obtain a second surgical opinion.
- Physician services for surgery and medical treatment, on an inpatient or outpatient basis.
- Nutritional supplements if approved by the Review Organization, except that with respect to Plan A Participants only, amino acid-based elemental formulas will be covered without precertification by the Review Organization to the extent that Union Health Services is required to provide such formulas pursuant to Illinois law.
- Acupuncture services.
- Hearing examinations and aids so long as the exam is performed and the hearing aid is prescribed by a licensed otologist, otolaryngologist, audiologist, or someone certified to dispense hearing aids.
- Restorative, developmental, and maintenance physical and speech therapy when the services are provided by an individual appropriately licensed to provide such services and acting within the scope of such license, are precertified as Medically Necessary by the Plan's Medical Review Program Provider, and there are documented results.
- Podiatry services (including routine foot care).

Mental Health And Substance Abuse Treatment

The Plan pays Physician and Hospital services and supplies for and in connection with treatment of mental health (Mental or Nervous Disorders) and substance abuse (Chemical Dependency and alcoholism) in the same way as any other illness, as specified and up to the limits shown on the *Schedule Of Benefits*.

The Plan pays for mental health and substance abuse treatment provided by a Psychiatrist, Psychologist, Social Worker, substance abuse counselor, or other healthcare provider who legally is licensed and/or authorized to practice or provide service, care or treatment of behavioral health disorders under the law of the state or jurisdiction where the services are rendered:

- Inpatient treatment;
- Partial hospitalization;
- Day care (intensive outpatient care);

- Outpatient (office) visits provided in or by a Hospital or approved treatment facility; and
- Outpatient (office) visits.

Outpatient Pre-Admission Testing Benefits

The Plan covers necessary outpatient pre-admission tests made before a Hospital admission, including X-rays, laboratory tests, and any other studies or tests related to the surgery or condition requiring the hospitalization.

To be considered Covered Expenses, the tests or services must be:

- Ordered by the attending Physician or surgeon;
  - ♦ *For Plan A Participants,* the attending Physician or surgeon must be a UHS Physician or surgeon;
- Performed in the outpatient department of the Hospital to which you are being admitted;
- Related to the condition or surgery requiring the Hospital confinement;
- Medically valid at the time of Hospital admission;
- Performed within seven days of the start of the Hospital confinement;

The Plan will not pay for:

- Any Hospital expenses (including Room and Board Charges and miscellaneous expenses) incurred for any day before the surgery or other procedure that required Hospitalization is performed if tests or services are performed after you are admitted to the Hospital when they could have been provided on an outpatient basis before the admission;
- Charges incurred for diagnoses, research, case findings, or surveys; and
- Charges incurred for the tests if the individual refuses to undergo, cancels, or postpones the surgery or cancels or postpones the Hospital confinement unless the cancellation or postponement is due to circumstances beyond the control of the individual.

Skilled Nursing Facility Care Benefits

The Plan covers services and supplies provided for, or in connection, with an approved confinement in a Skilled Nursing Facility following a Hospital confinement up to the maximums shown on the *Schedule Of Benefits* in the back pocket of this booklet.

To be considered an approved confinement, the confinement must be:

- At a facility that meets the Plan's definition of a Skilled Nursing Facility;

- Certified by the attending Physician as necessary for the patient's recuperation from an Injury or Sickness;
- Preceded by at least three consecutive days of a Hospital confinement for which Plan benefits are payable;
- Due to the condition that required the previous Hospital confinement; and
- Begin within three days after a Hospital or Skilled Nursing Facility confinement for which Plan benefits are payable ends.

For Plan A Participants, the attending Physician must be a UHS Physician.

Home Health Care Benefits

The Plan only covers home health care provided by an agency that meets the Plan's definition of an approved Home Health Agency. The Plan covers the following services and supplies provided by a Home Health Agency because of an approved program of home health care:

- Part-time or intermittent nursing care provided by or under the supervision of an RN;
- Part-time or intermittent home health aide services;
- Medical social services provided under the direction of a Physician;
- Medical services of interns and residents in training under an approved teaching program of a Hospital with which the Home Health Agency is affiliated; and
- Medical supplies (other than drugs and biologicals).

The above items will be covered on an outpatient basis at a Hospital or Skilled Nursing Facility if they are:

- Provided under arrangements made by the Home Health Agency;
- Involve the use of equipment of such a nature that the items and services can not readily be made available to the individual in his/her place of residence; and
- Are furnished at a facility to which the individual has gone to receive any item or service involved in the use of such equipment.

Occupational Therapy

The Plan generally covers restorative, developmental and maintenance occupational therapy sessions that are Medically Necessary in order to restore a loss of or achieve or maintain function provided there are demonstrable results. However, there will be no coverage under the Plan where such therapy is not provided by an individual appropriately licensed to provide such services or not acting within the scope of such license. In addition, in order for occupational therapy to be covered under the Plan, you must obtain precertification.

Developmental Delay Therapy

The Plan pays benefits for developmental delay therapy services, including those that treat autism spectrum disorders, such as applied behavior analysis (ABA) therapy, so long as such services are provided by a health care provider who is appropriately licensed or certified to provide such services and is acting within the scope of his or her license or certification under applicable state law. In addition, in order for developmental delay therapy to be covered under the Plan, you must obtain precertification.

Routine Examinations And Preventive Care Benefits (including Cancer Screenings and Well Child Care)

Notwithstanding anything herein to the contrary, the Plan pays 100% of the Reasonable and Customary Charge without copayments or Coinsurance or the application of a Deductible for preventive care and routine examinations that are required to be covered by the Affordable Care Act of 2010 if the preventive services are provided by a Network Provider, subject to the frequency, gender and age guidelines established under the Affordable Care Act. If a preventive service that is required to be covered by the Affordable Care Act is not provided by any Network Provider, and is provided only by a Non-Network Provider, the Plan will pay 100% of the cost of such service. Otherwise, benefits for services received from Non-Network Providers will be paid according to the *Schedule of Benefits*, subject to Deductible, a Coinsurance Percentage, and/or Copayments.

The Plan pays benefits each year as specified in the applicable *Schedule Of Benefits* insert in the back pocket of this booklet. Covered expenses include Physician services and screening tests order by the Physician, such as, but not limited to (as further detailed at https://www.healthcare.gov/preventive-care-benefits/):

- Routine physicals (one annually);
- X-rays;
- Laboratory tests;
- Mammograms;
- Pap smears;
- Cancer screenings;
- Genetic testing;
- Obesity screening and weight-management interventions;
- Inoculations;
- Vaccinations;
- Flu shots;

- Women's wellness services;
- Well child care (including routine Physician's office visits, checkups, and immunizations and inoculations); and
- Smoking cessation intervention.

For a complete list of covered preventive services, please visit https://www.healthcare.gov/preventive-care-benefits/.

If, as the result of a routine physical an Injury or Sickness is diagnosed that requires treatment, such treatment will not be considered part of the routine examination and preventive care benefits but will be covered as any other covered medical expense under the Plan. Likewise, expenses incurred in connection with the assessment or treatment of a developmental, behavioral, emotional, or learning disorder are not part of the routine examination and preventive care benefits but will be covered as any other covered medical expense under the Plan.

Live Donor Benefits

Live donor benefits include covered medical expenses in connection with donation of body tissue or organ(s) to an Eligible Individual.

If the donor is covered under another plan, the Plan will coordinate benefits with the donor's (if benefits are available) other coverage, with the donor's plan paying benefits first.

To be covered under the Plan's live donor benefits, the transplant procedure cannot be Experimental or Investigative.

Plan A: Additional Services Provided by Union Health Services

For Plan A Participants only, Union Health Services provides certain additional medical benefits not specified herein as required by law and as set forth in the subscription certificate issued by Union Health Services. If you have any questions about what additional benefits may be available, please review the subscription certificate or contact Union Health Services.

Medical Expenses Not Covered Under The Plan

Medical benefits provide coverage for most medical expenses related to a Sickness or Injury. You should be aware that some expenses are not covered by the Plan. See General Plan Exclusions And Limitations beginning on page 51 for expenses that are not covered under the Plan. Additionally, there is no coverage for Medical benefits for the following:

- Eye examinations, eye refractions, eyeglasses, contact lenses (except the first pair of contact lenses required following cataract surgery), dental prosthetic appliances, or any services provided for the fitting of such appliances. (However, while not a covered medical benefit expense, these services may be a covered dental or vision expense; see those sections of this document for more information.)

PRESCRIPTION DRUG BENEFITS

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Plan's prescription drug program offers a:

- Retail Pharmacy Program for your short-term prescription needs, up to a 30-day supply; and
- Mail Service Program for your long-term prescription needs, up to a 90-day supply at one time.

If you are taking a prescription on a long-term basis, you should use the Mail Service Program (see page 41).

Most prescription medications have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness – and the generic medication costs less.

You should discuss with your Physician if a generic equivalent is available for any prescriptions you need filled.

Generic Equivalents, Preferred Brand And Non-Preferred Brand Name Medications

A generic equivalent is a copy of a brand-name medication that is no longer protected by a patent. A generic medication usually serves the same purpose as the original medication, but the generic medication's purchase price is less than the brand name.

In general, using generic medications will help control the cost of health care while providing quality medications – and, generic equivalents can be a significant source of savings for you, and the Plan. Your doctor or pharmacist can assist you in substituting generic medications when appropriate.

If there is no generic substitute available for a brand name drug, a preferred brand name drug will cost you less out of pocket than a non-preferred equivalent in the same therapeutic class. The Plan's prescription benefit manager maintains a list of preferred brand name drugs. The current list of preferred brand name medications is available on the Web site of the prescription benefits manager or by calling the prescription benefits manager. The preferred list may change periodically at the discretion of the prescription benefits manager. Such changes are made in part to keep current with new drugs as they become available. If you have taken a preferred brand name drug in the last 90 days, you will be notified of any changes to the list of preferred brand name drugs that might impact you. The presence of a drug on the list of preferred medications is not a statement as to its appropriateness or effectiveness in any particular circumstance; the decision as to which drug should be prescribed and dispensed is to be made by you in consultation with your Physician.

If you or your eligible Dependent request a brand name medication when a generic equivalent is available (and approved by your Physician), you will be responsible for paying the difference in cost between the generic and brand name medication, in addition to your copayment amount.

Certain brand name drugs are not covered at all. However, this will only be the case where another drug in the same therapeutic class is available. If you receive one of these excluded drugs, you will pay the full cost out of your own pocket. For more information, please contact the prescription benefit manager.

For further information as to applicable Copayments and Coinsurance percentage with respect to prescription drugs, please see the *Schedule of Benefits* insert in the pocket of this booklet.

Prior Authorization

The Plan requires prior authorization by the prescription benefit manager for certain drugs or certain uses (including use at certain quantity levels). For a list of other drugs or uses for which Prior Authorization is required, contact the prescription benefit manager at the phone number included in the Important Contact Information sheet inserted into the pocket of the folder containing this document.

The Plan reserves the right to modify the list from time to time as new drugs reach the marketplace, or as the FDA approves established drugs to treat other diagnoses, or if it is determined that the drug is being used for off-label, cosmetic or wellness purposes. "Off-label" means that the drug is being used for a purpose not approved by the FDA when it approved the drug for sale in the United States or through subsequent applications by the manufacturer. The dispensing pharmacy will notify you if a drug is added to this list.

Drug Quantity Management

The Plan reserves the right to limit the number of units filled per prescription for certain drugs or for non-daily dosages or to adjust the dosage so as to assure cost-effective and medically effective dosing (for example, requiring that medication be taken once per day at 40mg instead of twice per day at 20 mg, or, as another example, requiring three 30-day fills to ensure therapy tolerance before moving to a 90-day fill). The Plan reserves the right to determine in consultation with the prescription benefits manager which drugs will be so limited and to modify at any time such determinations with respect to limits. You will be notified by the dispensing pharmacy of any applicable limitations.

Retail Pharmacy Program

Your ID Card

You will receive a prescription drug ID card. You should present your ID card when you have prescriptions filled at a participating retail pharmacy. When you present your ID card at a Participating Pharmacy, once you have met your prescription drug annual Deductible (applicable only to brand-name drugs at retail), all you need to do is pay your applicable copayment (see your *Schedule Of Benefits* in the back pocket of this

booklet for the copayment you pay). You do not have to complete any claim forms.

Prescription Drug Annual Deductible

Each year, you are responsible for meeting the Plan's per person annual prescription drug Deductible, up to the family maximum, before the Plan begins paying prescription drug benefits. The prescription drug annual Deductible only applies to brand-name drugs at retail.

To ensure that your expenses are applied to your prescription drug annual Deductible, you should use your prescription drug ID card at a participating retail pharmacy. If you do not show your ID card, you must submit your claim directly to the prescription benefits manager to have your expenses applied toward meeting your prescription drug annual Deductible. Also, keep in mind that if you do not show your ID card when filling a prescription at a retail pharmacy you do not receive your prescription at the discounted price, which means you pay more. Also, if you do not go to a Participating Pharmacy, not only will you pay full price, but there will be no Plan coverage. Prescription drugs are covered only when purchased at a Participating Pharmacy.

Please note that the amounts you pay toward the prescription drug annual Deductible are not counted toward the Plan's medical annual Deductible or medical Out-of-Pocket Maximum. However, a separate prescription drug Out-of-Pocket Maximum applies to prescription drugs as set forth in the *Schedule Of Benefits* inserts in the pocket of this booklet's cover.

When you have a prescription filled at a participating retail pharmacy:

- Present your ID card; and
- Pay your copayment.

Retail Pharmacy Program Limits

a prescription is for a long-term, maintenance medication, after the initial fill and one refill, you must have the prescription filled either at a CVS retail pharmacy or through the Mail Service Program for it to be covered under the Plan.

Participating Pharmacies

Once you meet your prescription drug annual Deductible, you can have your prescription filled for up to a 30-day supply of medication at a Participating Pharmacy by:

Prescriptions filled at non-participating pharmacies are not covered under the Plan.

- Presenting your ID card; and
- Paying the applicable copayment listed on the *Schedule Of Benefits*, depending on whether it is a generic or brand name medication.

There are no claim forms to file and you will receive your prescription at discounted prices. Remember that if a brand name medication is requested when a generic equivalent is available (and approved by your Physician), you are responsible for paying the difference in cost between the generic and brand name medication, in addition to your copayment amount.

If you do not have your ID card with you when purchasing a prescription, you must pay the full cost of the prescription. You will then need to submit a reimbursement form to the prescription benefit manager. You will be reimbursed the Reasonable and Customary Charge of each eligible prescription above your applicable copayment amount.

Prescriptions filled at non-participating pharmacies are not covered under the Plan.

