Railroad Maintenance and Industrial Health and Welfare Fund

Summary Plan Description

Plan D

Effective January 1, 2021

Railroad Maintenance and Industrial Health and Welfare Fund

2725 West Monroe Street
Springfield, Illinois 62704
Telephone: (217) 787-2923 or (800) 258-6534

UNION TRUSTEES

MR. STEVEN M. CISCO
IUOE Local 150
6200 Joliet Road
Countryside, Illinois 60525-3992

MR. DAVID A. FAGAN
IUOE Local 150
2193 West 84th Place
Merrillville, Indiana 46410

MR. JOHN PENN
Vice President/Midwest Regional Manager
LIUNA Midwest Regional Office
1 N. Old State Capitol Plaza, Ste. 525
Springfield, Illinois 62701

MR. MATTHEW E. SMITH
LIUNA Local 773
5102 Ed Smith Way
Marion, Illinois 62959

EMPLOYER TRUSTEES

MR. MARK A. BROWN
RailWorks Track Services, Inc.
7505 S. Belmont Avenue
Indianapolis, Indiana 46217

MR. JAMES J. DALOISIO
Railroad Constructors, Inc.
705 Mantua Avenue
Paulsboro, New Jersey 08066

MS. LINDA M. LAURELLO
Delta Railroad Construction
P.O. Box 1398
Ashtabula, Ohio 44005-1398

MR. WILLIAM C. MORREN
US Trackworks, LLC
1165 142nd Avenue
Wayland, Michigan 49348

ADMINISTRATOR
Board of Trustees

EXECUTIVE ADMINISTRATOR
Dora Crenshaw

FUND COUNSEL
Cavanagh & O'Hara, LLP

FUND CONSULTANT
Southern Benefit Administrators, Incorporated

TABLE OF CONTENTS

Schedule of Benefits

Employees Only

Death Benefit	Maximum Accidental Death and Dismemberment Benefit
$10,000	$10,000

Employees and Dependents

Preferred Provider Organization ("PPO")

The Fund has contracted with a Preferred Provider Organization (PPO) to provide comprehensive medical services at discounted rates.

Except under the very limited circumstances outlined below, you must use a PPO provider in order to receive benefits under the Fund.

See page 21 for important information concerning the Preferred Provider Organization and Hospital Pre-Certification Requirements.

HOSPITAL ADMISSIONS MUST BE PRECERTIFIED

Generally, all inpatient hospital admissions must be precertified. However, precertification is not required for maternity admissions for the first 48 hours following a normal vaginal delivery or 96 hours following a caesarean section. Maternity benefits are not provided for Dependent children other than those limited benefits outlined under the ACA Recommended Preventive Services.

Participating PPO hospitals are responsible for precertifying your stay, but be sure to present your ID card and to verify that the hospital is a United HealthCare Choice Plus participating provider.

If you are admitted to a non-PPO hospital, charges will be covered only under the very limited circumstances outlined below. The non-PPO hospital should precertify your stay, but it is ultimately your responsibility to see that your stay is precertified. **Failure to do so will result in benefits being denied for your claim.**

See page 21 for additional information.

EXCEPT AS SPECIFICALLY OUTLINED BELOW, NO CHARGES INCURRED WITH A NON-PPO PROVIDER WILL BE COVERED UNDER THE PLAN.

The following categories of out-of-network charges will be covered the same as if they were incurred with participating network providers:

- Out-of-Area Provisions. Charges for treatment incurred with an out-of-network provider when it is determined that there is no in-network provider qualified to administer that treatment within 50 miles of your home address or the place where the claim is incurred;

- Initial charges for Life-Threatening Emergencies;

- Charges for anesthesiology, radiology, pathology, lab services and emergency room Physicians when incurred in connection with treatment administered at a participating PPO covered facility and, if applicable, by a participating PPO attending Physician; and

- Charges for covered Dental Benefits

Basic Accident Benefit

Benefits for the treatment of an accidental Injury are payable at 100% up to $200 per covered person per accident for care provided within 72 hours of the accident. Any remaining balances are payable under the Major Medical Benefit after satisfaction of the annual deductible. An accidental Injury is a physical Injury that is caused by purely accidental means and by an external force, independent of all other causes.

Major Medical Benefits

Percentage Payable:	In-PPO Network Charges	85%
	Out-of-Network Charges	0%*

*Except as outlined above and on the previous page.

