AUTOMOBILE MECHANICS'
LOCAL NO. 701 UNION AND INDUSTRY
WELFARE FUND

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

CLASSIC NON – BARGAINED – 2013 EDITION

Automobile Mechanics' Local No. 701
Union and Industry Welfare Fund

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT – CLASSIC NON-BARGAINED

Dear Participant:

We are pleased to provide you with this new combination Plan Document and Summary Plan Description (Plan/SPD) booklet, which describes the Classic Non-Bargained Welfare Benefits "the Plan" for Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund "the Fund" as of April 1, 2011.

The Plan offers a comprehensive benefits program that is designed to protect you and your covered Dependents. Whether you are beginning a new job, having a child or adopting one, getting married or divorced, suffering from an Illness or disability, or looking forward to retirement, the Plan offers health care coverage that is designed to help meet you and your family's needs.

We have tried to describe all of your benefits as completely as possible in everyday language. We also organized the Plan/SPD to be useful to you. Please read this booklet carefully as it is important that you understand your benefits and the protection they provide. If you are married, be sure to share it with your spouse.

This Plan/SPD replaces and supersedes all booklets and/or certificates pertaining to benefits under the Union and Industry Welfare Fund that may have been issued previously. The Plan may be amended from time to time—either to revise the benefits or to bring the Plan into compliance with changes in the laws. If this occurs, you will be provided with written notification explaining the change(s).

We recommend that you keep this Plan/SPD with your important papers so you can refer to it when needed. If you have any questions about this booklet or the benefits offered under the Plan, please contact the Fund Office.

Sincerely,

Union Trustees	**Employer Trustees**
Armando Arreola	Ronald Fetty
Sam Cicinelli	Chris Konecki
Robert Keppler	David Mashek

The Board of Trustees has sole authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Board. Benefits under this Plan will be paid only if and when the Board of Trustees, or persons to whom such decision-making authority has been delegated by the Board, in their sole discretion, decides the Participant or beneficiary is entitled to benefits under the terms of the Plan. The decisions of the Board in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If the Plan makes inadvertent, mistaken, excessive, erroneous, or fraudulent payment of benefits, the Trustees or their representative will have the right to recover these types of payments. The Board of Trustees reserves the right to change, modify, or discontinue all or part of the benefits in this booklet at any time by action or amendment.

Table of Contents

Plan Document and Summary Plan Description
Classic Non-Bargained
Effective April 1, 2011

Schedule of Benefits

Comprehensive Medical Benefit (Active Employees and their Dependents)	
Deductibles	
• Calendar Year Deductible	$1,000 per person; $3,000 per family
• Non-PPO Hospital Deductible	$500 per person for each non-Emergency admission to a Non-PPO Hospital (in addition to the calendar year deductible)
Calendar Year Out-of-Pocket Maximums[1]	
• PPO Maximum	$6,000 per person; $18,000 per family
• Additional Non-PPO Maximum	$2,000 per person; $6,000 per family
Calendar Year Plan Maximums	
• Overall	$1,250,000 per person in 2012; $2,000,000 per person in 2013; none in 2014
• Chiropractic	12 visits per person
• Mental Health Treatment – Inpatient Maximum – Outpatient Maximum	 15 days per person with up to 15 Physician visits 30 visits per person
• Rehabilitative Physical Therapy	20 visits per person[2]
• Rehabilitative Speech Therapy (to restore normal speech)	30 visits per person
• Habilitative outpatient Physical and Speech Therapy	30 visits for Speech Therapy and a combined 70 visits for Speech and Physical Therapy
Special Benefit Maximums	
• Hospital Daily Room and Board	Semi-private room rate
• Hospital Intensive Care	Three times semi-private room rate
• Inpatient Substance Abuse Treatment	One 21-day course of treatment per person per lifetime
• Hearing Aid Program	$600 per person every three years
• Infertility Treatment[3]	$10,000 per person per lifetime

1 Excludes deductibles and amounts paid for substance abuse and/or Mental Health treatment that are reimbursed at 50%.

2 Rehabilitative Physical Therapy will be approved in excess of the Calendar Year Plan Maximum if approved in advance by pre-certification, case management, and utilization review. To ensure you receive the maximum benefits available under the Plan, you should ask your Physician to contact MCM prior to receiving treatment.

3 Expenses to determine Infertility are not included under the lifetime maximum.

Comprehensive Medical Benefit (Active Employees and their Dependents)		
Type of Service	**PPO Provider**	**Non-PPO Provider**
• Outpatient Pre-Admission Tests	Plan pays 100%; no deductible	Plan pays 100%; no deductible
• Hospital Inpatient and Outpatient Surgeries and Hospital Inpatient Services	Plan pays 80%	Plan pays 70%
• Emergency Room	Plan pays 80% after $400 deductible which is waived if admitted	Plan pays 80% (70% if not Emergency) after $400 deductible which is waived if admitted
• Preventive Services	Plan pays 100%; no deductible	Not covered
• Non-Hospital Services (e.g., Office Visits, Lab Tests)	Plan pays 80%	Plan pays 70%
• Chiropractic Care[4]	Plan pays 80% for up to 12 visits per person per calendar year	Plan pays 70% for up to 12 visits per person per calendar year
• Substance Abuse Treatment[5] – Inpatient – Outpatient[6]	 Plan pays 90% Plan pays 80% of first $5,000 in a year; 50% thereafter	 Plan pays 70%[7] Plan pays 50%
• Mental Health Treatment[8] – Inpatient – Outpatient	 Plan pays 90% Plan pays 50%	 Plan pays 50% Plan pays 50%
• Hearing Aid Program	Plan pays 100% up to $600 per person every three years	Plan pays 100% up to $600 per person every three years
• Ambulatory Surgical Center	Plan pays 80%	Not covered
• Other Covered Medical Expenses	Plan pays 80%	Plan pays 70%

[4] Chiropractic care includes all services and supplies provided by a licensed Chiropractor.

[5] Inpatient treatment is covered if it is provided by a Hospital or approved Treatment Facility and treatment is based on completion of a course of treatment and the discharge is certified by a Physician.

[6] Amounts paid by the Plan at the 50% level for substance abuse treatment do not apply to the out-of-pocket maximum.

[7] Inpatient treatment provided by a Non-PPO provider is subject to the $500 per person Non-PPO deductible for each non-Emergency admission, in addition to the calendar year deductible.

[8] Amounts paid by the Plan at the 50% level for treatment of Mental Health do not apply to the out-of-pocket maximum.

Prescription Drug Benefits (Active Employees and their Dependents)			
Participating Retail Pharmacy Program	**For up to a 30-day supply, you pay:**		**For each 30-day supply fill at Retail after two, you pay:**
• Generic Medication	25% ($5 minimum/$20 maximum)		25% ($5 minimum/$20 maximum) + $5 surcharge
• Single Source Brand Drug	30% ($25 minimum/$100 maximum)		30% ($25 minimum/$100 maximum) + $15 surcharge
• Multi-Source Brand Drug	35% ($31.25 minimum/$125 maximum)		35% ($31.25 minimum/$125 maximum) + $15 surcharge
Mail Order Service (preferred after two fills)	**For 1-30 day supply, you pay:**	**For 31-60 day supply, you pay:**	**For 61-90 day supply, you pay:**
• Generic Medication	25% ($5 minimum/$20 maximum)	25% ($10 minimum/$40 maximum)	25% ($15 minimum/$60 maximum)
• Single Source Brand Drug	30% ($25 minimum/$100 maximum)	30% ($50 minimum/$200 maximum)	30% ($75 minimum/$300 maximum)
• Multi-Source Brand Drug	35% ($31.25 minimum/$125 maximum) + surcharge	35% ($62.50 minimum/$250 maximum) + surcharge	35% ($93.75 minimum/$375 maximum) + surcharge

Dental Benefits (Active Employees and their Dependents)	
Calendar Year Maximum (not applicable to preventive oral care for eligible Dependent children under age 19)	$1,000 per person
Calendar Year Deductible • Routine Dental Services	 $25 per person
Copayment Percentages • Routine Dental Services • Basic Dental Services • Major Dental Services and Orthodontia	 Plan pays 100% after deductible Plan pays 50% Not Covered

Vision Benefits (Active Employees and Dependents)		
	Network Provider	**Non-Network Provider**
Complete Eye Exam (One per calendar year)	100%; no deductible	Plan pays up to $25 per person
Lenses and Frames or Contact Lenses (every 2 years)	Plan pays up to $75 maximum per person every 2 years; additionally, you will receive a 20% discount on materials	Not covered

Important Contact Information

If you have a question about:	Contact:
Eligibility for benefits or general questions about your benefits	Fund Office 1-708-482-0110 or toll-free at 1-800-704-6270 www.mech701-benefits.org
Participating PPO providers	BlueCross BlueShield of Illinois 1-800-810-2583 www.bcbsil.com
Pre-certification, Utilization Review, Large Case Management and Nurse Hotline	MCM Nurse Hotline 1-877-788-8812 Pre-certification, Utilization Review and Large Case Management 1-800-367-9938
Prescription drug benefits Retail Mail Order Specialty Pharmacy Program	 Catamaran 1-888-354-0090 www.mycatamaranrx.com Catamaran Home Delivery 1-800-881-1966 www.mycatamaranrx.com Ascend Specialty Pharmacy Program 1-800-850-9122
Dental benefits	Dental Network of America (DNoA) 1-866-522-6758 www.dnoa.com
Vision benefits	VSP 1-800-877-7195 www.vsp.com

Change of Address and Change in Family Status

Most information about the Plan is sent to you by mail. If you move, please notify the Fund Office in writing of your address change. Failure to do so may jeopardize your eligibility or benefits because we have no way to contact you about Plan changes.

Additionally, it is very important that you notify the Fund Office immediately if you have a change in family status, including you and/or your Dependents' entitlement to Medicare, adding a Dependent through marriage, birth or adoption or in the event you and your spouse legally separate or become divorced. The Plan requirements for notifying the Fund Office of a change in family status are explained in more detail in the applicable eligibility sections immediately following.

Eligibility for Active Employee Benefits

The following sections contain the Plan's eligibility rules for Active Employees and their Dependents. Active Employees and their Dependents are eligible for benefits under the Plan as of the date the conditions in the following sections are met.

Active Employee Eligibility

Initial Eligibility

You become eligible for Active Employee Benefits under the Plan after you work in Covered Employment for four consecutive weeks for which contributions are made on your behalf. Coverage as an Active Employee begins on the first day of the week following this four-consecutive-week period. Once you establish eligibility for Active Benefits, you are eligible for the Plan's Medical, Prescription Drug, Dental and Vision benefits until your coverage as an Active Employee terminates.

Example of Initial Eligibility

March

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

April

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Joe begins work in Covered Employment on March 1st. Because he worked two days that week, his Employer must submit the weekly contribution to the Plan for the week ending March 3rd. His Employer also submits the weekly contributions for the weeks ending March 10th, March 17th and March 24th. As a result, Joe's coverage under the Plan begins March 25th. However, if Joe does not work during the week ending March 24th and no contributions are submitted that week, the four-consecutive-week period begins again. Accordingly, the earliest he could receive coverage is April 22nd, if his Employer submits contributions for the weeks ending March 31st, April 7th, April 14th and April 21st.

Continuing Eligibility

You will continue to be eligible for Active Employee Benefits provided the required weekly contributions are made to the Plan on your behalf. If you are employed by two or more participating Employers, you will be treated as if you are employed by a single Employer; you are not eligible for multiple coverage.

Special Extension of Coverage/Grace Weeks

If you are laid-off, quit, are terminated, or are off work for any reason, your coverage for benefits will be extended up to four weeks (grace weeks) after Employer contributions end. This extension of coverage is limited to four weeks in a calendar year. After this extension period ends, you may be eligible for COBRA continuation coverage.

Grace weeks do not carry over from one year to the next. In addition, you must re-establish eligibility before a new calendar year's grace weeks are available to you.

Example of Grace Weeks

John begins work for an Employer in June 2012. Contributions are received on his behalf for the remainder of 2012 and through September 2013. He is laid off effective October 1, 2013, which is in the middle of the week so contributions are paid on his behalf for that week. John is laid off for 3 weeks. No contributions are received on his behalf for the weeks of October 12th, October 19th and October 26th. John has 4 grace weeks for 2013. Accordingly, his coverage is extended for the weeks of October 12th, October 19th and October 26th from the grace weeks. Contributions begin again for the week ending November 2nd. Because contributions begin on his behalf before his grace week coverage ends, John will not suffer a gap in coverage and he has one grace week left for his use in 2013, if needed.

Conversely, if no contributions were received for 5 weeks after his layoff (weeks ending October 12th, October 19th, October 26th, November 2nd and November 9th), he would suffer a gap the week of November 9th. If contributions began on his behalf again the week ending November 16th, he would need to re-establish initial eligibility with 4 consecutive weeks of contributions paid on his behalf in order to regain coverage. Accordingly, the earliest John's coverage could resume is December 8th.

October						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

When Active Employee Coverage Ends

Generally, your coverage as an Active Employee ends when the first of the following occurs:

- On the Saturday of the last week for which contributions were made on your behalf;
- On the Saturday of the last week in which your grace weeks end if you are receiving coverage from grace weeks as explained above;

- On the date the Trustees terminate the Plan; or
- Upon your death.

When your coverage ends, the Fund Office will automatically send you information regarding COBRA continuation coverage, if you are eligible. For more information on COBRA eligibility, please review the COBRA section of this booklet.

Reinstatement of Coverage

If your coverage under Active Employee Benefits ends, your coverage will be reinstated when you meet the Plan's initial eligibility requirements as explained above.

Coverage under USERRA

Your benefits under the Plan will end on the day you enter military service. However, under the terms of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), your medical, prescription drug, dental, and vision coverage may be continued. If you are called into active service and you have grace weeks available, your coverage will be extended during your available grace weeks and for 31 days after your grace week coverage ends. If you are called into active service and you do not have grace weeks available, your coverage will be extended for up to 31 days (or less if your active service ends prior to the end of the 31-day period). After you exhaust your grace weeks and the 31 days of USERRA coverage, you may continue your coverage during your active service for up to 24 months after your Plan health coverage ends or the end of the period during which you are eligible to apply for reemployment in accordance with the terms of USERRA; provided that you make a monthly self-payment equal to the COBRA continuation self-payment each month during your leave. Continuation coverage under USERRA will run concurrently with COBRA continuation coverage.

You must give advance notice and a copy of written documentation of your military service to your Employer and the Fund Office, unless you are unable to do so because of military necessity, or when advance notice is impossible or unreasonable under the circumstances. Dependents do not have a separate right, as they do under COBRA continuation coverage, to elect continuation coverage under USERRA.

Your Reemployment Rights

Upon your discharge from military service, you may apply for reemployment with your former Employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any health insurance coverage offered by that Employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service, as follows. When you are discharged or released from military service that lasted:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a contributing Employer;

- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a contributing Employer; or

- More than 180 days, you have up to 90 days after discharge to return to work for a contributing Employer.

When you are discharged, if you are hospitalized or recovering from an Illness or Injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to work for a contributing Employer, up to a maximum of five years.

If your Employer reports your return to the Fund Office during the USERRA required time period, your eligibility and your Dependents' eligibility will be reinstated on the day you return to work, provided you submit copies of your discharge papers to the Fund Office upon request.