Mail Service Pharmacy Program

The Mail Service Program allows you to get up to a 90-day supply of a prescription at one time.

After an initial fill at retail and one refill, you must either use a CVS retail pharmacy or use the Mail Service Program when you need to have prescriptions filled for maintenance medications. Maintenance medications are those you take on an ongoing basis for the treatment of chronic, long-term conditions, such as diabetes, asthma, depression, arthritis, heart conditions, or high blood pressure.

When you order a maintenance medication by mail or fill a maintenance medication prescription at a CVS pharmacy, you can get up to a 90-day supply at one time, often for a lower cost than you would pay at a retail pharmacy (other than CVS). The delivery service is free, and you don't have to make a trip to the pharmacy.

To use the Mail Service Program:

If you need to begin taking a medication right away, you may want to ask your Physician for two prescriptions:

- A short-term supply, up to 30 days, that you can have filled right away at a participating retail pharmacy; and
- A 90-day, refillable supply that you can have filled through the Mail Service Program.

- New prescriptions may be submitted directly from the doctor's office or through the mail or via the prescription benefit manager's web-based on-line portal. If your doctor does not submit the prescription to the Mail Service Program for you, then ask your doctor to provide you with a written prescription indicating the medication, dosage, your doctor's name, and your name, address, and phone number. Be sure to write the member's identification number on the back of your prescription.
- To order through the mail, fill out a mail service enrollment/order form, which can be obtained either by contacting the prescription benefit manager by phone or via its web-based on-line portal. (see the *Important Contact Information* insert in the back pocket of this booklet for provider information). Be sure to indicate SEIU Local No. 1 Health Fund on the form.
- Send the prescription, form, and your copayment to the benefit manager as directed on the paper form or via its web-based on-line

portal (see your *Schedule Of Benefits* insert in the back pocket of this booklet for copayment amounts).

That is all you need to do. The prescription drug provider will have your prescriptions delivered directly to your home.

Ordering Refills

When you need a refill for a Mail Service Prescription, all you need to do is:

- Contact the prescription benefit manager by visiting its web site, using its mobile app on your portable device, or calling its toll-free number (see the *Important Contact Information* insert in the back pocket of this booklet for provider information).
- Provide your member number and credit card number.

You may also mail in a prescription refill, using the same procedure you used to have the initial prescription filled (see previous section).

Specialty Pharmacy Program

Specialty Pharmacy is a unique service model designed to help people manage complex conditions and their associated treatments. Certain chronic and/or genetic conditions require special pharmacy products, often in the form of injected, inhaled or infused medicines. These drugs often require special handling and their use often requires extra monitoring. Medicines handled by the specialty pharmacy may include:

Any expenses you incur for covered prescription drugs do not apply toward meeting your medical annual Deductible or Out-of-Pocket Maximum.

- Injectable, inhalable or infusions,
- High cost medicines, and
- Medicines that have special delivery or storage requirements (such as refrigeration).

Certain medications may be obtained only through the Specialty Pharmacy. The prescription benefits manager has the sole discretion to determine which medications those are. Typically, your Physician, nurse, pharmacy, or other provider will inform you if a prescribed medication must be obtained through the Specialty Pharmacy. If you have questions concerning what medicines are provided by the Specialty Pharmacy under this plan, you may contact the prescription benefit manager directly at the telephone number provided in the Important Contact Information insert in the back pocket of this booklet.

SavOn Program

The Plan is implementing a Specialty Pharmacy Copay assistance program called the SavOn Program. Certain Specialty Pharmacy drugs are not considered Essential Health Benefits under the Plan, and thus the cost of

such drugs will not be applied toward satisfying your Out-of-Pocket Maximum. Although the cost of the SavOn Program drugs will not be applied towards satisfying your Out-of-Pocket Maximum, the cost of the Program drugs will be reimbursed by the manufacturer at no cost you. Copayment for medications that are included in the SavOn Program will be higher than the copayments otherwise set forth in the Schedule of Benefits; typically, those copayments will be set to the maximum level of available manufacturer-funded copayment assistance. However, you will not pay more for these drugs; rather due to the manufacturer copayment assistance, you may pay less or even nothing at all. To find out whether a particular drug is part of the SavOn Program, visit www.saveonsp.com/seiu1. If a drug you are taking is included in the program, the Specialty Pharmacy will work with you to secure the maximum amount of copayment assistance available.

Step Therapy Program

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

Any expenses you incur for covered prescription drugs do not apply toward meeting your medical annual Deductible or Out-of-Pocket Maximum.

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

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

Covered Expenses

For a prescription medication to be covered, the medication must be:

- Prescribed by a licensed Physician;
- A legend medication approved by the Food and Drug Administration (FDA); and

- Purchased at a Participating Pharmacy or through the Mail Service Program.

Covered Expenses also include certain over-the-counter contraceptives, diabetic supplies, smoking cessation products, aspirin, folic acid and certain other over-the-counter medications as prescribed by a licensed Physician to the extent required under the Affordable Care Act as set forth at https://www.healthcare.gov/preventive-care-benefits/.

Special Coverage for Preventive Medications

Certain preventive medications (including, but not limited to, contraceptives and smoking cessation medications and products, and breast-cancer risk reducing medications) will be covered without the application of a Deductible, copayment or Coinsurance Percentage, to the extent required under the Affordable Care Act as set forth at https://www.healthcare.gov/preventive-care-benefits/. This will apply only to generics unless no generic is available, or the generic is medically inappropriate.

Expenses Not Covered

In addition to the General Plan Exclusions on page 51, expenses not covered under the prescription drug benefit include:

1. Prescriptions for long-term or maintenance medications filled at a retail pharmacy (other than a CVS retail pharmacy), after an initial fill and two refills.

2. Prescriptions filled at a non-Participating Pharmacy.

3. Prescriptions incurred for or in connection with any Injury, Sickness, condition, or type of treatment that is excluded from coverage under the Plan.

4. Compound drugs that contain any ingredient on a list of excluded ingredients maintained by the Plan's prescription benefit manager.

5. Medications that are administered intravenously (such medications instead are covered under the Medical Benefit, as described in the previous section).

6. Medications purchased over-the-counter (except with respect to medications required to be covered by the Affordable Care Act as set forth at https://www.healthcare.gov/preventive-care-benefits/).

7. Medications that are excluded entirely from coverage. (To determine whether a mediation is excluded, please contact the prescription benefit manager by telephone or consult

the prescription benefit manager's website or mobile application.)

DENTAL BENEFITS

Dental Benefits are the same for Plan A and Plan B Participants.

Dental benefits help you manage the amount you pay for dental care and treatment. Dental benefits are provided through insured contracts with BlueCare Dental HMO and BlueCare Dental PPO. At open enrollment, you may choose to enroll in either the HMO or PPO. If you are enrolled in the HMO, services must be provided by a BlueCare Dental HMO provider except in cases of emergency (see below) or if you have received written authorization from your BlueCare Dental HMO provider. Under the PPO, you may see any provider you wish without a need for referral.

Benefits under the HMO are paid according to a schedule of maximum amounts, and under the PPO, according to a schedule of maximum allowances for participating providers and based on usual and customary fees for non-participating providers. Under the Dental HMO, you may be required to pay a copayment for services. Under the Dental PPO, you pay a portion of expenses, up to the annual maximum set forth in the Schedule of Benefits. In addition, there is a deductible under the PPO for restorative and major services.

Blue Care Dental PPO Providers

When you or your family use a PPO Provider (a provider that participates in the dental network), you maximize the amount of dental benefits you receive. Since dental PPO Providers have agreed to charge negotiated rates, your out-of-pocket expenses are less than if you use a Non-PPO Provider (a provider that does not participate in the network under which you are covered). A Non-Network Provider has not agreed to accept discounted amounts for services and may bill you for the full amount of charges, which may be above the amount eligible for payment under the Plan. Also, the Plan pays a higher Coinsurance Percentage with respect to PPO Providers as compared to Non-PPO Providers.

What provider you use is your decision. However, remember that the Plan and network administrator are not liable for any act or omission of any provider. The fact that a provider is a PPO Provider is not a recommendation or referral, nor is it a statement as to the ability or quality of that provider by the Plan or network administrator. In addition, the fact that a provider is a Non-PPO Provider is not a statement as to the provider's skill or quality by the Plan or network administrator.

To take advantage of the savings the network provides, you must check to see if your provider is in the network (providers participating in the

network change periodically). In addition, you must show your ID card at the time that you receive services.

To locate the nearest participating BlueCare Dental PPO provider:

- Ask your provider if he/she participates in the PPO network.
- Contact BlueCare Dental PPO directly by phone (see the *Important Contact Information* insert in the back pocket of this booklet).
- Consult the Dental Benefits Provider website as shown on the "Important Contact Information" sheet in the pocket of your folder. Periodically the list is updated. When you call for an appointment, verify with your provider that he or she participates in the BlueCare Dental PPO program.

Remember that PPO Providers have agreed with the network administrator to charge discounted rates for their services. As part of these agreements, the network administrator may receive payments or additional discounts, rebates, or allowances from the providers. These agreements between the network administrator and providers do not affect your entitlement to benefits under the Plan.

BlueCare Dental HMO Providers

When you receive care from a BlueCare Dental HMO provider, the Plan covers dental services up to the scheduled maximum amount after you pay any applicable copayment or coinsurance. If you do not use a BlueCare Dental HMO provider, your dental expenses are not covered under the HMO.

You must select a participating BlueCare Dental HMO provider for benefits to be covered under the Plan. You may change your dental office location at any time, effective the first of the month after the election to change, so long as the election is received by the 20th of the prior month. To locate the nearest participating BlueCare Dental HMO provider or to change your dental provider:

- Contact BlueCare Dental HMO directly by phone (see the *Important Contact Information* insert in the back pocket of this booklet).
- Consult the Dental Benefits Provider website as shown on the "Important Contact Information" sheet in the pocket of your folder. Periodically the list is updated. When you call for an appointment, verify with your provider that he or she participates in the BlueCare Dental program.

There are no claims to file. However, it is important to show your Provider your ID card.

Emergency Dental Care under the HMO

If you need Emergency dental care on a day when your dental office is closed, call the BlueCare Dental number to find an emergency provider.

If you are outside the area, Emergency dental care from a non-BlueCare dentist is limited to temporary palliative treatment for the immediate relief of the Emergency. Emergency dental care includes treatment for severe pain, trauma, swelling, or uncontrolled bleeding. Your BlueCare Dental provider must provide any follow up care. Care received on an Emergency basis from a non-BlueCare Dental provider is limited to the maximum amount shown on the BlueCare Dental HMO Schedule Of Benefits and should be authorized in advance by BlueCare Dental.

Broken fillings or broken prosthetic appliances are not considered an Emergency. You should contact your dental office during regular business hours for treatment.

Covered Services

A general description of covered dental services follows. See the BlueCare Dental HMO and PPO Benefits Schedules (either in the pocket of your folder or mailed to you separately) for more detailed information.

- ***Diagnostic Care:*** The Plan covers necessary procedures to aid in evaluating existing conditions and determining what dental care is needed, including:
  - ♦ Visits and consultations.
  - ♦ One full-mouth X-ray.
  - ♦ Other routine X-rays, including bitewing and panoramic.
  - ♦ Diagnostic and treatment planning services.
- ***Preventive Care:*** The Plan covers necessary procedures that prevent oral disease, including:
  - ♦ One prophylaxis (cleaning and polishing) in any six-month period, including an exam.
  - ♦ One topical fluoride application and nuvaseal treatment in any 12-month period for dependent children.
  - ♦ Palliative treatment (Emergency treatment for the relief of pain).
- ***Oral Surgery:*** The Plan covers necessary operative procedures (including preoperative and postoperative care) for extractions and other dental surgery under local anesthetics that do not require hospitalization.
- ***Restorative Care:*** The Plan covers necessary procedures for restorative dental services, including:

Hospitalization is covered for certain dental services, as explained in your BlueCare Dental Schedule of Benefits.

Gold, baked porcelain restorations, inlays, crowns, and bridges are only covered if a tooth cannot be restored with amalgam, composite, or resin.

- ♦ Amalgam and resin-based composite restorations.
- ♦ Crowns and bridges when teeth cannot be restored with a filling material.
- ♦ Mouth rehabilitation, limited to those procedures necessary to eliminate oral disease and replace missing teeth. (The balance of the treatment cost is the responsibility of the patient.)

- ***Periodontics:*** The Plan covers necessary surgical and non-surgical procedures for treatment of disease of the gums and bones supporting the teeth.
- ***Endodontics:*** The Plan covers necessary procedures for the treatment of diseases of the pulp chamber and pulp canals.
- ***Prosthodontics:*** The Plan covers necessary procedures for providing artificial replacement for missing natural teeth, including:
- Construction, placement, insertion, or repair of crowns or bridges.
- Partial and complete dentures.
- ***Orthodontics:*** The Plan covers necessary procedures for straightening teeth and providing proper occlusion.

Dental Expenses Not Covered Under The Plan

Please see your BlueCare Dental Schedule of Benefits for additional limitations and exclusions.

You should be aware that some expenses are not covered by the Plan. In addition to any General Plan Exclusions And Limitations (see page 51), those dental expenses listed in the BlueCare Dental certificates as excluded, are not covered under the Plan.

VISION BENEFITS

Vision Benefits are the same for Plan A and Plan B Participants.

Eye care is an important part of your overall health. The Trustees recognize this and, as a result, provide vision care benefits for you and your Dependents. Vision benefits are provided through an insured contract with EyeMed Vision Care. In-Network benefits are paid according to a schedule of maximum amounts after you pay any applicable Copayment or coinsurance. Out-of-Network benefits are paid up to a maximum allowance. The following is a summary of Covered Expenses; see the EyeMed Vision Care summary of benefits included in the back pocket of this booklet for more detailed information.

Covered Services

The Plan covers benefits for you and your Dependents as shown on the information in the back pocket of this booklet. Vision benefits are covered once in each 12-month period. Covered services include:

When you need vision care, schedule an appointment with an EyeMed provider. There are no claim forms to file.

If you do not go to an EyeMed provider, some vision care expenses are not covered under the Plan.

- Eye examinations with dilation as needed.
- When a vision analysis indicates that glasses should be prescribed, or that the existing prescription needs to be updated, the Plan covers lenses and/or frames.

In addition to the vision expenses covered under the Plan, Eligible Individuals are eligible to receive discounted pricing on additional pairs of glasses or contact lenses when obtained from an EyeMed provider.

Vision Expenses Not Covered Under The Plan

You should be aware that some expenses are not covered by the Plan. In addition to any General Plan Exclusions And Limitations (see page 51), the vision expenses listed in the EyeMed Vision Care Certificate included in the back pocket of this booklet for more detailed information as not covered are excluded.