Deductible Per Calendar Year:

$400 per person, $800 for all persons in the same family. Expenses incurred in the last three months of the year which were used to satisfy the deductible will be used to reduce the next year's deductible. Only one deductible applies for family members injured in the same accident. NOTE: **The deductible will be waived for covered physicians' office visits and other procedures performed by the physician and billed with such office visit.**

Hospital Emergency Room Deductible:

$100 per Hospital emergency room visit. This deductible must be satisfied for each and every visit by a covered person to a Hospital emergency room, regardless of the diagnosis or the treatment administered for the diagnosis. This deductible will be waived if the covered person's confinement to the Hospital is a direct result of and immediately follows the emergency room visit.

Full Payment Provision:

The maximum out-of-pocket expense (including the deductible) for major medical benefits during any one calendar year is $4,000 for all covered persons in the same family. After the out-of-pocket maximum is reached, the Plan will pay 100% of the covered expenses for the rest of the calendar year. Please note a separate maximum out-of-pocket expense applies to the Prescription Drug Benefit Program.

Mental and Nervous Disorders and Substance Abuse:

Treatment of these conditions is covered on the same basis as for any other covered illness.

Chiropractic Coverage:

$500 maximum annual benefit per covered person for chiropractic treatment, including x-rays and spinal manipulation.

Air Ambulance Benefit:

$12,000 maximum benefit per occurrence. Charges are covered only to the extent the service is medically necessary and only if the provider of the services agrees to accept the payment as payment in full, with no balance billing to the eligible employee or the patient.

Preventive/Wellness Benefits:

In accordance with provisions of the Affordable Care Act (the "ACA"), the Plan provides coverage for a wide range of preventive and wellness benefits. A list of those covered services can be found on pages 28 through 32. The listed benefits are covered in full by the Plan with no deductible, so long as the services are rendered by participating PPO providers and participating pharmacies, as applicable. The listing is subject to periodic change, as determined by applicable Federal agencies.

In addition to the ACA covered preventative services, the Plan provides additional expanded coverage for certain wellness services, as follows:

- **Colonoscopies.** The ACA provides for coverage of routine colonoscopies and other colorectal cancer screenings at specified intervals for covered individuals ages 50 through 75. The Plan provides that colonoscopies will be covered at five year frequencies, and provides for such coverage to continue after attainment of age 75.

- **Mammograms.** The ACA requires that routine mammograms must be covered every other year for women ages 50 through 74. The Plan expands that coverage so that a single baseline routine mammogram is covered between ages 35 and 40. Upon attainment of age 40, mammograms are then covered annually, and such coverage does not cease after attainment of age 74.

- **Pap Smears.** The ACA generally requires that Pap smears must be covered once every three years for women aged 21 to 65 years. The Plan expands that benefit by providing coverage regardless of age, and at more frequent intervals as medically appropriate.

- **Hearing Tests.** The ACA requires that hearing screenings be provided for all newborns. The Plan provides coverage for audiograms for all covered persons at reasonable intervals.

- **PSA Tests.** The ACA does not require any coverage for prostate-specific antigen (PSA) tests. The Plan however does cover such tests, in conjunction with a DRE, after age 50, or earlier with a family history of prostate cancer, at reasonable intervals.

Routine Drug Testing Benefit:

In addition to the Plan's coverage for medically necessary lab tests performed to diagnose or treat a covered condition, the Plan will cover charges incurred for a routine blood test, urinalysis, or any other type of testing or screening performed solely to determine the presence of controlled substances or illegal substances, subject to the provisions outlined below. For this purpose, a drug test or drug screening is the full series of tests performed in analyzing and assaying the single specimen provided by the patient, without regard to the number of tests performed.

- The maximum benefit per specimen drawn is $250

- The benefit is payable at 85% and is subject to the Deductible Per Calendar Year.

Prescription Drug Benefit Program:

Prescription drug coverage is provided to all active Eligible Employees and their Dependents. In general, the OptumRx Pharmacy Benefit Services program covers Federal legend drugs, state restricted drugs, and compound medications that are (a) FDA-approved and (b) included in the Prescription Drug Benefit Program's formulary. You should contact OptumRx to determine whether a particular drug is covered at 1-866-516-3121 or optumrx.com. If there is an FDA approved generic equivalent in existence and your physician DOES NOT indicate "Dispense as Written," your prescription will be filled with an approved generic equivalent. If you want the brand name drug, you will be responsible for the cost difference between the brand name drug and its generic equivalent.

PLEASE NOTE: Regardless of any other provisions, no prescription drugs will be covered if purchased at a Wal-Mart pharmacy or a Wal-Mart affiliated pharmacy.