How USERRA Works with COBRA

Continuation coverage under USERRA will run concurrently with COBRA continuation coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA continuation coverage. The procedures for electing coverage under USERRA will be the same procedures described for COBRA, except that only you have the right to elect USERRA coverage for yourself and your Dependents.

Your coverage under USERRA will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or

- 24 consecutive months after your coverage would have otherwise ended.

However, your coverage will end at midnight on the earliest of the day:

- You lose your rights under USERRA (for instance, for a dishonorable discharge);

- Your self-payment contribution is due and unpaid; or

- You again become covered under the Plan.

If you do not elect to continue coverage under USERRA, your coverage will end 31 days after the date on which you enter active military service. Your Dependents will have the opportunity to elect COBRA continuation coverage.

Coverage under FMLA

Under the Family and Medical Leave Act of 1993 (FMLA), you may qualify to take up to 12 weeks of unpaid leave for a serious Illness, to care for your newborn child or newly adopted child (including children placed for adoption), or to care for your seriously ill spouse, parent, or child. You may also qualify to take up to 12 weeks of unpaid leave if you have a qualifying exigency because your spouse, child, or parent is on active duty or notified of an impending call

to active duty status in support of a contingency military operation as either a member of the Reserves component of the Armed Forces of the U.S. or as a retired member of the regular U.S. Armed Forces.

In addition, you may be eligible for up to 26 weeks of leave within a single 12-month period to care for a spouse, child, parent or next of kin who is a covered service member suffering from a serious Illness or Injury sustained in the line of duty that renders him or her unfit to perform the duties of his or her office, grade, rank, or rating.

A "covered service member" is a current member of the U.S. Armed Forces (including the National Guard) who is undergoing medical treatment, recuperation or therapy, and is being treated as an Outpatient or is on temporary disability.

Maintenance of Plan Benefits

Coverage for all benefits to which you are eligible under this Plan will continue during FMLA leave on the same basis as other similarly situated Active Employees. If you and your Employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute. Any right to continuation coverage under other provisions of this Plan will still apply.

If FMLA applies to your Employer (small Employers are exempt), it requires your Employer to maintain your health coverage for the length of your leave for up to 12 weeks or 26 weeks (as applicable), as if you were actively at work. The Act also states that if you take a family or medical leave under FMLA, you cannot lose any benefits accrued before the leave.

The Plan will grant eligibility for a family or medical leave and maintain your current eligibility status for the duration of the leave, provided your Employer properly grants the leave of absence under the federal law and makes the required contributions to the Fund on your behalf if and as provided in the applicable Collective Bargaining Agreement.

Contact your Employer directly for more information about family or medical leave under FMLA.

How FMLA Works with COBRA

Taking a family or medical leave is not itself considered a COBRA continuation coverage qualifying event. If you return from leave within 12 weeks, or 26 weeks as applicable, there will not be a loss of coverage.

However, if you do not return to work after FMLA leave and lose coverage because you do not return to work, that is considered a qualifying event under COBRA (due to your termination). You will have up to 12 weeks (or 26 weeks, if applicable) of maintained health care coverage during FMLA leave and an additional 18 months (or 36 months, if applicable) of continued coverage under COBRA, provided you make an election as required and make the COBRA self-payment.

Dependent Eligibility under Active Employee Benefits

Initial Eligibility

Generally, your Dependents become eligible for Medical, Dental, Vision and Prescription Drug coverage under Active Employee Benefits on the date you are eligible for Active Employee Benefits or, if later, on the date they become a Dependent. To add a Dependent, contact the Fund Office for a new history card. To add a spouse, a registered marriage license (with the state's registration number) is required. To add a child, a registered birth certificate or adoption record is required. Please note that church or hospital copies are not considered registered copies. In addition, you must provide copies of social security cards for all Dependents listed on your history card.

You must notify the Fund Office and submit the required documentation within 90 days of the date the Dependent first became eligible under the Plan to receive coverage as of that date. If you do not provide the required documentation within this 90-day period, coverage will begin as of the date the documentation is received by the Fund Office.

When Dependent Coverage Ends under Active Employee Benefits

Your Dependent's coverage ends either when your Active Employee Benefits end (under any class of benefits), on the day he/she is no longer a Dependent as defined by the Plan, or when the Plan discontinues benefits for Dependents, whichever occurs first.

If coverage terminates, your Dependent(s) may be eligible to continue their Medical, Dental, Vision and Prescription Drug coverage through COBRA continuation coverage, provided that you submit the required notification to the Fund Office.

If Coverage Ends Due to Your Loss of Coverage or Your Dependent's Age

In the event your Dependent's coverage ends because you lose coverage as an Active Employee or because your child reaches age 26, the Fund Office will automatically notify you and your Dependent of the right to continue Medical, Dental, Vision and Prescription Drug coverage under COBRA.

If Coverage Ends Due to Divorce or Legal Separation

If you and your spouse legally separate or divorce, you must notify the Fund Office within 60 days of a court entry approving or finalizing the legal separation or divorce. Failure to do so may result in the Plan withholding future benefits or seeking repayment of benefits paid on behalf of an ineligible individual.

For determination of primary responsibility for medical coverage for Dependent children of divorced, legally separated, or unmarried parents, certified copies of the final divorce decree(s) or court order(s) will be requested.

You should also notify the Fund Office if your situation involves a Qualified Medical Child Support Order (QMCSO) as it may impact the Plan's Coordination of Benefits. The Plan has

written QMCSO procedures that describe the Plan's and your rights and responsibilities regarding a QMCSO. You may contact the Fund Office to obtain a free copy of the Plan's QMCSO procedures.

If Coverage Ends Due to Your Death

If you die while you are covered under the Plan as an Active Employee, coverage for your Dependents will continue without self-payment for a period of up to 90 days immediately following your death. After this 90-day period, they may be eligible for COBRA.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), is a federal law that requires plans to offer a temporary extension of benefits to employees and eligible dependents (qualified beneficiaries) who would otherwise lose coverage under a plan. Qualified beneficiaries include you and each Dependent who was covered under the Plan on the day before a qualifying event occurs and who would lose coverage as a result of a qualifying event. Children born, adopted, or placed for adoption have the same COBRA rights as a spouse or other Dependent who was covered by the Plan before the event that triggered COBRA continuation coverage.

Under COBRA, you may continue the benefits available to you prior to your loss of coverage for you and/or your Dependents, without evidence of good health.

Active Employee Qualifying Events

As an Active Employee, you are eligible for COBRA continuation coverage if you lose coverage due to:

- Your termination of employment (except due to gross misconduct); or
- A reduction of your hours of employment, causing loss of coverage.

Dependent Qualifying Events

Your Dependents are eligible for COBRA continuation coverage in the event of:

- Your termination of employment or reduction in the number of hours you work;
- Your death;
- Your divorce or legal separation;
- A child no longer meeting the Plan's definition of Dependent; or
- Your entitlement to Medicare.

A Dependent may also include someone you marry or gain as a child during a period of continuation coverage after a loss of Active Employee Benefits.

Notification to the Fund Office

If you and/or your Dependents become eligible for COBRA continuation coverage due to your termination of employment, reduction in hours, Medicare entitlement, or death, your Employer must notify the Fund Office within 30 days after the occurrence.

By law, within 60 days after your Dependent becomes eligible for COBRA continuation coverage because of legal separation or divorce, you or the Dependent must notify the Fund Office of that qualifying event. If you or your Dependents do not contact the Fund Office during the 60-day period, COBRA continuation coverage will not be available.

Notification should be made in writing to the Fund Office and should include the Active Employee's name and member identification number, qualified beneficiary's name, the qualifying event entitling them to COBRA continuation coverage, and the date of the event. Failure to provide timely notice may prevent you and/or your Dependents from obtaining or extending COBRA continuation coverage.

Active Employees, qualified beneficiaries, or any representative acting on behalf of the Active Employee or qualified beneficiary may provide notice. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

Electing COBRA Continuation Coverage

Within 45 days of receipt of notice(s), the Fund Office will send you and/or your Dependents an election form to continue coverage with instructions or, if you are not eligible, information as to why you are not eligible to elect this coverage. To be eligible for COBRA continuation coverage, you must return the completed election form to the Fund Office within 60 days after the date the Fund Office notifies you of your loss of coverage and eligibility for COBRA continuation coverage. This 60-day period is referred to as an election period.

- Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate COBRA continuation coverage election.

- If you do not elect COBRA continuation coverage for your Dependents when they are entitled to COBRA continuation coverage, your Dependents have the right to elect COBRA continuation coverage for themselves. Your spouse may elect COBRA continuation coverage for herself or himself and any children who are covered by the Plan on the date of the qualifying event.

- This provision applies if international trade adversely affects your employment. If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 2002, you may be eligible for both a new opportunity to elect COBRA continuation coverage and an individual Health Insurance Tax Credit. If you and/or your Dependents did not elect COBRA continuation coverage during your election period, but are later certified by the DOL for Trade Act benefits, you may be entitled to an additional 60-day COBRA continuation coverage election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA continuation coverage later than six months after your coverage ended under the Plan.

If the Fund Office does not receive your completed election form within the 60-day election period, coverage will automatically terminate for you and/or your Dependents effective as of

the original date coverage was lost. Failure to return the completed form within the time limit will also automatically terminate the right to continuation of benefits.

Type of Coverage

If you or your Dependent is eligible for and elects COBRA continuation coverage after a loss of coverage under Active Employee Benefits, the Plan will provide coverage for Medical, Prescription Drug, Dental and Vision care all covered in the same rate.

You or your Dependent would be responsible for paying the full premium cost of coverage plus administrative charges for COBRA continuation coverage. The cost of COBRA continuation coverage is determined based on Plan experience and applicable government regulations. Your premium will be due no later than 45 days after you elect coverage. The first payment must retroactively cover the period of time from the date on which your coverage was lost up through and including the current month. After that, payments are due monthly and must be continuous.

Failure to submit the initial required premium payment within the time limit specified automatically terminates the continuation of benefits and the right to continuation of benefits.

COBRA Continuation Coverage Period

Generally, you may continue coverage under COBRA for a period of up to 18 months from the date (or up to 29 months for disabled individuals, as described in the next section) your employment terminates or there is a reduction in the number of hours you work.

Your Dependents may qualify to continue coverage for a period of up to 36 months under the following qualifying events:

- You and your spouse become divorced or legally separated;
- You become entitled to Medicare;
- Your child loses eligibility as a Dependent; or
- Your death.

If COBRA continuation coverage is obtained after one qualifying event and a second qualifying event, as listed above, occurs during the initial 18-month COBRA continuation coverage period, your Dependent would then be eligible for an additional 18 month COBRA continuation coverage period (a total of 36 months from the date of the first qualifying event).

Example: COBRA Qualifying Events
If you are terminated, lose coverage under Active Employee Benefits, continue coverage under COBRA and then divorce six months later, you would be eligible for COBRA continuation coverage for a total of 18 months from the date of the first qualifying event (your termination). Your Dependents could extend their coverage for up to an additional 18-month period for a total of 36 months from the date of the first qualifying event (your termination).

Coverage for Disabled Individuals

If the Social Security Administration determines that you or one of your Dependents was totally and permanently disabled on the day your employment ended, or within 60 days after that, COBRA continuation coverage may be continued up to a maximum of 29 months, instead of 18 months for all covered family members who have elected COBRA continuation coverage. For coverage to continue, you must notify the Fund Office, in writing:

- Before the 18-month period ends; and
- Within 60 days of the date of the disability.

You must include any documentation of the determination of disability with a written request for extended coverage.

The cost of extended COBRA continuation coverage for disabled individuals and all other qualified beneficiaries for whom coverage is extended under this provision is determined based on Plan experience and applicable government regulations. The premium cost of such extended coverage is greater than that of continued coverage.

When the disability ends, you must notify the Fund Office within 30 days. The extended coverage will end for each qualified beneficiary covered under this extension unless he or she is still within the initial 18-month period of continued coverage.

When COBRA continuation coverage Ends

You lose your right to COBRA continuation coverage if:

- The Plan no longer provides medical, prescription drug, dental, and/or vision care coverage to any Participants;
- You do not pay the required premium when due;
- You become covered under another group medical plan. Note however, that if you have a pre-existing condition not covered by the other plan, your COBRA continuation coverage may be continued;
- You become entitled to Medicare; or
- The period of time for COBRA continuation coverage has expired.

Medical Benefit

Your medical benefit covers a large part of your expenses for the treatment of non-work related Illnesses (including pregnancy) or accidental Injuries, and protects you and your Dependents in the event of catastrophic Illnesses.

How the Medical Plan Works

Preferred Provider Organization (PPO)

You save money by using PPO providers. The Fund has contracted with a PPO to provide you and your Dependents with health care services at preferred prices. When you or a Dependent receives treatment from a Physician, Hospital, or Emergency Treatment Center that participates in the PPO, you save money for yourself and the Fund.

You save money because:

- Depending on the type of services you receive, the Fund may pay a higher percentage of covered charges when you use PPO providers, as shown in the Schedule of Benefits;
- You will not be held liable for any billed amount over the Reasonable and Customary amount, whereas Non-PPO providers may bill these excess charges directly to the patient.
- PPO providers have agreed to provide services at negotiated rates, which are typically lower than what they usually charge. Thus, your share of the bill will be less.

Additionally, PPO providers typically submit claims on your behalf. You do not have to pay your portion of the bill at the time you receive services. The PPO provider discounts your bill and, after processing by the Fund, you will be notified of your share of the bill.

You have the right to see any provider you choose. However, whether benefits are provided and the level of benefits may vary depending upon your choice of provider. Remember that non-PPO Ambulatory Surgical Centers and certain providers whose billing practices do not meet Fund requirements have been excluded from coverage. The provider you choose may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or referral procedures as required by the Plan.

For information about participating PPO providers:

- Go online to www.bcbsil.com; or call BlueCross BlueShield of Illinois at 1-800-810-2583. Information about PPO providers is supplied to you at no cost.

Calendar Year Deductible

The calendar year deductible is the amount of covered medical expenses you pay each year before the Plan begins to pay benefits. The amounts of the individual calendar year deductible and the family deductible are shown in the Schedule of Benefits at the front of this booklet. Additionally, the Schedule of Benefits lists the expenses that are not subject to the calendar year deductible.

The family calendar year deductible is satisfied when at least one family member has satisfied the individual calendar year deductible and either one of the other covered family members or a combination of the remaining covered individuals of a family satisfy the remaining balance of the family calendar year deductible.

Coinsurance

If you have additional covered medical expenses after the calendar year deductible is met, the Plan pays a part of these expenses and you pay the rest. This cost sharing arrangement is called coinsurance. Generally, the Plan pays a higher percentage of covered expenses when you use PPO providers.

Please see the following page for an example of deductibles and coinsurance.

Example: How the Deductible and Coinsurance Work

Steve, his wife Liz, and his son Joe's medical expenses for the calendar year look like this.