MEMBER ASSISTANCE PROGRAM

The Plan provides you and/or your Dependents a Member Assistance Program ("MAP") at no cost. The MAP offers confidential services to guide and assist you and/or your Dependents in the appropriate diagnosis and course of treatment for substance abuse care or mental health care. This may include developing and approving courses of treatment for alcohol or drug abuse, addiction issues, and/or mental health issues, or referring you to another provider.

You can receive your initial consultation over the telephone. If face-to-face counseling is necessary, you can be referred to a location near your home or work. The counselors will also be able to provide information on community resources for elder and child care, self-help groups such as Alcoholics Anonymous or Gamblers Anonymous, and financial and legal services for debt management.

The Plan has contracted with a MAP Provider (identified below in the "Administrative Information About the Plan" section) to provide MAP services. The Fund Office will not have access to the MAP Provider's records, which will remain strictly confidential.

Professional counselors are available 24 hours a day via telephone or the MAP Provider's website. For more information about the MAP, see the Map Provider's brochure which is included in the pocket of your folder.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The Plan provides coverage for many medical, prescription drug, dental, and vision benefits. In addition to any specific exclusions and limitations listed throughout this booklet, Plan benefits are not paid for the following.

1. Charges in excess of any specified limitation or Maximum Benefit specified on the applicable *Schedule Of Benefits*.

2. Any charge or any portion of a charge in excess of the amount considered a Reasonable and Customary Charge.

3. Any care, treatment, service, supply, or procedure provided or rendered to any person who is not covered under the Plan on the date provided or rendered.

4. Any care, treatment, service, supply, or procedure unless provided or rendered for the treatment of, correction of, or in connection with a defect, condition, specific Injury, or specific Sickness that is specifically identified as being a Covered Expense under the Plan.

5. Any care, treatment, service, supply, or procedure that, in the opinion of the Trustees, is not Medically Necessary.

6. Any care, treatment, service, supply, or procedure not rendered or provided within the applicable time limit specified on the applicable *Schedule Of Benefits*.

7. Any care, treatment, service, supply, or procedure that is not recommended or approved by the attending Physician.

8. Unless such services, supplies, or procedures otherwise are covered under the terms of the Plan, any care, treatment, service, supply, or procedure received from a health care provider who either does not meet the Plan's definition of a Physician or is not appropriately licensed or certified to provide the applicable services and acting within the scope of such license or certification under applicable state law.

9. Any care, treatment, service, supply, or procedure rendered or provided in or by a hospital, skilled nursing facility, home health agency, outpatient surgical center, emergency treatment center, or chemical dependency treatment facility that does not meet the definition of those terms as specified by the Plan.

10. Services or supplies received from a Physician, RN, or other individual who is related, in any way, to the individual receiving the care or who ordinarily resides in the individual's home.

11. Any special education rendered to any individual regardless of the type of education, the purpose of the education, the recommendation of the attending Physician, or the qualifications of the individual(s) rendering the special education.

12. Room and board, care, treatment, service, supply, or any other type of professional service provided or rendered during any period of confinement or Hospitalization that is for rest, domiciliary care, or sanitary care or any type of Custodial Care regardless of what the care is called.

13. Education, training, or room and board while the individual is confined in an institution that is primarily a school or other institution for training, a place for rest, or a place for the aged.

14. Care, treatment, service, supply, or procedure provided during a confinement in a nursing home, rest home, convalescent home, or similar establishment or facility unless it is a confinement in a Skilled Nursing Facility for which Precertification has been received.

15. Any care, treatment, service, supply, or procedure rendered or provided in any institution owned or operated by the federal or any state government (or any subdivision) for any individual admitted because of mental illness, mental deficiency, or mental treatment.

16. Any care, treatment, service, supply, or procedure rendered or provided while an individual is confined in a Hospital operated by the United States government (or an agency of such), except that the Plan, to the extent required by law, will reimburse a Veterans' Administration (VA) Hospital for care of a non-service-related disability if the Plan would normally consider charges for such care Covered Medical Expenses if the VA were not involved.

17. Hospital confinement or any medical care, treatment, service, supply, or procedure for which charges are made but which the individual is not legally required to pay.

18. Charges that would not have been made if the Plan did not exist.

19. Services or supplies for which there is no charge.

20. Services or supplies furnished by or payable under the plan or law of any government, federal or state, or any political subdivision.

21. Any condition for which Hospital service is received under local, state, or federal law, such as legislation covering the care of war veterans and merchant seamen in veterans or marine Hospitals, unless legally required otherwise.

22. Any care, treatment, service, supply, or procedure furnished, paid for, or otherwise provided for by reason of the past or present service of any individual in the armed forces of a government, or for services provided or made available by the Veteran's Administration or military facilities, unless legally required otherwise.

23. Any care, treatment, service, supply, or procedure provided as a result of any bodily Injury or Sickness caused by, war or any act of war (whether declared or undeclared), act of international armed conflict, conflict involving the armed forces of any international body, insurrection, or participating in a riot.

24. Any care, treatment, service, supply, or procedure provided for or as a result of any injury or sickness sustained while a person is performing any act or duty pertaining to any activity, occupation, or employment for remuneration or profit, whether employed, self-employed, or otherwise that does not meet the Plan's definition of an Injury or Sickness, regardless whether benefits would have been or are or may be payable in whole or in part under any Workers' Compensation law, employer's liability law, occupational diseases law, or similar law.

25. Any care, treatment, service, supply, or procedure provided for or as a result of an act of fraud or material misrepresentation by the Employee or Dependent.

26. Charges for completing of claim forms (or forms required by the Plan for the processing of claims) by a Physician or other provider of medical services or supplies.

27. Care or treatment of the child of a Dependent child.

28. Any care, treatment, service, supply, or procedure that is Experimental or Investigative in nature. That said, if a Participant participates in a clinical trial, the Plan will not deny or limit or impose additional conditions on coverage of routine patient costs for items and services furnished in connection with the trial merely because they are furnished as part of a trial. "Routine patient costs" for this purpose include items and services typically provided under the Plan for a Participant not enrolled in a clinical trial. In other words, the Plan will not deny coverage or impose additional conditions on coverage merely because a person receives these items or services as part of a trial. The Plan will not discriminate against individuals for participating in a clinical trial. This means, for example, that the Plan will not deny coverage for side effects that a Participant develops as a result of participation in the trial, so long as these conditions otherwise would be covered. However, there will be no coverage for: (1) the Experimental or Investigational item or service itself, (2) items and services not included in the direct clinical management of the patient, but provided in connection with data collection and analysis, or (3) a service clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

29. Any care, treatment, service, supply, or procedure for which payment under the Plan is specifically excluded by any other provision of the Plan.

30. Any inpatient confinement where the primary reason for the inpatient admission is for X-ray examinations, laboratory tests, or other diagnostic studies or for a routine health examination where the individual is not suffering from a Sickness.

31. For a non-Emergency Hospital admission, Hospital daily room and board or Hospital services and supplies provided to an individual on any day before inpatient surgery, where the primary reason for the admission is for the performance of X-ray examinations, laboratory tests, or other studies or tests that could have been performed on an outpatient basis before the admission for surgery.

32. Travel or transportation, whether or not recommended by a Physician, except as specifically provided otherwise under the Plan.

33. Services of technicians employed by the Hospital, Skilled Nursing Facility, Chemical Dependency Treatment Facility, Outpatient Surgical Center, or Emergency Treatment Center to which an individual has gone for treatment.

34. Any surgical care, treatment, service, supply, or procedure that is of an elective nature, or any non-Emergency plastic, beautifying, or cosmetic surgery on the body (including but not limited to such areas as the eyelids, nose, face, breasts, or abdominal tissue), except this does not apply to:

    a. Cosmetic surgery performed for the correction of defects incurred through traumatic Injuries sustained by an individual as a result of an accident;

    b. Corrective surgical procedures on organs of the body that perform or function improperly;

    c. Breast reconstruction following a mastectomy, including surgery and reconstruction of the non-affected breast to produce a symmetrical appearance;

    d. Prophylactic mastectomies for individuals who are considered "high risk" with respect to their proclivity for breast cancer, even without a prior cancer diagnosis.

    e. Abortion procedures; or

    f. Vasectomies and other sterilization procedures.

35. Reversal or the attempted reversal of vasectomies or other sterilization procedures.

36. Hearing aid examinations not performed by, or hearing aids not prescribed by, an audiologist, otologist, otolaryngologist, or one certified to perform hearing examinations or dispense hearing aids.

37. Toenail trimming (except with respect to diabetics) or surgical treatment of corns or calluses.

38. Administration of anesthesia by anyone other than a Physician.

39. Administration of anesthesia in connection with a non-covered surgical procedure.

40. Outpatient family planning services.

41. Services of blood donors.

42. Outpatient treatment of Chemical Dependency or a Mental or Nervous Disorder rendered other than by a Physician, a psychiatrist, Psychologist, Social Worker, substance abuse counselor, or other healthcare provider who legally is licensed and/or authorized to practice or provide service, care or treatment of behavioral health disorders under the law of the state or jurisdiction where the services are rendered.

43. Any psychiatric consultation with, or treatment of, an Eligible Individual when such treatment is not supported by a diagnosis of Sickness for that individual and that is provided primarily in connection with the treatment of another Eligible Individual.

44. Developmental delay therapy, physical therapy, speech therapy, or occupational therapy services, regardless of whether or not the services have been precertified and/or are Medically Necessary, to the extent that such services are available at no cost to a Participant through any governmental entity or governmental program reasonably available to the Participant, including any such program or services provided by the school district in which the Participant resides.

45. Physicians' services, unless specifically listed as covered under the Plan's Dental Benefits, in connection with:

    a. Mouth conditions due to periodontal or periapical disease;

    b. Surgical preparation of gums or jaws for artificial teeth;

    c. Removal of tooth root or infected and diseased gum tissues;

    d. Any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue; or

e. Extraction or filling of teeth, unless the services are rendered for the repair of an Injury to sound natural teeth as specified otherwise by this Plan. For the purposes of this provision, sound natural teeth are natural teeth in an individual's mouth that are free of defect or decay.

46. For X-ray, laboratory, and pathology tests and examinations:

a. Any X-rays, laboratory procedures, or the services of any facility that are used in surveys, case-finding programs, or research studies;

b. Physicians' services provided in connection with any X-ray or laboratory test if charges for such services are included in any bill from a Hospital, Skilled Nursing Facility, Outpatient Surgical Center, Emergency Treatment Center, clinic, or other facility where the services were provided;

c. Physician's services for supervising or interpreting X-rays, laboratory services, or pathological or cardiological tests if such services are performed by other than a Physician specializing in the field of radiology, pathology, or cardiology; or

d. Any X-ray or laboratory test that is performed as the result of, or in connection with, any condition other than the condition for which the individual is confined in a Hospital or other than the Emergency or surgery for which the individual seeks outpatient care and treatment.

47. Any items such as Hospital admission kits, rental of a radio, TV, or telephone, cosmetics or toiletries, slippers, newspapers, magazines, telegrams, personal laundry, guest trays, beds or cots for guests or family members, any other personal comfort items, or any other services or supplies that are not Medically Necessary.

48. Diagnostic or therapeutic services not related to the condition for which Hospital confinement or outpatient care is required.

49. Special braces, appliances, ambulatory apparatus, or specialized equipment, except if for:

a. Plan A Participants, and a Network Physician certifies that such equipment is Medically Necessary; or

b. Plan B Participants, and a Physician certifies that such equipment is Medically Necessary.

50. Administration of drugs or medicines.

51. Laser eye surgery, except as specifically provided otherwise by the Plan.

52. Private duty or special nursing services (including intensive nursing care by whatever name called) that are provided in connection with care and treatment provided in the outpatient or Emergency department of a Hospital, Outpatient Surgical Center, or Emergency Treatment Center, regardless of whether such services are provided under the direction of the facility or otherwise.

53. For radiation therapy:

a. Treatment of any non-malignant conditions other than the specific condition of hyperthyroidism, chronic angina pectoris, or chronic cardiac decompensation;

b. Diagnostic X-rays or the administration of radioactive substances for diagnostic purposes except as specifically provided otherwise under the Plan's Comprehensive Major Medical Benefits; or

c. Rental or purchase of radioactive substances.

54. Hospital room and board or services and supplies provided to an individual on a Saturday or Sunday if the individual is admitted to the Hospital on a Saturday or Sunday due to a non-Emergency.

55. Drugs, dressings, or other supplies taken home or away from a Hospital, Skilled Nursing Facility, Emergency Treatment Center, Outpatient Surgical Center, or any other facility from which the individual has received any care or treatment.

56. *For Plan A Participants only*, benefits are not paid for:

a. Care, treatment, services, or supplies that are furnished or provided at no charge by or through a UHS Physician.

b. Any service or supply that is not provided, recommended, referred, authorized, or approved by a UHS Physician.

c. Surgeons' services, anesthesia services and supplies, Hospital inpatient services and supplies, outpatient facility services and supplies, or any other services and supplies provided as a result of, or in connection with, non-Emergency surgery that is not performed by a Network Physician or a Physician referred by a UHS Physician.

d. Services or supplies, other than those provided by a Hospital or Skilled Nursing Facility, that are not provided by a UHS Physician or a Physician referred by a UHS Physician when such services or supplies would or could otherwise have been furnished by or through a UHS Provider.

e. Services and board for special nurses or group nursing services.

57. Prescription drugs, except as specifically provided otherwise under the Plan's Prescription Drug Benefits.

58. Services or supplies in connection with the removal of body tissue or a body organ(s) for the purpose of donating such tissue or organ(s) to a recipient, except to the extent that the recipient is covered by the Plan, in which case such services and supplies will be covered as expenses of the recipient as specified under "Live donor Benefits" under Covered Medical Expenses.

59. Expenses resulting from the commission of a criminal activity where the Eligible Individual is charged with or indicted for a felony or is convicted of that felony or a lesser offense or crime, except in the case of domestic violence. If the charges are later dismissed or the Eligible Individual is not convicted, the Eligible Individual may request that a claim be reconsidered.

60. Non-network Outpatient Surgical Center expenses.

61. Long-term care expenses.

62. Genetic testing unless Medically Necessary for the purpose of diagnosis and treatment or unless such service is a preventive service that is required to be covered by the Affordable Care Act.

63. Infertility treatment.

64. Hearing examinations required by an Employer as a condition of employment or which the Employer is required to provide by virtue of a Collective Bargaining Agreement.

65. Charges for rental or purchase of amplifiers.

66. Charges for services related to speech reading or lip-reading lessons.

67. Charges for food or nutritional supplements, except if the latter is approved by the Review Organization, or, with respect to Plan A Participants only, except amino acid-based elemental formulas to the extent that Union Health Services is required to provide such formulas pursuant to Illinois law.