The OptumRx Pharmacy Benefit Services program provides for both acute medication (immediate treatment) and maintenance medication (long term treatment). Maintenance medications are medications taken for long periods of time for chronic conditions.

Co-Payment Provisions:

Each prescription filled or refilled will be subject to the following co-payment amounts, for which you are responsible:

- Generic drugs –
    - $5 for each 30-day supply purchased; or
    - $10 for each 90-day supply purchased.

- Brand name drugs –
  - $50 for each 30-day supply purchased; or
  - $100 for each 90-day supply purchased.

- Specialty drugs –
  - 30% of the cost of the drug unless a Prescription Drug Cost Program applies.

However, the foregoing co-payment amounts only apply if you obtain your prescription at an OptumRx participating pharmacy. No coverage will be provided if the pharmacy is not in the OptumRx network.

Full Payment Provision:

The maximum out-of-pocket expense for the purchase of all prescription drugs (the total amount of actual co-payments paid by you as listed above) during any one calendar year is $4,550 per covered person, and $13,100 for all covered persons in the same family. After the out-of-pocket maximum is reached, the co-payments listed above will be waived, and prescription drugs will be covered at 100% for the rest of the calendar year. However, there is no maximum limit on the amount you pay out-of-pocket for medications you receive from non-network pharmacies.

Retail Card Program:

You must use your OptumRx Pharmacy Benefit Services prescription drug card to receive up to a 30-day supply at any participating OptumRx pharmacy. You may also choose to purchase up to a 90-day supply on a retail basis, if your prescription allows for such, upon payment of the applicable co-payment amount. OptumRx offers a large network of participating pharmacies, some of which should be conveniently located for you. If you cannot locate a pharmacy near your home or work, contact OptumRx at 1-866-516-3121 or member portal at www.optumrx.com. **You must obtain your prescription at an OptumRx participating pharmacy. No coverage will be provided if the pharmacy is not in the OptumRx network. The Fund office does not process prescription claims for reimbursement.**

When you have prescriptions filled by a participating OptumRx pharmacy, present your prescription drug card to the pharmacist. The pharmacist will then access your eligibility information by computer and you will be responsible for the co-payment amounts listed beginning on the previous page:

Formulary

The Prescription Drug Benefit Program utilizes a formulary. A formulary is a list of prescribed medications, including generic drugs, brand-name drugs, and specialty drugs, that have proven to be both clinically effective and cost effective. Prescriptions on the formulary are categorized into tiers and those tiers determine your cost for a particular medication. **Some prescriptions are excluded from the formulary, and these medications are not covered under the Prescription Drug Benefit Program.** As such, only prescriptions listed on the formulary (and not otherwise excluded) are covered by the Prescription Drug Benefit Program. Please note that the formulary is subject to change on January 1 and July 1 every year. Please refer to optumrx.com or contact OptumRx at 1-866-516-3121 for the current formulary.

Please also note that you can review the formulary when you register an account at optumrx.com or the OptumRx mobile app.

Home Delivery Program:

To use the OptumRx Mail Order Services, simply use the mail order form, enclose the original prescription completed by your doctor and enclose your co-payment. A mail order prescription transfer form was provided to you with your OptumRx prescription drug card. Should you require additional order forms, please contact OptumRx at **1-866-516-3121**. The Mail Order Services procedures are explained online at optumrx.com. While on the OptumRx website, you may wish to explore other features provided for your understanding and convenience.

You will be responsible for paying the co-payment listed on the previous page for each prescription or refill order under the OptumRx Mail Order Services program.

Specialty Drug Program:

While most medications are available through the Plan's Drug Card Program with OptumRx, on occasion drugs of a more specialized nature are required for treatment of an illness, disease or other condition. Such drugs, referred to as "specialty drugs," are covered only as outlined below. Of course, as with all prescription drugs covered by the Plan, specialty drugs must be prescribed by a Physician. Specialty drugs are generally defined as high cost oral, infused, injected or inhaled drugs that are used to treat chronic, complex conditions. Some of these conditions are hepatitis C, multiple sclerosis, rheumatoid arthritis and psoriasis. Local retail pharmacies are normally unable to supply these types of drugs due to their high cost and specialized handling and storage requirements. Since these medications have serious side effects, patients may require regular lab or diagnostic testing to ensure administration of the proper dosage and to monitor the progress of the patient. In some instances, the assistance of medical professionals is required in the administration of the specialty drug.

