Central Illinois Carpenters Health and Welfare Plan

Plan Description – Schedule I

Effective August 1, 2019

Central Illinois Carpenters
Health and Welfare Trust Fund

200 S. Madigan Dr.
Lincoln, Illinois 62656
Telephone: (217) 732-1919

Board of Trustees

Union Trustees	*Employer Trustees*
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Carl Bimm	Jason Brewer
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You may also communicate with the Board of Trustees by contacting them through the Administrative Manager.

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Cavanagh & O'Hara, LLP

Certified Public Accountants
Romolo & Associates

Consultant
J.L. Hubbard Insurance and Bonds

Utilization Review Administrator
Blue Cross and Blue Shield of Illinois

Pharmacy Benefit Manager
Express Scripts

Vision Program Manager
VSP

All questions about benefit interpretations should be referred to the Fund Office. Telephone contact with the Fund Office does not guarantee eligibility for benefits or benefit payments.

Though the Fund Office can provide you with general information on your plan or benefits, your eligibility for benefits and benefit payments will be determined only when a claim is submitted to the Plan.

Table of Contents

Central Illinois Carpenters
Health and Welfare Trust Fund

To All Eligible Participants:

Since the last Plan Description Booklet was printed, there have been changes made in the eligibility and benefit provisions of the Plan.

This booklet is designed to show you how to use the Central Illinois Carpenters Health and Welfare Trust Fund Plan during different stages of your life. The benefits described in this booklet are available to Eligible Participants and their Eligible Dependents. This booklet includes:

- A summary of coverage provided by the Plan;
- Eligibility information for you and your Dependents;
- A description of how your benefits will be affected at various stages of your life;
- An explanation of how your coverage works under each benefit program;
- Information about how to file claims and your appeal rights; and
- A glossary of terms.

Keep this booklet in a safe place for easy reference. In the event that you have questions about your eligibility or benefits, contact the office of the Health and Welfare Trust Fund Office for assistance.

Sincerely,

BOARD OF TRUSTEES

The Trustees reserve the right, in their sole discretion and without notice to members, employers, the union and others affected hereby, to interpret, amend, modify or terminate all or part of this Plan. Plan participants will be notified of changes in writing in accordance with federal law. This booklet contains a description of Plan coverages and benefits, limitations and exclusions in layman's language to help Participants understand the Plan. Only the Board of Trustees can interpret the Plan. If you have any questions, contact the Fund Office.

Schedule Of Benefits

Schedule of Benefits I		
	PREFERRED PROVIDERS	**NON-PREFERRED PROVIDERS**
MAXIMUM CALENDAR YEAR BENEFIT AMOUNT	Unlimited	
Note: The maximums listed below are the total for Preferred Provider and Non-Preferred Provider expenses. For example, if a maximum of 60 visits is listed twice under a service, the Calendar Year maximum is 60 visits total, which may be split between Preferred Provider and Non-Preferred Providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Person	$500	
Per Family Unit	$1,500	
The calendar year deductible is waived for the following: - Prescription drug card benefits - Wellness Benefit		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Person (including deductibles, copays, and coinsurance)	$5,000	$10,000
Per Family (including deductibles, copays, and coinsurance)	$10,000	$20,000
The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year. There is no out-of-pocket limit for the following: - Vision benefits - Dental benefits - Plan Exclusions The Preferred Provider and Non-Preferred Provider out-of-pocket maximums are **NOT** calculated on a combined basis.		
COVERED SERVICES		
Hospital Services		
Room and Board	80%	60%
Intensive Care Unit	80%	60%
Other Inpatient	80%	60%

Schedule of Benefits I (continued)	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Outpatient Surgery & Diagnostic	80%	60%
Outpatient Pre-Admission Testing	80%	60%
Outpatient Urgent Care Room	80%	60%
Outpatient Emergency Room	80% after $100 copay (waived if admitted)	80% after $100 copay (waived if admitted)
Inpatient Rehabilitation Facility	80%	60%
Skilled Nursing Facility	80% 90 days calendar year maximum	60% 90 days calendar year maximum
Physician Services		
Inpatient visits	80%	60%
Office visits, labs and x-rays	80%	60%
Surgery	80%	60%
Second Surgical Opinions	80%	60%
Home Health Care	80% 104 visits per calendar year maximum	60% 104 visits per calendar year maximum
Private Duty Nursing	80%	60%
Hospice Care	80%	60%
Ambulance Service	80%	
Occupational Therapy **Speech Therapy (due to accident or illness)** **Physical Therapy**	80% 60 visits combined per calendar year maximum	60% 60 visits combined per calendar year maximum
Chiropractic Services (muscle manipulation)	80% 35 visits per calendar year maximum	60% 35 visits per calendar year maximum
Durable Medical Equipment	80%	60%
Prosthetics	80%	60%

Schedule of Benefits I (continued)	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Orthotics	80% $3,000 per calendar year maximum	60% $3,000 per calendar year maximum
Medical Supplies	80%	60%
Hearing Aids	100% $2,500 maximum benefit each 5-year period (both ears combined)	
Corrective Vision Eye Surgery – LASIK (correction of nearsightedness or farsightedness only)	80% $1,600 per lifetime maximum per eye	60% $1,600 per lifetime maximum per eye
Infertility Testing (excluding treatment)	80%	60%
Birthing Center	80%	60%
Voluntary Sterilization	80%	60%
Mental Illness		
Inpatient	80%	60%
Outpatient Treatment	80%	60%
Partial Hospitalization	80%	60%
Substance Abuse		
Inpatient	80%	60%
Outpatient Treatment	80%	60%
Partial Hospitalization	80%	60%

Schedule of Benefits I (continued)	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Wellness/Preventive Benefit (Medical Services Only)	100% (not subject to deductible) Refer to the U.S. Preventive Services Task Force list of covered wellness/preventive services required under the Patient Protection and Affordable Care Act. Examples of covered services include *routine* colonoscopy, mammogram, pap test, PSA and blood profiles as well as HPV vaccine (when administered according to medical guidelines) are covered under wellness benefit when considered as routine services.	
Organ Transplants **(Refer to Page 33)**	80% if performed at Center of Excellence (BlueCross BlueShield Blue Distinction Center)	Not Covered
All Other Covered Services	80%	60%

Prescription Drugs	**Benefit**
Retail (30-day supply) Generic Drugs Brand Drugs *If actual cost of prescription is less than minimum, Participant only pays actual cost	<u>Participant Pays</u>: 15% with $10 minimum per prescription* 30% with $20 minimum per prescription*
Mail Order Program (90-day supply) Generic Drugs Brand Drugs	<u>Participant Pays:</u> $20 $60

Dental Services	**Benefit**
Calendar Year Deductible Per Individual Per Family	 $100 $300
Coinsurance Preventative Dental Care Minor restorative Major restorative Calendar Year Maximum for Preventive, Basic, and Major Dental per Individual	Plan Pays Usual, Customary and Reasonable charges After Deductible, as follows: 100% (not subject to Deductible) 70% 50% $1,200 Note: Pediatric Dental Benefits through age 18 are not subject to the $1,200 Calendar Year Maximum but are instead subject to the Maximum Calendar Year Benefit Amount listed in this Schedule of Benefits. See page 41 of this Plan Description for a listing of Pediatric Dental Benefits subject to the Maximum Calendar Year Benefit Amount.

Vision Care Services	Benefit
In-Network Benefits	Plan Pays After $10 Copay
Examination (every 12 months)	100% *
Lenses (every 12 months)	100% * $25.00 Copay for anti-reflective lens improvements
Retail Frames (every 24 months)	$175 maximum benefit
Contact Lenses (every 12 months)	
* Up to the plan allowance as established by VSP.	
Out-of-Network Benefits	Maximum Plan Pays After $10 Copay
Examination	$35
Lenses	
Single Vision	$25
Bifocal	$40
Trifocal	$55
Frames	$35
Contact Lenses	$105
Prescription Safety Glasses	Plan will reimburse a Participant up to $100 for the cost of prescription safety glasses (lenses and frames only) every 12 months from the last date of service. This benefit will be administered by the Fund Office. The Participant must be eligible for benefits with the Plan on the date of service to qualify for this reimbursement benefit. See the "Vision Care Benefit" section of this Summary Plan Description for further information.

NOTICES

The Utilization Review Administrator must be notified (i) prior to an elective admission to the Hospital or (ii) within forty-eight (48) hours after admission for Emergency Treatment or obstetric care.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following covered health services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such covered health services (including co-payments, co-insurance and any deductible) is the same as is required for any other covered health service. Limitations on benefits are the same as for any other covered health service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Schedule I is a summary of Plan benefits. Please read the remainder of this booklet carefully for a detailed explanation of Plan benefits and limitations.

For Active Participants	
Benefit	**Benefit Amount**
Life Insurance	$5,000
Accidental Death and Dismemberment Insurance	$5,000
Disability Non-occupational: 13-Week Maximum per Disability	$480 per week/$96.00 per day and 25 hours per week (5 hours per weekday) towards continuing eligibility with the Plan
Occupational: 13-Week Maximum per Disability	25 hours per week (5 hours per weekday) towards continuing eligibility with the Plan
For Eligible Retirees up to age 70	
Benefit	**Benefit Amount**
Life Insurance	$5,000

Contact Information

If You Need Information About …	Contact …
■ Medical Benefits ■ PPO Providers ■ Dental Benefits ■ Life Insurance ■ Accidental Death and Dismemberment Insurance ■ Weekly Disability Benefits	Central Illinois Carpenters Health and Welfare Trust Fund 200 S. Madigan Dr. Lincoln, Illinois 62656 Phone: (217) 732-1919 Toll Free: (866) 732-1919 Fax Number: (217) 732-7799 www.cichealth.org
Prescription Drug Benefits	Express Scripts, Inc. 1(800) 935-9963
Utilization Management Services for Inpatient Admissions	Blue Cross and Blue Shield of Illinois 1 (800) 635-1928
Vision Benefit	Vision Service Plan (VSP) P.O. Box 997105 Sacramento, CA 95899-7105 Phone: 1-800-877-7195 www.vsp.com

Definitions

Active Work and **Actively at Work** means a Participant who is in good standing with the Union and available for active full-time performance of all customary duties of his or her occupation.

Administrative Manager means the individual, corporation, or partnership appointed by the Trustees to perform the administrative functions of the Fund.

Ambulatory Surgical Center means any public or private establishment, which is either independent or part of a Hospital, with an organized medical staff of Physicians, permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, continuous Physician and Registered Nursing services whenever a patient is in the facility; and which does not provide services or other accommodations for patients to stay overnight.

Ambulatory Surgical Facility does not include an office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy.

Association means individually and collectively, the Builders' Association of Tazewell County, Central Illinois Builders Chapter of A.G.C., Greater Peoria Contractors and Suppliers Association, Inc., Associated General Contractors of Illinois and any other employer organization which may become a party to the Agreement and Declaration of Trust.

Bargaining-Unit Employee means any employee in the employ of any person, corporation, or partnership who has a collective bargaining agreement in effect with the Union requiring contributions to the Fund on employee's behalf.

Beneficiary means the individual who will receive the life insurance benefit because of the death of an Eligible Participant as defined on page 57.

Calendar Year means that period of time beginning on the first day of January in any calendar year and ending on the last day of December in the same calendar year.

Coinsurance means the percentage of Expenses Incurred which must be paid by a Covered Person after payment of the Deductible, as determined in accordance with the Schedule of Benefits, and subject to the maximum Out-of-Pocket limitation specified in the Schedule of Benefits. Coinsurance amounts do apply toward the satisfaction of the Out-of-Pocket maximum.

Collective Bargaining Agreement means the collective bargaining agreement or other written agreement between the Association, or an Employer and the Union requiring contributions to the Fund.

Copay means the fixed dollar amount that a Covered Person must pay each time for certain services. Copay amounts do apply towards the satisfaction of the Out-of-Pocket maximum.

Creditable Coverage means coverage of the Covered Person under any of the following:

1. Group health plan;

2. Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer;

3. Medicare (Parts A or B of Title XVIII of the Social Security Act);

4. Medicaid (Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928);

5. Chapter 55 of Title 10, United States Code;

6. a medical care program of the Indian Health Services or of a tribal organization;

7. a health plan offered under Chapter 89 of Title 5 of the United States Code;

8. a State health benefits risk pool;

9. a public health plan established or maintained by a State or any political subdivision of a State, the U.S. government or a foreign country;

10. a health benefit plan under Section 5(e) of the Peace Corps Act;

11. Medical care for employees and certain former members of the uniformed services and their dependents;

12. a health plan offered under the Federal Employees Health Benefits Program; or

13. State Children's Health Insurance Program (Title XXI of the Social Security Act).

Creditable Coverage shall not mean:

1. coverage only for accident, or disability income insurance, or any combination thereof;

2. coverage issued as a supplement to liability insurance;

3. liability insurance, including general liability insurance and automobile liability insurance;

4. workers' compensation or similar insurance;

5. automobile medical payment insurance;

6. credit-only insurance;

7. coverage for on-site medical clinics;

8. other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits;

9. limited benefits, such as limited scope dental benefits, vision benefits, or benefits for long-term care, nursing home care, home health care or community-based care;

10. coverage for only specific disease or illness if offered as an independent benefit;

11. hospital indemnity or other fixed indemnity insurance if offered as an independent, non-coordinated benefit; or

12. Medicare supplemental health insurance, coverage supplemental to coverage provided under Chapter 55 of Title 10 of the United States Code, and similar supplemental coverage provided to coverage under a group health plan.

Deductible means the total of Covered Expenses which a Covered Person must incur during a calendar year before the Plan pays benefits. Medical deductible expense shall apply toward satisfaction of the Medical Out-of-Pocket maximum.

Dental Service means care and treatment of the teeth and gums, or any services rendered by a Dentist or oral surgeon.

Dentist means a Doctor of Dental Surgery licensed and registered to practice his or her profession. The term Dentist will not include any person residing in Participant's household.

Dependent means the following:

1. The lawful spouse of an Active or Retired Participant.

2. Each child between birth and through the end of the month in which the child reaches age 26. The word "child" means:

   a) Your own or lawfully adopted child, or any child in your custody while adoption proceedings with respect to that child are pending;

   b) Any stepchild; and

   c) Any child for whom you have been appointed legal guardian.

3. Each unmarried child of a Participant who is incapable of self-sustaining employment by reason of mental or physical disability, and who became so incapable prior to the attainment of age 19 and while eligible for benefits under this Plan.

   Proof of the child's incapacity must be furnished to the Fund Office no later than 31 days before the end of the month in which the child reaches age 26 and additionally as required by the Fund Office.

Employer means any person, corporation, or partnership who has a collective bargaining agreement in effect with the Union requiring contributions to the Fund and shall include the Union, the Trust Fund and other Southern Region Chicago Regional Council of Carpenters Trust Funds when the same contribute on behalf of its employees. Further, Employer means any person, corporation, or partnership who has signed a Participation Agreement with the Fund.

Employer Contribution means payments by Employers to the Fund as provided by the Collective Bargaining Agreement or Participation Agreement.

Eligibility Date – *Initial* means the first day of the month which follows a period of not more than 12 consecutive months during which at least 500 hours of contributions were paid to the Fund for you by one or more Contributing Employers.

Eligibility Date – *Continued* means in order to continue your eligibility in later Benefit Quarters (after Initial Eligibility Date) you must have at least 250 hours of contributions paid for you by Contributing Employers in a Calendar Quarter as outlined in the schedule located in the *Eligibility Section* of this

document. However, if you do not receive credit for at least 250 hours of contributions in a Calendar Quarter, you may remain eligible for benefits if 1000 hours of contributions have been paid to the Fund for you by Contributing Employers over a 15-month period based on the schedule located in the *Eligibility Section* of this document.

Eligible Expenses Incurred (Expenses Incurred) means charges for purchase or services rendered and will be deemed to be incurred on the day the purchase is made or on the day the service is rendered for which the charge is made. *Please note:* Claims should be filed within 90 days after the occurrence for which claim is being made. If it is not reasonably possible to file a claim within the 90-day period, the claim may be accepted by the Fund Office. However, claims will not be eligible for payment 12 months after the claim was incurred.

Eligible Participant, Eligible Retired Participant and Eligible Dependent means those Participants, Retired Participants and Dependents who are eligible to receive benefits under this Plan in accordance with the Eligibility Requirements as stated within this document.

Experimental and/or Investigational means drugs, medical supplies, medical devices, medical equipment, medical or surgical procedures, treatments or services which do not meet accepted standards of medical practice. A drug, device, treatment or procedure is considered to be Experiment and/or investigational:

1. if the device, drug, treatment or procedure has not received the approval or endorsement of the American Medical Association (AMA), U.S. Food and Drug Administration (FDA) or the National Institute of Health (NIH) at the time the device, drug or procedure was furnished; or
2. if reliable evidence demonstrated that the device, drug, treatment or procedure is the subject of ongoing Phase I, II, or III Clinical Trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with standard means of treatment or diagnosis; or
3. if reliable evidence demonstrates that a consensus of opinion among medical experts regarding the device, drug, treatment or procedures is that further studies or Clinical Trials are necessary to determine it's maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

This Experimental or Investigative definition and its application by the Plan does not include participation in or the "Routine Patient Costs" for "Approved Clinical Trials" for which coverage is required by the Patient Protection and Affordable Care Act. An Approved Clinical Trial is a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application. The routine patient costs for Approved Clinical Trials include all items and services typically covered by the Plan for individuals not enrolled in an Approved Clinical Trial.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature, the written protocol(s) used by the treating facility, the protocol(s) of another facility studying substantially the same device, drug, treatment or procedure, or the written informed consent used by the treating facility or another facility studying substantially the same device, drug, treatment or procedure.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

Fund Office means the location designated by the Trustees where the Administrative Manager conducts the Fund's business. The Fund Office is at:

200 S. Madigan Dr.
Lincoln, Illinois 62656
Telephone: (217) 732-1919

Home Health Care Agency means an organization, or its distinct part, which:

1. is primarily engaged in providing skilled nursing care and other therapeutic services for, and in the private residences of, persons recovering from Sickness or Injury;

2. qualifies as a home health care agency under Medicare and is licensed or approved according to any applicable state or local standards and is operated pursuant to policies established by a professional staff, including at least one (1) Physician and one (1) Registered Nurse;

3. provides full-time supervision of its services by a Physician or Registered Nurse, and maintains clinical records on all of its patients;

4. has a full-time administrator; and

5. is not, other than incidentally, engaged in providing care or treatment of the mentally ill, or in providing custodial type care.