HOW TO FILE A CLAIM

This section, which describes the claims and appeals process, applies to all non-insured benefits, including all prescription drug benefits, and Plan B medical benefits. It also applies to Plan A benefits provided at or by UHS. Claims and appeals procedures for all insured benefits (i.e., the Plan A and B dental and vision benefits) are similar but are governed by the insurance certificates, which will be provided to you. To the extent that there is any conflict between this document and the insurance certificates, the certificates control. Generally, no claim forms are necessary for insured benefits. If a benefit is insured or provided at or by UHS, neither the Fund Office nor the Claim Appeal Committee will be involved in resolving a claim for benefits.

Filing Claims

If a claim is denied or reduced, there is a process you can follow to have your claim reviewed.

Most health care providers will submit claims for you. Be sure to show your ID card so your provider knows where to submit your claim. If you are a Plan A Participant using a UHS Physician, no claim forms are necessary; UHS automatically will process and pay all such claims. However, any pre-service claim (see definition below) with respect to obtaining a referral from UHS must be submitted in writing.

If your provider does not submit your claim for you, it is then your responsibility to do so. Contact the Network Provider (as identified in the "Important Contact Information" sheet in the pocket of your folder) for instructions on how to submit your claim and be sure to provide all requested information, as outlined below. All claims must be filed within 12 months of the date of service for benefits to be paid under the Plan. All claims must be submitted in writing (or electronic format). However, urgent care claims may be submitted orally, see page 63.

To assist in processing claims as quickly as possible, be sure to:

- Submit a separate claim for each unrelated Injury or Sickness and complete all requested information, including having your Physician complete and sign the appropriate section.
- Include your name and member identification number with your claim.
- If the claim is for a Dependent, include the Dependent's name and birth date.
- Include the name of the specific medical condition or symptom being treated.
- Attach any bills or receipts relating to services provided. Make sure each bill clearly identifies (or provides) the diagnosis, service, or supply, the fee, the date each charge was incurred, the patient's name, and the date of service.

- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- If you or a Dependent has coverage under more than one plan, include the name of the other health plan(s). Also, if this Plan is secondary (see page 78), include a copy of the Explanation of Benefits (EOB) form from the other plan(s).

If you or a Dependent has coverage under more than one health care plan, benefits are coordinated as explained on page 78.

- If Medicare also covers you or a Dependent, attach a copy of the itemized bill relating to the health service provided and a copy of Medicare's Explanation of Benefits (EOB).

Forward your claim and all related bills to the Network Provider (regardless of whether the claim is in-network or not) as identified on the "Important Contact Information" sheet in the pocket of your folder.

Types Of Claims

Health care claims, which include medical, prescription drug, dental, and vision benefit claims, are divided into four basic types of claims:

- **Pre-Service—**A pre-service claim is a claim for Plan benefits where precertification, prior authorization, or a referral (i.e., from UHS) is required before you obtain care (see page 25).
- **Urgent Care—**An urgent care claim is a special type of pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise would apply to pre-service claims would:
  - ♦ Seriously jeopardize your life, health, or ability to regain maximum function; or
  - ♦ In the opinion of a Physician with knowledge of your condition subject you to severe pain that cannot be adequately managed without the care or treatment that are the subject of the claim.

The Plan will defer to your treating Physician in determining whether or not a claim is an "urgent care claim."

- **Post-Service—**A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services that are the subject of your claim.
- **Concurrent Care—**A concurrent care claim is a claim that is reconsidered after it is initially approved (such as recertification or extension of the number of days of a Hospital stay or ongoing course of treatment to be provided over a period of time or number of treatments) and the reconsideration results in reduced benefits (for example, a reduction of the initially-approved period of time or number of treatments), a termination of benefits, or a denial of an

extension of a course of treatment (other than by Plan amendment or termination).

Claim Determinations: Plan A Health Benefits Provided at or by UHS

If you are a Plan A Participant using a UHS Physician, UHS will determine the services that will be available to you. UHS also will determine whether to refer you for treatment outside of UHS. A request for treatment outside of UHS is a pre-service claim (as defined above) and will be handled by UHS as described below. However, before invoking the formal pre-service claims procedures, you have other options. For example, you may seek a second opinion from another UHS Physician or switch to a different UHS Physician or you may bring the matter to the attention of the UHS Medical Director.

Once you have received a referral, your claims for benefits will be processed according to the procedures set forth below.

Health Claims under Plan B, Pre-Service Claims under Plan A, and Claims under Plan A for Services Received outside of UHS

When a provider on your behalf or you submit a claim for health care benefits to the Network Provider, the Network Provider will determine the Reasonable and Customary Charge, and then the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable (based on the Reasonable and Customary Charge determination made by the Network Provider), if any. All claims will be processed promptly after complete claim information is received by the Fund Office. Note that any quote for services or supplies provided to you or a provider by the Fund Office is merely an estimate based on the information as understood by the Fund Office at that time. A quote is in no way binding on the Fund and does not serve to alter the terms of the Plan. Nor is a quote an indication that your obligations have been fulfilled with respect to medical review and precertification, or in the case of a Plan A Participant, UHS approval. You will be notified of an initial determination within certain timeframes. If a claim for post-service or concurrent care is approved, payment will be made, and the payment will be considered your notice that the claim was approved. However, for urgent care and pre-service claims, you will be given written notice of a determination on your claim.

If circumstances require an extension of time for making a determination on your claim, you will be notified, in writing, that an extension is necessary. The notice will state the special circumstances and the date a determination is expected.

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

- **Urgent Care Claims—**An initial determination will be made as soon as possible, taking into account the medical exigencies, and no later

than 72 hours after receipt of your claim, unless additional information is needed. Notice of a determination on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified as soon as possible and within 24 hours of receipt of your claim. You will then have up to 48 hours to provide the additional information. The initial 72-hour deadline is suspended for up to 48 hours or, if sooner, until the information is received. Notice of the determination will be provided no later than 48 hours after the Fund Office receives the additional information or, if sooner, the end of the period given for you to provide this information. If requested information is not provided within the 48-hour period, the claim may be denied.

- **Pre-Service Claims—**An initial determination will be made within a reasonable time period appropriate to the medical circumstances and no later than 15 days after receipt of your claim. If the Fund Office or its delegate or UHS determines that additional time is necessary to make a determination, due to matters beyond the control of the Plan, you will be notified within the initial 15-day deadline that up to 15 additional days may be needed. If additional information is needed to process your claim, the initial period will be suspended, and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made within 15 days.
- **Post-Service Claims—**An initial determination will be made within a reasonable time and no later than 30 days after receipt of your claim. If the Fund Office determines that additional time is necessary to make a determination, due to matters beyond the control of the Plan, you will be notified within the initial 30-day deadline that up to 15 additional days may be needed. If additional information is needed to process your claim, the initial period will be suspended, and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. If the requested information is not provided within the time specified, the claim may be decided without that information. After 45 days or, if sooner, after the information is received, a determination will be made within 15 days.
- **Concurrent Care Claims—**While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced, terminated, or the requested extension would start to run. If you

request an extension of approved urgent care treatment (i.e., treatment that lasts longer than the prescribed period of time or requires a greater number of treatments than previously approved), the Plan will act on your request as soon as possible and you will be notified within 24 hours after the Fund Office receives your request, provided your claim is received at least 24 hours before the expiration of the approved treatment (i.e., prescribed period of time or number of treatments). Any other request to extend a concurrent care decision shall be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

Payment Of Benefits

Benefits are only paid for Covered Expenses incurred by persons who are covered under the Plan at the time the expenses are incurred, provided a claim(s) is made for the benefits within the applicable time limits.

Generally, payment for health care claims is made directly to the provider. However, if you submit the claim along with a paid receipt, or if the Plan Administrator or its delegate should otherwise choose, in its sole discretion, payment will be made directly to you.

If payment is made to you for health care claims, you are responsible for payment to the provider. Once you receive covered services from a provider, you do not have the right to request that the Plan not pay a claim submitted to the Plan by the provider for those covered services. Once the Fund makes payment on a health care claim, no further payment will be made. You will receive an Explanation of Benefits (EOB) form from the Fund Office showing what the Plan has paid. You are responsible for paying any amounts not paid by the Plan.

If an individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed, the Trustees may make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of such individual.

If an individual dies before all amounts due have been paid, the Trustees may make such payment to the individual's estate as determined under applicable law.

Any payment made by the Fund fully discharges the liability of the Trustees to the extent of such payment. However, self-funded benefits payable under the Plan are limited to the Fund assets available for payment of such benefits.

If the Plan makes a payment due to mistake or fraud, the Plan is entitled to recover any such payments from you, or to withhold future medical benefit payments otherwise payable to you or your Dependents until such overpayment has been recovered by the Plan.

Non-Assignment Of Benefits

Other than payments made directly to a provider, you cannot assign your benefits or other rights to which you are entitled to under the Plan. You may lose your Plan coverage if you attempt to assign or transfer coverage or aid any other person in fraudulently obtaining Plan coverage. The prohibition against assignment of rights includes rights such as the right to:

- Receive benefits;
- Claim benefits in accordance with Plan procedures and/or federal law;
- Begin legal action against the Plan, Trustees, Fund, its agents, or employees;
- Request Plan documents or other instruments under which the Plan is established or operated;
- Request any other information that a Participant or beneficiary, as defined in ERISA, Section 102, may be entitled to receive upon written request to a Plan Administrator; and
- Any and all other rights afforded a Participant or beneficiary under the Plan, Restated Trust Agreement, federal law, and state law.

The preceding restrictions on assignment of benefits do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or an appeal. To that end, the authorized representative, acting on behalf of the claimant in pursuing an appeal, is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits, which may include, for example, Plan Documents or excerpts of such documents.

Additionally, benefit payments are exempt from execution, attachment, garnishment, or other legal or equitable process for the debts of the Eligible Individual.

If A Claim Is Denied

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling UHS (with respect to Plan A services to be received from a UHS provider or with respect to referrals requested from UHS to a non-UHS provider) or the Fund Office (at the numbers provided in the *Important Contact Information* insert in the pocket of this booklet's folder). 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) this will be considered an "adverse benefit determination." For the purposes of the Plan's claims and appeals procedures, an adverse benefit determination is defined specifically as:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a denial of a benefit based on a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit;
- A reduction in a benefit resulting from the application of any utilization review decision (related to precertification of coverage), source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigative or not Medically Necessary or appropriate; or
- A determination to retroactively terminate an individual's Plan coverage.

If you receive an adverse benefit determination, you will be provided with certain information about your claim within the timeframes previously described. When you are notified of an initial denial on your claim, the notice will be written in a culturally and linguistically appropriate manner and will include:

- Information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable);
- The specific reason(s) for the determination, including the Plan's standard, if any, used in denying the claim;
- Reference to the Plan provision(s) on which the determination was based;
- Notification of your opportunity to request applicable diagnosis and treatment codes (and their meanings);
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A description of the Plan's appeal procedures (including your right to present evidence and testimony in some form) and external review procedures, and a statement of your right to bring a lawsuit under ERISA §502(a) following the review of your claim;
- A statement of your right to review your claim file and to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. This includes any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage (such additional evidence and/or rationale to be made

available as soon as practicable), and you will have a right to a reasonable opportunity to respond to any such new evidence or rationale.

- A copy of any rule, guideline, protocol, or similar criteria that was relied upon in denying your claim, or a statement that a copy of the rule, guideline, protocol, or similar criteria is available to you, at no cost, upon request; or
    - ♦ If your claim is denied based upon Medical Necessity, the Experimental nature of the treatment, or a similar exclusion or limit, a copy of an explanation of the scientific or clinical judgment on which the denial was based, or a statement that such copy is available to you upon request, at no cost.
- If your claim was an urgent care claim, a description of the expedited review process, and
- The contact information for the relevant office of health insurance consumer assistance or ombudsman (if available).

If you or your Dependent committed an act of fraud or misrepresentation with respect to the Plan, your claim will be denied, and benefits may be terminated retroactively.

Examples Of When A Claim May Be Denied

The Trustees, or their representatives, have the authority to make determinations on most claims; UHS has the authority to make determinations on claims with respect to services provided by UHS providers or with respect to referrals to non-UHS providers. Following are some examples of when a claim may be denied, or that may result in reduced benefits:

- The individual on whose behalf the claim was filed was not covered under the Plan on the date the expenses were incurred.
- The claim was not filed within the Plan time limits.
- The claim was not for Covered Expenses under the Plan.
- The claim was for expenses that were not actually incurred.
- The individual for whom the claim was filed already received the maximum allowable under the Plan for the type of expense.
- Another plan was primary for the Covered Expense.
- No payment was made, or a reduced amount was paid, because the applicable Deductible was not yet paid.
- A third party was responsible for paying the expenses and the required Subrogation and Reimbursement Agreement was not completed.

- An Eligible Individual's future benefits were reduced or temporarily suspended to recover an overpayment of benefits previously made.
- Hospital benefits were reduced by the amount of the Non-Precertification Deductible.
- The Plan was terminated.

This list is not all-inclusive, but rather representative of the types of circumstances, in addition to failure to meet the Plan's regular eligibility requirements for coverage under the Plan, that may cause benefits to be denied or reduced.

Appealing A Denied Claim

If your claim is denied (in whole or in part) – in other words, if you receive an adverse benefit determination or you disagree with the Plan's determination regarding the amount of the benefit, you have the right to have the initial determination reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits. **Any legal action for the recovery of any benefits must be commenced within two years after the date of service (or such shorter period as may apply under applicable law).**

Plan A Appeals with respect to Services to be Provided by UHS or referred by UHS

If a benefit is denied under Plan A with respect to services to be provided by UHS or referred by UHS to a non-UHS provider, you may appeal that denial by sending your written request for an appeal to UHS as soon as possible, and no later than 180 days after you have received notice of an adverse benefit determination. For urgent care claims, your appeal may be made orally.

Your appeal must explain the reasons you disagree with the determination 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.
- Request to review all relevant information and your claim file (free of charge). A document, record or other information is considered relevant if it:
    - ♦ Was relied upon by the Plan in making the decision;
    - ♦ Was submitted, considered or generated (regardless of whether it was relied upon); or
    - ♦ Demonstrates compliance with the claims processing requirements.

- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based.
- If your appeal is denied based on Medical Necessity, Experimental treatment, or similar exclusion or limit, request a copy, at no cost, of any explanation of the scientific or clinical judgment on which the denial was based.

Appeal Determinations

If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be conducted, and the determination will not be based on the initial benefit determination. An appropriate decision-maker at UHS who did not participate in the initial benefit determination, will conduct the review, and the determination will be based on all information used in the initial determination as well as any additional information submitted.