Month	Covered Medical Expense Incurred For	Expense
March	Steve	$50
August	Liz	$500
September	Joe	$2,600
October	Steve	$100

Assuming the individual deductible is $1,000, the family deductible is $3,000 and the Plan pays 80% of covered expenses after the deductible is met, here's how the deductible and coinsurance work:

- In March, Steve pays the entire $50, which is credited toward his individual $1,000 calendar year deductible.
- In August, Steve pays $500 of Liz's $500 expense which is credited towards her individual deductible. In addition, $550 (Steve's $50 + Liz's $500) has been credited to the family calendar year deductible of $3,000.
- In September, when Joe incurs $2,600 in covered medical expenses, Steve pays $2,450, which satisfies the family's $3,000 calendar year deductible. The Plan then pays 80% of the remaining $150, which equals $120, and Steve pays the balance of $30, his coinsurance amount.
- In October, when Steve incurs $100, because the family deductible is satisfied, the Plan pays $80 (80% of $100) and Steve pays the $20 balance, his coinsurance amount.

Non-PPO Hospital Deductible

In addition to the calendar year deductible, you and your Dependents are responsible for an additional deductible if you have a non-Emergency confinement in a Non-PPO Hospital. This deductible applies per person per non-Emergency confinement.

Please see the following page for an example about "How Using a PPO Hospital" may save you money.

Example: How Using a PPO Hospital May Save You Money		
Rich is admitted to the Hospital for non-Emergency Medical Treatment. The following chart is a comparison of what Rich would pay for a stay at a PPO Hospital and a Non-PPO Hospital. This example assumes that the Non-PPO Hospital deductible is $500, Rich has already met his calendar year deductible of $1,000, and that a PPO Hospital provides a 30% discount.		
Expenses	**PPO Hospital**	**Non-PPO Hospital**
Total covered medical expenses	$10,000	$10,000
PPO provider discount	-30%	-0%
Adjusted total covered medical expenses	$7,000	$10,000
Non-PPO Hospital deductible	-$0	**-$500**
Total amount subject to coinsurance	$7,000	$9,500
Percentage Plan pays	x 80%	x 70%
Amount paid by Plan	$5,600	$6,650
Amount Rich pays (coinsurance and Non-PPO Hospital deductible, if applicable)	**$1,400**	**$3,350**

Calendar Year Out-of-Pocket Maximum for Active Employees

If you have high medical expenses, the Plan protects you and your family by limiting the amount you have to pay out of your own pocket. This is called a calendar year out-of-pocket (OOP) maximum. When you and your family reach the OOP maximum set forth in the Schedule of Benefits, in any calendar year, the Plan pays 100% of any additional covered expenses, up to any specific Plan maximums, for that covered individual for the remainder of that year.

The family OOP maximum works the same way as the family calendar year deductible. The family OOP maximum is satisfied when one covered individual has satisfied one individual OOP maximum and either one covered individual or a combination of the remaining covered individuals of a family satisfy the remaining family OOP maximum. Once the family meets the annual OOP maximum (PPO and Non-PPO, as applicable), the Plan pays 100% of any additional covered medical expenses, up to any specific Plan maximums, for all covered family members for the remainder of that year.

Amounts paid to satisfy deductibles, amounts that exceed specific Plan limitations, non-covered expenses, and substance abuse and/or Mental Health expenses covered at 50% do not count toward the Plan's calendar year out-of-pocket maximum. See the notes following the Schedule of Benefits for more details or contact the Fund Office with questions.

Please see the following page for an example of "How the OOP Maximum Works."

Example: How the Out-of-Pocket Maximum Works assuming the OOP maximum is $6,000 per person and the additional Non-PPO OOP maximum is $2,000.

- **Scenario A:** Michael uses only PPO providers and pays $6,000 out of his pocket in covered medical expenses between January 1 and July 31. Provided he continues to use PPO providers, the Plan will pay 100% of most additional covered expenses he incurs for the remainder of the calendar year.
- **Scenario B:** Michael uses both PPO and Non-PPO providers and incurs $6,000 in out-of-pocket expenses between January 1 and July 31. If he uses only PPO providers after July 31, the Plan will pay 100% of most covered expenses for the rest of the calendar year. However, if he uses Non-PPO providers after July 31, he will need to incur an additional $2,000 in out-of-pocket expenses before the Plan pays 100% of most covered services.

Calendar Year Maximum Benefit

The Plan does not impose an overall lifetime maximum. However, until 2014, the Plan imposes a calendar year maximum. The Plan pays up to the calendar year plan maximums (listed in the Schedule of Benefits in the front of this booklet) per person per year for benefits deemed to be essential health benefits. The Board of Trustees has the sole discretion and responsibility to determine in good faith whether a benefit is deemed to be an "essential health benefit" pursuant to the guidance under the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). Benefits determined to be non-essential will not count toward the calendar year maximum for essential health benefits. Non-essential benefits offered by the Plan may be subject to additional annual or lifetime limitations as permitted under the Affordable Care Act.

Case Management, Pre-certification and Utilization Review

The Plan offers pre-certification, case management and utilization review to work with you and your Physician to keep your medical care costs as low as possible and consistent with good medical care. In many instances, review of the need for hospitalization and exploration of available alternatives will indicate that admission to the hospital may be avoided and that quality treatment is better provided in a less stressful environment. To ensure you receive the maximum benefits available under the Plan, you should ask your Physician to contact MCM, the case management and utilization review company selected by the Trustees, when your Physician refers you to Physical Therapy, chiropractic care, hospice, skilled nursing, home health care, orders durable medical equipment for you or your Dependent or before you incur expenses related to transplant procedures.

Covered Medical Expenses

The Plan will pay benefits as listed in the Schedule of Benefits in the front of this Plan/SPD up to the Reasonable and Customary charges for covered Medically Necessary expenses (subject to the terms and conditions of the Plan). However, such benefits are only payable if you or your Dependents are under the care of a Physician and the covered medical expenses are ordered or

provided by a Physician for the treatment of a non-occupational Illness or accidental Injury. Covered medical expenses include the following services and supplies:

- Hospital room and board charges, including:
  - Hospital charges for a private room for contagious or communicable diseases or when private rooms are only available;
  - Intensive care units; and
  - Nursery charges for newborns of Active Employees, whether sick or well.

  Pursuant to the Newborns' and Mothers Health Protection Act, group health plans, including this Plan, and health insurance issuers may not, under federal law, restrict benefits to less than 48 hours following a normal vaginal delivery for any mother or newborn stay in connection with childbirth for the mother or newborn child, or less than 96 hours following a cesarean section. However, federal law 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). In any case, plans and issuers may not require that a provider obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

- Other Hospital services and supplies and other miscellaneous services and supplies provided by a Skilled Nursing Facility, a Treatment Facility for alcohol and/or drug dependency, an approved surgical center (other than a Non-PPO Ambulatory surgical center), or an Emergency Treatment Center on an Inpatient or on an Outpatient basis.

- Physicians' services rendered either in or out of a Hospital, including surgical procedures and Medical Care and treatment.

- In general, dental services are not covered under the Plan's Medical Benefit except for:
  - Services and supplies required for the treatment of accidental Injury to the jaw or to sound natural teeth, including the initial replacement of such teeth and any necessary dental x-rays, provided the:
    - Individual receives services and/or supplies within 12 months of the date of the accident causing the Injury.
    - In the event treatment of the Injury exceeds the 12-month period allowed, coverage for such treatment may be extended for an additional six months (for a total of 18 months of coverage from the initial date of the Injury) if medical evidence, satisfactory to the Trustees, is furnished showing that the delay in treatment was due to:
      - Damage to nerves in the oral cavity suffered at the time of the Injury that required time to heal or regenerate;
      - Care of a fractured jaw(s) that required immobilization of the bone structure that prevented other treatment;
      - Additional time required for stabilization of the Injury;

- In the case of a Dependent child of an Active Employee, allowance for the normal growth process; or
- A delay in the healing process that is demonstrable by x-ray.

- Removal of impacted teeth.

- Services and supplies provided in an Emergency Treatment Center, Hospital emergency room, or Outpatient department for Emergency treatment of an accidental Injury or Illness. The Plan will cover certain Emergency Services provided in Hospital emergency rooms when you are suffering from an Emergency Medical Condition.

- X-ray examinations, and laboratory examinations, tests, or analyses made for diagnostic or treatment purposes.

- Necessary pre-admission tests (x-ray examinations and/or laboratory tests) made before Hospital admission. Payment for such tests will be made in accordance with the following provisions:
  - The tests must be ordered by the attending Physician or surgeon.
  - The tests must be performed in the Outpatient department of the Hospital to which the eligible individual is being admitted.
  - The Hospital confinement must begin within 10 days after the tests are performed.
  - The tests must be medically valid at the time of the Hospital admission.
  - No payments will be made for charges incurred for diagnoses, research, case of findings, or surveys.

- X ray, radon, radium, and radioactive isotope treatments.

- Home health care rendered in an eligible individual's home, if the Home Health Agency is licensed by the state, primarily engaged in providing skilled nursing care in patients' homes, operated under professionally developed policies and under the supervision of a Physician or registered nurse, and eligible for Medicare. Benefits are subject to the following provisions:
  - The plan of home nursing care must be established and approved in writing by the patient's Physician within seven days following termination of an Inpatient Hospital confinement.
  - The Physician must certify that the care is for the same or related condition for which the patient was hospitalized and that proper treatment of the patient's condition would require Hospital confinement in the absence of the services and supplies provided as part of the home plan of care.
  - Covered expenses include the following services and supplies, provided such services and supplies are provided by or through an organization that meets this Plan's definition of a Home Health Agency:

- Intermittent, part-time nursing care provided by or under the supervision of a registered professional nurse (services of an RN or LPN are covered if the patient's condition requires the professional services of a trained nurse);
- Medical social services provided under the direction of a Physician;
- Intermittent, part-time home health aide services;
- Medical supplies (other than drugs and biologicals) and the use of medical appliances;
- Medical services of interns and residents in training under an approved teaching program of a Hospital with which the Home Health Agency is affiliated;
- Any of the foregoing items and services that are provided on an Outpatient basis at a Hospital or Skilled Nursing Facility under arrangements made by the Home Health Agency and that involve the use of equipment of such a nature that the items and services cannot readily be made available to the eligible individual in the individual's place of residence or that are furnished at such facility to which the individual has gone to receive any item or service involved in the use of such equipment (excluding transportation of the individual).

- Transportation services, including:
  - Emergency local transportation by a professional Ambulance Service, limited to the first trip to and/or from a Hospital for any one Illness or for all Injuries sustained in any one accident; payable at the PPO coinsurance percentage, even in the event that the services are provided by a non-PPO provider.
  - If a Physician certifies that an individual's disability requires specialized or unique treatment that is not available in a local Hospital, charges incurred for transportation for such treatment will also be considered covered medical expenses, provided:
    - The transportation is by regularly scheduled commercial airlines or railroad or by professional air ambulance in an Emergency situation.
    - The transportation is only from the city or town where the Injury or Illness occurred to the nearest Hospital qualified to render the special treatment.
    - Only charges incurred for the first trip to and/or from the Hospital for any one Illness or for all injuries resulting from any one accident will be considered covered medical expenses.
    - The transportation is only within the continental limits of the United States and Canada, including the geographical boundaries of Puerto Rico and Hawaii.

- Anesthetics and their administration.

- Services of a qualified registered speech therapist for speech therapy to restore speech loss, or to correct impairment due to a congenital defect for which corrective surgery has been performed or due to a qualified Injury or Illness. The treatment may be rendered in or out of a Hospital and must be recommended by the attending Physician.

- The following medical supplies:

- Drugs and medicines administered while an Inpatient or during surgery at a PPO Outpatient surgical facility, Hospital Outpatient department, Physician's office, or clinic.
- Whole blood (if not replaced or donated) or blood plasma and the administration of such substances.
- Surgical supplies including appliances to replace physical organs or parts of organs. These include such items as artificial limbs, eyes, and larynxes. Only the initial charge for any such appliance will be considered a covered medical expense. In addition, the first charge incurred for surgical supplies required to aid any impaired physical organ or part of an organ in its natural body function will be a covered medical expense.
- Oxygen and the rental of the equipment for the administration of oxygen.
- Rental of durable hospital-type equipment, including a wheelchair, hospital bed, or other similar therapeutic equipment, unless purchase is determined to be more cost effective by the Plan Administrator or its designees.
- Casts, splints, braces, crutches, and trusses.

➢ Hospice Care program covered expenses.

➢ Services and supplies provided during an approved confinement in a Skilled Nursing Facility. An approved confinement is one that meets all of the following criteria:

- The attending Physician must certify that such confinement and nursing care is essential for recuperation from an Injury or Illness and that it is not, other than incidentally, for Custodial Care.
- The confinement must be preceded by at least three-consecutive days of a Hospital confinement for which Plan benefits are payable.
- The confinement must be due to the Injury or Illness that required the previous Hospital confinement.
- The confinement must commence within three days after termination of a Hospital confinement or within three days after termination of a Skilled Nursing Facility confinement for which Plan benefits are payable.
- The attending Physician must continue treatment of the individual and personally see the individual at least once each 14 days and must certify that continuation of such confinement is necessary for continued treatment of the Injury or Illness requiring the confinement.

➢ Services and supplies rendered for the purpose of obtaining a voluntary second surgical opinion.

➢ Services and supplies provided in a PPO Outpatient surgical facility, Hospital Outpatient department, Physician's office, clinic, or elsewhere, as a result of a surgical procedure performed other than in a Hospital. Benefits paid by the Plan include charges directly related to the surgery within the following time limits:

- The day of surgery for surgeon, consultations, and anesthesia; and

- Within 10 days either before or following the date of surgery for Outpatient services and supplies, x-rays and tests, laboratory procedures, and services and supplies provided by the facility.

- Services and supplies provided for pregnancy and pregnancy-related conditions of a Participant or Dependent spouse, including but not limited to Hospital charges, Physicians' delivery fees, prenatal laboratory and x-ray examinations, home birth delivery by a Physician, sonograms and ultrasound testing, prenatal office visits, anesthesia and its administration, and tubal ligations.

- Services and supplies for certain transplant procedures, as determined by Medicare guidelines. Please note that you or your Physician should contact MCM prior to incurring expenses related to transplant services.

- Pursuant to the Women's Health and Cancer Rights Act, reconstructive breast surgery following a mastectomy will be provided on the same basis as other surgical procedures covered by the Plan and include:
  - Reconstruction of the breast on which a mastectomy is performed;
  - Reconstructive surgery on the other breast to produce a symmetrical appearance;
  - Prostheses and surgical bras following a mastectomy; and
  - Physical complications of any stage of mastectomy, including lymphedemas.

- Services of a surgical assistant provided that:
  - The surgeon and surgical facility participate in the PPO network;
  - The surgical assistant is performing his or her duties under the supervision of a licensed surgeon; and
  - Payment is in accordance with the established PPO recommended payment schedule.

- Orthotics coverage is limited to one pair of orthotics for you and/or eligible spouse every 48 months, and one pair of orthotics for Dependent children under age 19 every 12 months. Orthotics are medical devices that support and gently reposition the heel, arch, muscles, ligaments, tendons, and bones in the feet (i.e., they are not shoe inserts sold over the counter).

- Respiratory assistance devices (such as CPAPs) and replacement of supplies once every six months.

- Supplies and services rendered by a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic Medicine, Naprapath, or a Registered Physical Therapist (under the direction of a Physician) for treatment of the back, neck, spine, and vertebra for conditions due to subluxation, strains, sprains, and nerve root problems (chiropractic/spinal care) as shown in the Schedule of Benefits. Chiropractic/spinal care expenses for children under the age of 8 are covered only in very limited situations. Pre-certification for children under age 8 is required before chiropractic/spinal care benefits are paid.