Home Health Care Plan means a program of continued care and treatment for a Covered Person or Covered Dependent, established and approved in writing by the Physician of the Covered Person or Covered Dependent. The program must be accompanied by the Physician's certification that the proper treatment of the Sickness or Injury would require continued confinement as a Hospital inpatient in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospice means an entity licensed, approved, or authorized to provide inpatient medical relief of pain to terminally ill patients. Such entity also provides supportive care to terminally ill patients and their family members. Such entity must have on its premises:

1. organized facilities to care for and treat terminally ill persons; and
2. a paid staff of medical professionals to supervise such care and treatment.

A Hospital or Skilled Nursing Facility shall not be considered Hospice.

Hospice Care means a centrally coordinated program of medically necessary home health, outpatient and inpatient services provided by an interdisciplinary team, directed by a qualified licensed Physician for a terminally ill individual for a maximum period of six months.

Hospital means an institution constituted and operated in accordance with the laws pertaining to Hospitals, is qualified to participate and eligible to receive payments under and in accordance with the

provisions of Medicare, equipped with permanent facilities for diagnosis, Surgery, twenty-four (24) hour continuous nursing service by Registered Nurses, a staff of one or more Physicians licensed to practice medicine available at all times and which requires compensation for medical and surgical treatment for Injury and Sickness on an inpatient basis, and a facility which may provide treatment for alcoholism or drug abuse. The term Hospital does not include a facility specializing in dentistry or an institution which is, other than incidentally, a place for rest, a place for the aged, a convalescent home or a skilled nursing facility or a facility providing custodial or educational care.

Intensive Care Unit means a section, ward or wing within the Hospital which is separated from other Hospital facilities and:

1. is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;

2. has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and

3. provides Room and Board and constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Immediate Family means a person's spouse, children, stepchildren, grandchildren, parents, brothers, sisters, or grandparents.

Licensed Clinical Social Worker means an individual who is licensed to perform mental health services by the state in which he performs such services and who provides services within the scope of his license, other than one whom ordinarily resides in the patient's home or who is a member of the patient's Immediate Family. Service provided must be a covered benefit.

Licensed Practical Nurse means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing service by the state in which he performs such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Medicare means Title XVIII of the Social Security Act and as hereafter amended.

Medically Necessary means services and supplies listed in the Plan that meet <u>all</u> of the following criteria, (1) through (6):

1. The service or supply must be provided by a Physician, Hospital or other covered provider under the Plan, and consistent with the diagnosis or treatment of the Sickness or Injury. Certain routine and preventative health care services and supplies will be considered needed and appropriately provided for medical care only if they are included in the list of covered health services under the Plan.

2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.

3. It is furnished by a provider with appropriate training, experience, staff and facilities for the administering of the particular service or supply.

4. It must be the appropriate supply or level of service which can be safely provided to a patient; and with regard to a person who is an inpatient, it must mean the patient's Sickness or Injury requires that the service or supply cannot be safely provided to that person on an outpatient basis.

5. It must not be primarily for the convenience of the patient, Physician, Hospital or other covered provider under the Plan.

6. It must not be scholastic, vocational training, educational or developmental in nature, or experimental or investigational.

The Plan Administrator has delegated the initial discretionary authority to determine Medical Necessity under the Plan to the Utilization Review Administrator. Covered Persons may appeal a denial based on Medically Necessary to the Plan Administrator by following the Plan appeal provisions as described on page 65.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury, Sickness, Mental Illness or pregnancy does not mean that it is a Medically Necessary service or supply as defined above. The definition of Medically Necessary used in this booklet relates only to coverage under this Plan and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

Mental Illness or Nervous Disorder means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

Non-Bargaining Unit Employee means any employee in the employ of any person, corporation, or partnership who has a Non-Bargaining Unit Participation Agreement with the Fund.

Non-Bargaining Unit Union Employee means any employee in the employ of the Union who has a Non-Bargaining Unit Participation Agreement with the Fund and employees of the Central Illinois Carpenters Health & Welfare Fund.

Non-Occupational Disease means a disease that does not arise and that is not caused or contributed by, or as a consequence of any disease arising out of or in the course of any employment or occupation for compensation or profit.

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

Oral Surgery means:

1. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

2. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; and

3. excision of exostosis of the jaws and hard palate (provided that these procedures are not done in preparation for dentures or prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts and the reduction of dislocations.

Participation Agreement means a written agreement between an Employer and the Trustees allowing the Employer to make contributions to the Fund.

Participant means an Eligible Bargaining Unit Employee, Non-Bargaining Unit Employee, or Non-Bargaining Unit Union Employee whether s/he is Active or Retired.

Pediatric means dependent infants, children and adolescents from birth through age 18.

Person means an Eligible Participant, Eligible Retired Participant, Beneficiary or Eligible Dependent, whichever is applicable.

Except as the context may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders, and the use of singular form will be understood to include the plural.

Physician means any individual licensed to practice medicine by the governmental authority having jurisdiction over such licensing. Chiropractor, podiatrist, audiologist, certified registered nurse anesthetist, certified midwife, occupational therapist, optometrist, physical therapist, physician's assistant, speech pathologist, psychologist, psychiatrist, and doctors of osteopathy shall be considered "Physicians" when performing services within the scope of their licenses; however, a licensed social worker shall not be considered a "Physician." The term Physician will not include any person residing in a Participant's household.

Plan means this document as adopted by the Trustees and as hereafter amended.

Plan Administrator means the Trustees of the Trust Fund.

Plan Year means the Plan's fiscal year which is the twelve-month period ending December 31.

Policies means the policy or policies of insurance issued pursuant to the Agreement and Declaration of Trust and accepted by the Trustees as part of the Fund and all other policies of insurance accepted by the Trustees as part of the Fund. The term "Policy" or "Policies" as used here includes any amendments or riders attached to such policy or policies.

Preferred Provider means the hospitals and physicians that have entered into a written agreement with the vendor selected by the Trustees and agree to offer services at a discounted rate.

Qualified Practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a bodily injury or sickness, and who provides services within the scope of that license.

Reciprocal Agreement means a written agreement between this Fund and any other health and welfare trust fund which provides that monies or a portion thereof contributed to the other health and welfare trust fund for a Participant will be transferred to this Fund in order to continue a Participant's eligibility under this Fund by crediting him with the hours of Employer Contributions, and vice versa.

Registered Nurse means a professional nurse who has the right to use the title Registered Nurse (R.N.) other than one whom ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Retired Employee means any Bargaining-Unit Employee and Non-Bargaining Unit Union Employee on whose behalf their employer is no longer required to make contributions to the Fund because of such person's retirement from active employment with that employer because of age or disability.

Room and Board means all charges commonly made by a Hospital or other facility on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

Sickness means disease, mental disorders, nervous disorders or pregnancy of a Covered Person which results in expenses incurred which are covered by the Plan.

Skilled Nursing Facility means an institution, or a distinct part thereof, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness, and:

1. is approved by and is a participating Skilled Nursing Facility of Medicare;

2. has organized facilities for medical treatment and provides twenty-four (24) hour nursing service under the full-time supervision of a Physician or Registered Nurse;

3. maintains daily clinical records on each patient and has available the services of a Physician under an established agreement; and

4. has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one Physician.

This definition does not include an institution operated primarily for care of the aged, or for treatment of mental disease, drug addiction, alcoholism or custodial care.

Substance/Alcoholism Abuse means uncontrollable or excessive abuse of any addictive substance and the resultant physiological or psychological dependence which develops with continued use, requiring medical treatment as determined by a Physician.

Spouse means the person, regardless of gender, recognized as a Participant's husband or wife under the laws of the state or foreign jurisdiction where the Participant lives or was married. The Administrative Manager may require documentation proving a legal marital relationship.

Substance/Alcoholism Abuse Treatment Facility means a facility whose primary function is the treatment of Substance/Alcoholism Abuse and which is duly licensed by the appropriate state and local authority to provide such services. Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment. Detoxification is care aimed primarily at overcoming after-effects of a specific episode of drinking or substance abuse. Maintenance care consists of providing an environment without access to alcohol or drugs.

Surgery: Means operative or cutting procedures including specialized instrumentations and the correction of fractures or complete dislocations.

Temporomandibular Joint Dysfunction means jaw joint conditions, including Temporomandibular joint disorders and all other conditions of the joint linking the jaw bone and skull and complex muscles, nerves and other tissues relating to that joint.

Total Disability means being unable, due to sickness, bodily injury, or pregnancy, to perform with reasonable continuity the essential tasks, functions and operations of your normal occupation. This includes the skills, abilities, knowledge, training and experience generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted.

Union means the Southern Region Chicago Regional Council of Carpenters for itself, and on behalf of the local unions under its jurisdiction, all of which are affiliates with the United Brotherhood of Carpenters and Joiners of America, and any other union that has a Participation Agreement with the Fund.

Urgent or Urgent/Emergency means treatment required for accidental Injury or treatment of a sudden and unexpected Sickness which is life threatening and has such severe symptoms that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in serious and permanent medical consequences. It shall not include treatment of symptoms of a chronic condition unless such symptoms are sudden, unexpected and severe.

Usual, Customary and Reasonable means the allowable expense for dental care charges made by the person, group or other entity rendering or furnishing the services, treatment or supplies, but in no event shall it mean a charge in excess of the general level of charges made by others rendering or furnishing such services, treatment or supplies, within the area in which the charge is incurred. With respect to out of network medical charges, Usual, Customary and Reasonable means 100% of the allowable expense permitted by Medicare's published fee schedule, as may be amended from time to time.

Working Owners means an owner, shareholder, officer, manager or director in the employ of any person, corporation or partnership who has a Working Owner Participation Agreement with the Fund.

Eligibility

Enrollment / Beneficiary Form
After you become eligible for coverage you must complete an enrollment form and return the form with supporting documentation to the Fund Office within 60 days of Fund Office mailing date. The form and supporting documentation must be post-marked or actually received by the Fund Office within this 60-day period.

You should immediately notify the Fund Office if:

- You change your home address;
- You want to change your Beneficiary for Life Insurance; or
- There is a change in your family status (for example, marriage, birth of child, adoption, legal guardianship, divorce, legal separation or death).

Eligibility Requirements

Initial Eligibility

You will become eligible on the first day of the month which follows a period of not more than 12 consecutive months during which at least 500 hours of contributions were paid to the Fund for you by one or more Contributing Employers.

Your completed enrollment form and supporting documentation MUST be post-marked or received by the Fund Office within 60 days of the date the Fund Office mailed the form to you. Your completed form and supporting documentation may be returned via mail, scan/email, fax or hand-delivery (during office hours) to the Fund Office. YOUR DEPENDENTS WILL NOT BE COVERED BY THE HEALTH PLAN IF YOU DO NOT RETURN THE COMPLETED ENROLLMENT FORM AND SUPPORTING DOCUMENTATION WITHIN THE REQUIRED TIMEFRAME. If you do properly enroll your Dependents after the 60-day timeframe you will have the opportunity to secure prospective coverage for your Dependents – see the "Late Enrollment of Dependents After Qualifying Event" Section of this Plan Description for further information.

When Coverage Begins

Your benefits start on the first day of the month after you meet the initial eligibility requirements. You will remain eligible until you fail to meet the requirements for "Continued Eligibility" as discussed below EXCEPT your initial eligibility will include eligibility through the next benefit quarter after which you begin coverage (regardless of number of contribution hours).

Continued Eligibility

After you have met the initial eligibility requirements, in order to continue your eligibility in later Benefit Quarters you must have at least 250 hours of contributions paid for you by Contributing Employers in a Calendar Quarter as outlined in the schedule below:

At Least 250 Contribution Hours During The Calendar Quarter…	Provides Eligibility For The Benefit Quarter…
January, February, March	June, July, August
April, May, June	September, October, November
July, August, September	December, January, February
October, November, December	March, April, May

If you do not receive credit for at least 250 hours of contributions in a Calendar Quarter, you may remain eligible for benefits if 1000 hours of contributions have been paid to the Fund for you by Contributing Employers over a 15-month period based on the following schedule:

At Least 1000 Contribution Hours During The 15-Month Period Ending…	Continues Eligibility For The Benefit Quarter…
March 31	June, July, August
June 30	September, October, November
September 30	December, January, February
December 31	March, April, May

However, an Employee (or former Employee) shall cease to be eligible to be a Participant in this Plan if such Employee is employed by an employer which performs bargaining unit work who is not obligated to make contributions to this Plan. An Employee's rights and coverage under this Plan shall terminate on the last day of the calendar month during which such employment commences. In addition, an Employee whose coverage terminates pursuant to this section shall also lose any accumulated hours. Non-bargaining unit participant's coverage and eligibility shall also terminate on the last day of the calendar month during which employment of the type described above commences.

Continued Eligibility During Disability Periods

You will be credited with 25 hours per week (5 hours/weekday) towards continuing eligibility when you are receiving non-occupational Disability Benefits or Workers' Compensation disability benefits under this Plan, subject to a maximum of 13 weeks per disability.

Reinstatement Of Eligibility Following A Disability

If your eligibility is terminated and you remain within the jurisdiction of a Local Union that participates in the Fund, but you are unavailable for work due to total disability, your eligibility will be reinstated on the first day of the Benefit Quarter following any Calendar Quarter in which you worked and had employer contributions paid to the Fund for at least 250 hours if you return to Active Work immediately after your total disability ceases.

Reinstatement Of Eligibility – a new enrollment form must be returned to the Fund Office

If you lose eligibility for benefits because you did not have the required hours of contribution, you may regain eligibility on the first day of the Benefit Quarter following any Calendar Quarter in which contributions for at least 250 hours are made on your behalf by contributing employers.

You must once again meet the "Initial Eligibility Requirements" to regain eligibility if your eligibility is terminated and:

- Is not reinstated within 12 consecutive Benefit Quarters because you (1) leave the jurisdiction of a Local Union that participates in this Health & Welfare Trust Fund for work opportunities but retained membership with the Local Union, or (2) you remain within the jurisdiction of a Local Union that participates in this Health & Welfare Trust Fund and are registered with the Local Union's work referral program.

Your completed enrollment form and supporting documentation MUST be post-marked or received by the Fund Office within 60 days of the date the Fund Office mailed the form to you. Your completed form may be returned via mail, scan/email, fax or hand-delivery (during office hours) to the Fund Office. YOUR DEPENDENTS WILL NOT BE COVERED BY THE HEALTH PLAN IF YOU DO NOT RETURN THE COMPLETED ENROLLMENT FORM AND SUPPORTING DOCUMENTATION WITHIN THE REQUIRED TIMEFRAME. If you do properly enroll your Dependents after the 60-day timeframe you will have the opportunity to secure prospective coverage for your Dependents – see the "Late Enrollment of Dependents After Qualifying Event" Section of this Plan Description for further information.

Dependent Coverage

When you become eligible for benefits, your qualified Dependents also become eligible. Your Dependents who are eligible for benefits are your lawful spouse and your child(ren) between birth through the end of the month in which the child(ren) reaches age 26.

"Child" includes any of the following:

- Your own or lawfully adopted child, or any child in your custody while adoption proceedings with respect to that child are pending;
- Any stepchild; and
- Any child for whom you have been appointed legal guardian.

In order to continue this coverage for disabled children, you must notify the Fund Office and request continuous coverage no later than 31 days before the end of the month in which the Dependent child reaches age 26.

Benefits for mentally or physically disabled children may be continued beyond the normal termination age if the child:

- Is unmarried;
- Is dependent upon you for support and maintenance;
- Is incapable of engaging in self-sustaining employment; and
- Has a disability that began before age 19 and while the child was eligible for benefits from this Plan.

When Dependent Coverage Begins

Generally, coverage for your Dependents becomes effective on the date you become eligible for coverage.

You will be required to provide proof of your Dependent's eligible status under the Plan.

Adding Dependents

If you are eligible for benefits and you acquire a Dependent through a qualifying event such as marriage, the birth of a child, adoption, or placement for adoption of a child or obtaining legal guardianship of a child, eligibility for that Dependent begins on the date of the qualifying event as long as you notify the Fund Office within 60 days of one of these events **AND** return a completed enrollment form with supporting documentation within the required timeframe.

In addition, coverage for your additional Dependents will be effective from the date of the event if you apply for a change within 60 days of any of the following events:

- Loss of eligibility for your Dependent when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- Your Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

Your completed enrollment form and supporting documentation MUST be post-marked or received by the Fund Office within 60 days of the date the Fund Office mailed the form to you. Your completed form and supporting documentation may be returned via mail, scan/email, fax or hand-delivery (during office hours) to the Fund Office. YOUR NEWLY ACQUIRED DEPENDENT(S) WILL NOT BE COVERED BY THE HEALTH PLAN IF YOU DO NOT RETURN THE COMPLETED ENROLLMENT FORM AND SUPPORTING DOCUMENTATION WITHIN THE REQUIRED TIMEFRAME. If you do properly enroll your dependents after the 60-day timeframe you will have the opportunity to secure prospective coverage for your dependents – see the "Late Enrollment Of Dependents After Qualifying Event" section of this Plan Description for further information.