You will be notified, in writing, of the determination on your appeal. The timeframes for notification of the determination and the contents of the notification will be the same as described below with respect to Plan B appeals, except that appeals of post-service claims will be decided within 60 days.

If a benefit is denied for a reason involving professional medical judgement, such as a denial based on lack of Medical Necessity, UHS will advise you of your rights to have the decision reviewed by an external organization.

Plan B Appeals and Appeals under Plan A with respect to Services Received outside of UHS

When appealing a claim, you may authorize a representative to act on your behalf, see page 73.

In general, you should send your written request for an appeal to the Claim Appeal Committee at the address of the Fund Office as soon as possible. However, appeals with respect to dental and vision must be made directly to the respective insurance provider, as identified in the Important Contact Information insert. First level appeals with respect to prescription drugs should be made to the prescription benefit manager. (A second level appeal of a prescription drug claim may be made thereafter to the Claim Appeal Committee.) For urgent care claims, your appeal may be made orally. If you receive an adverse benefit determination under the Plan, you must file your written appeal within 180 days after you receive the notice of the determination.

With respect to a health care claim regarding medical or prescription drug benefits, you may also request a hearing, and you or your authorized representative will have an opportunity to appear at the hearing before the Claim Appeal Committee, but any such appearance will be granted by the Committee in its sole discretion. If you do not request to appear before the Committee, or the Committee does not approve such a request, you will

lose your right to so request and the Committee will proceed to consider your appeal based on the written information submitted. If you do request a hearing and the Committee grants your request, you will be notified in writing, by certified mail of the date, time, and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. In conducting the hearing, the Committee will not be bound by the usual common law or statutory rules of evidence. All information upon which the Board bases its decision will be disclosed to you or your representative. You will be given the opportunity to present any evidence on your behalf. If you request and are granted a hearing and do not appear at the hearing (without requesting a continuance), the Committee will proceed to consider your appeal based on the written information submitted.

Your written appeal must explain the reasons you disagree with the determination 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.
- Request to review all relevant information and your claim file (free of charge). A document, record or other information is considered relevant if it:
  - ♦ Was relied upon by the Plan in making the decision;
  - ♦ Was submitted, considered or generated (regardless of whether it was relied upon); or
  - ♦ Demonstrates compliance with the claims processing requirements.
- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based.
- If your appeal is denied based on Medical Necessity, Experimental treatment, or similar exclusion or limit, request a copy, at no cost, of any explanation of the scientific or clinical judgment on which the denial was based.

Appeal Determinations

If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be conducted, and the determination will not be based on the initial benefit determination. An appropriate fiduciary of the Plan that did not participate in the initial benefit determination, generally the Claim Appeal Committee, will conduct the review and the determination will be based on all information used in the initial determination as well as any additional information submitted.

You will be notified, in writing, of the determination on your appeal no later than five days after the determination is made, as set forth in the timeframes below. However, oral notice of a determination on your urgent care claim may be provided to you sooner.

Appeal Determination Timeframes

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

- ***Urgent Care Claims*—**A determination will be made within 72 hours from receipt of your appeal.
- ***Pre-Service Claims*—**A determination will be made within 30 days from receipt of your appeal.
- ***Post-Service Claims*—**A determination will be made at the Claim Appeal Committee's next regularly scheduled quarterly meeting following receipt of your appeal. However, if the appeal is filed within 30 days of the date of the meeting, the determination may be made at the second meeting following receipt of your appeal. If special circumstances require a further extension, a determination will be made at the third meeting following receipt of your appeal. You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a determination.
- ***Concurrent Care Claims*—**A determination will be made before the proposed reduction or termination of your benefit, provided the appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment was filed sufficiently in advance. However, in the case of an appeal concerning a request to extend a course of treatment, the Claim Appeal Committee will make a determination in accordance with the deadlines described above based on the type of claim (urgent care, pre-service, or post-service, as appropriate).

Appeal Determination Notice

When you are notified of a determination on your appeal, the notice will be written in a culturally and linguistically appropriate manner and will include:

- Information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable);
- A statement that you are entitled to receive, at no cost upon request, reasonable access to or copies of all documents, records, and other information relevant to the claim.
- A statement that you and the Plan may have other voluntary alternative dispute resolution options, such as mediation;

- A statement regarding external review rights as well as your right to bring a civil action under ERISA §502(a) following the denial of your claim, and a notice of any applicable contractual limitations period for bringing a civil action, and its expiration date;
- The specific reason(s) for the determination, including the Plan's standard, if any, used in denying the claim;
- A statement notifying you of your opportunity to request applicable diagnosis and treatment codes (and their meanings);
- Reference to the Plan provision(s) on which the determination was based;
- If your claim is denied based on:
    - ♦ Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or
    - ♦ Medical Necessity, Experimental treatment, or a similar exclusion or limit, a statement that a copy of the scientific or clinical judgment that served as the basis for the decision is available to you at no cost upon request, and an explanation that you also will be provided, and will be afforded a reasonable opportunity to respond to, any new evidence or rationale relied upon on appeal.
    - ♦ The contact information for the relevant office of health insurance consumer assistance or ombudsman (if available).

Authorized Representatives

When appealing a claim, you may authorize a representative to act on your behalf. You must provide written notification to the Fund Office (or insurance carrier, as applicable) authorizing this representative. The written notification must include the individual's name, address, and phone number. However, if you are unable to provide a written authorization, the Plan may require other written proof (such as power of attorney for health care purposes or court order of guardian/conservator) that the proposed authorized representative has been authorized to act on the individual's behalf.

Authorized representatives may include a:

- Health care provider that has knowledge of the condition;
- Spouse;
- Dependent child age 18 or over;
- Parent or adult sibling;
- Grandparent;

- Court-ordered representative, such as an individual with power of attorney for health care purposes, legal guardian, or conservator; or
- Other adult.

Once a representative is authorized, future claims and appeals related correspondence will be sent to the authorized representative and not to the claimant. The Plan will recognize the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization. However, the individual may revoke a designated authorized representative at any time by submitting a signed statement.

The Plan Administrator or its designated representative has the discretion to determine whether an authorized representative has been properly designated in accordance with the Plan's terms. The Plan Administrator reserves the right to withhold information from a person who claims to be an authorized representative if there is suspicion about the qualifications of that individual.

Medical Judgments

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

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

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

Trustee Authority and Interpretation/Exhaustion of Administrative Remedies/Legal Actions

The Trustees or, where Trustee responsibility has been delegated by the Trustees to others, such other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of this Plan. The decisions of the Trustees or their delegates with respect to eligibility, claims and all other matters of Plan interpretation are final and binding. Benefits under this Plan will be paid only when the Trustees, or persons to whom the Trustees have delegated such responsibilities, decides, in their discretion, that the Participant or beneficiary is entitled to benefits in accordance with the terms of the Plan. In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure adopted by the Trustees, from time to time, the decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be

arbitrary or capricious by a court or arbitrator having jurisdiction over such matter.

You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the procedures described in this section. No such action may be brought more than two years after the date of service (or such shorter period as may apply under applicable law, the Trust Agreement, any individual program of benefits under the Plan, or pursuant to regulations issued by the Trustees). In addition, no legal action may be brought with respect to a benefit claim unless you have followed and exhausted the Plan's claims and appeals procedures. If you do not include any theories or facts in your written claim or appeal, they will be waived. In other words, you will lose the right to raise factual arguments and theories that support your claim if you do not include them in your written claim or appeal. You may, at your own expense, have legal representation at any stage of the review process. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner.

If the Plan fails to strictly adhere to the above claims appeal procedures, you will be deemed to have exhausted the Plan's internal claims appeal process and may initiate any available external review process (described below) or other available legal remedies. Notwithstanding the previous sentence, if the violation of these procedures was (1) minor, (2) non-prejudicial, (3) due to errors attributable to good cause or outside the Plan Administrator's control, (4) in the context of a good faith exchange of information, and (5) not reflective of a pattern of noncompliance, you will be obligated to exhaust the above internal claims and appeal procedures before initiating external review or filing suit.

Standard External Review

You may file a request for an external review of a claim if:

- You received a final adverse benefit determination on appeal, or
- if the Plan failed to strictly adhere to the Plan's internal claims and appeals process.

Following a final adverse benefit determination on appeal, Claimant may file a request for an external review of the denied claim only if the adverse benefit determination on appeal involved either (1) medical judgment (e.g., determinations of whether a treatment is Medically Necessary, or Experimental or Investigative, and evaluations of level of care, appropriateness of care, health care setting, or effectiveness) or (2) a rescission of benefits (i.e., a retroactive termination of benefit coverage). For example, external review will not be available where a denial solely relates to your failure to meet Plan eligibility requirements.

You may file a request for an external review with the Plan through the Fund Office, provided such request is filed by the first day of the fifth

month following the receipt of the notice of an adverse benefit determination or final adverse benefit determination. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether external review is available. Specifically, the Plan will consider whether:

- You are or were covered under the Plan at the time the health care item or service was requested;
- The adverse benefit determination relates to your failure to meet the requirements for eligibility under the terms of the Plan (eligibility determinations are not entitled to external review);
- You have exhausted the Plan's internal appeal process (unless you are not required to exhaust the internal appeals process under the interim final regulations due to the Plan's failure to strictly adhere to the claims appeal procedures); and
- You have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to you (or your authorized representative) advising as to whether external review is available.

If the request is complete but the claim is not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete, and you will have the right to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

An independent review organization ("IRO") will conduct the external review. The IRO review process shall consist of the following:

- The IRO will provide you timely notice of its acceptance of the claim for external review. Within ten business days of the receipt of this notice, you may submit additional written evidence, which the IRO *must* consider. The IRO *may* consider evidence submitted after ten business days.
- Within five business days after the assignment of the IRO, the Plan will provide the IRO the documents and information that had been considered in making the adverse benefit determination. The IRO may reverse the adverse benefit determination if the Plan fails to provide these materials.

- Within one business day of receipt of information from you, the IRO must forward this information to the Plan, which may reconsider its adverse benefit determination.
- The IRO will use legal experts to make any determinations pertaining to coverage issues.

The IRO must provide you and the Plan written notice of its decision within 45 days after the IRO receives the request for the external review. The IRO's decision shall contain:

- the reason for the decision, including specific information about the claim and the IRO's involvement with the claim;
- the rationale and the evidence-based standards relied on by the IRO;
- a statement that the decision is binding, but that there may be other state or federal remedies, which may include judicial review; and
- the contact number for the relevant office of health insurance consumer assistance or ombudsman (if available).

After a final external review decision, the IRO will maintain for six years the records of all claims and notices associated with the external review process. Such records will be available for examination, upon request by you, the Plan, or a state or federal oversight agency (unless such disclosure would violate state or federal privacy laws).

Upon receipt of a final external review decision reversing the adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

You may request an expedited external review from the Fund Office at the time you receive an adverse benefit determination, if

- the adverse benefit determination involves a medical condition with respect to which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or ability to regain maximum function, and
- you have filed a request for an expedited internal appeal.

A preliminary review (as provided above with respect to a standard external review) will be conducted immediately upon receipt of the request for expedited external review. Immediately following a preliminary review of the request for an expedited external review, the Plan will issue a notification in writing to you (or your authorized representative) as to whether an expedited external review is available.

If the request is complete but the claim is not eligible for external review, such notification must include the reasons for its ineligibility and contact

information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is complete and the claim is eligible for a standard external review, but not an expedited review, the procedures for a standard external review (described above) shall apply. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and you will have the right to perfect the request.

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Plan will assign an IRO under the procedures for a standard external review (described above). The Plan will provide the IRO electronically, by telephone or facsimile, or by any other available expeditious method, all necessary documents and information considered in making the adverse benefit determination.

The review of the IRO shall consist of providing a notice of the final external review decision, in accordance with the requirements for a standard external review and resulting decision (described above), as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice of the decision is not initially provided in writing, then within 48 hours after the date of providing the notice, the IRO must provide written confirmation of the decision to you and the Plan.

After a final external review decision, the IRO will maintain for six years the records of all claims and notices associated with the external review process. Such records will be available for examination, upon request by you, the Plan, or a state or federal oversight agency (unless such disclosure would violate state or federal privacy laws).

Upon receipt of a final external review decision reversing the adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Coordination Of Benefits

The Plan has been designed to help you meet the cost of medical, prescription drug, dental, and vision benefits. It is not intended that you receive greater benefits than your actual health care expenses. The amount of benefits payable under this Plan will be coordinated with any coverage you or your Dependent has under any:

- Group, blanket, or franchise insurance coverage;
- Group coverage or group-type coverage through HMOs and other prepayment, group practice, and individual practice plans;
- Coverage under employee benefit welfare plans as defined by ERISA;

- Coverage under any plan largely tax-supported or otherwise provided for by or through action of any government and any coverage required or provided by any statute;
- Any plan that is paid for entirely by an Employee only if such plan contains a provision for coordinating benefits; and
- Part A and Part B of Medicare, regardless of whether or not the Eligible Individual is enrolled.

Allowable Expenses

Any necessary, Reasonable and Customary Charge, at least part of which is covered under one of the plans covering the Eligible Individual.

This Plan will always pay you either its regular benefits in full or a reduced amount that when added to the benefits payable to you by the other plan(s), will equal the total allowable expenses. If a plan provides benefits in the form of services or supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an allowable expense) will be considered both an allowable expense and a benefit paid. However, no more than the Maximum Benefits payable under this Plan will be paid.

Please note that you must file a claim for any benefits you are entitled to from any other source. Whether you file a claim with any other source, your payments from this Plan will be calculated as though you have received any benefits you are entitled to from other sources. In addition, you must comply with all rules of any other plan. If you do not and benefits are reduced from the other plan for failure to follow the appropriate procedures, benefits paid under this Plan will be limited to the amount that would have been paid had you followed the appropriate procedures.

Please note that where this Plan pays secondary to another plan, this Plan will exclude from coverage payment of any claims denied under your primary coverage due to your failure to obtain a required precertification, pre-authorization, or referral from your primary care provider.

Order Of Payment

If you and/or your Dependent is covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits payable does not exceed 100% of the allowable expense incurred.

If you and/or your Dependents are covered under another plan, you must report all other coverage when you file a claim.

Notwithstanding anything herein to the contrary, with respect to any services provided at or by Union Health Services on behalf of Plan A participants, Union Health Services has its own rules regarding coordination of benefits. Those rules may be different than those set forth herein; if there is a conflict, the Union Health Services' rules control where the services have been provided or paid for by Union Health Services.