- Services and supplies, including room and board charges for Inpatient confinements, provided in connection with the treatment of drug and alcohol dependency (substance abuse).

- Services and supplies, including room and board charges for Inpatient confinements provided in connection with the treatment of Mental and Nervous Disorders.

- Infertility Treatment for you and your Dependent spouse. Covered Infertility services include, but are not limited to:

  - Evaluation.
  - In vitro fertilization.
  - Uterine embryo lavage.
  - Embryo transfer.
  - Artificial insemination.
  - Gamete intrafallopian tube transfer.
  - Zygote intrafallopian tube transfer.
  - Low tubal ovum transfer.
  - Prescribed drugs and medicines.
  - For in vitro fertilization expenses to be covered, the procedures must be performed at a facility that conforms to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for program in vitro fertilization.

- Hearing aids and hearing examinations for Active Employees and their Dependents only subject to the limits and maximums in the Schedule of Benefits.

- Preventive Services as required by the Affordable Care Act, including well child and adult care, routine physical exams, mammograms and colon cancer screenings. For an up-to-date list of Preventive Services covered by the Plan, please contact the Fund Office or visit http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforChildren.

  - If a Preventive Service item is billed separately from an office visit, the Plan will impose cost sharing with respect to the office visit. If such services are not billed separately, then whether or not the Plan imposes a co-payment for the office visit will depend on if the primary reason for the visit was the delivery of the Preventive Service.
  - PPO-covered provider restrictions apply to all preventive services as stated on the Schedule of Benefits (with the exception of breast pumps for the purpose of

breastfeeding, which do not have to be purchased through a PPO-covered provider). The Plan will reimburse 100% of the cost of a reasonably priced electric breast pump, up to the Reasonable and Customary amount, for the purpose of breastfeeding, but not all breast pump models are required to be covered. As of July 1, 2013, the Reasonable and Customary amount allowable for breast pump coverage is $275. Please verify coverage of a particular model with the Plan and the current Reasonable and Customary amount allowable prior to your purchase.

- The Plan is permitted to use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent not specified in the recommendation or guideline.

- FDA approved birth control methods as required by federal law, with the exception of those prescription drug methods covered under the Plan's Prescription Drug Benefit.

- Rehabilitative and restorative Physical, Speech and Occupational Therapy will be covered if all of the following criteria are met:
  - The treatment is ordered by a Physician after the Participant or Dependent suffers from an Illness or Injury;
  - The treatment is provided pursuant to a treatment plan that requires the services of a licensed and skilled therapist specializing in the area of services provided;
  - There is an expectation that treatment will result in measurable improvement in a reasonable and predictable period of time for the particular diagnosis and phase of recovery; and
  - There is a demonstration of measurable, objective, and functional progress as a direct result of treatment.

- Habilitative and developmental Physical and Speech Therapy will be covered if all of the following criteria are met:
  - The treatment is for the correction of a Congenital Anomaly or neurological disorder;
  - The treatment is ordered by a Physician and is provided pursuant to a treatment plan that requires the services of a licensed and skilled therapist specializing in the area of services provided;
  - There is an expectation that treatment will result in measurable improvement in a reasonable and predictable period of time for the particular diagnosis and phase of recovery; and
  - There is a demonstration of measurable, objective, and functional progress as a direct result of treatment.

Expenses Not Covered

The Plan is designed to cover a broad range of Medically Necessary services, supplies, and expenses. However, it is important to be aware that the Plan does not cover all of the medical expenses you or your family may incur.

The Fund reserves the right to question and have any claim professionally reviewed to determine whether it is a reasonable and Medically Necessary expense. Following is a list of medical services, supplies, and expenses not covered by the Plan.

- Any expense that, in the opinion of the Trustees, is not Medically Necessary.
- Any Injury or Illness for which the individual is not under the regular care of a Physician.
- Any care, treatment, service, surgical procedure, supply, or Hospital confinement that is rendered by or received from or on the recommendation of a Physician who does not meet this Plan's definition of a Physician or that is received from or in a Hospital that does not meet this Plan's definition of a Hospital.
- Any care, treatment, service, surgical procedure, supply, or Hospital confinement that is not recommended or approved by the attending Physician.
- Any care, treatment, service, surgical procedure, supply, or Hospital confinement that is not rendered for the treatment or correction of, or in connection with, a specific non-occupational accidental bodily Injury, Illness, or congenital defect, unless specifically identified as being covered under the Plan.

  Exception: This exclusion will not apply to charges incurred for routine Medical Care of a newborn child during the mother's confinement if such child is an eligible Dependent of an Active Employee.
- Care or treatment of an eligible individual where the person providing the care or treatment is related by blood or marriage to the Active Employee or to any of their Dependents or who ordinarily lives in the Active Employee's or Dependent's home.
- Any type of Custodial Care (care that is designed primarily to assist an individual in meeting the activities of daily living, i.e., milieu therapy), regardless of what the care is called.
- Any special education rendered to any individual, regardless of the type of education, purpose of the education, recommendation of the attending Physician, or the qualifications of the individual(s) rendering the special education.

  Exception: This exclusion will not apply to charges incurred for Outpatient psychiatric treatment.
- Education, training, or room and board while the individual is confined in an institution that is primarily a school or institution of learning or training.

- Physical Therapy, Speech Therapy, or any other type of therapy if either the prognosis or history of the individual receiving the treatment or therapy does not indicate that there is a reasonable chance of improvement.

- Any confinement in an institution that is primarily a place of rest, place for the aged, or nursing home (other than a Skilled Nursing Facility).

- Any accidental bodily Injury, Illness, or disease sustained while, or resulting from, 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 paid in whole or in part under any workers' compensation, employer liability, occupational diseases, or similar law.

- Claims (past, present or future) by a Participant or beneficiary related to Injury or Illness caused by, or claimed to be caused by, a third party; or claims (past, present or future) related to an Injury or Illness for which settlement, judgment or any payment is claimed or received unless the Plan agrees to pay such claims pursuant to a written subrogation and reimbursement agreement.

- Services rendered while the individual is confined in a Hospital operated by the U.S. Government or an agency of the U.S. Government or, with respect to a Hospital confinement in any other Hospital, for charges incurred for which the eligible individual is not required to make payment.

- Any medical expense incurred by any individual before the date they become covered under the Plan.

- Travel, whether or not recommended by a Physician, except as specified otherwise under the Covered Medical Expenses Section.

- Patent medicines or other drugs or medicines that can be obtained without a Physician's prescription.

- Any treatment of substance abuse that is provided in a treatment facility that does not meet this Plan's definition of a Treatment Facility for alcohol and/or drug dependency.

- Any Inpatient course of substance abuse treatment that is terminated without the recommendation or approval of a Physician.

- With the exception of Physician's visits and lab services, any care, treatment, service, surgical procedure, supply, or Hospital confinement provided or rendered in connection with an overweight condition or condition of obesity, including gastric restrictive procedures such as gastric or intestinal bypass, even if performed to treat a co-morbid or underlying health condition.

- Any treatment, service, supply, Hospital confinement, or surgical procedure that is of an elective nature, which includes any non-Emergency plastic or cosmetic surgery on the body

(including but not limited to such areas as the eyelids, nose, face, breasts, or abdominal tissue).

Exception: This exclusion does not apply to:

- Cosmetic surgery that is performed for the correction of defects incurred through traumatic injuries sustained by an individual as a result of an Injury;
- The correction of a deformity resulting from a Congenital Anomaly that causes a functional defect or is pre-determined by the Plan to be Medically Necessary;
- Reconstruction of the breast following a mastectomy;
- Corrective surgical procedures on organs of the body that perform or function improperly; and
- Voluntary vasectomies and other sterilization procedures performed on Active Employees and Dependent spouses of Active Employees.

➢ Expenses for genetic tests, including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics.

Exception: This exclusion does not apply to tests listed as a Preventive Service under the Affordable Care Act.

➢ Reversal of, or attempts to reverse, a previous elective sterilization, except as required by federal law.

➢ Vasectomies or other sterilization procedures for Dependent children, except as required by federal law.

➢ Consultations and sessions with other family members, unless such consultations and sessions are required as part of a psychological or psychiatric Outpatient treatment of an individual.

➢ Treatment or consultation with a social worker, marriage counselor, or naturopath.

Exception: This exclusion does not apply to benefits for outpatient psychiatric treatment by a Licensed Clinical Social Worker when referred by a Physician.

➢ Treatment or consultation provided by a psychologist, unless a psychologist is providing the treatment at the request of and is referred by a Physician specializing in psychiatry.

➢ Any operation or treatment in connection with sex transformations of any type.

➢ Charges incurred for or in connection with acupuncture, if performed by other than a Medical Doctor (MD), Doctor of Osteopathic Medicine (OD), Doctor of Chiropractic (DC), or Doctor of Neuropathy (DN).

- Confinement in a facility providing nursing services, unless the facility meets this Plan's definition of a Skilled Nursing Facility and the confinement in such facility meets the criteria for an approved confinement as specified under the Covered Medical Expenses Section.

- Program of home nursing care, unless the nursing care is provided through a provider that meets this Plan's definition of a Home Health Agency.

- Any treatments, services, or supplies furnished or provided by a clinic, center, or other provider for the purpose of helping individuals to stop smoking, regardless of what the program is called.

  Exception: This exclusion does not apply to services listed as a Preventive Service under the Affordable Care Act.

- Any treatments, care, procedures, Hospital confinements, services, or supplies that are in excess of any Plan limitations or maximum benefits or specified as not covered.

- Radial keratotomy, lasik surgery, or any procedure to correct refractive errors.

- Dental implants.

- Personal items, such as newspapers, magazines, books, telephone, telegrams, rental of radio or television, personal laundry, toiletries, admission kits or trays, and slippers. This also includes guest cots, guest trays, and sanitary napkins.

- Services, drugs, supplies or expenses that are not the result of an initial, in-person Physician or office visit with a health care provider, such as a fee for telephone calls or an Internet provider.

- Non-PPO Ambulatory surgical center charges.

- Treatment of injuries caused by suicide, attempted suicide, or self-inflicted Injury, unless the injuries resulted from an underlying medical condition (including both physical and Mental Health conditions). However, benefits will not be paid for such charges if the self-inflicted Injury, suicide, or suicide attempt was the result of the illegal use of drugs, whether or not the person has a medical (physical or Mental Health) condition.

- Orthoptics or vision training.

- Unlicensed facilities or providers.

- Treatment rendered outside the United States, unless you or your Dependent is traveling for business, pleasure or as a registered full-time student in a foreign country.

- Treatment for injuries sustained while participating in an act which violates state or federal statute, except that injuries sustained as the result of domestic violence will be covered.

- Any of the following items for any condition or indication, including for supplementation of an inadequate diet, replacement of foods due to intolerances, to provide nutritional alternatives, or for weight loss or maintenance:
  - Standardized or specialized infant formula for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitive enteropathy/celiac disease; milk allergies; sensitivities to intact protein; protein or fat maldigestion; or intolerances to soy formulas or protein hydrolysates;
  - Food thickeners;
  - Dietary and food supplements;
  - Lactose-free products and products to aid in lactose digestion;
  - Gluten-free food products;
  - Weight-loss foods and formula and products to aid weight loss;
  - Normal grocery items;
  - Low carbohydrate diets;
  - Baby food;
  - Grocery items that can be blenderized and used with an enteral feeding system;
  - Nutritional supplement puddings;
  - High protein powders and mixes; and
  - Oral vitamins and minerals.
- Expenses for any medical services, supplies, or drugs or medicines that are determined to be Experimental or Investigative.
- Expenses which are not specifically listed as covered under the Plan.
- Expenses related to a Dependent child's pregnancy diagnosed by a Physician after January 1, 2013.
- Physical Therapy services for educational or developmental purposes except as specifically covered under the Plan.
- Speech Therapy services which are the result of an idiopathic developmental delay, are educational based or are otherwise provided by a school based provider.

Prescription Drug Benefit

*Your Prescription Drug benefit helps you pay for covered drugs and medicines for you and your eligible Dependents under Active Employee Benefits. The Plan provides coverage through a retail pharmacy program and a mail order service. To receive Prescription Drug benefits under the Plan, you **must** have prescriptions filled through a participating retail pharmacy, the mail service program, or specialty pharmacy.*

When filling prescriptions, you must receive a Generic Medication when available unless your doctor writes on your prescription "dispense as written." If you request a Brand Name Medication when a Generic Medication is available, you must pay the higher copayment amount plus the difference in cost between the Brand Name Medication and the Generic Medication.

Retail Pharmacy Program

The Plan has contracted with a network of retail pharmacies (called participating pharmacies) that fill your prescriptions at negotiated rates. When you become eligible for benefits, you will receive a prescription drug card. You can fill up to a 30-day supply at a participating retail pharmacy.

Payment is taken at the point of purchase. The Plan covers the remaining cost of the prescription after you have satisfied your copayment. The amount of your copayment depends on whether you receive a Generic Medication, single source brand medication or multi source brand medication as shown in the Schedule of Benefits in the front of this booklet. You do not need to complete or submit a claim form. Prescriptions filled at non-participating pharmacies are not covered under the Plan.

Mail Order Service

Maintenance medications (i.e., for conditions such as high blood pressure or asthma) should be filled through the mail order service program. The Plan allows two initial fills of a maintenance medication to be filled at any participating network retail pharmacy without incurring a surcharge. Thereafter, if you have your maintenance medication filled at a participating network retail pharmacy, you will be charged a $5 surcharge for refills of Generic Medications and $15 for each brand medication not filled through the mail order service.

Refills through Catamaran Home Delivery can be dispensed no more than 30 days before your present supply runs out.

The first time you have a prescription filled through the mail order pharmacy, you will need to submit a copy of your prescription, and the appropriate copayment along with an order form. The amount of your copayment depends on whether you receive a Generic Medication, single

source brand medication or multi source brand medication as shown in the Schedule of Benefits in the front of this booklet.

You can obtain order forms by calling Catamaran Member Services at 1-800-881-1966. Order forms are also available online at www.mycatamaranrx.com.

Specialty Pharmacy Program

The specialty mail order program is provided by the Ascend Specialty Pharmacy. Specialty medications covered under this program include prescriptions for the treatment of multiple sclerosis, hepatitis C, Crohn's disease, Gauchers disease, growth hormone, hemophilia, immune system/IVIG, Infertility, oncology, psoriasis, rheumatoid arthritis, transplants, and HIV/AIDS.

You can initiate a request to fill a specialty medication by calling an Ascend Care Coordinator at 1-800-850-9122.

Step Therapy Program

The Plan requires that, when available, a Generic or over-the-counter (OTC) medication be filled prior to the Plan covering the cost of any Brand Name Medication. This program is referred to as Step Therapy. Medications covered under this Step Therapy Program are those used on an ongoing basis to treat chronic conditions, such as asthma or allergies.

If your Physician prescribes a Brand Name Medication, the Plan requires a Generic or OTC equivalent medication be filled first. The Brand Name Drug will not be covered. If it is determined by your Physician that the Generic or OTC equivalent medication did not work as expected, the Plan will at that time allow the fill of the brand medication.