Late Enrollment of Dependents after Qualifying Event

If you are eligible for benefits and you acquire a Dependent through a qualifying event but fail to notify the Fund Office and return a completed enrollment form within the required timeframes discussed in the "Adding Dependents" section above, you may still seek to enroll the Dependent with the Fund Office. Under these circumstances, you would need to request an enrollment form and return the completed enrollment form and supporting documentation to the Fund Office. Thereafter, the Dependent will be provided coverage from the date the completed enrollment form and supporting documentation are post-marked or received by the Fund Office. Please note that coverage for the Dependent will not be provided retroactively to the date of the qualifying event, and you must be eligible for benefits with the Fund to enroll the Dependent.

Family Status Changes

At some point in your life, you may experience a change in family status that affects your health benefits. The information below is designed to explain what you need to do when you experience a change in family status.

Notifying the Fund Office – What you need to do

By notifying the Fund Office of Qualifying Events or Changes in Family Status, such as gaining new Dependents, you help avoid delays or denials in payment of benefits. It is also important to notify the Fund Office when a Dependent loses eligibility. This helps ensure your Dependent is offered COBRA continuation coverage if applicable.

You should notify the Fund Office within 60 days of the date you experience a Qualifying Event or any change in your family status because various paperwork will be needed from you. For example:

- **When your Dependent acquires other health and/or dental plan coverage (Certificate of Credible Coverage with effective date will be needed);**
- **When your Dependent loses his/her other health plan coverage (Certificate of Credible Coverage with effective date will be needed);**
- **When you have a baby (birth certificate will be needed);**
- **When you adopt a child, or a child is placed with you for adoption or guardianship (court paperwork will be needed);**
- **When you get married (marriage certificate will be needed);**
- **When you get divorced (court paperwork will be needed);**
- **When your child is no longer eligible for coverage.**

Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order that requires a Participant to provide medical coverage for his or her child(ren) (called alternate recipient(s) in situations involving divorce, legal separation or a paternity dispute). If the Plan receives a valid QMCSO and a Participant does not enroll the child(ren), the custodial parent or state agency may enroll the affected child(ren). A QMCSO is either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing the Plan to cover a child(ren) as Dependent(s) of the Participant. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid.

The Plan shall comply with the terms of a Qualified Medical Child Support Order ("QMCSO"), directing the Plan to provide benefits to one or more alternate recipients, pursuant to the procedure set forth below:

- An order which purports to be a QMCSO must be served on the Fund Office.

- The Fund Office shall, within twenty (20) days of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:

    - a clause which creates or recognizes the existence of a Dependent's right to receive benefits under the Plan;

    - the name and last known mailing address of the Covered Person with respect to whom the order is issued and each Dependent covered by the order;

    - a reasonable description of the type of coverage to be provided by the Plan to each Dependent;

    - a clause which specifies that the order applies to the Plan, as well as the time period to which the order applies; and

    - a clause which states that the order does not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.

An order which, in the judgment of the Fund Counsel, does not meet the requirements of a QMCSO shall be returned, for revision, to legal counsel who prepared the order. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.

- The Fund Office shall notify all parties involved, including a designated representative of the Covered Dependent, of the Fund Counsel's decision and of the respective parties' entitlement to benefits.

Reimbursement of benefit payments under the Plan pursuant to a QMCSO may be made to the Covered Dependent or the Covered Dependent's custodial parent.

When Coverage Ends

For You

Your eligibility will terminate on one of the four termination dates shown below if you do not have the required hours of contributions outlined in one of the two schedules on pages 21 and 22.

Termination Dates
May 31
August 31
November 30
Last Day of February

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

If your coverage terminates, you may be able to continue coverage under the Plan. See page 53, for a detailed description of your self-payment rights under the Plan.

For Your Dependents

When your eligibility terminates, your Dependent's eligibility also terminates. However, if you die while eligible, Dependent medical benefits will be continued until the earlier of:

- The date your eligibility would normally terminate; or
- The end of the Benefit Quarter in which accumulated hours have been exhausted; or
- The date your spouse remarries.

If you die while eligible, your Dependent's medical benefits may also be continued through COBRA. Please review the section entitled "Continuing Coverage under Special Circumstances" on page 47 of this Plan Description for details regarding COBRA continuation coverage. Your dependent may also qualify to continue coverage through the Plan's Self-Payment Option if you die while eligible. See the "Self-Pay for Eligible Dependent" section of this Plan Description on page 53 for further information.

When your Dependent's coverage ends, your Dependent will be provided with certification of their length of coverage under the Plan. This may help reduce or eliminate any pre-existing limitation under a new group medical plan.

Withdrawal Of Local Union Or Other Participating Group

If a Contributing Employer no longer covers Employees under this Plan, the Trustees must be advised in writing, of their decision to withdraw from the Plan 30 days prior to the effective date of the withdrawal.

This Plan will receive all Employer and Employee self-contributions and penalties due it through the effective date of such withdrawal.

Benefit Coverage While You are Covered Under the Plan

Medical Benefit

This Medical Benefit covers most of the expenses that you or your Eligible Dependents incur for the diagnosis and treatment of a non-occupational injury or sickness. This benefit is payable not only for Hospital expenses, but also for Physician bills and other medical charges.

If you or an eligible Dependent are in excess of the calendar year deductible shown in the Schedule of Benefits, the Medical Benefit will pay the percentage of such covered medical expenses shown in the Schedule until you reach your calendar year out-of-pocket maximum as shown. After you have reached the out of pocket maximum, the Plan pays 100% of your eligible expenses for the remainder of that calendar year.

Preferred Provider Organization (PPO)

The Plan offers a Physician and Hospital Preferred Provider Organization (PPO). A PPO is a network of Physicians and Hospitals that have agreed to charge negotiated rates. When you use a PPO provider, you save money for yourself and the Plan because the PPO provider has agreed to charge a negotiated dollar amount.

It's your decision whether or not to use a network provider. You always have the final say about the Physicians and Hospitals you and your family use. To encourage you to use PPO providers whenever possible, the Plans pays a higher percentage of covered charges when you use PPO providers.

There are some exceptions when Non PPO charges may be paid at the higher percentage

- Test is performed by a PPO provider however the reading is performed by a Non PPO independent radiologist or pathologist.
- Surgery is performed by a PPO physician at a PPO facility, however, anesthesiology is performed by a Non PPO anesthesiologist.
- Service deemed medically necessary is not available from a PPO provider. Please contact the Fund Office to request approval prior to obtaining services.
- Non-network Emergency Room Hospital and Physician services rendered for an Urgent or Urgent/Emergent situation.

If you have questions about or need a listing of Physicians and Hospitals that participate in the PPO network, visit www.cichealth.org and click on the *Health and Welfare* tab and then click on the *Providers* link.

Deductible

The deductible is the amount of covered medical expenses that you pay before the Medical Benefit Plan begins to pay benefits. The amount of your deductible is shown in the Schedule of Benefits.

You must satisfy the deductible only once in any calendar year. Any expenses incurred and applied against the individual deductible in the last three months of a calendar year may be also applied against the individual deductible for the next calendar year, so you will not have to pay a deductible late in one calendar year and soon again in the next following year.

A separate deductible will apply to each eligible individual up to the family limit shown in the Schedule of Benefits. To ease the financial burden, the Plan provides a maximum family limit equal to an accumulative amount as shown in the Schedule of Benefits. The family deductible does not include any amounts carried over from the prior calendar year.

Coinsurance

Once you or your family has met the annual deductible, the Plan pays a percentage of charges called "coinsurance." The amount the Plan pays depends on the type of charge. The coinsurance is shown in the Schedule of Benefits.

Out-Of-Pocket Maximum

The calendar year out-of-pocket maximum, including the deductible, is shown in the Schedule of Benefits. The out-of-pocket maximum limits the amount you pay out-of-pocket in a calendar year for covered medical expenses. Expenses incurred for the following do not count towards the out-of-pocket maximum:

- Vision benefits
- Dental benefit
- Plan exclusions.

Utilization Review (Pre-Certification for Inpatient admissions only)

For treatment involving the provision of Hospital services, the Utilization Review Administrator must be notified with respect to any Covered Person or Covered Dependent (i) prior to any scheduled or non-emergency Hospital Confinement/Admission or (ii) within two (2) business days after Hospital Confinement/Admission for Emergency Treatment or obstetric care.

Upon notification, the Utilization Review Administrator will review:

- the Medical Necessity for the Hospital Confinement/Admission;
- the appropriateness of the place of treatment for the Sickness or Injury;
- the duration of the Hospital Confinement/Admission; and
- the extension, if necessary, of a previously reviewed Hospital Confinement/Admission.

Expenses excluded in accordance with this Section shall not apply toward satisfaction of any other limitation herein.

Maternity Benefits

Expenses incurred as a result of the pregnancy will be eligible for benefits the same as any other Sickness under the Plan, except that the following provisions shall be applicable:

- a minimum of forty-eight (48) hours of inpatient Hospital care for the mother and newborn child shall be provided following a vaginal delivery; and

- a minimum of ninety-six (96) hours of inpatient Hospital care for the mother and newborn child shall be provided following a delivery by Caesarean section.

A shorter inpatient Hospital stay may be provided if a Physician licensed to practice medicine in all of its branches determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn child meet the appropriate guidelines for a shorter stay, based upon an evaluation of the mother and newborn child and taking into consideration the availability of a post-discharge visit within forty-eight (48) hours following the discharge, with either a Physician in his office or with an R.N., or L.P.N. supervised by an R.N., in the child's home.

A mother and newborn child are considered separate persons for all purposes under the Plan. Benefits will be available for the mother if the mother is properly enrolled in the Plan on the date the services were rendered. Maternity coverage will be available for covered participants, eligible spouses and eligible dependent children. No coverage will be available for the newborn child of covered Dependent children.

Covered Medical Expenses

The expenses which you are required to pay for the following services and supplies for treatment of non-occupational injury or sickness are "covered medical expenses" under the Medical Benefit within the limits shown in the Schedule of Benefits.

1. Hospital Expenses including:

    - Semi-private Hospital room and board while Hospital confined.

    - If you occupy a private room the benefit covers only the most common semi-private room rate charged by the Hospital, unless the Hospital only offers private rooms.

    - Intensive care unit charges made by the Hospital in which you are confined as an inpatient.

    - All Medically Necessary services and supplies furnished by the Hospital while you are confined as an inpatient such as operating room charges and other miscellaneous Hospital expenses.

2. Diagnostic Laboratory and X-ray Expenses including:

    - Laboratory or X-ray examinations.

    - X-ray radium.

- Radioactive isotope therapy.

3. Outpatient Surgical Expenses including:

   - The services of the operating surgeon and the anesthesiologist.

   - The services and supplies furnished by an Ambulatory Surgical Center, the outpatient facility of a Hospital or in a Physician's office.

4. Other Covered Medical Expenses including the following services and supplies:

   - The services of a licensed Physician for professional services.

   - Muscle manipulation services by a chiropractor are limited to a plan maximum of 35 visits per covered individual per calendar year.

   - Hearing aids, limited to purchase, whether temporary or permanent, once every five years per person with maximum benefit payable as listed in the Schedule of Benefits for both ears combined.

   - Procedures to correct nearsightedness or farsightedness (LASIK) as listed in the Schedule of Benefits.

   - The services of a legally licensed physiotherapist and a registered graduate nurse (R.N.) other than a nurse who ordinarily resides in your home or who is a member of your family or your spouse's family.

   - Care in a recognized hospice facility.

   - Anesthetics, blood and blood plasma, oxygen and rental of equipment for administration of oxygen.

   - Rental or purchase of durable medical and surgical equipment, which is pre-approved by the Fund such as a non-electric wheelchair, artificial respirator but not including items which are not specifically designated for a medical purpose such as air conditioners, dehumidifiers, etc.

   - Artificial limbs and artificial eyes.

   - Dental work and oral surgery for the prompt repair of natural teeth or other body tissues and required because of a non-occupational bodily injury.

   - Dental work and oral surgery in the Hospital, for which the Person’s medical condition makes it necessary for the procedure to be performed in the Hospital and not in a Dentist’s office, if the procedure is performed after the Person *has received prior approval from the Fund Office*. Only the charges for the hospitalization related medical services are eligible. Charges for the dentist/oral surgeon are covered under the dental plan.

   - Fully or Partially Impacted wisdom teeth including charges from the oral surgeon and related dental services performed on the same day as the extraction of the teeth (tooth).

- Cosmetic surgery which is Medically Necessary for prompt repair of a non-occupational accidental bodily injury. Also, for cosmetic surgery which is for the treatment of birth defects of a Dependent child.

- Local ground transportation provided by a professional ambulance service, to the nearest Hospital, between Hospitals or between a Hospital and a Skilled Nursing Facility, including air ambulance service, when Medically Necessary.

- Growth hormones that require special supervised administration and are not available through normal pharmacy distribution channels. The charges shall be payable to the extent that such eligible charges are usual, customary and reasonable.

- Rental or, at the option of the Plan, purchase of standard model orthotic devices and/or leg braces**.**

- Treatment of corns, calluses or toenails but only when *medically necessary* because of diabetes or circulatory problems.

- Cataract Surgery including the initial purchase of eyeglasses or contact lenses following cataract surgery.

- Services of a Physician or licensed physical therapist for outpatient therapy. Outpatient physical therapy, combined with occupational therapy and speech therapy, have a Plan benefit maximum of 60 visits per calendar year per covered person unless the physical therapy is Medically Necessary for the treatment of the following conditions:

  - Fracture;

  - Stroke;

  - Surgery; or

  - Palsy or similar muscle diseases.

- Services of a Physician or licensed occupational therapist for constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Outpatient occupational therapy, combined with physical therapy and speech therapy, have a Plan benefit maximum of 60 visits per calendar year per person.

- Services of a Physician or licensed speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to Sickness, Injury, or due to a congenital anomaly. Outpatient speech therapy, combined with physical therapy and occupational therapy, have a Plan benefit maximum of 60 visits per calendar year per person.

- Services of a qualified Physician or registered therapist for vision therapy to correct the physical impairment but not for correction of nearsightedness or farsightedness up to a lifetime maximum of $500 per covered person.

- Private duty professional nursing services by a Registered Nurse or Licensed Practical Nurse, but only if the services provided are of such a nature that they cannot be provided by non-professional personnel.

- Charges for the following will be covered expenses for a Person to whom the Plan is providing benefits in connection with a mastectomy:

  - reconstruction of the breast on which the mastectomy has been performed;

  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphedemas;

  - Support garments limited to two (2) per person per calendar year.

5. Mental Illness or Nervous Disorders

   - Treated the same as any other medical illness or disorder.

6. Substance/Alcoholism Abuse

   - Treated the same as any other medical illness or disorder.

7. Skilled Nursing Facility Confinement:

   - Room and Board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, benefits available for Room and Board will not exceed the average semi-private rate charged by the facility or a representative cross section of similar institutions in the area, unless the facility only offers private rooms;

   - Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physician's fees; and

   - Drugs, biologicals, solutions, dressings, and casts furnished for use during the convalescent period, but no other supplies.

   - A Covered Person or Covered Dependent shall be eligible for benefits under this Subsection only to the extent confinement in a Skilled Nursing Facility:

   - is certified by a Physician as essential for recuperation from Sickness or Injury that caused such Hospital Confinement;

   - is not incurred for custodial care; and

   - commences within fourteen (14) days after a confinement of at least three (3) days duration in a Hospital for which benefits were payable under the Plan up to 90 days per calendar year maximum.

8. Transplant procedures for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Allowable procedures are limited to the transplant procedures referenced above or as allowed by Medicare. Covered medical expenses for an organ transplant are the charges incurred for recipient care, follow-up care and donor expense as described below.

- **When a transplant is NOT performed at a Center of Excellence, the Plan does not cover any services related to the transplant.**

- Recipient care includes charges for:

  - The use of temporary mechanical equipment, pending the acquisition of matched human organs;

  - Hospital and related facilities, Physician professional fees and ancillary charges;

  - Direct, non-medical costs for one member of the recipient's immediate family (two members if the recipient is under the age of eighteen) for;

    (1) Transportation to and from the approved facility where the transplant is performed, and

    (2) Temporary lodging and meals at a prearranged location during the recipient's confinement in an approved transplant facility not to exceed $200 per day. Direct non-medical costs are only payable if the recipient lives more than 50 miles from the approved transplant facility. Benefits for transportation, lodging and meals are limited to a combined Plan maximum of $10,000 per transplant.

- Follow-up care includes charges for:

  - professional fees,

  - Hospital,

  - prescription drugs, and

  - related facility charges and ancillary charges which result directly from the transplant procedure incurred after discharge from the Hospital stay during which the transplant occurred.

- Donor expense includes charges for the following:

  - testing to identify a suitable donor;

  - the expense for the acquisition of organs from a donor;

  - transportation of an organ or a donor on life support; and

  - the expense of life support of a donor pending the removal of usable organs.

Donor expense charges are reimbursable by the Plan only when the donor has no other coverage available from any other source and the transplant recipient is an Eligible Participant or Eligible Dependent under this Plan. Benefit coverage for all covered transplants requires prior authorization by the Fund Office.