A plan that covers an individual as an employee, member, subscriber, policy holder, or retiree is primary, and the plan covering a person as a

spouse or dependent will be second. However, if the dependent person is a Medicare beneficiary, and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, (e.g., a retiree), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, member, subscriber, policy holder, or retiree is the secondary plan and the other plan is the primary plan.

A plan that covers an individual as an active employee (an employee who is not terminated, laid-off, or retired) is the primary plan, and the plan covering that same person as a COBRA qualified beneficiary or as a retired or laid-off employee or as a result of a disability extension or an extension due to leave of absence is the secondary plan. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

A plan that covers an individual as a full-time employee or as a dependent of a full-time employee is the primary plan and the plan that provides coverage due to part-time employment is the secondary plan.

If an individual is an employee under more than one plan or no other rule determines the order of payment, the plan that has covered the Eligible Individual longer is primary.

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

- This Plan's coverage is secondary; and
- The primary plan includes a provision that results in the primary plan paying a lesser benefit when there is secondary coverage.

In this situation, as the secondary payer, this Plan will limit benefits to no more than the lesser of the:

- Difference between the amount that the covered person's primary plan would have paid if the primary plan had been the only plan providing coverage and the total amount of covered charges; or
- Amount that this Plan would have paid had this Plan's coverage been primary.

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

If a Dependent child is covered under more than one plan and the parents are *not* divorced or legally separated, the following rules determine which plan's benefits are primary:

- The plan that covers the parent whose date of birth occurs earlier in the Calendar Year, excluding the year of birth, is primary (this is known as the birthday rule);
- If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary;

If a Dependent child is covered under more than one plan and the parents are divorced or legally separated, the following rules determine which plan's benefits are primary:

- Where there is a court decree or ruling or order of an administrative tribunal with appropriate jurisdiction that establishes financial responsibility for medical expenses, the plan covering the Dependent child of the parent who has financial responsibility for medical expenses will pay first, and the plan covering the other parent will pay second;
- Where there is a court decree or ruling or order of an administrative tribunal with appropriate jurisdiction that establishes both parents are equally responsible for medical expenses, the provisions of the birthday rule above will determine the order of benefits;
- Where there is no court decree or ruling or order of an administrative tribunal with appropriate jurisdiction that specifies which plan is primary, the plan of the parent with custody is primary. If the parent with custody has remarried, then the:
    - ♦ Step-parent with custody of the child pays second; and
    - ♦ Parent not having custody of the child pays third.
- The other plan covering the Dependent child may have coordination of benefit provisions that are not consistent with this Plan's rules. In these circumstances, regardless of any such provisions found in the other plan, this Plan will not pay more than 50% of the benefit amount that the Plan would have paid were it not for the existence of the other coverage.

A person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, policy holder, or retiree (or as that person's dependent) is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a Dependent works for an employer that tries to avoid paying the Dependent's claims under its health plan by excluding or reducing benefits for those Dependents that are covered under this Plan, the Plan will exclude the Dependent from coverage entirely. The Dependent's

employer's plan(s) will be responsible for the claims incurred. This exclusion applies only if a Dependent's employer's plan(s) attempts to limit the amount of benefits it has to pay on behalf of the Dependent's employer's employees because of coverage under the Plan. If the Dependent's employer's plan pays benefits for the Dependent in the same manner and in the same amount as it does for all of its other employees without regard to any other coverage that an individual may have, then this rule will not affect the Dependent's coverage under the Plan.

If the Fund makes payments it is not required to pay, it may recover and collect those payments from you, your Dependents, or any organization or insurance company that should have made the payment.

When coordinating benefits, the Plan will assume that you and your Dependents have complied with any other plan rules necessary for your expenses to be covered by that plan.

This Plan is not responsible for medical expenses that could have been paid or would otherwise be paid under another plan had you followed that plan's rules. If the other plan is considered the primary plan and is not used, this Plan will only pay for medical expenses covered under this Plan that are in excess of the expenses that would have been covered had the other plan been used.

Coordination of Benefits with Noncomplying Plan

The Plan shall coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination standards which are inconsistent with those set forth above (the "Noncomplying Plan") on the following basis:

1. If the Plan is the primary plan under the Plan, it shall pay or provide its benefits on a primary basis.

2. If the Plan is the secondary plan under the Plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Plan were the secondary plan. In such a situation, such payment shall be the limit of the Plan's liability.

3. If the Noncomplying Plan does not provide the information needed by the Plan to determine its benefits within sixty (60) days after it is requested to do so, the Plan shall assume that the benefits of the Noncomplying Plan are identical to its own and shall pay its benefits accordingly. However, the Plan shall adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

4. If the Noncomplying Plan refuses to pay in accordance with the benefit determination standards set forth here, then

the Plan, in consideration of being subrogated to the Eligible Individual's rights of recovery against the Noncomplying Plan in accordance with those benefit determination standards, may provide benefits as if it were primary.

Coordination of Benefits with Medicaid

This Plan does not coordinate benefit payments with Medicaid.

Coordination of Benefits with Medicare

If you are Eligible for Medicare and you enroll in a Medicare Advantage plan, you must use network providers and comply with the managed care provider's requirements. If you do not, benefits paid under this Plan will be limited to the amount that would have been paid by Medicare had you used a Network Provider and/or complied with the managed care provider's requirements.

Medicare consists of four parts. The first part, officially called Hospital Insurance Benefits for the Aged and Disabled, is commonly referred to as Part A of Medicare. The second part, officially called Supplementary Medical Insurance Benefits for the Aged and Disabled, is commonly referred to as Part B of Medicare. The third part, Medicare Advantage, is commonly referred to as Part C of Medicare. Part A of Medicare primarily covers Hospital benefits, although it also provides other benefits. Part B of Medicare primarily covers Physician's services, although it, too, covers a number of other items and services. Part C is the managed care program under Medicare. Part D of Medicare is prescription drug coverage.

Typically, you become eligible for Medicare when you reach age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are disabled, a dependent widow, or have chronic End-Stage Renal Disease (ESRD). If you are eligible for Medicare based solely on permanent kidney failure (ESRD), there is a period of time when the Plan is primary and will pay health care bills first. This Plan is primary and pays benefits first with respect to an Eligible Individual who is entitled to or eligible for Medicare ESRD benefits during the 30-month period that begins with the first month in which the individual becomes entitled to ESRD Medicare benefits, or if earlier, the first month in which the individual would have been entitled to such benefits had the individual filed an application.

In general, this Plan is primary over Medicare for you and/or your Dependent(s), if you are:

- Not disabled;
- Age 65 or over and actively working; or
- During the first 30 months of eligibility for Medicare due to ESRD, as described above.

However, if you and/or your Dependents are covered under Medicare as a result of being over age 65, and your employer employs fewer than 20 employees, the "small employer" exception may apply such that the Plan will pay secondary to Medicare even if you are actively working.

Generally, the Plan is secondary when you are not actively working, except in the case of the first 30 months of Medicare based on ESRD.
Any benefits payable to you or your Dependents under any portion of this Plan will be reduced by the amount of any benefits or other compensation to which you are entitled under any federal law, rules, or regulations constituting a governmental health plan, such as Medicare.

If you or your Dependent are eligible to participate in Medicare Part A and to enroll in Medicare Part B, the Plan will coordinate its benefits with Medicare Part A and Medicare Part B with respect to claims filed by you or your Dependent or on your behalves whether or not you have enrolled for both Parts. The Plan will only pay benefits equal to the benefits it would have paid if you or your Dependent enrolled in both Medicare Part A and Medicare Part B when first eligible to do so.

When Medicare is, should be, or could be your or your Dependent's primary coverage due to age, disability or ESRD, the Plan will coordinate its benefits with the benefits paid or presumed payable by Medicare as if you or your Dependent were eligible for and enrolled in Medicare. In such cases, the Plan will coordinate its benefits as if Medicare benefits also were paid on the claim, even if you or your Dependent are ineligible for Medicare for reasons other than failure to meet the age, disability or ESRD requirements.

You are responsible for keeping the Fund Office informed of your and your Dependent's Medicare status.

Information Gathering

Protected Health Information (PHI)

All individually identifiable health information transmitted or maintained by the Plan that relates to your past, present, or future health, treatment, or payment for health care services.

To implement the provisions in this coordination of benefits section, the Trustees may release or obtain any information necessary to or from any insurance company, organization, or person without your consent or release, in accordance with the Plan's Privacy Policy (see following section). Any person claiming benefits under this Plan must provide any information necessary to implement the coordination of benefits provisions or to determine their applicability.

Privacy Policy

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

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

procedures and outlines your rights under the privacy rules and regulations.

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

Subrogation And Reimbursement

Subrogation

A rule that gives the Plan the right to be repaid for benefits it pays on a claim if a third party is responsible for paying the expenses for which the claim is made.

By accepting benefits under the Plan, you and your eligible Dependents agree to be subject to the terms and conditions of this Subrogation and Reimbursement Section. As such, you (and any adult eligible Dependent for whom reimbursement of covered expenses is claimed under the Plan) must agree to and execute the Plan's Subrogation and Reimbursement agreement in a form acceptable to the Trustees or legal counsel for the Trustees before benefits will be payable under the Plan.

Please note that regarding services provided or paid for by Union Health Services on behalf of Plan A participants, Union Health Services has its own subrogation policies and procedures. Those policies and procedures may be different from the terms set forth herein; if there is any conflict, the Union Health Services' subrogation policies and procedures govern regarding services provided or paid for by Union Health Services.

It is the intent of the Trustees that no individual shall receive any profit from the payment of insurance or other benefits from the Plan, or from the payment of any compensation for injuries. Therefore, expenses that are caused by, contributed to, or the responsibility of any Third Party are not covered expenses under the terms of the Plan to the extent that any amounts are recovered by a Claimant from a Third Party related to such Third Party Incident, regardless of how the recovered amounts are characterized.

To the extent of any payments the Plan makes or may be obligated to make for a claim related to a Third Party Incident, the Plan shall be subrogated to any and all rights of recovery and causes of action that the Claimant may have against any and all parties responsible for causing the injuries or illness relating to the Third Party Incident. Further, upon settlement or adjudication of any claim arising out of the Third Party Incident, the Claimant shall reimburse the Plan in full for any benefits advanced by the Plan related to the Third Party incident, regardless of how the settlement or award is characterized. The Trustees may require the execution of a Subrogation and Reimbursement agreement, in a form to be provided by the Trustees, but the Plan's rights to Subrogation and Reimbursement apply regardless of whether the Claimant executes a Subrogation and Reimbursement agreement.

If Claimant obtains a recovery with respect to the Third Party Incident, until the total covered expenses arising out of the Third Party Incident equal or exceed the total amount of compensation paid by the Third Party to or on behalf of the Claimant with respect to the Third Party Incident, no benefits will be payable. The Plan then will consider only the amount of claims that exceeds the amount of the gross recovery. However, the Trustees may choose to advance amounts as payment for medical care expenses in situations where or at a point in time when liability for such expenses has not been established.

For the purposes of this Section:

- "Claimant" is the Employee or Dependent, and includes representatives, guardians, trustees, estate representatives, heirs, executors, administrators of special needs trusts and any other agents, persons or entities that may receive a benefit on behalf of or for Claimant.
- "Compensation" for injuries includes any judgment, award or any settlement, whether or not the terms of the judgment, award or settlement expressly include or exclude medical expenses and disability recovery. It specifically is intended to give the Plan the right to recover all benefits it paid on a claim, whether or not the Claimant has been made whole.
- A "Third Party Incident" is any incident where a Third Party causes injuries or illness and/or is or may be responsible or liable for paying all or part of the expenses for which a claim is filed with the Plan, or any injury that is work-related.
- A "Third Party" could be, but is not limited to:
    - ♦ a third-party tortfeasor or other individual or other entity of any kind who causes harm (such as the driver of another automobile or motor vehicle in an automobile or motor vehicle accident);
    - ♦ an employee welfare plan or arrangement;
    - ♦ a medical or Hospital benefit plan;
    - ♦ a no-fault or other automobile or motor vehicle insurance policy;
    - ♦ an uninsured or underinsured motorist provision or medical pay provision of an automobile or motor vehicle insurance policy;
    - ♦ a homeowners, school or athletic insurance policy;
    - ♦ an employer or workers' compensation insurance carrier;
    - ♦ a liability insurance policy of any kind or nature; or
    - ♦ any other Third Party that is obligated to make payments which the Plan would otherwise be obligated to make.

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

Right to Subrogate

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

Right to Reimbursement

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

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

Enforcement of Rights

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

Further, where the Claimant or its agent receives a recovery from any Third Party but does not reimburse the Plan, the Plan shall have the right to offset the amount of future benefit payments on the claims submitted by the Claimant, the eligible Employee (if different from the Claimant) and any of the eligible Employee's Dependents covered under the terms of the Plan until the Plan has recovered the full amount allowed under this Section.

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

Coordination of Benefits

These Subrogation and Reimbursement rules do not apply to benefits Claimant recovers under another employer-sponsored group health plan if that coverage is subject to Coordination of Benefits (COB) rules described in the section entitled "Coordination of Benefits".

Subrogation and Reimbursement Agreement

The Plan is not and will not be liable for, nor does it or will it have any obligation to pay, any benefit arising out of a Third-Party Incident. If a claim is submitted for expenses for which someone else is or may be legally responsible, the Claimant, or their agent, must execute a

Subrogation and Reimbursement agreement, in a form as to be provided by the Trustees, and return it to the Plan Administrator as soon as possible. However, notwithstanding the preceding, as described above, simply by accepting benefits under the Plan, you and/or your Dependent agree to be subject to the terms and conditions of this Subrogation and Reimbursement Section of this booklet. Failure to comply with this section may result in offsets or other collective actions against the Employee and/or his/her Dependents. If Claimant is a minor or otherwise is legally incompetent, Claimant's parent, legal guardian or "next friend" must execute the Subrogation and Reimbursement Agreement on his/her behalf.

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

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

Separate Rights

The Plan's right to Reimbursement and the Plan's right to Subrogation, are separate and distinct rights and obligations. The failure or invalidity, in whole or in part, of one such right or obligation will not impair or otherwise adversely affect any such other right or obligation.

Attorney's Fees

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

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

Plan Right to Waive

The Plan may waive the above Subrogation and/or Reimbursement rights, or any part thereof, if they decide such action is in the best interest of the Plan and its Participants.

Anti-Assignment

By accepting benefits under the Plan, Claimants are prohibited from doing anything that will impair, release, discharge or prejudice the Plan's Subrogation or Reimbursement rights.

No Claimant may assign any rights or causes of action that he or she might have against a third-party, which would grant the Claimant the right to recover medical expenses or other damages, without the express, prior written consent of the Plan. The Plan's Subrogation and Reimbursement rights apply even where a person has died as a result of his or her injuries and the Claimant is asserting a wrongful death or survivor claim against the third-party under the laws of any state. The Plan's right to recover by Subrogation or Reimbursement thus shall apply to any settlements, recoveries, or causes of action owned or obtained by a decedent, minor, incompetent, or disabled person.