Step Therapy Pharmacy Program Affected Medications	Preferred Medications
Proton Pump Inhibitors, which include Aciphex, Nexium, Prevacid, Protonix	Prilosec OTC
Non-Sedating Antihistamines, which include Allegra, Allegra-D, Clarinex, Clarinex-D, Zyrtec, Zyrtec-D	Claritin OTC
Anti-Inflammatory Cox-2 Inhibitors, which include Celebrex	Traditional non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen or naproxen
Angiotensin II Receptor Blockers, which include Diovan, Teveten, Atacand, Benicar, Micardis, Avapro	ACE Inhibitors, such as Captopril, Enalopril, Fosinopril, Lisinopril, Quinapril, etc.
Dermatological, which include Elidel, Protopic	Generic topical steroidal anti-inflammatory agents, such as triamcinolone or fluocinonide
Anti-Asthmatic Agents, which include Xopenex	Generic Albuterol
Allergic Rhinitis (runny nose, itchy/teary eyes), which include Singulair	Steroid nasal spray and an Antihistamine

Beginning on November 1, 2011, the Step Therapy Program was expanded to include the following five drug classes and medications:

Drug Class	Step 1 Preferred Alternatives	Step 2 Affected Medications
Bisphosphonates **For treating osteoporosis**	alendronate	Actonel, Actonel with Calcium, Atelvia, Boniva, Fosamax Plus D
Intranasal Corticosteroids **For treating allergies**	fluticasone propionate, flunisolide	Beconase AQ, Nasacort AQ, Nasonex, Omnaris, Rhinocort Aqua, Veramyst
Sedative Hypnotics **For treating sleeping disorders**	zolpidem, zaleplon	Edluar, Lunesta, Rozerem, Zolpimist
SSRIs **For treating depression/anxiety**	paroxetine, fluoxetine, sertraline, citalopram	Lexapro, Luvox CR, Viibryd
Triptans **For treating migraines**	naratriptan, sumatriptan	Amerge, Axert, Frova, Imitrex, Maxalt, Maxalt MLT, Relpax, Sumavel, Treximet, Zomig

Does this change affect my prescriptions?

If you were taking one of the affected medications listed above before November 1, 2011, you are a 'grandfathered' Participant and the Plan will continue covering that drug. The change to the Program ***did not*** *affect this prescription*.

If your doctor first prescribes an affected medication on or after November 1, 2011, the Program change *affects your prescription*. It will be subject to the Step Therapy criteria. When possible, your doctor should prescribe the Step 1 medication that is appropriate for your condition. If your doctor believes that medication is not appropriate for you or is not effective in treating your condition, your doctor can work with a Catamaran clinical pharmacist to determine whether you meet the criteria for the Plan to cover the affected medication.

Step Therapy

The Step Therapy Program helps you use the lowest cost medication within a *drug class*. A drug class is a group of medications that may work in the same way, have a similar chemical structure, or treat the same health condition.

The Step Therapy Program groups drugs into *categories* based on cost.

1. Preferred Alternative – Step 1 – medications are widely considered equivalent to other products within the class by Physicians and pharmacists; yet on average, cost between 30% and 80% less than the equivalent brand-name drug.
2. Affected – Step 2 – medications are brand-name drugs that typically cost more.

Covered Expenses

The following Prescription Drug expenses are covered subject to the Plan limitations and copayments provided in the Schedule of Benefits:

- Medications that by federal law can be dispensed only pursuant to a prescription and that are required to bear the legend, "Caution, Federal Law Prohibits Dispensing without Prescription."
- Compounded medications of which at least one ingredient is a prescription legend drug.
- Insulin.
- Insulin syringes/needles.
- OTC medications prescribed by a Physician under the Step Therapy Program.
- Prescription drug expenses.

Expenses Not Covered

The following Prescription Drug expenses are not covered under the Plan:

- Drugs or medicine lawfully obtainable without a Physician's prescription, except insulin and OTC medications prescribed by a Physician under the Step Therapy Program and OTC medications identified by the Affordable Care Act.
- Appliances, devices, or prosthetics other than insulin syringes and needles are excluded except as required under the Affordable Care Act.
- Charges for the administration of prescription legend drugs or injectable insulin.
- Prescriptions dispensed by or administered to the individual, in whole or in part, while a patient is in a licensed Hospital, Physician's office, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home, or similar institution that operates on its premises, or is allowed to be operated on its premises, a facility for dispensing pharmaceuticals.
- Prescription Drugs that may be properly received without charge under local, state, or federal programs, including workers' compensation laws.
- Existing and new drugs that are not uniformly and professionally endorsed by the general medical community for prescription in the course of standard Medical Care, including existing and new drugs that are Experimental in nature.

- Anti-wrinkle agents.
- Rogaine.
- Smoking cessation drugs, including patches, gum, and lozenges except as required under the Affordable Care Act.
- Fluoride supplements, except as required by the Affordable Care Act.
- Weight loss medications.
- Vitamin or mineral supplements (except pre-natal vitamins or those medications required under the Affordable Care Act).
- Anabolic steroids.
- Viagra and similar drugs for impotence, unless Medically Necessary.
- Any drugs or medications that are otherwise specified by the Plan as not covered.
- Treatment rendered outside the United States, unless you or your Dependent is traveling for business, pleasure or is a registered full-time student in a foreign country.
- Drugs or medications that are not Medically Necessary, except as required by law.
- Drugs or medications that are related to a Dependent child's pregnancy diagnosed by a Physician after January 1, 2013.
- Expenses that are excluded from coverage elsewhere in this booklet.

Dental Benefit for Active Employees

The Dental Benefit provides services to Active Employees and their Dependents that are furnished or recommended by a licensed Dentist, up to the Reasonable and Customary charge subject to the Plan limitations and maximums as identified below and in the Schedule of Benefits in the front of this booklet.

To inquire whether a particular dental expense is covered under the Plan and receive an estimate of your expected out-of-pocket costs for the proposed treatment, your Dentist should submit a request for a pre-determination of benefits to Benefit Management Group, Inc., 1520 Kensington Road, Suite 200, Oak Brook, IL 60523 before beginning treatment.

The Dental Plan Network

The Plan has contracted with Dental Network of America (DNoA), a network of general and specialty Dentists that will help to reduce your out-of-pocket costs every time you utilize the services of a participating dental provider.

The benefits of using a participating dental provider include:

- Reduced out-of-pocket costs because network providers reduce their fees which in turn reduce your costs.
- Participating providers will not bill you for fees and costs above what is allowed and agreed as Reasonable and Customary.
- Referrals are not required for specialty Dentists.
- You will not need to file a claim; the participating Dentist will submit claims on your behalf.

For information about DNoA participating Dentists, call 866-522-6758 or visit the DNoA Web site at www.dnoa.com.

Reasonable and Customary Charges

Reasonable and Customary charges billed by a non-DNoA provider will be determined by the Trustees or their designee to be the lowest of the following:

- The usual charge by the provider for the same or similar service or supply; or
- No more than 80% of the customary charge; or
- The provider's actual charges.

A Reasonable and Customary charge shall not exceed charges actually incurred.

Covered Expenses

Covered dental services and supplies must be (1) authorized by a Dentist; (2) the usual type furnished for the condition; and (3) performed by a Dentist, orthodontist (as applicable) or oral hygienist.

Routine Dental Services

Routine Dental Services include the following:

- Oral examinations and prophylaxis (scaling and cleaning of the teeth), limited to twice per calendar year.
- X-rays, limited to twice per calendar year.
- Topical application of fluoride, limited to twice per calendar year.
- Sealants for Dependent children, limited to twice per calendar year. Effective September 1, 2012, the coverage for sealants will be limited to two per lifetime per individual permanent unrestored 1st and 2nd molars without cavities and will be provided for Dependent children under age 19.

Basic Dental Services

Basic Dental Services include the following:

- Extractions.
- Oral surgery.
- Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations.
- General anesthetics when Medically Necessary and administered in connection with oral or dental surgery.

Expenses Not Covered

Some dental expenses not covered under the Plan are:

- Charges incurred for any services rendered before eligibility for benefits became effective.
- Charges incurred for any dental procedures that are listed as covered expenses under the Plan's Medical Benefit.
- Charges incurred for services or supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures.

- Charges made by anyone other than a Dentist or for treatment provided by anyone other than a Dentist except, cleaning or scaling of teeth may be performed by a licensed dental hygienist if the work is directed and supervised by a Dentist.
- Any separate charge made for a base under a filling, local anesthesia, oral hygiene instruction, application of sealants (except for Dependent children), or diet consultation.
- Charges incurred for any treatments, care, procedures, services, or supplies that are in excess of any limitations shown in the Schedule of Benefits in the front of this booklet.
- Services rendered outside the United States, unless you or your Dependent is traveling for business, pleasure or is a registered full-time student in a foreign country.
- Occulsal/night guards or adjustments.
- Treatment of injuries caused by suicide, attempted suicide, or self-inflicted Injury, unless the injuries resulted from an underlying medical condition (including both physical and Mental Health conditions). However, benefits will not be paid for such charges if the self-inflicted Injury, suicide, or suicide attempt was the result of the illegal use of drugs, whether or not the person has a medical (physical or Mental Health) condition.
- Unlicensed facilities or providers.
- Treatment for injuries sustained while participating in an act which violates state or federal statute, except that injuries sustained as the result of domestic violence will be covered.
- Expenses for any services, supplies, or drugs or medicines that are determined to be Experimental or Investigative.
- Orthodontia Expenses and Major Dental Services which include, but are not limited to the following:
    - Treatment of periodontal and other diseases of the gums and tissues of the mouth.
    - Endodontic treatment, including root canal therapy.
    - Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures
    - Initial installation of fixed bridgework to replace missing natural teeth (including inlays and crowns and abutments).
    - Initial installation of partial or full removable dentures (including precision attachments and adjustments).
    - Replacement of an existing bridge, crown, or denture.
    - Implants.

- Preliminary studies, care for, diagnostic casts, retainers, dephalometric radiographs and the appliance or placement of orthodontia appliances.

➢ Expenses which are not specifically listed as covered above.

Extension of Dental Expense Benefits

If your coverage ends, Dental benefits may be extended for an eligible individual for up to 90 days for fillings if the tooth was prepared while the individual was eligible for benefits.

Vision Benefit for Active Employees

The Vision Benefit helps Active Employees and their Dependents pay for the cost of eye examinations, frames, and lenses subject to the Plan limitations and maximums in the Schedule of Benefits in the front of this booklet. For benefits to be paid, a licensed Ophthalmologist or Optometrist must provide the vision care.

How the Plan Works

When you need vision services or supplies, you may go to any Ophthalmologist or Optometrist you wish. However, the Plan has contracted with the VSP Preferred Provider Organization (PPO), a network of vision care professionals, to provide you with services and supplies at discounted prices. Your out-of-pocket costs are listed in the Schedule of Benefits in the front of this booklet and depend on the vision-related service or supply rendered and whether it is received in network through a VSP provider or from a provider who is not in the network.

If You Use a VSP PPO Provider

It is always your decision to use or not to use a VSP PPO provider, but keep in mind that when you utilize a PPO provider, you will gain the following advantages:

- You will have greater coverage and less out of pocket expense.
- You do not need to file a claim because PPO providers send them directly to VSP for you.
- You will receive discount prices on all your vision care needs, including some procedures that are not covered under the rules of the Plan.

With VSP providers you also save:

- An average of 30% on lens options such as scratch resistant coatings, anti-reflective coatings and progressives.
- 20% off additional prescription glasses and sunglasses including lens options purchased within 12 months of your last eye exam.
- 15% off a contact lens exam (fitting and evaluation) if within 12 months of your last eye exam.

When you identify yourself as a VSP PPO Participant at the time you purchase your products and/or services, the discount will be applied at the counter, before you pay your bill.

To locate a VSP PPO network provider in your area, visit VSP's Web site at www.vsp.com, or call the VSP PPO member services toll-free line at 1-800-877-7195, Monday through Friday from 7 am to 9 pm central standard time.

If You Use a Non-Network Provider

If you receive services or supplies from a vision professional who is not in the VSP PPO network, you pay the full cost of the services or supplies you receive and then submit a completed claim form to VSP for reimbursement, along with proof of payment for examinations and supplies. The Plan pays up to a specific dollar amount per covered person toward the cost of covered vision care expenses, as shown in the Schedule of Benefits in the front of this booklet and you are responsible for paying amounts in excess of Plan payments.

Expenses Not Covered

Vision care expenses that are not covered are:

- Charges incurred for medical or surgical treatment of the eyes or any other charges incurred for vision care that are listed as a covered expense under the Plan's Medical Benefit.
- Any portion of an incurred charge that is in excess of the Reasonable and Customary charge.
- Charges incurred for vision care other than those specified in the Schedule of Benefits in the front of this booklet, including those that are in excess of any limitations provided.
- Cleaning solutions, heat cleaning units, contact lens insurance, scratch resistant coating, or lense tint.
- Services or supplies for:
  - Orthoptics or vision training.
  - Subnormal vision aids.
  - Anti-reflective coatings.
  - Oversized lenses.
  - Non-prescription lenses.
  - Sunglasses (prescription or non-prescription).
  - Duplicate or spare frames and lenses.
- Expenses that are excluded from coverage elsewhere in this booklet.
- Services rendered outside the United States, unless you or a Dependent is traveling for business, pleasure or is a registered full-time student in a foreign country.

Coordination of Benefits

The Plan contains a Coordination of Benefits (COB) provision to ensure that if you are covered under more than one group medical plan, your combination of benefits will not exceed 100% of the total allowable expenses. For example, benefits will be coordinated when you and your spouse work and are both covered as a dependent under the other's group medical plan.

For coordination of benefits, a "plan" is defined as coverage of medical expenses provided by:

- Group, blanket, or franchise insurance coverage;
- Group insurance, group practice, individual practice, or other prepayment coverage on a group basis;
- Labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- Governmental programs or any coverage required or provided by any statute, including Medicare.

If you have a claim that is covered by two or more plans, one plan, the primary plan, will pay its benefits first as if the other plan does not exist. The other plan, or the secondary plan, will adjust so that the total benefits paid to you will not be greater than the total allowable expenses.

If your Dependent is covered under a Health Maintenance Organization (HMO) or dental equivalent and voluntarily elects not to use those services or follow their referral guidelines, no benefits will be payable from this Plan.

A plan without a COB provision is always the primary plan. If all plans have COB provisions, the following rules apply:

- A plan that covers a covered individual as an employee is primary over a plan that covers the covered individual as a dependent.
- A plan that covers a covered individual as an employee is primary over a plan that covers the covered individual as a laid off or retired employee.
- When both parents have medical coverage for their dependent children, the plan of the parent whose birthday (not including year of birth) comes earlier in the year is the primary plan for the children. If the other plan does not use this rule to determine order of payment, then the rules of the other plan will determine order of payment.
- When both parents have medical coverage for their dependent children and the parents are legally separated or divorced, their plans will pay their children's medical expenses in the following order:

- Pursuant to the terms of a Qualified Medical Child Support Order or other court order;
- The plan of the natural parent with custody of the child;
- The plan of the step-parent married to the natural parent with custody of the child;
- The plan of the natural parent without custody of the child.

➢ A plan that covers a covered individual as an employee, member, or subscriber (that is, other than as a dependent) is primary over a plan that provides coverage pursuant to a right of continuation under federal or state law.