9. Diabetes Self-Management Training and Education

10. Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits for such health care professionals will be provided at the benefit level for Other Covered Services. Benefits are also available for regular foot care examinations by a Physician.

11. Sexual Assault or Abuse Acts

    - Hospital and medical services in connection with sexual abuse or assaults of an emergency nature are covered.

Wellness/Preventive Services Benefit

One hundred percent of all expenses incurred for routine preventative/wellness care, including but not limited to physical examinations, immunizations, and related diagnostic testing when performed by an eligible provider. The Plan will cover *routine* colonoscopy, mammogram, PAP test, PSA, blood profiles and HPV vaccine (administered according to established medical guidelines) and deductible will not apply. Routine vision exams and routine dental services are not considered eligible Expenses Incurred for the purpose of this Section. A complete list of covered wellness/preventive services required under the Patient Protection and Affordable Care Act can be located on the website for the United States Preventive Services Task Force at **http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm** or a copy can be provided to you by the Fund Administrator upon request.

Non-Covered Medical Expenses

In addition to any limitations or exclusions stated elsewhere in the Plan, no Medical Expense Benefits are payable for the following:

1. Charges which exceed the Reasonable and Customary charge for the service rendered or charges for which payment is not legally required.

2. Any treatment or service unless such expense is incurred upon the recommendation of a physician for diagnosis or treatment for an Injury or Sickness.

3. Any treatment or service resulting from accidental bodily injury, sickness or disease sustained while a person was performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit, or for which benefits are or may be payable in whole or in part under any Workers' Compensation Law, Employer's Liability Law, Occupational Diseases Law or similar law. The Plan shall withhold benefits for any injury, which may be compensable under Workers' Compensation or Occupational Disease Law, until you have (1) secured a final determination of your claim from the Illinois Workers' Compensation Commission, or similar state entity designed to adjudicate workers' compensation or occupation disease claims, and submitted the final determination to the Fund Office within sixty (60) days of issuance, or (2) demonstrated, by appeal, to the Board of Trustees by clear and convincing evidence that filing a claim for Workers' Compensation would be futile.

4. Services or supplies that are compensated for or furnished by the local, state or Federal government or any agency thereof, and that part of charges for any services or supplies for which payment is provided or available from the local, state or Federal government (for example, Medicare) whether or not that payment is received.

5. Charges for services or supplies that are furnished, paid for or otherwise provided for, by reason of the past or present service of any Person in the armed forces of a government.

6. Charges for services and supplies that are not necessary for treatment of the injury or sickness or are not recommended and approved by the attending Physician or charges to the extent that they are unreasonable or not medically necessary. The following standards shall be used to determine medical necessity. Such services must be:

   - consistent with the symptoms or diagnosis and treatment of the injury or sickness;
   - appropriate with regard to standards of good medical practice;
   - not solely for the convenience of you or your Dependent, Physician, Hospital or another provider; and
   - the most appropriate supply or level of service that can be safely provided.

   When specifically applied to confinement, it further means that the medical symptoms, conditions, diagnosis or treatment cannot be safely provided as an outpatient. The Board of Trustees may rely on advice of medical professionals of their choosing.

7. Charges for services or supplies which are the result of Injury or Sickness sustained (i) during the voluntary participation in a riot or the commission of an illegal act or crime of which the Participant or Dependent is convicted, or (ii) while under the influence of alcohol or other drug or controlled substance which is not prescribed by a Physician. For purposes of this section, a person shall be presumed to be under the influence of alcohol if his blood alcohol level equals or exceeds the limit for driving under the influence of alcohol as determined by the law of the state in which the Injury occurred. In addition, a person may be considered to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by the Board of Trustees.

   The limitations of this section shall not apply unless there is a direct causal relationship between the activity described in (i) or (ii) and the Sickness or Injuries sustained. The limitations also do not apply to injuries to a victim of domestic violence.

8. Drugs unless administered and used while Hospital confined or drugs which require special supervised administration. Out-of-Hospital drug expenses are covered under a separate benefit. See page 45.

9. Charges for services that are incurred as a result of a court order.

10. Charges for services and supplies which are for the treatment of any condition caused by war or by any act of war, declared or undeclared.

11. Medical or surgical services, procedures, medications or supplies that are not in accord with generally accepted medical standards as being safe and effective for the treatment of a condition, or that are deemed to be experimental or investigational in the judgement of a technological assessment body established by state or Federal government, or by a professional medical association.

12. Routine physical examinations for employment purposes.

13. Glasses or routine eye examinations or the correction of vision or fitting of glasses. Eye examinations and glasses are provided under the Vision Care Benefit on page 42. This does not apply to the first pair of glasses or contact lenses following cataract surgery.

14. Repairs to hearing aids.

15. Cosmetic surgery except for the treatment of injuries sustained in an accident, treatment of birth defects of your dependent child and as specifically provided following a mastectomy as described on page 33.

16. Services or supplies for which no payment is required or would be required if you or your Dependent was not eligible for benefits from this Plan.

17. Charges for failure to keep a scheduled visit or charges for completion of a claim form.

18. Supplies or equipment for personal hygiene, comfort or convenience such as air conditioners, air purifiers, hospital beds, humidifiers, hypoallergenic pillows, mattresses, waterbeds or physical fitness equipment.

19. Services performed by any person who normally resides in the Covered Person's or Covered Dependent's home.

20. Charges incurred outside the United States if the Covered Person or Covered Dependent traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.

21. Occupational therapy unless it is required to restore a physical function.

22. Any service, supply or treatment for Speech therapy connected with a learning disability, developmental disorder or functional nervous disorder is not covered. Therapy for conditions when improvement is not anticipated within two (2) months is also not covered.

23. Any expense or charge that results from treatment for weight control or obesity (except as provided by the prescription plan).

24. Treatment of infertility or restoration or enhancement of fertility, including but not limited to, therapeutic injections, fertility and other drugs, surgery, artificial insemination, in-vitro fertilization.

25. Any expense resulting from and/or directly related to the completion of a transplant except for those specifically listed as eligible within this document.

26. Any expense or charge in connection with dental work or surgery (except as provided by the Plan), including:

    - treatment involving any tooth structure, alveolar process, abscess or diseases of the gums; or

    - treatment for temporomandibular joint dysfunction.

27. Professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's or Covered Dependent's life, and unless such care is specifically listed as a benefit elsewhere in the Plan;

28. Hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care.

29. Any treatment or service related to an elective abortion, except to preserve the life of the mother.

30. Telephone charges.

31. Expenses for bunions, unless an open cutting operation is performed or treatment of corns, calluses or toenails, unless at least part of the nail root is removed, or purchase of orthopedic shoes. Charges for routine footcare, including the removal of calluses and corns and the trimming of toenails, except as expressly provided.

32. Charges for nutritional or vitamin supplements.

33. Charges for ear plugs.

34. Charges for sales tax, postage, late fees, interest or finance charges.

35. Duplicate charges that are due to the negligence of the patient.

36. Charges for chelation therapy.

37. Charges for acupuncture, acupressure treatments and massage therapy.

38. Sex transformation and hormones related to such treatment.

39. Services and supplies rendered to treat hair loss or to promote hair growth, including but not limited to hair transplants and wigs. This does not apply if the wig is for hair loss due to chemotherapy, radiation treatment, or other medically necessary procedure. Limited to one (1) wig per person per calendar year with a maximum benefit of $300 per wig.

40. Surgical reversal of elective sterilization.

41. Expenses Incurred for behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness.

42. Expenses Incurred for special education or training for learning disabilities.

43. Charges made for functional therapy for learning or vocational disabilities or hearing therapy if such therapy is due to developmental delay.

44. IQ testing or educational testing.

45. Enrollment in a health, athletic, or similar club or weight loss, non-smoking or similar programs.

46. Genetic testing except to determine individual's interaction with prescribed medication.

47. Genomic testing except as approved per Medicare guidelines.

48. Blood storage or costs associated with direct donation of blood.

49. Services that are not covered by a primary insurance program (as determined by the guidelines within this plan) as a result of not following the primary insurance program guidelines.

50. Pharmacy copays from either this plan or from a primary insurance program (as determined by the guidelines within this plan).

51. Treatment or service due to injury or sickness caused by a third party in the event the Person has a right to receive damages for the treatment or service from the third party. The Plan shall withhold benefits for any injury, which may be compensable by a third party, until you have (1) secured a final judicial determination of your claim from such State or Federal court which confirms your inability to receive damages from a third party and submitted the final judicial determination to the Fund Office within sixty (60) days of issuance, or (2) demonstrated, by appeal, to the Board of Trustees by clear and convincing evidence that filing a claim against the third party would be futile.

52. Batteries for Durable Medical Equipment.

53. Custodial care which means that care consists of watching, maintaining, protecting, or is for the purpose of providing personal needs rather than being able to cure, or primarily to assist with activities of daily living, and where such care is not reasonably expected to cure you or your Dependent of any injury or sickness. Custodial care may include but not be limited to the following services:

    - Assistance in the activities of daily living, such as walking, dressing, getting in and out of bed; bathing, eating, feeding or using toilet or help with other functions of daily living or personal needs of a similar nature.

    - Changes of dressings, diapers, protective sheets or periodic turning or positioning in bed.

    - Administration of, or help in using or applying, medications, creams and ointments, whether oral, inhaled, topical, rectal or injected.

    - Administration of oxygen.

    - Care or maintenance in connection with casts, braces or other similar devices.

    - Care in connection with ostomy bags or devices or indwelling catheters.

    - Feeding by tube, including cleaning and care of the tube site.

    - Tracheostomy care, including cleaning, suctioning and site care.

    - Urinary bladder catheterization.

    - Monitoring, routine adjustments, maintenance or cleaning of an electronic or mechanical device used to support a physiological function, including, but not limited to, a ventilator, phrenic nerve or diaphragmatic pacer.

    - General supervision of exercise programs, including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitative services.

Dental Benefit

If a licensed Dentist or hygienist treats you or an Eligible Dependent, the Dental Benefit will pay up to the calendar year maximum shown in the Schedule of Benefits for covered dental expenses.

Dental Deductible

The deductible is the amount of covered dental expenses that you pay before the Dental Benefit begins to pay benefits. The amount of the deductible is shown in Schedule of Benefits. The dental deductible is separate from the medical deductible.

A separate deductible will apply to each eligible individual under Schedule of Benefits. However, there is a calendar year Family deductible maximum of 3 individual dental deductibles which will be calculated on an aggregate basis.

Coinsurance

Once you have met the annual dental deductible, the Plan pays a percentage of charges called "coinsurance." The amount the Plan pays depends on the type of charge. Your payment is the remaining percentage of charges.

Covered Dental Expenses

The covered dental expenses referred to in this section are those charges made for the following services, supplies and treatments when performed by a legally qualified Dentist for oral examination and treatment of diseased teeth or supporting bone or tissue to the extent that such charges are usual, customary and reasonable.

1. Preventive Dental Expenses are covered at 100% of the charges for, not subject to the deductible:

    - Routine periodic oral examinations of no more than two (2) such examinations or treatments in a calendar year.
    - Bitewing x-rays but not more than two (2) in a calendar year.
    - Dental prophylaxis as prescribed by the Dentist, but not more than two (2) in a calendar year.
    - Topical fluoride application, but not more than two (2) in a calendar year.

2. Minor Dental Expenses are covered at 70% of the charges for:

    - Full-mouth x-ray.
    - Periapical x-rays or x-rays not considered Preventative Dental Services.
    - Treatment for Temporomandibular Joint Disorders.
    - Emergency treatment for relief of pain.
    - Restorative services: Amalgam, synthetic porcelain and plastic and composite restorations.

- Oral Surgery which includes extractions other than fully or partially impacted wisdom teeth.

- Endodontics: Includes pulpal therapy and root canal fillings.

- Sealants through age 18.

- Periodontal including cleaning, gingivectomy and gingivoplasty, gingival curettage, osseous surgery, surgical periodontics examination, mucogingivoplastic surgery and management of acute periodontal infection and oral lesions.

- General anesthesia or IV Sedation is covered as a separate procedure only when required for oral surgical procedures covered under this plan (and only when performed in a dental office).

3. Major Dental Expenses are covered at 50% of the charges for:

    - Inlays, onlays and crowns. In regard to coverage of crowns, the "seat date" is considered the date of service.

    - Replacement Prosthetics: Partial or full removable dentures, fixed bridgework or implanted teeth by a new denture, by new bridgework or the addition of teeth to an existing partial, removable denture or to bridgework to replace extracted natural teeth or replacement of implants only if:

        - the replacement or addition of teeth is required to replace one or more additional natural teeth extracted after the existing denture or bridgework was installed; or

        - the existing denture, bridgework or implant was installed at least five (5) years prior to its replacement and cannot be made serviceable; or

        - the existing denture is an immediate temporary denture that cannot be made permanent and replacement by a permanent denture takes place within twelve (12) months from the date of initial installation of the temporary denture.

    - New Prosthetics: Bridges, partial dentures, complete dentures and space maintainers.

    - Implanted teeth.

4. Pediatric dental coverage from birth through age 18 will be provided according to the Schedule of Benefits and include the following:

    - A total of two (2) oral cleanings every twelve (12) months.

    - Preventive dental examinations, including charges for fluoride treatment, sealants, and x-rays.

    - Medically necessary orthodontia treatment (Note: Plan will provide coverage for eligible treatment charges at 50% after payment of deductible).

    - Restorative crowns and fillings.

Non-Covered Dental Expenses

No Dental Benefits are payable for the following:

1. Treatment by other than a licensed Dentist, except charges by a licensed dental hygienist, under the supervision and direction of a Dentist.

2. Orthodontia treatment, except as expressly provided for elsewhere in this Plan Description.

3. Charges which exceed the Reasonable and Customary charge for the service rendered or charges for which payment is not legally required.

4. Dental care which is included as a covered expense under the Medical Benefit.

5. Dental services or supplies furnished without charge or paid for by a governmental unit, employer, benefit association, union or similar group, or for which no charge would be made in the absence of dental benefits.

6. Dental expense which is compensable under any Workers' Compensation law or similar legislation.

7. Treatment of any condition caused by war or by any act of war, declared or undeclared or by participating in a riot or as the result of the commission of a felony. This limitation does not apply to injuries to a victim of domestic violence.

8. Replacement of a lost or stolen prosthetic device.

9. Charges for failure to keep a scheduled appointment with a Dentist.

10. Charges for a duplicate prosthetic device or any other duplicate appliance.

11. Charges for the completion of insurance forms.

12. Expenses for athletic mouth guards, oral hygiene, dietary, plaque control and other educational programs.

13. Charges for sealants for covered Participants/Dependents beyond the age of 18.

14. Duplicate charges that are due to the negligence of the patient.

15. Any limitations on benefits contained in the Schedule of Benefits.

16. Charges for whitening of the teeth.

17. Telephone charges.

Vision Care Benefit

The vision care benefit is self-insured by the Fund using the administrative services of Vision Service Plan. The Plan provides coverage for:

- An eye examination; and

- Lenses and frames or contact lenses.

You and/or your Eligible Dependents will receive benefits for vision care regardless of where you are examined or where you purchase glasses or contact lenses, but you will receive a higher level of benefits if you use a Vision Service Plan (VSP) Member Doctor. A VSP Member Doctor is a licensed optometrist, ophthalmologist, and/or dispensing optician who is in an agreement with VSP to provide vision care benefits. A list of VSP Member Doctors is available online at www.vsp.com.

Vision Service Plan In-Network Benefits

You and/or your Eligible Dependent will pay a copay for a comprehensive vision examination from a VSP Member Doctor as listed in the Schedule of Benefits. You are eligible for one (1) vision exam per 12-month period.

If the VSP Member Doctor prescribes lenses for you, and you receive the lenses from a VSP Member Doctor, you will have to pay a copay. Also, you may obtain a new frame for a copay if you choose a frame within the Plan's allowance. Otherwise, you will be responsible for the difference between the VSP allowance and the cost of the frame you chose. You may obtain one (1) pair of lenses in a 12-month period and one (1) new frame in a 24-month period. If you choose contact lenses you will receive a flat dollar benefit (after you pay the copay) in lieu of lenses and frame. Refer to the Schedule of Benefits for a detailed listing of services and benefits payable.

Out-Of-Network Vision Benefits

If you use a non-member doctor, the Plan will pay a flat dollar amount towards your eye examination, lenses and frames after you pay a small copay as listed in the Schedule of Benefits. You are eligible for a vision examination once per 12-month period.

If you obtain lenses from a non-member doctor, the Plan will pay a flat dollar amount per pair of lenses based on the type of lenses after you pay a copay. You may obtain one (1) pair of lenses in a 12-month period and one (1) new frame in a 24-month period.

The Plan pays a benefit towards contact lenses from a non-member doctor, after you pay the copay, you will receive a flat dollar benefit in lieu of lenses and frame. Refer to the Schedule of Benefits for a detailed listing of services and benefits payable.

Filing Non-Participating Provider Vision Claims

If you obtain services from a non-participating provider, follow these steps:

Step 1: Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type and frame.

Step 2: Send a copy of the itemized bill(s) and reimbursement form to VSP. The reimbursement form is available from the Fund Office. The following information must be included in your documentation:

- Participant’s name and mailing address.
- Participant’s identification number (usually the social security number).
- Participant’s group name.

- Patient's name, relationship to participant and date of birth.

Step 3: Mail the itemized bill(s) and VSP member reimbursement form to the following address:

Vision Service Plan
P.O. Box 385018
Birmingham, AL 35238-5018
Phone: 1-800-877-7195

Please note that vision claims for reimbursement must be filed within six (6) months of the date services were completed.