Maximum Amount of Recovery

Neither Claimant nor any other person will be required to reimburse to the Plan more than the benefits the Plan pays on the claim, or more than the gross amount the Claimant receives in recovery, whichever is less, without regard to attorney's fees and expenses incurred in obtaining such recovery.

Recovery and Offset

The Plan shall be entitled to recover (including by means of offset against future benefits or any other means of recovery) from you and/or your Dependent any excess payments paid to you or your Dependent, or on your or your Dependent's behalf due to mistake or fraud or any other reason or if the Plan otherwise determines that you or your Dependent are not entitled to such benefit payments or to the full amount of the payment made. The right of recovery and offset shall not limit the rights of the Plan to recover overpayment in any other manner.

Fiduciary Status

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

ADMINISTRATIVE INFORMATION

Information About The Plan

Plan Sponsor And Administrator/Fund Office

The Plan is sponsored and administered by the Board of Trustees. The Board of Trustees consists of Employer and Union representatives selected by the Employers and Unions who have entered into Collective Bargaining Agreements that relate to this Plan. A copy of any such Collective Bargaining Agreement may be obtained upon written request to the Board of Trustees. The Board also serves as the "Named Fiduciary" under ERISA.

If you wish to contact the Board of Trustees, you may use the address and phone or fax numbers below for the Fund Office:

Local No. 1 Health Fund – Fund Office
Wilson-McShane
1431 Opus Place, Suite 350,
Downers Grove, IL 60515

Phone: 630-288-6868
Claims: 630-288-6868 or
866-844-0488
Fax: 630-686-4128

Board Of Trustees

Union Trustees	Employer Trustees
Thomas Balanoff, President Service Employees Local 1 111 E. Wacker Drive, Suite 1700 Chicago, IL 60601	John Bieg, Trustee Wilson-McShane Wilson-McShane 1431 Opus Place, Suite 350 Downers Grove, IL 60515
Walter Dreschler, Trustee Service Employees Local 1 111 E. Wacker Drive, Suite 1700 Chicago, IL 60601	Bob Graf, Executive Vice President Sudler Property Management John Hancock Center 875 N. Michigan Avenue, Ste. 3980 Chicago, IL 60611
Efrain Elias, Trustee Service Employees Local 1 111 E. Wacker Drive, Suite 1700 Chicago, IL 60601	Sheila Byrne, Trustee The Habitat Company 350 West Hubbard Street Chicago, IL 60654
Vince Pesha, Trustee Service Employees Local 1 111 E. Wacker Drive, Suite 1700 Chicago, IL 60601	James C. Watts, Trustee Leasing & Management Co., Inc. 5000 N. Elston Avenue Chicago, IL 60630

Carl Rocconi, Trustee
Service Employees Local 1
111 E. Wacker Drive, Suite 1700
Chicago, IL 60601

Leon Wolin, Trustee
c/o Wilson-McShane
1431 Opus Place, Suite 350
Downers Grove, IL 60515

Lonnell Saffold, Trustee
Service Employees Local 1
111 E. Wacker Drive, Suite 1700
Chicago, IL 60601

Douglas Woodworth, Trustee
c/o Wilson-McShane
1431 Opus Place, Suite 350
Downers Grove, IL 60515

Administrators and Other Service Providers

See the *Important Contact Information* insert to this booklet for addresses, phone numbers, and Web sites of providers associated with this Plan, including those to whom the Board of Trustees has delegated administrative responsibilities.

The Board of Trustees has delegated administrative responsibilities to other individuals or organizations as follows:

- Wilson-McShane serves as the Fund Office and maintains eligibility records, accounts for Employer Contributions, answers Participant inquiries, and handles other administrative functions.
- Wilson-McShane serves as the Fund Office and is responsible for processing claims.
- Union Health Service (UHS) administers the Plan's Comprehensive Major Medical Benefits for Plan A Participants as a "voluntary health services plan" for which it issues subscription certificates.
- BlueCross BlueShield of Illinois (BCBSIL) provides access to Preferred Providers for medical care under a service contract.
- The Plan's Review Organization is responsible for precertification of all Hospital admissions (Emergency and non-Emergency), outpatient surgery, home health care, and Skilled Nursing Facility care.
- Express Scripts, as the prescription benefit manager, provides access to participating pharmacies and administers the Mail Service Program.
- Blue Cross Blue Shield administers the Plan's Dental Benefits under an insured contract.
- EyeMed administers the Plan's Vision Benefits under an insured contract.
- Employee Resource Systems administers the Member Assistance Program.
- The Fund's auditor, Bansley & Kiener, is responsible for preparing certain required government reports.

Plan Name

The name of the Plan is the Local No. 1 Health Fund.

Together the Plan's name, number, and the Trustee's EIN identify the Plan with government agencies.

Plan Numbers

The employer identification number (EIN), assigned to the Board of Trustees by the Internal Revenue Service, is 36-2525603. The Plan number assigned by the Board of Trustees is 501.

Legal Counsel

Asher, Gittler, Greenfield & D'Alba
Laner Muchin, Ltd.

Consultant

The Segal Company

Contributing Employers Under The Collective Bargaining Agreement

Those Employers who:

- Are members of the Apartment Building Owners and Managers Association (Apartment BOMA);
- Are members of another association that has negotiated a Collective Bargaining Agreement with the Union;
- Have directly negotiated a Collective Bargaining Agreement with the Union; or
- Have entered into a participation agreement with the Funds.

Participants and Dependents may obtain, upon written request to the Fund Office, information as to whether a particular employer or employee organization is a sponsor of the Plan, and if the employer or employee organization is a Plan sponsor, the sponsor's address.

Agent For Service Of Legal Process

Wilson-McShane is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon Wilson-McShane at:

Wilson-McShane
1431 Opus Place, Suite 350
Downers Grove, IL 60515

However, such documents may also be served upon any individual Trustee at the address of the Local No. 1 Health Fund.

Choice of Law/Venue

To the extent not superseded by the laws of the United States, the Plan will be construed in accordance with and governed by the laws of the state of Illinois. Any action brought because of a claim under this Plan will be

litigated in the United States District Court for the Northern District of Illinois, Eastern Division.

Plan Funding

Employer Contributions and certain Self-Payments finance the benefits described in this booklet. All Employer Contributions are paid to the Trust Fund subject to provisions in the Collective Bargaining or Participation Agreements. A copy of the Collective Bargaining or Participation Agreement under which you are covered is available, upon written request, from the Fund Office and is available for examination at the Fund Office.

The Collective Bargaining Agreements specify the amount of Contributions, due date of Employer Contributions, type of work for which Contributions are payable, and the geographic area covered by these agreements.

The Plan's benefits (other than certain medical services provided by UHS under Plan A, Dental Benefits, and Vision Benefits) are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Fund assets is allocated for reserves to carry out the objectives of the Plan.

The Board of Trustees holds all assets in trust. Benefits and administrative expenses are paid from the Trust.

Contract/Insured Benefits

In some instances, it is more economical for the Fund to offer certain benefits through a contract with an insurance provider. Contract providers collect premiums from the Fund and pay benefits. The Fund has contracts with respect to the following benefits:

- Certain Plan A Medical Benefits are provided through a contract with Union Health Service.
- Dental Benefits are provided through a contract with Blue Cross/Blue Shield of Illinois.
- Vision Benefits are provided through a contract with EyeMed.

See the *Important Contact Information* insert to this booklet for the addresses and phone numbers for these organizations.

Plan Year

The records of the Plan are kept on a fiscal year basis, beginning each July 1 and ending June 30.

Type of Plan

This Plan is considered a welfare plan, providing medical, prescription drug, dental, vision, and MAP benefits for Participants and Dependents who meet the eligibility requirements described in this booklet.

Eligibility Requirements

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

Workers' Compensation And The Plan

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

Plan Amendment And Termination

The Board of Trustees expects to continue the Plan indefinitely. However, the Trustees have the authority in their sole discretion at any time and for any reason to increase, decrease, or change benefits, eligibility rules, or other provisions of the Plan as they may determine to be in the best interests of Plan Participants and beneficiaries. Any such amendment, which will be communicated in writing, will not affect valid claims that originated before the date of the amendment.

This Plan may be discontinued or terminated by the Trustees in their sole discretion at any time, for example, if future Collective Bargaining Agreements or Participation Agreements do not require Employer Contributions to the Fund. In such event, all coverage for Eligible Individuals will end immediately. Any such discontinuation will not affect valid claims that originate before the termination date of the Plan as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the assets available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

Board Of Trustees' Discretion And Authority

All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement. The Plan is maintained for the exclusive benefit of the Participants and beneficiaries.

Under the Plan and the Trust Agreement creating the Welfare Fund, the Trustees or persons acting for them, such as a Claim Appeal Committee, have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement, and any regulations, procedures, or administrative rules

adopted by the Trustees. Decisions of the Trustees (or where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner and the Trustees decisions will be afforded judicial deference. Benefits under this Plan will be paid only when the Board of Trustees (or persons delegated by the Trustees) decide, in their sole discretion, that the Participant or beneficiary is entitled to benefits in accordance with the Plan's terms.

If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefits provided to different classes of Participants may vary. In addition, any required Contributions may vary depending on the benefits provided and other factors.

The Trustees have the general right, in their sole discretion, to settle claims and waive Plan terms. However, a waiver of Plan terms in one instance is not to be construed as a general waiver of those terms in other circumstances.

Your 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 Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each Participant.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. (You or your Dependents may have to pay for such coverage; review this Summary Plan Description and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.).

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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.

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures (starting on page 61). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by:

- Calling 866-444-3272; or
- Visiting the Web site of the EBSA at www.dol.gov/ebsa.

GLOSSARY

Association means the Apartment Building Owners and Managers Association of Illinois or its successor, and any other association that becomes a party to the Trust Agreement by written agreement with the Board of Trustees.

Benefit Plan, Plan of Benefits, or **Plan** means the program of benefits sponsored by the Local No. 1 Health Fund.

Board of Trustees or **Trustees** means the Union and Employer Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement.

Calendar Year means the 12-month period starting on January 1 and ending on December 31 of that year.

Chemical Dependency means any abuse of, addiction to, or dependency on the use of drugs, narcotics, alcohol, or any other chemical.

Chemical Dependency Treatment Facility means a rehabilitation facility for the treatment of individuals suffering from Chemical Dependency. Under the Plan, the facility must be accredited by a recognized accrediting body or there will be no coverage for services provided by the facility.

- **Collective Bargaining Agreement** means any applicable written labor agreement existing between an Association or an Employer and the Union that provides for Contributions to the Trust Fund, including any extensions, amendments, or renewals.

Contributing Employer or **Employer** means:

- Any individual, firm, association, partnership, corporation, or pension fund that has or is a member of an Association that has a Collective Bargaining Agreement with the Union or a Participation Agreement with the Trustees that requires periodic Contributions to the Trust Fund on behalf of its Employees;
- Any individual, firm, association, partnership, or corporation that otherwise is required to make Contributions to the Trust Fund on behalf of its Employees pursuant to an agreement with the Union or Trust Fund, and acceptance by the Trustees;
- The Union solely for the purpose of making Contributions to the Fund on behalf of its Employees pursuant to the provisions of a written Participation Agreement with the Trustees, provided that the Union in its role as an Employer has no voice in the selection of Employer Trustees or any other rights granted to Employers; and
- The Local No. 1 Health Fund and Local No. 1 Pension Fund, if the Pension Fund has a Participation Agreement with the Health Fund

provided that the Boards of Trustees in their role as an Employer have no voice in the selection of Employer Trustees or any other rights granted to Employers.

Contributions means payments made by an Employer to the Fund on behalf of that Employer's Employees in accordance with the terms of a Collective Bargaining Agreement or Participation Agreement. Contributions include funds from the Employer as well as remittance by the Employer of payroll deductions to cover the Employee's share of the costs, sometimes referenced as the "Employee co-payment."

Copayment or **Coinsurance Percentage** means, after all applicable Deductibles have been satisfied and subject to all applicable Maximum Benefits, the percentage paid by the Plan for Covered Expenses incurred by an Eligible Individual.

Covered Employment means work performed by an Employee for an Employer for which an Employer is required to make Contributions to the Fund on the Employee's behalf, in accordance with the terms of a Collective Bargaining Agreement or Participation Agreement.

Covered Expenses means the Reasonable and Customary Charges incurred by an Eligible Individual that are eligible for payment under one or more provisions of the Plan.

Custodial Care means services and supplies, including room and board and other institutional services, provided to an individual, whether disabled or not, primarily to assist him in the activities of daily living. Such services and supplies are Custodial Care regardless of by whom they are prescribed, recommended, or performed.

Deductible means the amount paid by an Eligible Individual before the Plan pays Covered Expenses.

Dependent means an Employee's:

- Legal spouse, including same or opposite sex as the Employee from whom the Employee is not legally separated, who is not eligible for benefits under the Plan as an Employee, and is not a full-time active member of the military service or armed forces of any country or nation.
- A party to a legal civil union with the Employee as recognized under the laws of any state of the United States or any province of Canada (not including relationships recognized solely through registration with a political subdivision or body other than a state or province) and who is not married or in a civil union with anyone else; and

For Plan purposes, throughout this document, unless specified otherwise, "Spouse" is also used to refer to an individual that meets the Plan's requirements of a domestic partner. In addition, "marriage" throughout this document may also refer to a legal civil union as described in this section.

- A domestic partner who is not in a marriage, civil union or domestic partnership with anyone other than the Employee, and meets the following criteria as indicated in an Affidavit of Domestic Partnership and evidenced by supporting documentation:
  - Is at least age 18 and mentally competent to consent to contract when domestic partnership began; and
  - Is not related to the Employee by blood closer than would bar marriage; and
  - Shares the same regular and permanent residence with the Employee and intends to continue doing so indefinitely; and
  - Shares joint responsibility for the cost of basic food, shelter, and any medical expenses with the Employee; and
  - Is not a domestic partner solely for the purpose of obtaining benefits under the Plan; and
  - Can provide at least two of the following documents upon request:
    - Joint ownership of real estate or a common lease,
    - Joint ownership of an automobile,
    - A joint bank account or joint credit card account,
    - A will that designates the other partner as the primary beneficiary, or
    - A beneficiary designation on a life insurance policy.

    NOTE: As a general matter, Domestic Partners are covered only if they were covered under the Plan prior to July 1, 2017; however, Employees of the Union covered under Plans C and D (also known as Supplemental Plans A and B, respectively), as described in this Summary Plan Description, may continue to add new Domestic Partners.