➢ In the event that a husband and wife are both covered under this Plan as employees, benefits will be coordinated for the husband and wife and any dependent children.

If none of these rules apply, the Plan that has covered the covered individual for the longest period of time will be primary.

Individual Policies of Insurance

In the event that Participants or their Dependents are covered by an individual policy of insurance not purchased through a federal or state exchange and not a group medical plan as defined in this section, reimbursement under the Plan will not exceed 100% of the expenses billed, taking into account any amounts payable from such individual policy of insurance where there is no coordination of benefits.

Coordination of Benefits with Medicare

Medicare consists of four parts. Part A of Medicare primarily covers Hospital benefits, although it also provides other benefits. Part B of Medicare primarily covers Physician's services, although it, too, covers a number of other items and services. Part C is the managed care program under Medicare. Medicare Part D provides prescription drug coverage.

Typically, you become eligible for Medicare when you reach age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, Dependent widow, or have chronic End-Stage Renal Disease (ESRD).

When the Plan Pays First for Active Employees and Their Dependents

This Plan is primary and pays benefits first for you and your Dependents, without regard to an eligible individual's entitlement to Medicare if you maintain eligibility for benefits under the Plan as an Active Employee. If you are an Active Employee, whose Dependent is entitled to Medicare, this Plan will be primary to Medicare for that Dependent.

When the Plan Pays Second

If you retire and are eligible for Retiree Benefits, Medicare will have primary responsibility and the Plan will pay second.

The Plan will pay its normal Plan benefits or the balance due after Medicare payments, whichever is less.

The Plan considers payments from Medicare Part A, Part B, and Medicare Advantage Part C whether or not you enrolled in these programs. **Accordingly, be sure that you enroll in both Medicare Part A and Medicare Part B when you are first eligible to do so.**

If you are eligible for, or are provided with, medical assistance under a Medicare program, this coverage will not affect your eligibility for coverage. However, once you are eligible for coverage, such medical assistance coverage will be taken into consideration when determining your benefits coverage. If payment is made under a state Medicaid program when this Plan has legal liability to make such payment, payment for benefits under this Plan will be made in accordance with any state law relating to this payment.

End Stage Renal Disease (ESRD)

There are special rules that apply to the first 30 months of an ESRD, (the initial 30-month period). The primary/secondary rules depend on whether the covered individual is eligible for Medicare due to age or disability as of the beginning of the initial 30-month period. After the 30-month period, Medicare is always primary.

Eligibility due to the Employee's active status.

If you are eligible for benefits because of the Employee's active status and become entitled to Medicare solely because of ESRD, this Plan will have primary responsibility for your claims during the initial 30-month period and Medicare pays second.

After the initial 30-month period, Medicare has primary responsibility and this Plan will pay second.

Eligibility due to the Employee's retired status.

If you are retired and not otherwise eligible for Medicare at the time you become entitled to Medicare ESRD benefits, the Plan will have primary responsibility for ESRD during the initial 30-month period and Medicare will pay second.

If you are retired and already eligible for Medicare at the time you become entitled to Medicare ESRD benefits, Medicare will have primary responsibility for ESRD during the initial 30-month period and this Plan will pay second.

After the initial 30-month period, Medicare continues to pay primary and the Plan pays second.

Filing and Appealing Claims

Filing Claims

To ensure prompt processing of your claims, please follow the claim submission guidelines indicated. All health care claims must be submitted to the Fund Office no later than one year from the date the services were received. No benefits will be paid on claims submitted after the one-year period.

What is a Claim

A claim for benefits is a request for Plan benefits that you make in accordance with the Fund's reasonable claims procedures. Health claims can be filed for the following benefits: medical, dental, vision care and prescription drugs.

There are four categories of health claims according to the Department of Labor Regulations at 2560.503-1; however, with limited exceptions (e.g., pre-authorization requirement for chiropractic services for Dependent children under the age 8), the Fund generally administers one type of health claim, referred to as "post-service claims." Post-service claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided, are examples of post-service claims.

If you make a simple inquiry about the Plan's provisions without a claim form, the Fund will not treat your inquiry as a claim for benefits. In addition, if you request prior approval for a benefit that does not require prior approval by the Fund, that will not be treated as a claim for benefits. When you present a prescription to a participating pharmacy to be filled out under the terms of the Plan, that request is not a claim under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

How to File Health Care Claims

- Generally, your provider will file a claim on your behalf. To request a claim form, contact Blue Cross Blue Shield.
- Complete the employee portion of the claim form in its entirety. Attach an itemized bill(s) to the claim form. Remember that all itemized bills must contain the following information:
  - Active Employee's name and social security number and/or member ID;
  - Patient's name, social security number, and relationship to member;
  - Date(s) of service;
  - Description of service;

- Total charge for service; and
- Provider's name, address, and federal tax identification number.

When you do not include this information on each claim submitted, there will be a delay in the processing of your claim payment. Note that the Fund Office cannot accept cash register receipts, payment on account statements, or balance due statements in the place of itemized bills.

- Providing all information necessary to process a claim is the responsibility of the member. If this Plan is secondary coverage, please be sure that all itemized bills and Explanations of Benefits (EOB) from the primary carrier are submitted with your claim.

- Return the completed and signed claim form to BMGI for processing. BMGI's address is:

  Benefits Management Group, Inc.
  1520 Kensington Road, Suite 200
  Oak Brook, IL 60523

- For information on the status of a claim or to verify benefits, call the Claims Department at 1-708-482-0110, and follow the prompts.

Types of Health Care Claims

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

- Urgent Care — A claim for Medical Care or treatment that would:
  - Seriously jeopardizes your life, health, or ability to regain maximum function if normal pre-service standards were applied; or
  - Subjects you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

- Pre-Service — A claim where pre-certification is required before you obtain care. The Plan requires pre-certification of services related to chiropractic or spinal care for children under age eight and for all transplant procedures.

- Concurrent Care — A claim that is reconsidered after it is initially approved (such as recertification of the number of chiropractic or spinal treatments for children under age eight) and the reconsideration results in reduced benefits or a termination of benefits (other than by Plan amendment or termination).

- Post-Service — A claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim.

Claim Determinations

When you submit a claim for benefits, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits, if any. All claims are processed promptly and will be paid as soon as administratively possible by the Fund Office, when complete claim information is received. The Fund Office will notify you of an initial determination within certain timeframes. If circumstances require an extension of time for making a determination on your claim, you will be notified, in writing, that an extension is necessary. The notice will state the special circumstances and the date a determination is expected.

The chart below describes the timeframes for claim determinations.

Deadline	Type of Claim		
	Urgent Care	**Pre-Service**	**Post-Service Health**
Initial determination not later than:	72 hours from receipt of claim.	15 days from receipt of claim.	30 days from receipt of claim.
Deadline extensions:	None.	15 days if beyond the control of the Plan.	15 days if beyond the control of the Plan.
Notification of extension not later than:	Not applicable.	The initial 15-day deadline.	The initial 30-day deadline.
Deadline if additional information is needed:	Within 24 hours of receipt of your claim, you will be notified if additional information is needed. You will have up to 48 hours to respond. The initial 72- hour deadline is suspended for 48 hours or until the information is received, if sooner.	If an extension is necessary because you did not provide the necessary information, you will be notified of the information needed. You will have up to 45 days to respond. The initial deadline is suspended for 45 days or until the information is received, if sooner.	If an extension is necessary because you did not provide the necessary information, you will be notified of the information needed. You will have up to 45 days to respond. The initial deadline is suspended for 45 days or until the information is received, if sooner.

If a Claim Is Denied

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

If your claim is denied (in whole or in part), also referred to as an "adverse benefit determination," you will be provided with certain information about your claim within the timeframes previously described.

A claim denial or adverse benefit determination for purposes of the claims and appeals process, is defined as:

- 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 a payment that is based on:
  - A determination of an individual's eligibility to participate in the Plan; or
  - A determination that a benefit is not a covered benefit;
- A reduction in a benefit resulting from the application of any utilization review decision, preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits, or 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; or
- Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

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

- Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason(s) for the determination, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
- Reference to the Plan provision(s) on which the determination was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A copy of the Plan's internal claims review procedures, and external review processes, along with the time limits and information regarding how to initiate an appeal of your claim;

- A statement of your right to bring a lawsuit under ERISA §502(a) following the denial of a claim; and

- If your claim is denied based on:
  - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the rule, guideline, protocol, or similar criteria is available to you, at no cost, upon request; or
  - Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment or exclusion or limit is available to you, at no cost, upon request.

- If your appeal is due to the denial of an urgent care claim, a description of the expedited review process;

- A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

Examples of When a Claim May Be Denied

The Trustees, or their representatives, have the authority make determinations on claims. Following are some examples of when a claim may be denied, or that may result in reduced benefits:

- The individual on whose behalf the claim was filed was not covered under the Plan on the date the expenses were incurred.

- The claim was not filed within the Plan time limits.

- The claim was not for covered expenses under the Plan.

- The claim was for expenses that were not actually incurred.

- The individual for whom the claim was filed already received the maximum allowable under the Plan for the type of expense.

- Another plan was primarily responsible for paying benefits for the covered expense.

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

- A third party was responsible for paying the expenses and the individual on whose behalf the claim was filed did not submit the required subrogation agreement that would permit the Plan to process the claim and recover payment from the third party or his insurance company.

- Plan eligibility rules or benefits were amended.

- An eligible individual's future benefits were reduced or temporarily suspended to recover an overpayment of benefits previously made.
- Hospital benefits were reduced by the amount of the Non-PPO Hospital deductible.
- The Plan was terminated.

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

Appealing a Denied Claim

If your claim is denied (in whole or in part) and you receive an adverse benefit determination or you disagree with the Plan's determination regarding your eligibility for benefits or the amount of the benefit, you have the right to have the initial determination reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Board of Trustees at the address of the Fund Office as soon as possible. For urgent care claims, your appeal may be made orally. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within 180 days after you receive the notice of denial. Your written appeal must explain the reasons you disagree with the determination on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- Submit additional materials, including comments, statements, or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based; and
- Request a copy of any explanation of the scientific or clinical judgment on which the denial was based if the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit.

Appeal Determinations

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

You will be notified, in writing, of the determination on your appeal no later than within the stated timeframes. However, oral notice of a determination on your urgent care claim may be provided to you sooner. After the Fund issues a final determination of your claim on appeal, you may institute legal action as described in the Trustee Authority and Interpretation Section below.

Appeal Determination Timeframes

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

- ***Urgent Care Claims*** — A determination will be made as soon as possible but no later than within 72 hours from receipt of your appeal.

- ***Pre-Service Claims*** — A determination will be made within 30 days from receipt of your appeal.

- ***Post-Service*** — A determination will be made at the Board of Trustees' next regularly scheduled quarterly meeting following receipt of your appeal and you will receive a written determination within five days of the meeting at which the determination is made. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second meeting following receipt of your appeal. If special circumstances require a further extension, a determination will be made at the third meeting following receipt of your appeal. You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a determination.

- ***Concurrent Care Claims*** — A determination will be made before reduction or termination of your benefit. However, in the case of an appeal concerning a request to extend a course of treatment, the Board of Trustees will make a determination in accordance with the previously stated deadlines based on the type of claim (urgent care, pre-service, or post-service, as appropriate).

Appeal Determination Notice

When you are notified of a determination on your appeal, the notice will include:

- Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- A statement that you and the Plan may have other voluntary alternative dispute resolution options, such as mediation; one way to find out what may be available is to contact your local U. S. Department of Labor Office and your state insurance regulatory agency;

- A statement explaining the external review process, along with any time limits and information regarding how to initiate the external review of your claim;
- A statement that you have a right to bring a civil action under ERISA §502(a) following the denial of your claim;
- The specific reason(s) for the determination, including the denial code and its corresponding meaning, and a discussion of the decision, as well as any Plan standards used in denying the claim;
- Reference to the Plan provision(s) on which the determination was based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- If your claim is denied based on:
  - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or
  - Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.
- A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

Authorized Representatives

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

Authorized representatives may include a:

- Health care provider that has knowledge of the condition in an Emergency situation;
- Legal spouse;
- Dependent child age 18 or over;
- Parent or adult sibling;
- Grandparent;

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

- Other adult.

Once a representative is authorized, all future claims and appeals related correspondence will be sent to the authorized representative. The Plan will recognize the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization. However, the individual may revoke a designated authorized representative at any time by submitting a signed statement.

The Plan Administrator, or its designated representative, has the discretion to determine whether an authorized representative has been properly designated in accordance with the Plan's terms. The Plan Administrator reserves the right to withhold information from a person who claims to be an authorized representative if there is suspicion about the qualifications of that individual. Under no circumstances does the designation of a person as an "authorized representative" provide that person with any of the rights of a "Participant" or "beneficiary" under this Plan.

Elimination of Conflict of Interest

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

External Review of Adverse Benefit Determination

If your appeal of a claim, whether pre-service, post-service or urgent care claim, is denied, you may request further review by an independent review organization ("IRO"). In the normal course, you may only request external review after you have exhausted the internal review and appeal process.

NOTE that if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan, external review is not available.

External Review Filing Deadline

If your claim was denied under the internal appeals procedures, resulting in an adverse benefit determination, you have the right to file a request for an external review by an independent review organization with the Fund Office within four months of the date of the internal appeal decision. However, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you or your Dependent fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

Determination of Eligibility for Review

Within five business days of the Plan's receipt of the request for external review, the Plan must determine whether:

- you are or were covered under the Plan at the time of service or requested service,
- the adverse benefit determination relates to a Medical Necessity determination or rescission of coverage;
- you exhausted or are deemed to have exhausted the Plan's internal appeal process; and
- you have provided all information and forms required to process an external review.

Within one business day after the completion of this review, the Plan must notify you (or your authorized representative) whether the request is complete and is eligible for review. If the request is not complete, the Plan must provide notice of what information or materials are needed and allow you to perfect the request within the four-month filing period or 48 hours following receipt of the notification, whichever is later. If the request is not eligible for external review, the notice must include the reason(s) for ineligibility and contact information for the Employee Benefits Security Administration.

Referral to an Independent Review Organization (IRO).

If your request is eligible for review, the Plan will utilize an unbiased method to assign the external review to one of its three IRO's. The timeline for completion of the external review is as follows:

- The IRO will timely notify you of receipt of assignment of the external review and such notice will inform you that you may provide additional information within ten business days following receipt of the notice. The IRO is not required, but may, accept and consider additional information submitted after ten business days.
- The Plan must provide the claim file and any information considered in making the adverse benefit determination within five business days after the date of assignment to the IRO. Failure by the Plan to submit the information to the IRO may result in an immediate reversal of the adverse benefit determination. The IRO must send notice of such to you and the Plan within one business day.
- The IRO must forward any additional information received from you to the Plan within one day of receipt and the Plan may reconsider and reverse its decision, terminating the external review. The Plan must provide notice within one business day of such a decision to you and the IRO.
- The IRO will review all information received de novo. In addition to all information provided, the IRO may consider the following information, if the IRO deems it appropriate:

- the claimant's medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan, claimant or treating provider;
- the terms of the Plan;
- appropriate practice guidelines, which must include all evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- any applicable clinical review criteria developed and used by the Plan, unless the criteria inconsistent with the terms of the Plan or applicable law; and
- the opinion of the IRO's clinical reviewer or reviewers after considering the information described in this section to the extent the information or documents are available and the clinical reviewer or reviewers consider it appropriate.