Prescription Safety Glasses Benefit

The Plan will reimburse a Participant for the cost of prescription safety glasses up to the amount shown in the Vision Care Services Schedule of Benefits. This benefit is only available to a Participant and is not available to Dependent(s).

The reimbursement benefit is available every twelve (12) months from the last date of service and is limited to lenses and frames only. To qualify for this reimbursement benefit, a Participant must be eligible for benefits under the Plan on the date of service.

To apply for the reimbursement benefit, a Participant must submit an itemized receipt for the prescription safety glasses and complete the Fund Office reimbursement request form.

Prescription Drug Benefit

Prescription drugs are self-insured by the Fund using the administrative services of a Pharmacy Benefit Manager. The drug plan is designed to cover the major portion of prescription drug costs incurred by you and your Eligible Dependents. The program consists of two parts – the retail program and the mail order program. Benefits are not payable if you do not obtain your prescription from a participating pharmacy.

Retail Prescription Program

If you go to a participating pharmacy, you are required to pay the applicable coinsurance as shown in the Schedule of Benefits. The retail prescription program is best used for short-term medications for up to a 30-day supply.

Mail Order Prescription Program

You should use the mail-order program when you need to have prescriptions filled for maintenance medications. When you order by mail, you can get up to a 90-day supply at one time. You will be required to pay the applicable copay as shown in the Schedule of Benefits.

Maintenance Medications are prescription drugs that are used on a long-term or on-going basis for illnesses including, but not limited to:

- Arthritis;
- Diabetes;

- Depression;
- Heart disorders;
- High blood pressure; and
- Ulcers.

When you need to order medication through the mail-order program you should follow these steps:

- Ask your Physician to prescribe a 90-day supply of medication with refills.
- Mail the original prescription along with a completed order form/envelope to the mail order program. The order form/envelope may be downloaded from www.cichealth.org by clicking on the *Health and Welfare* tab and then click on *Forms* link.
- Allow approximately fourteen (14) days from the time you mail in your order to receive the prescription.

Covered Medications

Covered expenses include legend drugs, which require a written prescription from a Physician or Dentist. A licensed pharmacist must dispense these prescriptions. Legend drugs are drugs with the following wording on the container "Caution: Federal Law Prohibits Dispensing without a Prescription." Needles and syringes used for the injection of insulin available by prescription are also covered. To find out if a medication is covered, contact the Fund Office.

Prescription Drug Limitations

Prescription drug benefits will not be provided for any charges for the following:

1. Drugs or medicines lawfully obtainable without a prescription order of a Physician or Dentist, unless such drug, medicine or medication is on the Women's Healthcare Drug List and you have a prescription from a qualified practitioner for the item.

2. Vitamins or dietary supplements, except for prenatal vitamins with a prescription for such.

3. Any charge for the administration or injection of any drug.

4. Medication which is to be taken by or administered to the individual, in whole or in part, while he or she is an in-patient or out-patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

5. Refilling of a prescription in excess of the number specified by the Physician or Dentist or a refill dispensed after one (1) year from the order of a Physician or Dentist.

6. Prescription drugs that may be properly received without charge under local, state or federal programs, including Workers' Compensation.

7. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given or dispensed by the qualified practitioner.

8. Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use", or any drug, medicine or medication that is experimental, investigation or for research purposes, even though a charge is made to you.

9. Any prescription or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled or damaged.

10. Any amount you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription.

11. Any drug for which prior authorization is required and not obtained, if applicable.

12. Drug delivery implants.

13. Prescriptions filled at a non-participating pharmacy.

Family Status Changes

At some point in your life, you may experience a change in family status that affects your health benefits. The information below is designed to explain what you need to do when you experience a change in family status.

Notifying the Fund Office – What You Need to Do

By notifying the Fund Office of Qualifying Events or Changes in Family Status, such as gaining new Dependents, you help avoid delays or denials in payment of benefits. It is also important to notify the Fund Office when a Dependent loses eligibility. This helps ensure your Dependent is offered COBRA continuation coverage if applicable.

You should notify the Fund Office within 60 days of the date you experience a Qualifying Event or any change in your family status because various paperwork will be needed from you. For example:

- **when your Dependent acquires other health and/or dental plan coverage (Certificate of Credible Coverage with effective date will be needed);**
- **when your Dependent loses his/her other health plan coverage (Certificate of Credible Coverage with effective date will be needed);**
- **when you have a baby (birth certificate will be needed);**
- **when you adopt a child, or a child is placed with you for adoption/guardianship (court paperwork will be needed);**
- **when you get married (marriage certificate will be needed);**
- **when you get divorced (court paperwork will be needed);**
- **when your child is no longer eligible for coverage.**

Completing an Enrollment/Beneficiary Form

If you experience a qualifying event or a change in family status, you will also be asked to complete a new enrollment/beneficiary form. Your completed enrollment form and supporting documentation MUST be post-marked or received by the Fund Office within 60 days of the date the Fund Office mailed the

form to you. Your completed form and supporting documentation may be returned via mail, scan/email, fax or hand-delivery (during office hours) to the Fund Office.

YOUR NEW DEPENDENT(S) WILL NOT BE COVERED RETROACTIVELY TO THE DATE OF THE QUALIFYING EVENT BY THE HEALTH PLAN IF YOU DO NOT RETURN THE COMPLETED ENROLLMENT FORM AND SUPPORTING DOCUMENTATION WITHIN THE REQUIRED TIMEFRAME.

This enables the Fund Office to maintain up-to-date Dependent data and information about whether you or your Dependents have other health coverage. All of this information allows the Fund Office to process your claims more quickly and more accurately.

Other Changes

When You Have A Change of Address

- Contact the Fund Office for a change of address form or download the form at www.cichealth.org; and

- Send completed change of address form to the Fund Office as soon as possible after the address change.

In The Event Of Your Death

- Your surviving spouse and/or dependents must contact the Fund Office.

- If your Dependents want to continue coverage under COBRA after your death, they must contact the Fund Office within 60 days of the date of your death and request COBRA coverage, unless your Dependents qualify for extended coverage after your death as described on page 53 of this Plan Description. For more information about COBRA, see page 47 of this Plan Description.

IF YOU HAVE ANY QUESTIONS ABOUT QUALIFYING EVENTS OR CHANGES IN FAMILY STATUS, PLEASE CONTACT THE FUND OFFICE.

Continuing Coverage Under Special Circumstances

Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage

To request COBRA continuation of coverage, a Participant or Dependent **must notify the Fund Office** in writing. The Fund Office mailing address is 200 S. Madigan Drive, Lincoln, IL 62656. Contacting your local Business Representative is NOT considered sufficient notification to request COBRA coverage.

You and your Eligible Dependent(s) have the right to continue your medical, dental, vision and prescription drug coverage under this Plan by paying the established Cobra Rate if coverage would otherwise terminate due to a "qualifying event." This provision does not apply to Life Insurance, Accidental Death and Dismemberment Insurance or Disability Benefits.

If you are a participant, you will be eligible to elect COBRA continuation coverage if your coverage is lost due to one of the following qualifying events:

- Loss of eligibility under the Plan due to your failure to be credited with the required hours of contributions for continued eligibility;

- Your eligibility ends for any reason other than your gross misconduct.

If you are the spouse of a participant, you will be eligible to elect COBRA continuation coverage if your coverage is lost due to one of the following qualifying events:

- Your spouse dies;
- Your spouse loses eligibility under the Plan due to failure to be credited with the required hours of contributions for continued eligibility;
- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B or both);
- You become divorced or legally separated from your spouse.

If you are a dependent child of a participant, you will be eligible to elect COBRA continuation coverage if your coverage is lost due to one of the following qualifying events:

- Your parent-participant dies;
- Your parent-participant loses eligibility under the Plan due to failure to be credited with the required hours of contributions for continued eligibility;
- Your parent-participant's employment ends for any reason other than gross misconduct;
- Your parent-participant becomes enrolled in Medicare benefits (under Part A, Part B or both);
- Your parent-participant becomes divorced or legally separated;
- You stop being eligible for coverage under this Plan as a "Dependent child".

Notification Period

You or your Dependent(s) must notify the Fund if you divorce or become legally separated or your Dependent no longer qualifies as a Dependent under the Plan. You and/or your Dependent(s) must provide such notification within 60 days of the date of the qualifying event.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Participants may elect COBRA on behalf of their spouses, and parents may elect COBRA on behalf of their children.

Election Period

You and/or your Dependent(s) may elect to continue coverage within 60 days of the later of:

- The date you and/or your Dependent(s) would otherwise lose coverage due to the qualifying event; or
- The date you and/or your Dependent(s) are notified of your right to elect the continuation coverage.

The election must be in writing, on a form provided by the Fund Office. Elected benefits will be continued provided:

- The election form is completed and returned to the Fund within the 60-day period noted above; and
- The initial premium is paid to the Fund within 45 days of your and/or your Dependent's election.

If you (the participant) have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA continuation coverage is in effect, you may add such child to your coverage. You must notify the Fund Office, in writing and within 60 days, of the birth or placement in order to have this child added to your coverage.

Children born, adopted or placed for adoption as described above, have the same COBRA rights as a spouse or dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA continuation coverage, their continued coverage depends on timely and uninterrupted payment of premiums on their behalf.

The initial premium must include the monthly premium for each full month that has passed from the date coverage would otherwise terminate until the date the initial premium is received by the Fund Office. Premium payments for subsequent months, including the month during which the initial premium is paid, are due on the first of the month. However, such payment will be considered timely if received by the Fund Office within 30 days of the due date.

Period Of Coverage

When the qualifying event is your end of employment/loss of eligibility due to lack of required hours, coverage may continue for up to 18-months. When the qualifying event is the death of the Participant, the Participant becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage may continue for up to 36 months.

When the qualifying event is the end of employment or reduction of the Participant's hours of employment, and the Participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Participant lasts until 36 months after the date of Medicare entitlement. For example, if a covered Participant becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children 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 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Participant's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

Disability Extension of 18-Month Period of Continuation Coverage

COBRA coverage can be extended from 18 months up to 29 months if you (or another qualified beneficiary) are totally disabled when you (or the other qualified beneficiary) become eligible for COBRA coverage or become disabled during the first 60 days of COBRA coverage. Monthly contributions for continuation coverage increase to 150% (from 102%) of the monthly amount for each of the 11 additional months of continuation coverage. (Any covered Dependents can also continue their COBRA coverage during this extension period.)

To be eligible for this extension, the individual must:

- Receive a determination of disability from the Social Security Administration (SSA) that the individual was disabled on the date coverage ended, or become disabled during the first 60 days of COBRA coverage, and

- Notify the Fund Administrator within 60 days after the later of:

- The date of the SSA's determination of disability; or
- The date of the qualifying event.

If the SSA determines that the individual is no longer totally disabled, continuation of coverage will cease. The individual must notify the Fund Administrator within 30 days of any such finding. Coverage will terminate on the earlier of the first day of the month that is at least 30 days after the SSA's findings or at the end of the 29-month period.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Fund Office. This extension may be available to the spouse and Dependent children receiving continuation coverage if the Participant or former Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated of if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Termination Of COBRA Coverage

COBRA continuation coverage will cease on the first of the following dates:

- The date the Plan terminates;
- The date a required payment is due and unpaid;
- The date you and/or your Dependent(s) become covered under another group plan.
- The date you and/or your Dependent(s) become entitled to Medicare;
- The date of an occurrence of any event (i.e. submission of a fraudulent claim) permitting termination of coverage for cause under this Plan;
- With respect to the 11-month extension for disability, the date the person is no longer disabled (you must notify the Fund Administrator within 30 days of a determination by the Social Security Administration that you or a covered Dependent is no longer disabled), however, continuation coverage will not end until the month that begins more than 30 days after the determination; or
- The date the maximum period of continuation coverage is exhausted.

Family and Medical Leave Act (FMLA)

Federal law requires that eligible Participants be provided a continuation period in accordance with the provisions of the Family and Medical Leave Act of 1993 (FMLA). This is a general summary of the FMLA and how it affects your Plan. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- Are in addition to any other continuation provision of this plan, if any; and
- Will run concurrently with any other continuation provisions of this plan for sickness, injury, layoff, or approved leave of absence, if any.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligibility

You are eligible for FMLA benefits if you:

- Work for the same Employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months preceding the start of the leave; and
- Work at a location where at least 50 employees are employed by the Employer within a 75-mile radius.

FMLA Unpaid Leave

Eligible Employers are required to allow up to 12 workweeks of unpaid leave during any 12-month period to eligible employees for one or more of the following reasons:

- A "serious health condition" that makes you unable to perform the functions of your job; or
- Birth, adoption or placement of a child for adoption or foster care; or
- To care (physical or psychological care) for your spouse, child or parent if they have a "serious health condition"; or
- Family leave due to a call to active duty of your spouse, son, daughter or parent (leave may be used for any "qualifying exigency" arising out of the servicemember's current tour of active duty or because the servicemember is notified of an impending call to duty in support of a contingency operation).

Caregiver Leave for an Injured Servicemember – this benefit provides 26 weeks of FMLA leave during a single 12-month period for a spouse, son, daughter, parent or nearest blood relative caring for a recovering service member. A recovering servicemember is defined as a member of the Armed Forces who suffered an injury or illness while on active duty that may render the person unable to perform the duties of the member's office, grade, rank or rating.

If you are eligible and take FMLA leave, you will NOT be credited with work hours while absent from employment. You will need to contact the Fund Office to set up arrangements for self-payment to maintain your eligibility under the Plan.

When taking an FMLA leave, you and your employer need to inform the Fund Office in writing so that your rights to medical coverage are protected during the leave.

If you and your Employer disagree over your eligibility or coverage under FMLA, your benefits will be suspended until the disagreement is resolved. Such disputes are between you and your Employer. The Fund Office will not become involved in resolving this type of dispute.

Maintenance Of Health Benefits

If you return to work within the timeframe of your FMLA leave, you will not lose your medical coverage. If you do not return to work within the timeframe of your FMLA leave, you will then qualify to continue your coverage under COBRA Continuation Coverage described on page 49. You may self-pay for COBRA for up to 18 additional months. Contact the Fund Office for more information about FMLA or continuing your coverage under COBRA.

Uniformed Services and Reemployment Rights Act (USERRA)

A Participant is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service or any other category of persons designated by the President of the United States of America in a time of war or national emergency. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and for the purpose of an examination to determine fitness for duty.

A Participant's Dependent who has coverage under this Plan immediately prior to the date of the Participant's covered absence is eligible to elect continuation under USERRA.

If you serve in active service for up to 30 days, your health care coverage during that leave period will be continued at no cost to you.

If you serve in active service for more than 30 days, you may elect to continue your coverage from the effective date of your military leave until:

- The last day of the 24-month period beginning on the effective date of your military leave;
- The date you fail to make a required USERRA premium payment; or
- The date your reemployment rights under USERRA expire.

During your military leave, the USERRA premium payment you will be required to contribute to maintain eligibility is the hourly contribution rate paid by your Employer plus two percent (2%). Alternatively, you may utilize your banked hours, if available, to continue coverage for you and your Dependents. You will have the option of using all or some of your banked hours to continue coverage. If you do not exhaust all of your banked hours, any remaining banked hours can be utilized to reestablish eligibility for coverage upon returning from military leave. If you elect to use your banked hours to continue coverage while on military leave and you exhaust all banked hours during the military leave, you

may continue coverage by making the required USERRA premium payment for the remainder of the 24-month period measured from the date of your military leave.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to a Participant and/or eligible Dependents.

If your eligibility for benefits ends because you enter the military service or other service as described under USERRA for a period of one or more years, any banked hours in your account will be reinstated on the date of your discharge from military leave, if you:

- Did not previously exhaust your banked hours to continue your eligibility for benefits during your military leave;
- Previously notified the Fund Office, in writing, of the date entered military service;
- Provide a copy of your discharge papers to the Fund Office; and
- Are employed by an employer in the jurisdiction of the Fund (or you make yourself available for employment), within the time described by federal law after discharge or release from active military service or other service described in USERRA and meet other requirements stated in USERRA.

In addition, upon reemployment in the jurisdiction of the Fund after you are discharged from military leave, you will be provided the opportunity to pay the required contribution amount necessary to establish eligibility for coverage. If you do not elect to do so, your eligibility for coverage will commence at the time your employer pays the contribution amount necessary to reestablish coverage as described in the Eligibility Requirements section of this Plan Description.

Contact the Fund Office for further information regarding USERRA.

Self-Pay Option

If your eligibility terminates because you were involuntarily unemployed, and the Fund had not received the required contributions outlined in “Continued Eligibility” on page 21, you may make self-payments to the Fund to maintain your eligibility.

Eligibility for Self-Pay Option

To be eligible to make self-payments, you must (1) be a Local Union Member in good standing and not in arrears with membership dues and fees, and (2) available for employment covered under a Collective Bargaining Agreement with a Local Union for which the Employer is required to make contributions to the Central Illinois Carpenters Health and Welfare Trust Fund. You are not considered available for employment if you work for yourself, any person, corporation or partnership that does not have a Collective Bargaining Agreement requiring contributions to the Fund. **If you do not meet both of the above listed requirements, you will not be eligible to make self-payments and your Plan eligibility will terminate as of the last day of the Benefit Quarter.**

Before the beginning of a Benefit Quarter, you will receive a status report indicating your eligibility. If you fail to receive your status report, it is your responsibility to contact the Fund Office prior to such Benefit Quarter.

Amount for Self-Pay Option

The amount you must self-pay is equal to a number of hours as determined by the Fund times the hourly contribution rate. The number of determined hours will be reduced by the hours of Employer Contribution, shown on your status report, that were credited on your behalf for that Calendar Quarter. The hourly contribution rate is determined by the Union's Collective Bargaining Agreement.