If a child or spouse works for a Contributing Employer and is eligible for benefits under the Plan as an Employee, or if the spouse is a full-time active member of the military or armed forces of any country, the child or spouse is not considered a Dependent under the Plan except for continuing coverage in accordance with applicable law in the event of military service.

- A Child who is:
  - Less than age 26; or
  - Any age, provided such child is totally and permanently disabled, which means that the child is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more. Coverage of such a child will continue for as long as the Employee remains eligible under the Plan, provided the child:
    - Became so disabled before age 26 and while covered under the Plan;

- Remains so disabled continuously;
- Meets the other requirements of the Plan's definition of a child;

Within 31 days before the date Plan coverage would otherwise end due to reaching age 26, the Employee must furnish, at no expense to the Fund, proof that the child is disabled and that the child was so disabled before reaching age 26. If the Employee does not provide the proper proof, the child will not be eligible for coverage under the Plan beyond the date the child reaches age 26. The Employee must furnish proof of the child's continued disability from time to time thereafter if requested by the Trustees. If the proof is requested but not received on or before a reasonable date set by the Trustees, the child's coverage will end on that date.

Child for purposes of the Plan's definition of Dependent includes any:

- Natural child born of the Employee;
- Child legally adopted by the Employee, including any child lawfully placed in and who remains in the Employee's home for the purpose of adoption by the Employee;
- A foster child (meaning an individual placed with you or your spouse, civil union partner, or eligible domestic partner by an authorized placement agency or by judgment decree or other order of any court of competent jurisdiction);
- A Stepchild (meaning a child of the Employee's current spouse, civil union partner, or eligible domestic partner who was born to or legally adopted by such spouse, civil union partner, or eligible domestic partner before the Employee's marriage, civil union, or domestic partnership to that individual); or
- A child recognized by the Trustees as an alternate recipient under the terms of a Qualified Medical Child Support Order (QMCSO), provided the Plan is required to provide health care coverage for the child under the terms of the QMCSO (residency or support requirements will not apply).

Durable Medical Equipment means equipment that:

- Can withstand repeated use;
- Is primarily and customarily used for a medical purpose;
- Is not generally useful in the absence of an injury or illness;
- Is not disposable or non-durable; and
- Is appropriate for the patient's home.

Eligible Individual means an eligible Employee or Dependent.

Emergency means a medical condition that results in acute symptoms that are of sufficient severity that a prudent layperson who possesses an average knowledge of health and medicine reasonably could expect to lead to death, serious impairment of health or dysfunction of any bodily organ or part, or other serious medical consequences if immediate medical attention is not provided. These conditions must be severe, sudden in onset and involve one or more of the major organ systems of the body, (e.g., the cardiovascular, metabolic, respiratory, nervous, gastrointestinal, or urinary system.)

However, if symptoms exist that reasonably may have been interpreted as an Emergency (as defined above), that condition is considered an Emergency even if the final diagnosis is of another condition. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an Emergency even if a final diagnosis of heart attack is not made.

In addition, the following will be considered an Emergency (even though it does not meet the above definition):

- Conditions that result from accidents that appear to be serious and so threatening to a body part that Emergency Room treatment is indicated; and
- Being taken for treatment to the nearest Hospital or trauma center by police, fire department, or ambulance, when such transportation is made under circumstances over which the person has no control, except in the case of transportation to a Hospital for reasons related to the use of alcohol or the non-legal use of controlled substances.

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

Employee means any:

- Person employed by an Employer on whose behalf Contributions are made to the Trust Fund pursuant to and under the terms of a Collective Bargaining Agreement between the Union and the Employer or pursuant to and under the terms of a Participation Agreement between the Employer and the Trustees;
- Employee of the Union on whose behalf the Union, as an Employer, makes Contributions to the Trust Fund pursuant to and under the terms of a Participation Agreement;
- Employee of the Local No. 1 Health Fund or Local No. 1 Pension Fund that as an Employer has signed a Participation Agreement; and

- Owner of a Contributing Employer on whose behalf such Employer is obligated to make Contributions to the Fund pursuant to and under the terms of a Participation Agreement between the Employer and the Trustees.

Essential Health Benefits means items and services covered by the Plan within the following general categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services (including behavioral health treatment);
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services for individuals under the age of 19, including oral and vision care.

Whether a benefit is an "Essential Health Benefit" as defined here will be determined by the Trustees with reference to the Utah Benchmark Plan, as permitted under the Affordable Care Act.

Experimental or **Investigative** means any treatment, procedure, facility, equipment, drug, device, or supply that:

- Is not yet generally accepted among experts as accepted medical practice;
- Cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other federal agency, for which such approval had not been granted at the time it was rendered, provided, or utilized; or
- Is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental, study, or investigative arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnoses; or if the prevailing opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnoses.

The Trustees determine whether a treatment, procedure, facility, equipment, drug, device, or supply is Experimental or Investigative, in their sole discretion and judgment, in consultation with medical consultants of their choosing.

Fund or **Trust Fund** means all property of the trust established by the Trust Agreement, including but not limited to all Contributions and Self-Payments to the Trust Fund that are received by the Trustees, together with all income, increments, earnings, and profits, and all assets or claims, accrued or contingent, held by the Trustees for the uses, purposes, and trusts set forth in the Trust Agreement.

Home Health Agency means a public agency or private organization, including a subdivision of such agency or organization, that:

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

Hospice means an agency or organization that is not a free-standing facility but is affiliated with a Hospital and that is primarily engaged in providing a coordinated set of services to persons suffering from a terminal medical condition.

Generally, an Eligible Individual is considered to have a "terminal medical condition" if he/she has a life expectancy of six months or less, as certified by a Physician.

Hospital means an institution that is engaged primarily in providing medical care and treatment to individuals suffering from Sickness or Injury on an inpatient basis at the patient's expense. A Hospital under the Plan must:

- Be accredited by a recognized accrediting body;
- Be a hospital, psychiatric hospital, or tuberculosis hospital, as those terms are defined in Medicare, that is qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare; or
- Be an institution that:
    - ♦ Provides, on an inpatient basis, diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment, and care of

injured and sick individuals under the supervision of a staff of Physicians licensed to practice medicine;

- ♦ Provides, on the premises, 24-hour-a-day nursing services by or under the supervision of RNs;
- ♦ Is operated continuously with organized facilities for operative surgery on the premises; and
- ♦ Is not an institution that is primarily a clinic or, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing or convalescent home or similar establishment.

Injury means an accidental bodily injury that does not arise out of, in the course of, or is not caused or contributed to by or as a consequence of any employment or occupation for compensation or profit.

Maximum Benefit means the maximum dollar amount paid by the Plan during a specified period of time (as specified in the Schedules of Benefits). (Note: The Plan does not apply an annual Maximum Benefit to Essential Health Benefits.)

For certain types of treatment, Maximum Benefit means the maximum allowable number of days, visits, or course or treatment that represents the maximum amount of benefits to which an Eligible Individual is entitled under the Plan during a specified period of time.

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

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

A decision as to Medical Necessity is merely a decision regarding provision of coverage under the Plan. **Decisions as to the appropriate treatment and care must be made by you in consultation with your Physician.**

Medicare means the Health Insurance Program under Title XVIII of the Social Security Act, as currently constituted and as it may later be amended.

Mental or Nervous Disorder means an emotional Sickness, including a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, regardless of whether such condition, disease, or disorder has causes or origins that are organic, physiological, traumatic, or functional.

Non-precertification Deductible means the penalty that a Participants pays when the Participant fails to receive precertification where required by the Plan.

Out-of-Pocket Limit or Maximum, as specified in the Schedule Of Benefits for Plan A and Plan B, means the maximum amount of out-of-pocket payments paid by, or on behalf of, an Eligible Individual or all Eligible Family Members for their share of most Covered Expenses incurred during a Calendar Year for a particular category of expenses (network or non-network).

Outpatient Surgical Center or **Surgical Center** means a facility that:

- Is a health care institution or facility, either freestanding or as part of a Hospital, equipped and operated with permanent facilities for the primary purpose of performing surgical procedures on patients on an outpatient basis and which a patient is admitted to and discharged from within a 24-hour period;
- Is regularly licensed by the governmental or other agency that has the responsibility for such licensing;
- Keeps medical records on all patients;
- Employs a licensed anesthesiologist and an RN,
- Is supervised by a full-time Physician who is an MD or DO;
- Has at least two operating rooms and a recovery room;
- Is equipped to take care of emergencies;
- Has an agreement with at least one local Hospital to take patients who develop problems; and
- Employs surgeons who are also allowed to perform surgery in a local Hospital.

An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, is not considered an Outpatient Surgical Center.

Participant or **Plan Participant** means any Eligible Individual entitled to receive benefits under this Plan.

Participating Pharmacy means one of a number of specified pharmacies that has an agreement with the prescription drug program provider to provide prescription drugs to the Fund's Participants at negotiated, reduced rates. Eligible Individuals who use the prescription drug program are required to purchase their short-term or acute prescription drugs at such pharmacies.

Participation Agreement means a written agreement, approved by the Trustees, executed by an Employer to allow participation by its Employees in the Plan, provided that Employer evidences the commitment to be bound by the Trust Agreement, and that the Employer agrees to make, and the Trustees agree to accept, Contributions to the Fund on behalf of the Employer's Employees who are not members of a collective bargaining unit.

Physician means a legally qualified physician or surgeon, provided the physician is a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) and is licensed to practice medicine in all of its branches. A dentist (DDS), podiatrist (DPM), or chiropractor (DC) is also considered a Physician under the Plan for services performed within the scope of such individual's specialty within the provisions and limitations of the Plan.

Plan Administrator means the Local No. 1 Health Fund Board of Trustees that, as named fiduciary, has the authority to control and manage the operation and administration of the Plan and that may, at its discretion, delegate responsibilities for the operation and administration of the Plan.

PPO or Preferred Provider Organization means a network of providers (Hospitals and/or Physicians) available for use by Plan Participants at negotiated rates as the result of the Trustees having entered into an agreement with the network administrator.

PPO Provider or Network Provider means a provider (Hospital or Physician) that has a negotiated service agreement with the Preferred Provider Organization on the date on which an Eligible Individual receives services and/or supplies from such provider.

A provider (Hospital or Physician) that is not a PPO or Network Provider is referred to as a Non-PPO or Non-Network Provider.

Psychiatrist means a Physician that specializes in the prevention, diagnosis and treatment of Mental or Nervous Disorders.

Psychologist means a practitioner with a doctorate in psychology (or equivalent discipline) licensed by the applicable governmental agency to provide clinical psychological services and treatment to individuals.

Reasonable and Customary Charge or **Reasonable and Customary** means the maximum allowable charge considered as a Covered Expense under the Plan. With respect to PPO Providers, the Reasonable and Customary Charge is the negotiated rate charged by PPO Providers under the agreement with the network administrator pursuant to which the PPO

Provider participates in the PPO. With respect to non-PPO, contracted providers, the Reasonable and Customary Charge is the rate that the provider has agreed to by contract with the Plan's PPO or network administrator. These rates may vary over time, and as a result, your Copayment may vary. You should consider this when choosing a provider who is in or out of the PPO. With respect to non-PPO, non-contracted providers, the Plan uses as a starting point the definition of reasonable and customary charge that is applied by the PPO administrator. The PPO administrator makes changes from time to time in the methodology that it utilizes to determine the Reasonable and Customary Charge for non-PPO, non-contracted providers. As a result, what is considered to be a "Reasonable and Customary Charge" with respect to these providers may fluctuate over time, and, as a result, your financial responsibility for a provider's bill may vary. If, because of a change in methodology for determining the Reasonable and Customary Charge, the Plan pays less, then you may owe the provider more. If a particular charge is more than the amount considered to be Reasonable and Customary, any amount over the Reasonable and Customary Charge is not considered a Covered Expense under the Plan. Amounts in excess of the Reasonable and Customary Charge do not count toward your annual Deductible or Out-of-Pocket Maximum.

Registered Nurse (RN) means a practitioner licensed by the appropriate governmental agency to provide nursing services.

Review Organization means a professional organization having an agreement with the Trustees to administer the Medical Review Program in accordance with the terms of the Plan.

Room and Board Charges means all charges made by a Hospital, a Skilled Nursing Facility, or a Chemical Dependency Treatment Facility for room, board, general duty nursing, and any other charges regularly made by such institution on a daily, weekly, or monthly rate as a condition of occupancy of the class of accommodations occupied. For a Hospital, charges made for intensive care units and nursery charges for well newborn care (other than for newborns of Dependent children) are included as part of the Room and Board Charges. Room and Board Charges do not include charges for professional services of Physicians, private duty nurses, or charges for intensive nursing care.

Self-Payment means:

- Regular self-payments made to the Fund by an Employee to maintain eligibility for benefits, or for benefits when insufficient Employer Contributions are made to the Fund due to lack of employment or reduced hours; or
- COBRA Continuation Coverage self-payments made to the Fund by an Employee or Dependent to maintain eligibility when eligibility would otherwise end due to a COBRA Qualifying Event; or

- USERRA Continuation Coverage self-payments made to the Fund by an Employee or Dependent to maintain eligibility when eligibility would otherwise end due to the Employee's military service.

Sickness means an illness or sickness that does not arise out of, or in the course of, and is not caused or contributed to by, or as a consequence of, any employment or occupation for compensation or profit. Pregnancy is considered a Sickness.

Skilled Nursing Facility means an institution, or a distinct part of an institution, that is:

- Duly licensed by the appropriate governmental authorities and complies with all other legal requirements;
- Primarily engaged in providing inpatient skilled nursing care, physical restoration services, and related services to individuals recovering from an Injury or Sickness that require medical or nursing care to assist them in reaching a degree of body functioning to permit self-care in essential daily living activities; and
- Not, other than incidentally, a place for rest, Custodial Care, aged, drug addiction, alcoholism, hotel, care and treatment of mental diseases or tuberculosis, or a similar institution.

Social Worker means a practitioner with a master's degree in social work and licensed by the appropriate governmental agency to provide professional services and treatment.

TMJ means any conditions or disorders involving the temporomandibular or craniomandibular joints, including any condition of the joints linking the jawbone and the skull, along with the complex of muscles, nerves, and other tissues related to those joints.

Trust Agreement means the Agreement and Declaration of Trust dated July 10, 1963 that established the Local No. 1 Health Fund, as amended and/or restated.

UHS means Union Health Service, Inc.

UHS Physician means a Physician whose services are provided by, through, or pursuant to a contract with Union Health Service, Inc.

Union means the Service Employees International Union Local No. 1, affiliated with Service Employees International Union.

Welfare Fund means the Local No. 1 Health Fund created by the Trust Agreement.