Request for an Expedited External Review.

You may make a request for an expedited external review if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review as described above would seriously jeopardize the life or health of the claimant or would jeopardize the ability to regain maximum function or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

An expedited external review will occur in accordance with the procedures stated above for a standard external review, except that each step must be performed in the most expeditious method and the IRO must provide the claimant of its decision as expeditiously as the circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the decision is not communicated in writing, the notice must provide written confirmation to you and the Plan within 48 hours after notice is provided.

Timing of Notice of Decision on External Review

The assigned IRO must provide written notice of the final external review to the claimant and the Plan within 45 days after the IRO first receives the request for review.

Content of Notice of Decision on External Review

The IRO will provide you and the Plan with a written decision. The notice of the decision will contain all of the following:

- A general description of the reason for the request for external review including sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial.
- The date the IRO received the assignment and the date of the IRO decision.
- Reference to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision.
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making its decision.
- 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 Plan or the claimant.
- A statement that judicial review may be available to the claimant.
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen established under PHS Act section 2793.

Payment of Claims

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

Guidance under the Patient Protection and Affordable Care Act of 2010

These external review procedures apply to health care claims (i.e., health, dental and vision claims) that are denied on appeal by the Trustees. They are intended to comply with the interim safe harbor provisions contained in the U.S. Department of Labor Technical Release 2010-01. As such time as the guidance is revised or replaced by the DOL, the new guidance shall be incorporated by reference herein and these procedures will be superseded by such new guidance to the extent necessary to comply with the Patient Protection and Affordable Care Act of 2010.

Medical Judgments

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

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

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

Trustee Authority and Interpretation

The Trustees or, where Trustee responsibility has been delegated to others, such other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of this Plan, and decisions of the Trustees or their delegates are final and binding. *Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them, decide, in their discretion, that the eligible employee or beneficiary is entitled to benefits in accordance with the terms of the Plan.* In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure adopted by the Trustees. The decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matter.

You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the procedures described in this section. You may, at your own expense, have legal representation at any stage of the review process. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner.

The final decision on an appeal will be accorded judicial deference in any later court action or administrative proceeding to the extent that it does not constitute an abuse of discretion and is not arbitrary or capricious.

The Plan contains a two (2) year statute of limitations. Notwithstanding any other state or federal law, any and all legal actions relating to the Plan must be filed within two (2) years of the action or inaction complained of. This includes but is not limited to actions to recover benefits that must be filed within two (2) years of the final decision on your claim. The situs of Plan is in Cook County, Illinois. Legal actions must be brought in the United States District Court for the Northern District of Illinois.

Subrogation and Reimbursement

The Plan's right of subrogation and reimbursement arises when benefits are paid on behalf of an eligible individual as a result of an accidental Injury or Illness for which another party may be responsible.

The Plan's subrogation or reimbursement rules apply if the Fund pays any benefits that arise out of an accidental Injury or Illness which results or could result in a claim against a third party. By accepting benefits under the Plan you are agreeing to reimburse the Fund for all such expenses paid on your behalf related to the accidental Injury or Illness.

Under these circumstances, the Fund is entitled to full and total reimbursement (100%) of its past, present or future expenditures related to the Injury or Illness from all third party recoveries and as such, you shall be deemed to hold the right to recovery against such party in trust for the Plan.

Third parties may include, but are not limited to: (1) any person or entity legally responsible for your Injury; (2) other benefit plans; (3) an insurance company; (4) workers' compensation; or (5) any other person or entity that is obligated to make payments which the Fund would otherwise be obligated to make.

As an eligible individual, by accepting benefits under this Plan, your responsibilities include the following:

- You and/or your Dependent must immediately notify the Fund Office whenever a claim against a third party is made for yourself and/or your Dependent regarding any loss for which the Fund paid benefits on your and/or your Dependent's behalf.

- You and/or your Dependent must cooperate with the Fund by providing information requested by the Fund concerning subrogation or reimbursement. This includes providing the Fund Office with (1) a signed subrogation and reimbursement agreement; (2) the names and addresses of all potential third parties and their insurer, adjusters and claim numbers; (3) any accident reports; and (4) any other information the Fund Office requests, including contact information of an attorney representing you in your claim against a third party.

- You and/or your Dependent agree to give the Fund the right to prosecute your claim and maintain an action against the third party on your behalf.

- You and/or your Dependent agree to reimburse the Fund in full for the benefits expended on your and/or your Dependent's behalf related to the claim against a third party.

If you fail to meet your responsibilities, the Fund may withhold future benefit payments for both you and your Dependents until you comply with these requirements.

If you and/or your Dependent receive payment from a third party for benefits paid by the Fund, you or the third party must reimburse the Fund. The proceeds of the settlement or judgment must be divided as follows:

- The Plan has priority over all funds recovered. Accordingly, you or your representative must pay the Fund a sum sufficient to fully reimburse the Fund for all (100%) benefits advanced prior to satisfying any other existing lien or claims. No reductions or deductions are allowed for attorneys' fees pursuant to the "make-whole" doctrine or any other state law affecting these rights is preempted by ERISA (i.e., the common fund doctrine).

- Any remaining funds may be paid to you and/or your Dependent.

The proceeds of any claim against a third party must be divided as stated above even if you and/or your Dependent are not fully compensated for the loss. However, the Fund is not entitled to receive reimbursement in excess of the amount you and/or your Dependent receive from all third parties.

You and your Dependents (if applicable) shall be responsible for compliance with these provisions and the provisions of any subrogation and reimbursement agreement. You will also be responsible for compliance by your or your Dependents' agents, representatives and attorneys.

Furthermore, if you and/or your Dependent receive payment from a third party for Plan benefits already received and you do not reimburse the Fund as stated above, the Fund may take any action to recover the benefits paid. Such action includes, but is not limited to: (1) initiating a claim to compel compliance with these terms or the terms of the subrogation and reimbursement agreement; (2) withholding benefits payable to you or your Dependent(s) until you or your Dependent(s) complies; or (3) initiating such other equitable or legal action it deems appropriate.

Overpayment and Duty of Cooperation

Whenever payment(s) have been made in excess of the allowable amount under the Plan, the Fund has the right to recover such excess payments from any providers, person(s), service, plan, or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of the Active Employee or Dependent, the Fund, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments, or institute legal action to collect the overpayment.

Eligible individuals must provide the Fund with any information the Fund deems necessary to determine eligibility, process claims, or implement Plan terms. Failure to provide any information requested by the Fund or its agents may result in the rejection of claims for benefits.

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

Misrepresentation or Falsification of Claims

A claim for benefits will be rejected and the Fund will be entitled to recover money that an eligible individual or a service provider has received if a false statement or omission of a material fact was purposely made by any person to receive benefits. The Fund may also obtain reimbursement of interest on this money as well as professional fees incurred and other damages.

If any individual knowingly misrepresents or falsifies any information or matter in connection with a claim filed for Plan benefits, the Trustees may, in their sole discretion, deny all or part of the benefits that might otherwise be due in connection with that claim.

Wrongfully Paid Benefits

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

If an overpayment of benefits has been made to or on behalf of an eligible Active Employee or Dependent, the Fund, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments or institute legal action to collect the overpayment.

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

Administrative Information

This section provides information about how the Welfare Fund is administered.

Plan Name

The name of the plan is Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund – Classic Non-Bargained Plan.

Board of Trustees

A Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of Union and Employer representatives selected by the local Union and the Employer Associations that have entered into Collective Bargaining Agreements that relate to the Plan. The Board of Trustees may be contacted at the following address and phone numbers:

Board of Trustees
Automobile Mechanics' Local No. 701
Union and Industry Welfare Fund
500 West Plainfield Road
Countryside, Illinois 60525
Telephone: 1-708-482-0110 or toll-free at 1-800-704-6270

The present Trustees are:

Union Trustees	Employer Trustees
Armando Arreola Automobile Mechanics' Union Local 701 450 Gundersen Drive Carol Stream, IL 60188	Ronald Fetty ABF Freight Systems 1900 East Route 30 Sauk Village, IL 60411
Sam Cicinelli Automobile Mechanics' Union Local 701 450 Gundersen Drive Carol Stream, IL 60188	Chris Konecki Chicago Automobile Trade Association 18W200 Butterfield Road Oakbrook Terrace, IL 60181
Robert Keppler Automobile Mechanics' Union Local 701 450 Gundersen Drive Carol Stream, IL 60188	David Mashek Prairie Material 7601 W 79th Street Bridgeview, IL 60455

Administration of the Plan

The Board of Trustees makes the rules and regulations to administer your Plan. By amendment, the Board of Trustees may change the terms, conditions, or benefits of the Plan. Only the Board

of Trustees can make a final decision regarding any question, interpretation, or application of any part of the Plan. No Employer or Union or any representative of any Employer or Union, is authorized to interpret the Plan. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner, and the Trustees decisions will be awarded judicial deference. Benefits under this Plan will be paid only when the Board of Trustees (or persons delegated by the Trustees) decides, in their discretion, that the eligible individual is entitled to benefits in accordance with the Plan's terms.

The Welfare Fund employees, who are hired by the Trustees and answer to them, conduct plan administration. All rules, regulations, and policies adopted by the Trustees will be binding upon all parties to the Trust Agreement, all parties dealing with the Plan and all persons claiming benefits provided by 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.

Amendments to the Plan can be made for any reason and are "settlor" issues that are not subject to review for conformity with fiduciary duties. In the event of elimination, reduction, or modification of benefits you or your beneficiary may be required to pay providers for benefits that were formerly covered by the Plan. In the event of increases or other modification of benefits, you or your beneficiary may find yourself relieved of requirements to pay providers for benefits that were formerly not covered by the Plan.

Plan Termination

The Plan may be terminated under circumstances allowable under ERISA and the terms of the governing Trust Agreement. For example, this Plan may be terminated if future collective bargaining agreements and participation agreements do not require Employer contributions to the Plan. Termination may be made for any reason conforming to ERISA and the terms of the Trust Agreement and is a "settlor" issue that is not subject to review for conformity with fiduciary duties.

In the event of Plan termination, the Trustees will notify the Union, Employers, and any insurance carriers and the Trustees will take necessary steps to wind down the Trust. In conformity with the provisions of the Trust Agreement, the Trustees will apply the Plan assets to pay or to provide for the payment of any and all obligations of the Plan. Benefits for covered expenses incurred before the termination date fixed by the Trustees will be paid to eligible individuals as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets.

However, any remaining surplus will, in accordance with the terms of the Trust Agreement, be used in such manner as the Trustees believe will best effectuate the purpose of the Plan, subject to the requirement that no part of the corpus may be diverted to any purpose other than the exclusive benefit of Participants and beneficiaries and payment of the administrative

expenses of the Plan. Upon termination, no part of the assets of the Plan will revert or accrue, directly or indirectly, to the benefit of an Employer or the Union.

Plan Sponsor and Administrator

The Board of Trustees is both the Plan Sponsor and Plan Administrator. The Trustees have designated Steve M. Bukovac as Administrative Manager. It is the Administrative Manager's responsibility to handle the day-to-day activities of the Fund. You may contact Mr. Bukovac at the following address and phone numbers:

Automobile Mechanics' Local No. 701
Union and Industry Welfare Fund
500 West Plainfield Road
Countryside, Illinois 60525
Telephone: 1-708-482-0110 or toll-free at 1-800-704-6270

Identification Numbers

The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 36-2331071.

The Plan number is 501.

Plan Year

The records of the Plan are kept separately for each calendar year (January 1 through December 31).

Agent for Service of Legal Process

If legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees or the Administrative Manager, Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund, 500 West Plainfield Road, Countryside, Illinois 60525.

Plan Description

This Plan is a group health plan maintained for the purposes of providing medical, prescription drug, dental and vision benefits.

All benefits described in this booklet, except for vision benefits, are self-funded by the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund. Vision benefits are provided under an insured arrangement with VSP. A list of the providers servicing the Plan will be provided to you, free of charge, upon request.

Source of Contributions

The benefits described in this booklet are provided through Employer and Active Employee contributions. The amounts of the Employer and Active Employee contributions and the Active Employees on whose behalf contributions are made are determined by the provisions of the Collective Bargaining Agreements.

The Fund Office also maintains a complete list of all Employers who contribute to the Plan on behalf of Plan Participants whom they employ. The Fund Office will, on request, tell you and/or your Dependents if an employer is contributing to the Plan.

Collective Bargaining Agreements

Your Collective Bargaining Agreement, the Plan terms, and the eligibility rules summarized in this booklet determine your participation in the Plan. Your Collective Bargaining Agreement is the contract between your Employer and the Automobile Mechanics Local No. 701 Union that requires your Employer to contribute to the Plan on your behalf. For a copy of your Collective Bargaining Agreement, contact the Union Office at 1-708-482-1720.

Workers' Compensation and the Plan

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

If the Fund denies an eligible individual's claim for the reason that it is work-related, and the workers' compensation carrier also denies the claim, the Fund may agree to provide benefits under certain conditions. These conditions include the Trustees' determination, in their sole discretion, that a meritorious appeal of the workers' compensation claim exists, that a timely appeal of the workers' compensation claim exists, and that the eligible individual and the workers' compensation carrier are responsible for reimbursing the Fund out of any recovery obtained for the full amount of benefits that the Fund had provided in connection with a work-related claim. In addition, the Participant must agree to reimburse the Fund out of any recovery and fully comply with the Fund's subrogation and reimbursement provisions.

Welfare Trust's Assets and Reserves

The Board of Trustees holds all assets in trust for the purposes of providing benefits to eligible Participants and defraying reasonable administrative expenses.

Eligibility, Benefits and Discretionary Authority

The Plan's requirements for eligibility for benefits are shown in this booklet. Circumstances that may cause you to lose eligibility are also explained. Your coverage by this Plan does not

constitute a guarantee of your continued employment and you are not vested in the benefits described in this booklet. All Plan benefits are made available to you and your Dependents by the Plan as a privilege and not as a right.

The Board of Trustees has sole authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Board. Benefits under this Plan will be paid only if and when the Board of Trustees, or persons to whom such decision-making authority has been delegated by the Board, in their sole discretion, decides the Participant or beneficiary is entitled to benefits under the terms of the Plan. The decisions of the Board in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If the Plan makes inadvertent, mistaken, excessive, erroneous, or fraudulent payment of benefits, the Trustees or their representative will have the right to recover these types of payments. The Board of Trustees reserves the right to change, modify, or discontinue all or part of the benefits in this booklet at any time by action or amendment.

Extended Coverage Provision

If a covered individual is totally disabled on the date his/her coverage would normally end for any reason other than for payment of the annual maximum benefit, then the coverage in effect at the time will be extended for the disabling condition only. The extended coverage is provided up to the annual maximum benefit and will extend until the covered individual is no longer totally disabled for that condition or exhausts the following time period, whichever occurs first:

- If the covered individual was covered under the Plan less than 12 months, the extension period for the disabling condition will equal the number of months the covered individual was covered; or

- If the covered individual was covered under the Plan for more than 12 months, the extension period for the disabling Illness will be 12 months provided:

  - That before the expiration of three months following termination, covered medical expenses incurred for the treatment of the disability must be at least equal to the individual annual deductible amount; and

  - That the covered individual does not become covered, either as an individual or as a Dependent, under any other group, franchise, or other plan providing benefits with respect to Hospital, surgical, or Medical Care.