Your self-payment is due to the Fund Office prior to the first day of the Benefit Quarter for which you are making payment. However, such payment will be considered timely if post-marked or received by the Fund Office on or before the last day of the month in which the self-payment is due. **If your self-payment is post-marked or received after the deadline, it will not be accepted, and your eligibility will terminate.**

Your self-payment will extend your eligibility for the period of self-payment only. **No hours will be credited on your behalf for the self-payment.**

Self-payments must be made for consecutive Benefit Quarters so that there is no break in eligibility and coverage remains continuous.

Loss Of Eligibility for Self-Pay Option

If your eligibility ends because you did not make the self-payment on time, you must return to work and be eligible by Employer Contributions for two consecutive Benefit Quarters before being allowed to make future self-payments.

If you become covered for medical benefits through another group health plan as a result of your employment, your coverage under this Plan will continue on a secondary basis until such time as your eligibility for coverage under this Plan terminates. You will **not** be permitted to self-pay under this Plan after you become covered under another Plan.

If you are a sole proprietor, corporate officer, partner or owner of any employer that is signatory to a Collective Bargaining Agreement requiring contributions to this Plan, and the employer is delinquent in the payment of contributions to this Plan, you will not be eligible for the self-payment option.

Self-Pay For An Eligible Dependent

If you should die while eligible by making self-payments under the Plan, whether as an Active Participant or a Retired Participant, your surviving Eligible Dependent(s) may continue to make self-payments to maintain eligibility provided your Eligible Dependent notifies the Fund Office in writing within 31 days of your death. The coverage will terminate for each Dependent when the first of the following events occurs:

- The failure to make self-payments when due;
- The date on which your Eligible Dependent becomes an Eligible Person under any other group health plan;
- The date on which your surviving spouse remarries;
- The date on which your Eligible Dependent becomes eligible for Medicare; or

- The date your Eligible Dependent no longer meets the definition of an "Eligible Dependent" under the Plan.

Your Eligible Dependent(s) must contact the Fund Office to obtain information regarding the notice requirements for self-pay continuation and the required amount of the self-payment.

When You Retire – Self-Pay

A Retired Employee may apply to make self-payments and/or exhaust any available banked hours to continue coverage under the Plan as long as you meet Eligibility Requirements. Working Owners or Non-Bargaining Unit Employees are not eligible to self-pay, but they may exhaust any available banked hours to continue coverage under the Plan. It is expressly understood that a Non-Bargaining Unit Union Employee (as defined in this Plan Description) may apply to make self-payments and/or exhaust any available banked hours to continue coverage under the Plan as long as he or she meets Eligibility Requirements.

Eligibility – Retiree Self-Pay

You become eligible if:

- You apply and qualify for an Early or Disability Retirement Benefit from the Carpenters Pension Fund of Illinois. (If you are receiving a Normal Retirement Benefit from this pension fund, you may still be eligible if your spouse or a Dependent are eligible for benefits with the Central Illinois Carpenters Health & Welfare Trust Fund); **and**

- You were eligible for benefits from the Central Illinois Carpenters Health and Welfare Trust Fund in at least one out of the last four (4) Benefit Quarters preceding the date you retired, and had at least four (4) consecutive Benefit Quarters of prior eligibility under the plan at any point prior to the date you retired; **and**

- If you retired as a Bargaining Unit Employee, you are a member in good standing, and not in arrears with membership dues and fees, with a participating local union located within the Fund's jurisdiction or a local union affiliated with the United Brotherhood of Carpenters and Joiners of America. This requirement must be met prospectively in order for you to continue to make self-payments as a Retiree; **and**

- You must notify the Fund Office within 31 days of the date of your retirement.

If you meet the above eligibility requirements and make the necessary self-payments or use lookback hours, you will become eligible on the first day of the quarter following your retirement.

If you are a retiree and participated the last 5 years in any Chicago Regional Council of Carpenters sponsored Health and Welfare Trust Fund you will pay the retiree self-pay rate; but if you have participated less than 5 years, you will pay the active self-pay rate.

Loss Of Eligibility – Retiree Self-Pay

Your eligibility for benefits of the Retired Participant Program will terminate the date you fail to make a self-payment when due or the later of:

- The last day of the month prior to month in which you attain age 65 and/or become eligible for Medicare; or
- The last day of the month prior to month in which your Eligible Spouse attains age 65 and/or becomes eligible for Medicare; or
- The date your Eligible Dependent child ceases to be an Eligible Dependent; or
- For retired Bargaining Unit Employees, the last day of any Benefit Quarter during which you failed to maintain good standing and remit all required membership dues and fees to your local union.

Your self-payments for the Retired Participant Program must be made for consecutive Benefit Quarters so there is not a break in coverage and thus, your eligibility remains continuous. If your eligibility terminates because of failure to make self-payments, you will lose the right to make future self-payments, unless you return to work and requalify per the eligibility requirements stated in this Plan Description.

Return To Employment After Retirement

If, after you retire, you return to active employment with an employer that is required to report and pay contributions to the Plan, you will be eligible to make self-payments for the Retired Participant Program upon your subsequent retirement if you meet the requirements outlined earlier in this section.

Participant Crediting of Hours Procedure

In the event a Participating Employer fails to report and pay contributions to the Fund Office for hours worked by a Participant in Covered Employment, the Participant may request a crediting of the hours worked for purposes of maintaining eligibility with the Fund. All such requests for crediting will be evaluated according to the following procedure:

1. Written requests for crediting hours shall be submitted to the Fund Office after the Participant's receipt of the Fund's contribution status report.

2. The Fund Office shall verify that the hours claimed to have been worked were in Covered Employment and are due to the Fund. The Fund Office may request supporting documentation, if needed, to verify the number of hours worked by a Participant. The Fund Office may summarily deny said request if additional and supporting documentation is not provided.

3. After the request and supporting documentation (where applicable) are considered by the Fund Office, the Participant will be notified in writing as to whether the hours submitted for crediting purposes were accepted or denied.

4. The Fund Office shall review requests for crediting of hours under the following criteria:

    a) Written requests must include supporting documentation to establish the hours sought to be credited were worked in Covered Employment with an Employer signatory to the Fund.

    b) A Participant will be eligible for a crediting of hours one (1) time every twelve (12) months per signatory Employer. However, if the signatory Employer remits payment of all delinquent contributions owed within thirty (30) days from the date the Fund Office mails the Participant his quarterly hours report, any crediting provided to the Participant

of those contributions will not count against his one (1) time every twelve (12) month crediting opportunity.

c) Any request for a crediting of hours must be received by the Fund Office at least five (5) business days prior to the start of the Benefit Quarter for which credited hours will be prospectively applied to maintain eligibility for coverage. Crediting requests which are received in a timely manner and accepted may be applied retroactively to the immediately previous Benefit Quarter or to the date the Participant is notified of the contributing employer's delinquency, whichever is sooner.

d) Crediting requests which are accepted will be applied by the Fund Office to obtain coverage in the next immediate Benefit Quarter.

e) In no event shall any Participant receive a crediting of hours that exceeds the minimum amount of contributions necessary for the Participant to continue eligibility during the next immediate Benefit Quarter.

f) If you are a sole proprietor, corporate officer, partner or owner of an Employer that is signatory to a Collective Bargaining Agreement requiring contributions to this Fund, and the Employer is delinquent in the payment of contributions to this Fund, you will not be eligible for a crediting of hours as defined within this procedure.

5. Should the Fund Office approve the request for crediting of hours, then:

a) The Participant shall be notified via certified mail that his/her hours were credited by the Fund. Said notification shall also specify the number of hours deemed to be credited. The notification shall, when applicable, also indicate that prospective requests for a crediting of hours with the employer will not be considered or accepted for a period of twelve (12) months.

b) No hours shall be credited to any Participant for purposes of funding a Participant's hours and/or dollar bank, if applicable.

In The Event Of Your Death Or Disability

Life and Accidental Death and Dismemberment (AD&D) Benefits and Disability Benefits help provide financial protection to you and/or your family in the event you die, become terminally ill, or become injured. This section describes these benefits.

Life Insurance Benefit - For Active Participants and Eligible Retirees up to age 70**.**

The Life Insurance Benefit is payable in the event of your death from any cause at any time while you are covered by the Plan. The Life Insurance Benefit amount is listed in the Schedule of Benefits.

Beneficiary Designation

Your life insurance benefit payment will be made in a lump sum to the Beneficiary you designate. You may change your Beneficiary by obtaining a new enrollment form from the Fund Office. The designation

or change shall take effect as of the date such request is **received at the Fund Office** or the post-marked date of such request, whichever is earlier.

It is important to keep updated Beneficiary information on file at the Fund Office. Be sure to notify the Fund Office if you get married or divorced.

Any amount payable to your Beneficiary(ies) will be paid as follows:

- If more than one Primary Beneficiary is designated, the designated Primary Beneficiaries will share the benefit equally;

- If your designated Primary Beneficiary predeceases you, the share your Primary Beneficiary would have received will be payable equally to the remaining designated Beneficiary(ies) if any; and

- If no designated Beneficiary survives you, or if no Beneficiary has been designated, payment will be made to:

    - Your surviving spouse, or if none;

    - Your surviving children in equal shares, or if none;

    - Your parents in equal shares, or if none;

    - Your brothers and sisters in equal shares, or if none;

    - Your estate.

Accidental Death And Dismemberment Insurance Benefit – For Active Participants

The Accidental Death and Dismemberment insurance provides benefits for loss of life, limb(s) or sight, including losses resulting from occupational accidents which occurred while insured under this benefit. Benefits are payable only if the loss results directly from bodily injuries sustained solely through accidental means and occurs within 90 days after the date of the accident causing the loss.

A claim for accidental death or dismemberment benefits must be filed with the Fund Office within 365 days from the date of the accident causing the loss.

The principal sum benefit amount is shown in the Schedule of Benefits. Benefits are payable for the following losses:

Type Of Loss	Benefit Amount
Life	100% of benefit
• Both hands • One hand and sight of one eye • Both feet • One foot and sight of one eye • Loss of sight in both eyes • One hand and one foot	100% of benefit
• Loss of one hand • Loss of one foot • Loss of sight in one eye	50% of benefit

The loss of hands or feet must be by severance at or above the wrists or ankles and sight must be total and not recoverable. Benefits will be paid directly to you, if living, otherwise to your Beneficiary. No more than the full principal sum will be paid for all losses resulting from one accident.

Exclusions

Because this is coverage for losses due to accidents, no benefits are paid on account of a loss caused or contributed to by:

- Intentionally self-inflicted injury while sane;
- Committing or attempting to commit a felony;
- Travel in or descent from any moving aircraft aboard which:
    - You are giving or receiving training;
    - You have any duties; or
    - You are being flown for the purpose of descent from the aircraft while it is in flight;
- Bodily or mental infirmity, bacterial infections, disease, medical or surgical treatment not made necessary by injury covered under the Plan; or
- War or any act of war, whether declared or not.

Disability Benefit – Active Participants Only

If you become disabled and unable to work as a result of a non-occupational injury or sickness, or an occupational related injury or sickness, you may be eligible for Disability Benefits.

Eligibility

To qualify for this benefit, you must: 1) be actively at work immediately prior to the disability; 2) be under the direct care of a Physician; and 3) return the completed Participant Request for Disability Benefit form and Physician Statement form to the Fund Office within 30 days of the date of disability. The Fund Office will then review the Request for benefits and contact you regarding the decision. To be considered disabled, you must be unable to engage in any gainful employment within the industry or usual occupation and be ineligible for any salary continuation from an Employer.

Benefit

The non-occupational disability benefit is $480 per week for all eligible Participants. One-fifth of the weekly benefit ($96.00) will be paid for each weekday of disability if the disability lasts for part of a week. The weekly benefit is payable up to a maximum of 13 weeks per disability. While you are receiving non-occupational Disability benefits, you will receive 25 hours per week (5 hours per weekday) towards continuing eligibility.

In accordance with federal law, Social Security taxes will be withheld from your Disability Benefits. If you want federal income tax withheld, please contact the Fund Office.

The occupational disability benefit will provide you with 25 hours per week (5 hours per weekday) towards continuing eligibility. The weekly eligibility benefit is provided up to a maximum of 13 weeks per disability.

When the Benefit Begins

Your benefit will begin with the first day of disability due to an injury (if treated by a Physician within 72 hours of the injury) and the eighth day of a disability due to sickness.

Two or more periods of disability due to the same cause will be considered one period of disability unless they are separated by a return to active employment for 30 days.

Exclusions

No weekly benefit will be payable if you are:

- Not under the direct care of a Physician; or
- Not a Union member in good standing; or
- Receiving any income from any employment or self-employment.

Administrative Information

Coordination Of Benefits

The purpose of the Plan is to help you meet the cost of needed medical care or treatment. It is not intended that anyone receive benefits greater than actual expenses incurred. Benefits payable by this Plan and any "other plan" will be coordinated so that the total benefits allowed will not exceed 100% of allowable expenses. In no event will payment under this Plan exceed the amount that would have been allowed if no other plan were involved. All benefits except Life Insurance, Accidental Death and Dismemberment Insurance and the Disability Benefits are subject to this provision. **There is no coordination of benefits for the prescription benefits.**

The term "other plan" means any plan providing benefits or services for dental, vision or medical care for which benefits, or services are provided by:

- Any coverage under labor-management trusteed plans, union welfare plan, employer organization plans, employee benefits organization plans or any other arrangement of benefits for a group;
- Any coverage under governmental programs and any coverage required or provided by any statute;
- Any automobile or homeowner's insurance providing medical coverage; and
- This Plan in the event a husband and wife are both Eligible Employees under the Plan.

"Allowable expenses" means any eligible item of expense for medical care and services, at least a portion of which is covered under this Plan or any plan covering the Person for whom claim is made. Items not covered by any of the plans covering the Person for whom claim is made are not considered allowable expenses. For example, Personal comfort items (such as television) or PPO Discounts from primary carrier, would generally not be covered under any plan and, therefore, are not considered to be allowable expenses.

Who Pays First

If you or your Dependent is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then the other plan(s) pay(s).

This Plan will not pay benefits when the Primary Plan denied benefits due to failure of timely filing or due to misrepresentation of fact or willful omission of fact.

1. The primary plan (which is the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.
2. The secondary plan (which is the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed the greater of:
   a) 100% of total allowable expense; or
   b) The amount of benefits it would have paid had it been the primary plan.

If you or your Dependents are eligible under another plan, there are rules that determine the order in which benefits are paid.

1. When another plan **does not** have a Coordination of Benefits provision, that plan must determine benefits first.

2. When another plan **does** have a COB provision, the first of the following rules applies:

   a) If a plan is providing coverage to a Person as an employee of the plan or is providing coverage to a person as a Bargaining Unit Employee through current contributions paid by a contributing Employer to the plan, then that plan will pay its benefits first. If a child Dependent is married and is covered by his or her spouse's plan, then the spouse's plan will pay its benefits first.

   b) A group health plan other than this Plan is primary in the event an Eligible Employee or Dependent is covered under another group health plan and elects continuation coverage under this Plan.

   c) For an Eligible Dependent child whose parents **are not** divorced or separated, the plan of the parent whose birthday, excluding year of birth, is earlier in the calendar year will pay first; except if both parents' birthdays are on the same day, rule (e) will apply.

   d) If an Eligible Dependent child whose parents **are** divorced or separated (regardless of marital status), then the following rules apply:

      i) A plan that covers a child as a Dependent of a parent who by court decree has financial responsibility for medical expenses will pay first regardless of whether or not a plan of benefits (insured or self-insured) exists. If a child's medical expenses are to be paid by the responsible parent as set forth in a court decree but the responsible parent does not provide the court-ordered medical expense coverage, the non-responsible parent must seek court enforcement of the court decree so that the responsible parent pays for the medical expenses. In the event the medical expenses remain unpaid by the responsible parent after enforcement of the court decree is unsuccessful, the Fund will consider the medical expenses as covered medical expenses under the Plan.

         This paragraph does not apply with respect to any Claim Determination Period or Group Health Plan year during which any benefits are actually paid or provided before the Plan has that actual knowledge. It is the obligation of the person claiming benefits to notify the Claim Administrator and, upon its request, to provide additional information.

      ii) When there is no court decree which requires a parent to provide health coverage to a Dependent child, the following rules will apply:

         (1) When the parent who has custody of the child has not remarried, that parent's plan will pay first.

         (2) When the parent who has custody of the child has remarried, then benefits will be determined by that parent's plan first, by the step-parent's plan second and by the plan of the parent **without** custody third.

      iii) Dependent Child if Parents Share Joint Custody

         If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the

Group Health Plan covering the child shall follow the order of benefit determination rules outlined in (c) above.

e) If none of the above rules apply, the plan which has covered the claimant for the longer period of time will pay its benefits first; except when:

   i) One plan covers the claimant as a laid-off or Retired Employee (or a Dependent of an employee); and

   ii) The other plan includes this COB rule for laid-off or Retired Employees (or is issued in a state which requires this COB rule by law);

   Then the plan which covers the claimant as other than a laid-off or Retired Employee (or a Dependent of an employee) will pay first.

Where part of the plan coordinates benefits and a part does not, each part will be treated like a separate plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION FOR CLAIM PROCESSING ONLY

Certain information is needed to apply these COB rules. The Claim Administrator has the right to determine which information is necessary and obtain or give such information to any other organization or person. The Claim Administrator may do this without consent of any person. Each person claiming benefits under this Plan must provide the Claim Administrator any information necessary to process the Claim.

Coordination Of Benefits For Dependents With HMO Coverage

If your Dependent for whom the Fund is not primary is eligible for medical care treatment provided by a Health Maintenance Organization (HMO) and does not use the facilities or providers of the HMO, the Dependent will not be eligible for benefits from this Plan.

Right of Recovery

If the amount of payments made by the Fund is more than it should have paid under this COB provision, the Fund may recover the excess from one or more of:

1. the person it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Of Benefits With Medicare

Medicare is a two-part program. The first part is officially called "Hospital Insurance Benefits for the Aged and Disabled" and this part is commonly referred to as Part A of Medicare. The second part is officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled" and this part is commonly referred to as Part B of Medicare. Part A of Medicare primarily covers Hospital benefits,

although other benefits are also provided. Part B of Medicare primarily covers Physician's services, although it, too, covers a number of other items and services.

Typically, a Person becomes eligible for Medicare upon reaching age 65. Under certain circumstances a Person may become eligible for Medicare before age 65 if the Person is a disabled worker, disabled widow or Dependent widower or has chronic renal disease.

You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare anyway. Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You are required to pay a monthly premium for Part B of Medicare. If you are not yet receiving Social Security benefits, you must pay this premium to the Social Security Administration. If you are receiving Social Security Benefits, the premium will be deducted from your monthly check.

Medicare Part D – Prescription Coverage

Medicare added a new prescription program commonly referred to as Part D of Medicare effective January 1, 2006. This Part D is for prescription coverage only. Since the prescription plan benefit of Schedule I is equal to or greater than the benefits provided under the Part D standard, you are considered to have Creditable Coverage for Prescription Benefits and do not need to enroll in a Part D plan until you lose coverage through the Fund. Because you have Creditable Coverage for prescriptions, you will not incur a penalty for late enrollment in Part D UNLESS you go 63 days or more without prescription benefits. The penalty adds 1% per month for every month you could have signed up for Part D (but did not do so) to your monthly premium.

When Medicare Is Primary

Coordination of your benefits under the Welfare Fund and under Medicare is different, depending on whether you are an Active Participant (any age), a Retired Participant NOT eligible for Medicare or a Retired Participant eligible for Medicare.

This Welfare Plan is the primary plan responsible for payment of your benefits and your Dependents' benefits if you are an eligible active participant. This means that if you are an active participant and you are also covered by Medicare, when you or your Dependents incur covered medical expenses, the Plan will pay benefits first and then Medicare may (but probably will not) pay some of the remaining expense not covered by the Plan.

However, when you retire and are eligible for Medicare, Medicare is primary. This means that the medical expenses covered under this Plan will be reduced by the benefits Medicare pays or would have paid if you had applied for Medicare when eligible and paid the premium. Therefore, it is essential when you retire that you enroll in Medicare Parts A and B coverage within seven months of the first day of the first month in which you leave covered employment. If you do not enroll for Part B coverage within this seven-month period, you may enroll during the "general enrollment period." This "general enrollment period" occurs between January 1 and March 31 of each year and coverage begins July 1 thereafter. As a retiree eligible for Medicare, the Fund will be primary for your prescription claims.

Offset

If payment is made by this Plan to you or your provider and you are not entitled to payment (or any partial payment), the Plan has the right to reduce future payments due you by the amount of the erroneous payment. This right does not limit the rights of the Plan to recover overpayments in any other manner.

How To File Claims And Appeals

Life and Accidental Death And Dismemberment Insurance

To file a Life or Accidental Death and Dismemberment Insurance claim, contact the Fund Office. The Fund Office will send the necessary forms to you or your Beneficiary. The Fund Office will provide instructions on how to file the claim and include any necessary documentation (for example, a death certificate).

A claim for life and/or accidental death or dismemberment benefits must be filed with the Fund Office within 365 days from the date of death or the date of the accident causing the loss.

If you have been denied benefits, you are entitled to a full and fair review of your claim under the following appeal procedure:

1. Upon denial of your claim for benefits, you will be furnished with a written statement of the specific reason or reasons for denial including reference to the specific Plan provisions on which the denial is based, a description of any additional material or information necessary for you to establish your right to benefits and an explanation of why such material or information is necessary. This written notice will also contain an explanation of the appeal procedure that you can follow to have your claim for benefits reviewed.

2. If you have been denied benefits, you or your duly authorized representative, have the following rights in appealing this initial decision:

   (a) The right to submit additional proof of entitlement to benefits.
   (b) The right to examine any document in possession of the Plan related to the application.
   (c) The right within 60 days of receipt of the notice of the denial of benefits to appeal the decision to the Board of Trustees by submitting a written statement setting forth which of the reasons for denial of the application you disagree with along with any supporting documents or additional comments related to your appeal. You must submit your written statement to the Board of Trustees at the Fund Office address.
   (d) The right upon appeal to the Board of Trustees to request in your appeal petition to appear before the Board for an oral presentation on the merits of your appeal petition. If such a request, the hearing will be held at the next regular meeting of the Trustees or at such other time as may be agreed upon by you and the Board of Trustees with reasonable notice to you of the date and place of the hearing.

3. The Board of Trustees will make a full and complete review of each appeal and issue its decision in writing within 60 days after reviewing the written request for an appeal unless such circumstances require an extension of time for processing, in which case the decision will be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

Disability Benefit

To file a Disability Benefit claim, follow these steps.

Step 1: Obtain a Claim form and Physician's Statement form from the Fund Office within 30 days of the illness or injury. Claims must be filed within 30 days after the occurrence for which claim is being made. If it is not reasonably possible to file a claim within the 30-day period, the claim may be accepted by the Fund Office. However, claims may not be eligible for payment six (6) months after the claim was incurred.

Step 2: Complete the Claim form by filling in all requested information and signing on the line specified.

Submitting a completed claim form to the Fund Office will expedite the review and decision process.

Step 3: Obtain the completed Physician's Statement form from your medical care provider(s). **Important:** Make certain the Physician's Statement form(s) are completed properly with all information requested.

Step 4: Send the completed forms to:

Central Illinois Carpenters
Health and Welfare Trust Fund
200 S. Madigan Dr.
Lincoln, Illinois 62656
Telephone: (217) 732-1919
Fax: (217) 732-7799

Disability Benefit Claim Decision

If a claim for benefits is denied by the Fund Office, in whole or in part, the Fund Office shall provide adequate notice in writing to, the claimant within the 45-day period following receipt of the claim by the Trustees. If, under special circumstances, the Fund Office requires an extension of time for processing the claim, written notice of the extension may be furnished to the claimant prior to the termination of the initial 45-day period. Such extension shall not exceed a period of 30 days from the end of such initial period unless special circumstances warrant an additional 30-day extension, in which case, written notice of the need for the additional extension will be provided to the claimant before the expiration of the initial 30-day extension. In the case of any required extension, the notice of the extension shall notify the claimant of the circumstances requiring the extension and the date as of which the Fund Office expects to render a decision. The notice of extension further shall explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. If the Fund Office requests additional information from the claimant in order to process the claim, the claimant will be afforded 45 days following receipt of the request for information in which to provide such information. The Fund Office may require a claimant to submit to examination by experts of the Fund's choosing in connection with a determination as to disability.

Denial Of Claim for Disability Benefit

The written notice regarding a denial of disability benefits shall include the following:

- The specific reason or reasons for the adverse determination;

- Reference to the specific Plan provisions on which the determination was based;A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
- A description of Plan's review procedures and applicable time limits applicable to such procedures, including a statement of the right to bring a civil action under ERISA Section 502(a) of the Act following an adverse benefit determination on review;
- A discussion of the adverse benefit determination, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - The views of medical or vocational experts whose advise was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and,
    - A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- The specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and,
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant, as that term is defined at 29CFR 2560.503-1(m)(8), to the claimant's claim for benefits.
- If the Participant fails to appeal such action to the Trustees in writing within the 180-day period, the Fund Office's initial determination shall be final, binding and conclusive.

Your Appeal Deadline for a Disability Claim

If the Trustees receive from a Participant, within the 180-day period following the notice of the claim denial, a notice of an appeal of the denial, such notice shall be considered by the Trustees. The Trustees or their authorized designee may hold a hearing or otherwise ascertain such facts as they deem necessary. A claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim, and the review by the Trustees shall take into account all information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination. On review, the claimant is entitled to access to and free copies of all documents relevant to his claim whether or not those documents were relied upon by the Fund Office in denying the claim. The decision of the Trustees will be in writing and a copy thereof shall be sent to each party within 45 days after the receipt by the Trustees of the notice of appeal, unless special circumstances (such as the need to hold a hearing) require a reasonable extension of such 45-day period, but in any event, not later than 90 days after such receipt. If an extension of time is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period, and such notice shall indicate the special circumstances requiring an extension and the date by which the Plan expects to render the determination on review.

The review and decision of the Trustees shall be independent of the Fund Office's initial decision with respect to the claim and shall give no deference to that initial decision. If the initial determination was

based wholly or partly on medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the relevant area of medicine and who is independent of and not a subordinate of any professional consulted with respect to the initial determination. The Trustees also may, but are not required to, consult with other experts (such as vocational or occupational experts) as it deems appropriate. The identity of any experts whose advice is obtained during this process shall be provided to the claimant upon request even if the advice was not relied upon in making a benefit determination.

If the Trustees render a decision adverse to the claimant, its notice to the claimant regarding that decision shall include the following:

- The specific reason or reasons for the adverse disability benefit determination;
- Reference to the specific Plan provisions on which the adverse disability benefit determination is based;
- A statement that the claimant 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 disability benefits;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse disability benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
- If the adverse disability benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- A statement of the claimant's right to bring an action under Section 502(a) of ERISA; which statement shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

Before the Plan can issue an adverse benefit determination on review on a disability benefit claim, the Fund Office shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, or other person making the benefit determination (or at the direction of the plan or such other person) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under the Plan to give the claimant a reasonable opportunity to respond prior to that date.

In addition, before the Plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the Fund Office shall provide the claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under the Plan to give the claimant a reasonable opportunity to respond prior to that date.

If written notice of the denial on appeal of a claim for benefits is not received within the 45 or 90-day period, as applicable, then the claim shall be treated as a denied claim on appeal.

In the event that a period of time in which the Plan is to respond to a claim or appeal is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making either the initial benefit determination or the determination on review shall be tolled from the date on which notification of the extension (and the need for additional information) is sent to the claimant until the date on which the claimant responds to the request for additional information.

All notifications under this section shall be provided in a culturally and linguistically appropriate manner as required by U.S. Department of Labor regulations.

Claims for disability benefits filed before April 1, 2018, shall be subject to the disability claims procedures then in effect.

Exclusivity of Procedures and Exhaustion

The procedure specified in this Section shall be the sole and exclusive procedure available to a Participant or Beneficiary of a Participant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees. A Participant or Beneficiary must follow the procedures described above before taking any legal action with respect to a claim for benefits from the Plan.

Medical, Dental And Prescription Drug Claims

Most health care providers and pharmacies will file claims on your behalf. If your provider's office does not submit claims, follow the steps below.

Step 1: Obtain from your provider an itemized bill showing the diagnosis, the services and supplies provided, the charge for each item, and the date of each charge. If additional information is necessary, the Fund Office will notify you. *Please note:* If you received services outside the United States and the provider's statement is written in another language besides English, the Fund Office will assist in having the document translated into English as well as to provide the exchange rate on the date services were rendered.

Claims for medical, dental and prescription drug benefits must be filed within 90 days after the occurrence for which claim is being made. If it is not reasonably possible to file a claim within the 90-day period, the claim may be accepted by the Fund Office. **However, claims will NOT be eligible for payment 12 months after the claim was incurred.**

Step 2: Forward the itemized bills to:

Central Illinois Carpenters
Health and Welfare Trust Fund
200 S. Madigan Dr.
Lincoln, Illinois 62656

Facility Of Payment

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, claim administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

Types Of Claims

There are four basic types of health care claims:

- Urgent care;
- Pre-service;
- Post-service; or
- Concurrent care.

Urgent Care Claims. An urgent claim is a claim for medical care or treatment that:

- Would seriously jeopardize your life, health or ability to regain maximum function if normal pre-service standards were applied; or
- Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

A healthcare professional that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

If you request an extension of approved urgent care treatment, the Plan Administrator must act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment.

Pre-Service Claims. Pre-service claims are claims for Hospital admissions or stays where the Plan requires that you obtain certification. The Plan will not deny benefits for these procedures or services if:

- It is not possible for you to obtain certification; or
- The certification process would jeopardize your life or health.

Post-Service Claims. Post-service claims are any claims for Plan benefits that are not pre-service claims. When you file a post-service claim, you have already received the services in your claim.

Concurrent Care Claims. A concurrent claim is a claim that is reconsidered after it is initially approved, and the reconsideration results in:

- Reduced benefits; or
- A termination of benefits.

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, the Plan Administrator must notify you:

- As soon as possible; and
- In time to allow you to have an appeal decided before the benefit is reduced or terminated.

When Benefits Are Paid

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Fund Administrator will either deny the claim or send a written explanation prior to the expiration of the 30 calendar days. If the Fund Administrator does not deny the claim and requests additional information to complete the review, the Claimant is then allowed up to 45 calendar days to provide all additional information requested. The Fund Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Plan may be processed and paid within a few days after the Fund Administrator receives completed proof of loss. If a claim cannot be paid, the Fund Administrator will promptly explain why.

For purposes of this section, "Claimant" means you or your Dependent.

When you submit a claim for benefits, the Fund will determine if you are eligible for benefits and calculate the amount of the benefit payable, if any.

Generally, all health care benefits will be paid within 15 days after acceptable proof is received.

Reimbursement for covered charges will be made to the provider of service unless the bill is clearly marked "Paid-in-Full" by the provider. The provider will be paid directly, and you will be billed the copayment, coinsurance and deductible as applicable.

If benefits are not paid directly to the provider of service, unpaid benefits for outstanding Hospital, nursing, medical or surgical claims are payable to you, if living. Otherwise, any outstanding claims will be payable to your estate.

The choice of a provider is solely your choice and the claim administrator will not interfere with your relationship with any provider. The claim administrator does not itself undertake to furnish health care services, but solely to make payments to providers for the covered services received by you. The claim administrator is not in any event liable for any act or omission of any provider or the agent or employee of such provider, including, but not limited to, the failure or refusal to render services to you.

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 a fraud, an intentional misrepresentation of material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- The Plan terminates your coverage back to the date of your 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.
- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plan retroactively terminates your former spouse's and stepchild(ren) 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 – going forward – once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 30 days advance written notice.

Your Claim Decision Notice

If a claim for post-service or concurrent care is approved, payment will be made, and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, the Plan must give you written notice of its decision about your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing up to three days after the oral notice.

Claim Filing and Appeals Procedures – Internal Claims Determinations and Appeal Process

The Fund Office will usually pay all Claims within 30 days of receipt of all information required to process a Claim. The Fund Office will usually notify you, your valid assignee or your authorized representative, when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. If you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim [as defined below]). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If a claim for benefits is denied in whole or in part, you will receive a notice from the Fund Office within the following time limits:

1. For non-urgent pre-service claims, within 15 days after receipt of the claim by the Fund Office. A "pre-service claim" is any non-urgent request for benefits or for a determination, with respect to which

the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

2. For post-service Claims, within 30 days after receipt of the Claim by the Fund Office. A "post-service claim" is a Claim as defined above.

If the Fund Office determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, the Fund Office shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period.

If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

If the claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

a. The reasons for denial;

b. A reference to the benefit plan provisions on which the denial is based;

c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, lien amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used;

e. An explanation of the Fund Office's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

f. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);

g. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

h. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

i. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

j. In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as written notice is furnished to the claimant within 3 days of oral notification;

k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

3. For benefit determinations relating to urgent care/expedited clinical claim (as defined below), such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.

4. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

An "urgent care/expedited clinical claim" is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

Inquiries and Complaints

An **"Inquiry**" is a general request for information regarding claims, benefits, or membership.

A **"Complaint"** is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims

- Quality of care

When your Complaint relates to dissatisfaction with a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the **Claims Appeal Procedures** section.

To pursue an Inquiry or a Complaint, you may contact the Fund Office at the number on the back of your ID card, or you may write to:

Central Illinois Carpenters Health & Welfare Trust Fund
200 South Madigan Drive
Lincoln, Illinois 62656
(217) 732-1919

When you contact the Fund Office to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by the Fund Office. Sometimes the acknowledgement and the response will be combined. If the Fund Office needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

An appeal is a written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Fund Office, its employees or a participating provider.

Claim Appeal Procedure - Definitions

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Fund Office at the number on the back of your ID card.

An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to pro- vide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Fund Office and the Fund Office reduces or terminates such treatment (other than by amendment or termination of the benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

In addition, an Adverse Benefit Determination, also includes an "Adverse Determination." An **"Adverse Determination"** means a determination by the Fund Office or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. For purposes of this benefit program, we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

A **"Final Internal Adverse Benefit Determination"** means an Adverse Benefit Determination that has been upheld by the Fund Office at the completion of the Fund Office's internal review/appeal process.

Claim Appeal Procedures

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. The Fund Office will review its decision in accordance with the following procedures. The following review procedures will also be used for Fund Office's (i) coverage determinations that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits and (ii) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as "appeals."

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Fund Office to request a claim review. The Fund Office will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1 (217) 732-1919 or send your request to:

Central Illinois Carpenters Health & Welfare Trust Fund
200 South Madigan Drive
Lincoln, Illinois 62656

In support of your Claim review, you have the option of presenting evidence and testimony to the Board of Trustees, by phone or in person at a location of the Fund Office's choice. You and your authorized

representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.