For the purposes of this Section, totally disabled/total disability means that the individual is:

- Prevented, solely by reason of such Illness, from engaging in his regular or customary occupation; and

- Is performing no work of any kind for compensation or profit;

- Or if a Dependent, is prevented, solely by reason of such Illness, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

It is your responsibility to provide a Physician's statement verifying continued disability to the Fund Office.

Rescission of Your Coverage

The Plan may rescind your coverage for fraud or intentional misrepresentation of a material fact. 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 Trustees may in their discretion, extend coverage beyond the date of loss of eligibility when there is a delay in administrative recordkeeping between your loss of eligibility and notice to the Plan of that loss, or when you fail to make timely required self-payments for coverage provided that contributions are made for that time. For any other unintentional mistakes or errors under which you were covered by the Plan when you should not have been covered, the Trustees may in their discretion cancel your coverage prospectively once the mistake is identified provided that contributions were made during that time.

Privacy Notice

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

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

Your rights under HIPAA include the right to:

- Receive confidential communications of your health information, as applicable;
- Copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

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

Breach Notification Rights under HIPAA

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Fund Office to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Fund Office is also required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Fund Office to provide notification to the media.

If your unsecured PHI is breached, the Fund Office will notify you without unreasonable delay and in no case no later than 60 calendar days after discover of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Plan up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Fund Office or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Fund Office has improperly followed the breach notification process.

CHIPRA

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") provides for new special enrollment rights. CHIPRA sets forth special opportunities to enroll in an employer group health plan for individuals who (i) lose coverage under their state Medicaid program established by Title XIX of the Social Security Act or their state Children's Health Insurance Program established by Title XXI of the Social Security Act (CHIP) or (ii) become eligible for assistance under these programs.

Medicaid and CHIP are state-administered health programs which are jointly funded by the states and the federal government. Medicaid covers individuals and families with limited incomes and resources who fit into an eligibility group recognized by federal and state law. CHIP is health insurance for children who meet the eligibility criteria established by each state.

Pursuant to CHIPRA, you (and your dependents that are eligible for coverage) have the right to enroll in the Plan *at any time* during a plan year, after one of the following two events occurs:

- Your and/or your dependent's coverage under your state Medicaid, or your state CHIP is terminated as a result of loss of eligibility; or

- You and/or your dependent become eligible for premium assistance subsidy under your state Medicaid or your state CHIP.

In order to take advantage of these special enrollment opportunities, you *must request enrollment within 60 days* of the occurrence of either one of these two events.

If you have any questions concerning your rights under CHIPRA, or if you would like to request enrollment, you may contact the Fund Office.

Because all eligible Active Employees and their eligible Dependents automatically are enrolled in this Plan as soon as they meet the Plan's eligibility requirements, and there is no option to decline coverage, this Plan complies with the federal law regarding special enrollment procedures.

Affordable Care Act

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like. The Trustees have made a good faith effort to comply with the Affordable Care Act and a reasonable interpretation of the term ''essential health benefits.'' The Trustees' intent was and is to make only those changes that are minimally necessary to comply with the Affordable Care Act. In the event that those changes or other provisions of the Plan are no longer required by the Affordable Care Act, the Employee Retirement Income Security Act of 1974, as amended (ERISA) or the Internal Revenue Code, the Trustees reserve the unilateral right to return the Plan to its pre-Affordable Care Act terms or other terms that meet the minimum requirements of the Affordable Care Act, ERISA or the Internal Revenue Code.

Your ERISA Rights

As a Participant in the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each Participant.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD/Plan and any documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the Plan;
  - You become entitled to elect COBRA continuation coverage; or
  - Your COBRA continuation coverage ends.

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

To request a copy of the Plan's procedures for obtaining a Certificate of Creditable Coverage or to obtain a Certificate of Creditable Coverage, please contact the Fund Office at 1-708-482-0110 or toll-free at 1-800-704-6270 or at 701claim@mech701-benefits.org.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Please note that you or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and review procedures.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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 EBSA, Department of Labor:

Local Office
Employee Benefits Security Administration
Illinois Department of Labor
230 South Dearborn Street
Suite 2160
Chicago, Illinois 60604
1-312-793-2800 (General Information)

National Office
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210
1-866-444-3272

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by visiting EBSA's Web site at www.dol.gov/ebsa.

Definitions

Throughout this booklet, many words are used that have a specific meaning when applied to your Plan coverage. When you come across these terms while reading this booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. All definitions have been arranged in alphabetical order and are capitalized when used in the booklet.

Active Employee	An individual who engages in Covered Employment for an Employer.
Allowable Charge	The maximum amount the Plan will reimburse a Physician or Hospital for a given service.
Ambulance Service	Local transportation in a specially equipped certified vehicle from your home, scene of the accident or Medical Emergency to a Hospital, between Hospitals, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Service is then defined as the transportation to the closest facility that can provide the necessary service. Ambulance Service does not include transportation to a medical facility for patient convenience (i.e., transportation from you home to a Physician's appointment or therapy session).
Ambulatory	A facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and is duly licensed by the appropriate state and local authority to provide such services.
Brand Name Drug or Medication	A drug that has been approved by the U.S. Food and Drug Administration (FDA) and has been granted a patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has a right to sell that drug. A Brand Name Drug cannot have competition form a Generic Drug until after the patent or other marketing exclusivities have expired and the FDA grants approval for a Generic Drug version.
Certificate of Creditable Coverage	A certificate disclosing information relating to your Creditable Coverage under a healthcare benefit program for purposes of reducing any pre-existing condition exclusion imposed by any group health plan coverage.
Classic Non-Bargained Participant or Participant	An Active Employee who meets the Plan's eligibility rules, who is not covered under a CBA and whose Employer signed a participation agreement designating that the Employee will be covered under the class of benefits known as Classic Non-Bargained Benefits.
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985 which regulates the conditions and manner under which an employer can offer continuation of group health insurance to eligible persons whose coverage would otherwise terminate.
COBRA Participant	A former covered individual under any class of benefits who has elected to continue coverage through COBRA.
Collective Bargaining Agreement (CBA)	Any applicable collective bargaining agreement or existing in the future between an Employer and the Union providing for contributions to the Fund.
Congenital Anomaly	A physical developmental defect that is present at birth, and is identified within the first twelve months of birth.
Covered Employment	Covered Employment is work performed by an employee for an Employer for which contributions are required pursuant to a CBA and/or participation agreement and are actually made to the Plan.
Creditable Coverage	Coverage under a nationally recognized group health plan, Medicare or Medicaid programs.
Custodial Care	Any services or supplies provided primarily for personal comfort or convenience that provide

	general maintenance, preventive, and/or protective care without any clinical likelihood of condition improvement. Custodial Care also means those services that do not require the technical skills, professional training, and/or clinical assessment ability of medical and/or nursing personnel to be safely and effectively performed.
Dentist	Also known as a 'dental surgeon', is a doctor that specializes in the diagnosis, prevention, and treatment of diseases and conditions of the oral cavity.
Dependent	For purposes of the Plan a Dependent is: ➢ The opposite sex spouse of an Active Employee who is not divorced or legally separated from the Active Employee; ➢ The child of an Active Employee who is under the age of 26; ➢ The unmarried child of an Active Employee age 26 or older who is disabled due to a mental or physical disability, provided the child: (1) became disabled due to mental or physical disability before age 26; (2) is incapable of self-sustaining employment and continues to be incapable of such employment; (3) is dependent on you for more than one-half of his or her financial support and maintenance; and (4) has his or her principle place of residence with you for more than one-half of the calendar year. Initially, you must provide written proof of your child's disability within 90 days after the date proof is requested. Thereafter, you need to provide proof of your child's continued disability as requested by the Fund Office but no more than annually. For the purposes of this definition of Dependent, the term "child" includes the following: natural child; legally adopted child, including a child placed with an Active Employee for adoption; foster child; stepchild who is the natural or adopted child of an Active Employee's spouse, or child identified as an alternate recipient under a Qualified Medical Child Support Order (QMSCO) entered by a court.
Emergency Medical Condition	A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including extreme pain) such that the absence of immediate medical attention could reasonably be expected to result in: ➢ Placing the patient's health in serious jeopardy, ➢ Serious impairment to bodily functions, or ➢ Serious dysfunction of any bodily organ or part.
Emergency Services	Services for an Emergency Medical Condition, including medical screening exam and treatment to stabilize the patient.
Emergency Treatment Center	A free-standing facility that is engaged primarily in providing minor Emergency and episodic Medical Care.
Employer	For the purposes of the Plan, Employer includes: ➢ Any person, firm, association, partnership, or corporation that enters into a CBA with the Union requiring contributions to be made to the Fund on behalf of full-time employees; ➢ The Union, which is required to make contributions to the Fund for its full-time employees under the terms of a participation agreement; ➢ The Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund and Pension Fund with respect to its full-time employees; and

	➢ Any employer that is required to make contributions to the Fund under the terms of a participation agreement for its full-time employees whose employment is not subject to a CBA.
Experimental or Investigative	Applies to a service, procedure, drug, device, or treatment modality for a specific diagnosis (referred to herein as such treatment or procedure) that meets one of the following criteria: ➢ Such treatment or procedure has failed to obtain final approval for a specific diagnosis from the appropriate governmental body; ➢ Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of such treatment or procedure on health outcomes for a specific diagnosis; ➢ Such treatment or procedure, or the patient-informed consent document utilized with such treatment or procedure was reviewed and approved by the treating facility "institutional review board" or other body serving a similar function, or if federal law requires such review or approval; ➢ Reliable evidence shows that such treatment or procedure is (1) the subject of ongoing phase I or phase II clinical trials, (2) the subject of on-going phase III clinical trials or (3) otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or ➢ Reliable evidence shows that the prevailing opinion among experts regarding such treatment or procedure is that further studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Reliable evidence means only: published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure. Note: The Trustees have the authority to determine whether a service, procedure, drug, device or treatment modality is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device or treatment does not, in itself, make it eligible for payment.
Generic Drug or Medication	A drug with the same or bio-equivalent of a Brand Name Drug in the following respects: the active ingredients (those that are responsible for the drug's effect); the dosage amount, the way in which the drug is taken; the safety; and the amount of time it takes to absorb into the body. A Generic Drug has been approved by the U.S. Food and Drug Administration (FDA) and is basically a "copy" of a Brand Name Drug. Generic Drugs may have different names, shapes, colors and inactive ingredients than the Brand Name Drug.
Hospice Care	Palliative and supportive care designed to provide for the physical and psychological well being of dying persons and their families.
Home Health Agency	A program of care provided by a public agency or private organization, or a subdivision of such agency or organization that: ➢ Is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;

	➢ Has established policies for governing the services that it provides; ➢ Provides for the supervision of its services by a Physician or registered professional nurse; ➢ Maintains clerical records of all patients; ➢ Is licensed according to the applicable state laws and of the locality in which it is located or provides services; and ➢ Is eligible to participate under Medicare.
Hospital	A lawfully operated institution that has permanent and full-time facilities for bed care of five or more resident patients; has a doctor in regular attendance; and provides 24-hour nursing services rendered by registered nurses.
Illness	A disease, disorder, or condition (including pregnancy, childbirth, and any related conditions) that requires treatment by a Physician.
Infertility	The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy, as certified by your Physician.
Injury	Physical damage or hurt caused by a sudden unforeseen event resulting from an external source.
Inpatient	A registered bed patient receiving treatment at a Hospital or other healthcare facility.
Medical Care	The ordinary and usual professional services rendered by a Physician or other specified provider during a professional visit for treatment of an Illness or Injury.
Medically Necessary or Medical Necessity	Services, treatments, or supplies ordered by your Physician that are: ➢ Required to identify or treat an Injury or Illness; ➢ Appropriate and consistent with the symptoms, diagnosis, or treatment of the condition, disease, Illness, or Injury; ➢ In keeping with acceptable National Standards of Good Medical Practice; and ➢ The most appropriate that can be safely provided under the circumstances on a cost-effective basis.
Medicare	Medicare is a social insurance program administered by the United States government, providing health insurance coverage to people who are aged 65 and over; to those who are under 65 and are permanently physically disabled or who have a congenital physical disability; or to those who meet other special criteria.
Mental Health; Mental or Nervous Disorder	A disorder classified in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or a neurosis, psychoneurosis, psychopathy or psychosis or a mental or emotional disease of any kind.
Occupational Therapy	Therapeutic use of self-care, work, and recreational activities to increase independent function, enhance development, and prevent disability; may include adaptation of tasks or environment to achieve maximum independence and optimal quality of life.
Outpatient	Treatment received while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room, diagnostic laboratory tests and x-rays, medications, and supplies.
Ophthalmologist/ Optometrist	A person legally qualified and licensed to practice such profession by the appropriate governmental authority.
Physical Therapy	Services and providers that are expected to address specific clinical and functional restrictions by applying skilled physical therapy techniques and utilizing appropriate physical therapy

	modalities, therapeutic exercise, manipulative techniques and soft tissue care with concurrent initiation of a progressive exercise and stabilization program. Additionally, emphasis of treatment is expected to be self-symptom management and an independent home or community-based exercise program.
Physician	A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (D.P.M.) and authorized to practice medicine, perform surgery, and to administer drugs under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.
Preventive Services	➢ Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, except as provided below; ➢ Immunizations for routine use in children, adolescents, and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention); ➢ With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and ➢ With respect to women, to the extent not described above, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. ➢ Where the federal guidelines are unclear regarding whether an expense is considered a Preventive Service, the Trustees will decide whether such expense is a Preventive Service under the Plan. ➢ For a complete up-to-date list of Preventive Services under the Affordable Care Act, please visit: http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforChildren
Reasonable and Customary	With regard to medical expenses Reasonable and Customary means: ➢ The usual charge by the provider for the same or similar service or supply; ➢ No more than 80% of the prevailing charge; ➢ With respect to a PPO provider, the charge set forth in the PPO agreement; or ➢ The provider's actual charges. Reasonable and Customary shall not exceed the charges actually incurred.
Retiree	A former Active Employee who retires while covered under the Plan's Active Employee Benefits and is covered under the Retiree Plan of Benefits.
Retirement	Retirement means that the Active Employee ceases employment from an Employer and intends to abstain from actively working.
Skilled Nursing Facility	A licensed institution that has a transfer agreement with a Hospital, that provides 24-hour

	Inpatient nursing services under the supervision of a Physician or registered nurse, is eligible for Medicare, has a utilization review plan in place, is not an institution that is primarily for the care and treatment of mental diseases, and every patient must be under the supervision of a Physician.
Speech Therapy	Speech–language pathology services for the treatment of disorders of speech, language, voice, communication and auditory processing.
Treatment Facility	A rehabilitation facility for the treatment of individuals suffering from alcohol and/or drug dependency. Such a facility may be a free-standing facility or may be a designated portion of a Hospital or other facility, provided such designated portion is solely for the purpose of providing rehabilitative treatment for individuals suffering from alcohol and/or drug dependency, accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and approved by the Trustees.
Union	Automobile Mechanics' Local No. 701, affiliated with the International Association of Machinists, AFL-CIO.

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