The Fund Office will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Fund Office and/or by external advisors, but who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits the claimant much exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Fund Office, by and through the Board of Trustees.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical claim, or health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Fund Office will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, the Fund Office will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Fund Office, by and through the Board of Trustees, shall render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal the Fund Office, by and through the Board of Trustees, shall render a determination of the appeal within 30 days after the appeal has been received by the Fund Office or such other time as required or permitted by law.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Fund office at (217) 732-1919. The Fund Office is open from 8:00 A.M. to 4:30 P.M., Monday through Friday.

Central Illinois Carpenters Health & Welfare Trust Fund
200 South Madigan Drive
Lincoln, Illinois 62656

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431 or call the Fund Office number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Notice of Appeal Determination

The Fund Office will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;

2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;

4. An explanation of the Fund Office's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;

5. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);

6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;

9. A description of the standard that was used in denying the claim and a discussion of the decision.

If the Fund Office's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Independent External Review** section below.

If an appeal is not resolved to your satisfaction, you may appeal the Board of Trustees decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the appeal. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

Some of the operations of the Fund Office/Plan are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

Standard External Review

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

An **"Adverse Benefit Determination"** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Fund Office and the Fund Office reduces or terminates such treatment (other than by amendment or termination of the benefit plan) before the end of the approved treatment period that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

A **"Final Internal Adverse Benefit Determination"** means an Adverse Benefit Determination that has been upheld by the Fund Office at the completion of the Fund Office's internal review/appeal process.

1. Request for external review. Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Fund Office, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. 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.

2. Preliminary review. Within 5 business days following the date of receipt of the external review request, the Fund Office must complete a preliminary review of the request to determine whether:

a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

c. You have exhausted the Plan/Fund Office internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** section below for additional information an exhaustion of the internal appeal process; and

d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, the Fund Office will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Fund Office will take action against bias and to ensure independence. Accordingly, the Fund Office must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

a. Utilization of legal experts where appropriate to make coverage determinations under the Plan.

b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within 5 business days after the date of assignment of the IRO, the Fund Office must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Fund Office to timely provide the documents and information must not delay the conduct of the external review. If the Fund Office fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Fund Office and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Fund Office. Upon receipt of any such information, the Fund Office may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Fund Office must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Fund Office decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Fund Office must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Fund Office.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Fund Office's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents

are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Fund Office, you, or your treating provider;

(4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the Fund Office, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Fund Office and you or your authorized representative.

g. The notice of final external review decision will contain:

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

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

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

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

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Fund Office or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Fund Office, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Fund Office will immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. Request for expedited external review. The Fund Office must allow you or your authorized representative to make a request for an expedited external review with the Fund Office at the time you receive:

a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Fund Office must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. The Fund Office must immediately send you a notice of its eligibility determination that meets the requirements set forth in the **Standard External Review** section above.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the **Standard Internal Review** section above. The Fund Office must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Fund Office's internal claims and appeals process.

4. Notice of final external review decision. The Fund Office’s contract with the assigned IRO must require the IRO to provide notice of contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard Internal Review** section 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 is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Fund Office and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Fund Office has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Fund Office to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

Legal Action

Legal action for a claim may not be started earlier than 60 calendar days after proof of loss is filed and before the appeal procedures have been exhausted. Furthermore, no legal action may be started later than three years after proof is required to be filed.

Privacy Notice

The information listed below is to advise you of the privacy policy of the Central Illinois Carpenters Health and Welfare Trust Fund, and to help you understand the types of non-public personal information that it collects about you, how that information is collected, and to whom that information is or may be disclosed.

Non-Public Personal Information

Non-public personal information is information that identifies an individual or could be used to identify an individual and includes both personal financial information, such as payment history, policy number and social security number; and personal health information, such as medical history, medical records, and claims.

Source of Information

It is necessary for the Central Illinois Carpenters Health and Welfare Trust Fund and its Administrator to collect personal information in order to accurately identify you, service your account, and administer its normal business operations. Some of the sources from which information is gathered are you, your application, transactions that you conduct with us or our administrator and health care providers.

Disclosure of Information to Non-Affiliated Third Parties

The Central Illinois Carpenters Health and Welfare Trust Fund or its Administrator may disclose this information to non-affiliated third parties, as permitted by law, in order to administer its business functions. Some examples of these functions are claims administration, underwriting, reinsurance, rate development and utilization management. The types of non-affiliated third parties to which the Plan or its Administrator may disclose information may include, but are not limited to, the Central Illinois Carpenters Health and Welfare Trust Fund program's pharmacy benefit manager, utilization manager, preferred provider organizations, persons that provide actuarial services, a government agency or other organization pursuant to an audit of the records, claims investigators and medical consultants. The Fund will require non-affiliated third parties to agree in writing to safeguard your PHI in a manner consistent with HIPAA, as amended.

There will be no disclosure of your personal financial information to non-affiliated third parties (except as permitted by law), unless you first are offered an opportunity to "opt-out" of such disclosure, or unless you provide a written authorization, as may be required by applicable state law.

There will be no disclosure of your personal health information to non-affiliated third parties (except as permitted by law), unless you first provide a written authorization.

Non-public personal information regarding a Spouse or Dependent children will be disclosed to the Participant (or the covered former Participant) in the form of an explanation of benefits when a claim is processed.

Additional Uses and Disclosures

In addition to the general uses and disclosures of your information mentioned above, there may be some more specific and extremely rare situations when it is necessary, and permissible, for the Central Illinois

Carpenters Health & Welfare Trust Fund or its Administrator to use or disclose of your medical information without your permission. Examples include, but are not limited to:

- **As Required by Law –** The Fund or Fund Administrator may use or disclose PHI to the extent that such use or disclosure is required by law and complies with and is limited to the relevant requirements of such law.

- **For Public Health Activities –** Where disclosures are necessary for public health activities, the Fund or Fund Administrator may disclose to certain designated agencies, authorities and organizations.

- **For Health Oversight Activities –** A health oversight agency may receive PHI for designated oversight activities.

- **For Judicial and Administrative Proceedings –** The Fund or Fund Administrator may disclose PHI in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal, provided only that PHI expressly authorized is disclosed; or in response to a subpoena, discovery request or other lawful process if certain specific requirements are met.

- **For Law Enforcement Purposes –** The Privacy Standards prescribe several specific circumstances of appropriate disclosure for law enforcement purposes, including: pursuant to legal process and as otherwise required by law; for identification and location purposes, as long as no more than the specified limited information is released; for identification of a victim of a crime if certain protective requirements are met; about decedents; to report crime on the covered entity's premises; and to report crime in emergencies. Again, disclosure is appropriate only in the specific situations described in the Privacy Standards and only after the specific requirements are met.

- **About Decedents –** Certain disclosures may be made to coroners, medical examiners and funeral directors related to deceased individuals.

- **For Cadaveric Organ, Eye or Tissue Donation Purposes –** The Fund or Fund Administrator may use or disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for donation and transplantation purposes.

- **For Specialized Government Functions –** The Privacy Standards recognize the need for special disclosure rules for certain military and veterans' activities, national security and intelligence activity, protective services for the President and others, medical suitability determinations, correctional institutions and other law enforcement custodial situations and covered entities that are government programs providing public benefits.

Security

The Central Illinois Carpenters Health and Welfare Trust Fund and its administrator maintain procedural and electronic safeguards to protect the confidentiality of the non-public personal information that it obtains. Access to personal information is restricted to only those employees and service providers who

need this information to provide products and service to you. The Central Illinois Carpenters Health and Welfare Trust Fund program and its Administrator will continue to abide by this policy even when a customer relationship no longer exists.

Contact Information

If you have questions or would like additional information about this Privacy Notice, you may contact the Fund Office at 200 S. Madigan Drive, Lincoln, IL 62656 or phone 217-732-1919 or fax 217-732-7799. If you believe your privacy rights have been violated, you may make a complaint to the Fund Office or to the U.S. Department of Health & Human Services at 233 N. Michigan Ave., Suite 240, Chicago, IL 60601.

Revision of the Privacy Notice

The Trustees of the Central Illinois Carpenters Health and Welfare Trust Fund reserve the right to revise the privacy procedures at any time. If a change is made, you will be provided with a revised Privacy Notice within 60 days of the effective date of the change.

Self-Audit Program

The self-audit program is designed to provide you with a cash incentive if you discover and arrange for recovery of an overcharge on your Hospital bills, which also saves money for the Fund. Here's how the program works:

1) The cash incentive paid to you for recovering an amount that was initially overcharged on a Hospital bill for you or your Dependent will be 25% of the actual amount of the overcharge that the Hospital agrees is invalid as a result of direct negotiations between you and the Hospital.

2) The maximum paid by the Fund in any calendar year under this program is $500. Hospital overcharges totaling less than $25 are not eligible for the recovery incentive.

3) For purposes of the cash incentive, only Hospital expenses that the Plan covers, not telephone bills, television rental, newspaper, etc. will be considered in determining the amount payable to you under this program. Claims involving coordination of benefits will be eligible only if this Plan is primary.

4) To be eligible for a cash incentive you must submit proof to the Health and Welfare Trust Fund in the form of a copy of the initial itemized Hospital bill with the overcharges circled and a copy of the adjusted bill showing that the Hospital dropped the discrepancy. Such proof must be submitted to the Health and Welfare Trust Fund within 45 days following the date of discharge from the Hospital. Within 30 days after receipt of proof and verification that the overcharge has been recovered, the Health and Welfare Trust Fund will disburse a check in the amount of the cash incentive to you. It should be noted that such reimbursements are considered income and should be reported to the Internal Revenue Service.

5) The Trustees and administrative staff of the Health and Welfare Trust Fund will not get involved in resolving any differences between you and the Hospital with respect to disputed charges. You are solely responsible for handling such disputes.

6) The Trustees have the sole right at any time to amend or modify these rules or terminate the Participant self-audit plan entirely.

7) Here are some suggestions for a careful and complete review of a Hospital bill:

    a) Before leaving the Hospital, make sure the Hospital either provides or arranges to send an itemized bill.

    b) List everything that happens while in the Hospital by reconstructing events, daily or immediately upon discharge.

    c) Match this list against bills to detect any discrepancies.

    d) Check bills carefully for charges that represent any treatments, services or supplies that were not received. Go through the following or similar check list:

        i) Were you billed for the correct number of days you occupied the room?

        ii) If intensive care was required, were you billed for the correct number of days you were confined to an intensive care unit?

iii) Were you charged for the day you were discharged even though you left before the day's charges began?

iv) Were you charged for the correct type of room you occupied (private, semi-private, ward, etc.)?

v) Were you billed only for tests or x-rays that you actually received?

vi) Were you billed for medications, injections, dressings, supplies, etc. that you did not receive? For quantities in excess of what you remember?

vii) Do you recognize medications, injections, dressings, supplies, etc. that you did not receive as belonging to a roommate or some Hospital neighbor?

viii) Were medications that your Physician ordered billed throughout your entire stay even though you took them only a limited period of time?

ix) Were you billed for the purchase of humidifiers, bedpans, admission kits, etc. that you never received or that you were not allowed to take with you?

x) If you received physical, radiation, inhalation and/or occupational therapy, were you charged for the correct type of treatment? The correct number of hours of treatment?

xi) If you received a blood transfusion, were you charged for blood that a donor, blood bank or a Red Cross family or community assurance program replaced?

xii) If admitted to the maternity wing, were you billed for a labor room that may not have been used because of a swift delivery?

xiii) If permitted to retain your newborn in your room, did you incur improper nursery charges?

xiv) Were you billed for miscellaneous charges? Did you ask the Hospital to explain them in specific terms?

e) Circle any overcharges. Report the overcharges to the Hospital billing department and request a corrected bill. If the patient properly identifies the specific discrepancies in the Hospital bill, Hospitals must drop unsubstantiated charges unless there is evidence in the medical file to the contrary. A copy of the adjusted bill will be used as proof that the Hospital dropped the discrepancies.

f) Earn a recovery reward by sending the Health and Welfare Trust Fund a copy of the initial bill with the overcharges circled and a copy of the corrected bill.

Important Information About The Health And Welfare Plan

The following information is provided to help you identify this Health and Welfare Plan and the people who are involved in its operation as required under the Employee Retirement Income Security Act (ERISA).

Plan Name

This Plan is known as the Central Illinois Carpenters Health and Welfare Trust Fund.

Board Of Trustees

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer and Union representatives selected by the employers and the unions that have entered into Collective Bargaining Agreements which relate to this Health and Welfare Fund. If you wish to contact the Board of Trustees, you may use the address and phone number below:

Board of Trustees
Central Illinois Carpenters
Health and Welfare Trust Fund
200 S. Madigan Dr.
Lincoln, Illinois 62656
Telephone: (217) 732-1919

The Board of Trustees is both the Plan Sponsor and the Plan Administrator. The Trustees of this Health and Welfare Fund as of August 1, 2019 are:

Union Trustees	Employer Trustees
Nathan German, Chairman Southern Region Chicago Regional Council of Carpenters #1 Kalmia Way Springfield, IL 62702	Jeff Fuerst, Secretary Associated General Contractors of Illinois 3219 Executive Drive Springfield, IL 62703
Randy Johnson, Business Representative Carpenters Local #243 402 S. Duncan Rd Champaign, IL 61821	Jason Brewer Central Illinois Builders 300 W. Edwards, Ste. 300 Springfield, IL 62704
Carl Bimm, Business Representative Carpenters Local #270 211 W. Lawrence Springfield, IL 62704	Steve Aupperle Builders Association of Tazewell County 182 East Washington Street Morton, IL 61550
Riki Dial, Organizing Coordinator Southern Region Chicago Regional Council of Carpenters #1 Kalmia Way Springfield, IL 62702	John Sutherland Central Illinois Builders 300 West Edwards, Suite 300 Springfield, IL 62704
Matthew Bender, Business Representative Carpenters Local #237 2412 North Main Street East Peoria, IL 61611	Joseph Hart Greater Peoria Contractors Association 1811 W. Altorfer Drive #1 Peoria, IL 61615

Plan Number

The number assigned to this Fund by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 37-1117215.

Agent For The Service Of Legal Process

The Chairman of the Board of Trustees is the Fund's agent for the service of legal process. Accordingly, if legal disputes involving the Fund arise, any legal documents should be served upon the Chairman of the Board of Trustees or upon any individual Trustee at the address of the Health and Welfare Trust Fund Office shown on page 88 of this document.

Source Of Contributions

All contributions to the Fund are made by employers in accordance with their Collective Bargaining Agreements with the Southern Region Chicago Regional Council Carpenters and other participating local Unions, or through Participation Agreements with the Fund. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Fund on behalf of participants working under a Collective Bargaining Agreement, Participation Agreement, or both.

The Collective Bargaining Agreements and Participation Agreements require contributions to the Fund at the fixed rates per hour worked.

The Fund also provides under certain circumstances for a participant whose eligibility is about to terminate to continue coverage by making self-payments directly to the Fund.

Type Of Plan

The Fund is maintained for the purpose of providing death, disability, medical, dental, prescription drug and vision benefits for eligible Participants and their Dependents in accordance with the Schedule of Benefits and eligibility rules described in this booklet.

Funding Of Benefits

All benefits are provided on a self-funded basis directly from the Fund's assets with reinsurance as approved by the Board of Trustees.

Trust Fund

All assets are held in trust by the Board of Trustees for the purpose of paying benefits to Eligible Employees and their Eligible Dependents and defraying reasonable administrative expenses.

Plan Year

The Fund's Plan Year for the purpose of maintaining records and filing various government reports is the twelve-month period ending December 31.

Amendment Or Termination Of The Plan

While the Board of Trustees fully intend to continue the Plan, they reserve the right to alter or, if necessary, discontinue the Plan. The provisions of the Plan may be amended from time to time by a majority vote of the Trustees. Amendments may include increases, modifications, reductions or the elimination, in whole or in part, of certain benefits.

The Plan may be terminated under circumstances allowed by ERISA and the terms of the governing Trust Agreement. If the Board of Trustees amend or terminate the Plan, they will notify you in writing of the changes that are made to your coverage.

Plan Interpretation

A reviewing court shall not substitute its judgment for that of the Board of Trustees except to evaluate the Trustees' decision pursuant to the standards set forth in the Firestone Tire and Rubber et al., v. Richard Bruch, 489 U.S. 101 (1989), decision.

Vesting

All of the benefits of this Plan are made available to you and your Eligible Dependents by the Board of Trustees as a privilege and not as a right. You and your Eligible Dependents do not acquire any vested right to Plan benefits either before or after your retirement.

No Employment Guarantee

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

Certificates of Creditable Coverage

When you or your Dependent's coverage for health benefits ends, the Plan automatically provides you or your Dependents with a certificate of creditable coverage. If you or your Dependents elect COBRA continuation coverage, another certificate of creditable coverage is provided when COBRA continuation coverage ends. These certificates are important because they may enable you to reduce any pre-existing condition exclusion period under your next plan. You should keep the certificate with your other important papers. If you do not receive a certificate, or if you lose the certificate, you may request another one by contacting the Fund Administrator (phone 217-732-1919) within 24 months after your coverage ends.

Statement Of ERISA Rights

As a Participant or Dependent 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 and Dependents 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 all documents governing the Plan. These include insurance contracts and 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.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and Collective Bargaining Agreements and copies of the latest annual report (Form 5500 Series) and updated Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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 Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

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

Assistance With Your Questions

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

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

For more information or to request publications about your rights and responsibilities under ERISA:

- Call (866) 444-3272; or
- Visit www.dol.gov/ebsa.