In order to ensure that specialty drugs are available to covered persons who require them and to verify that they are being administered in accordance with your Physician's instructions, the Plan has retained the services of OptumRx to administer this program, under the oversight of the Fund office. OptumRx works with the patient, Physician and Plan to maximize the effectiveness of the specialty drugs, improve the patient's chances of recovery, and help control health care costs. OptumRx maintains an experienced team of specialists who are available to respond to each patient's needs or inquiries. They also make sure that required specialty drugs are delivered in a timely fashion to the patient's home, Physician's office or other location where they are required.

The Plan will provide coverage for specialty drugs if your Physician obtains a prior authorization from OptumRx. To do this, your Physician will need to complete OptumRx's prior authorization form, which your Physician will have access to through OptumRx's website. Your Physician will also need to send certain clinical documentation/information to OptumRx. Once OptumRx has received the required information and approved the prior authorization as a preliminary matter, OptumRx will send this information to the Fund office for a determination. Once approved by the Fund office, OptumRx will facilitate the receipt of your specialty drug, which may include delivering the specialty drug directly to you or your Physician. Purchase of a specialty drug, other than as described herein, will result in the denial of benefits for that purchase. You can check on the status of this review by calling 1-866-516-4121.

In order for a specialty drug to be covered by the Plan, preauthorization/prior authorization must continue to be obtained as described herein. Fund office staff will continue to help you determine if a particular drug is a "specialty drug" and will assist you in submitting your prescription to OptumRx for processing.

Prescription Drug Cost Reduction Programs

OptumRx has clinical management and patient assistance programs in place to ensure that patients receive safe, clinically proven, and cost-effective medications for their conditions. Because of this, you and/or the prescribing doctor may be required to submit proof of medical necessity for certain drugs or dosages, and in certain cases, alternative medications may be recommended or required.

One of these programs, the SAV Program, manages the use of selected specialty medications to reduce or eliminate your out of pocket expense, as well as reducing the cost to the Plan. In order to continue receiving your medication at the most affordable cost, your prescription will be filled at the OptumRx Specialty Pharmacy, as noted above. OptumRx will facilitate your enrollment into a manufacturer sponsored coupon program or other rebate program. Medications included in the program may be discontinued and excluded from the program at any time without notice. Contact OptumRx for more information regarding the SAV Program.

Additionally, in order for some prescriptions to be covered, a Prior Authorization (PA) evaluation or Drug Utilization Review (DUR) may be required to determine if the medications' prescribed use meets defined clinical criteria. Through this process, your doctor and OptumRx pharmacists will work together to ensure that the drug you are prescribed is the most appropriate for your condition. Please visit optumrx.com to determine which drugs have a PA or DUR.

Prescription Drug Program Exclusions

In addition to the Exclusions and Limitation listed on pages 33 through 35, Prescription Drug Program Benefits are not provided for any of the following:

- Any drug that has not secured full FDA approval for safety and efficacy;
- Any drug labeled "Caution: Limited by Federal Law to Investigational Use" or any experimental drug;
- Any drug that is subject to OptumRx's new to market product exclusion;
- Devices or appliances;
- Drugs used for cosmetic purposes;
- Drugs used to treat hemophilia;
- Drugs which are not considered to be medically necessary;
- Over-the-counter medications to the extent allowed by applicable law;
- Cellular Immunotherapy drugs;
- Gene therapy drugs, regardless of their intended use or stated purpose;
- Proton pump inhibitors (PPIs);
- Drugs excluded by the Plan to the extent allowed by applicable law (for a list of drugs excluded by the Plan, please contact the Fund Office at 1-800-258-6534); and
- Drugs excluded by the Prescription Drug Program's formulary.

In addition, dispensing limits may apply to certain medications based on the manufacturer's recommended dosage and duration of therapy, common usage, FDA and state recommendations and/or clinical studies.

Pharmacy Benefit Manager Contact Information

OptumRx
1-866-516-3121
1-866-516-4121 (for specialty drugs)
Optumrx.com

Supplemental Family Medical Benefit

If you or any of your Dependents should incur expenses for Necessary Treatment which are not otherwise covered by and reimbursed by the Plan, the Plan will cover and reimburse you for those expenses in an amount not to exceed $300 per family per calendar year. In order for such expenses to be covered by the Plan, the guidelines and restrictions listed on pages 36 and 37 must be satisfied for each and every such expense.

PLEASE NOTE: Regardless of any other provisions, no charges will be covered for services rendered, or items purchased, at a Wal-Mart store, a Wal-Mart pharmacy or affiliated pharmacy or at a Wal-Mart vision center.

Dental Benefits

Percentage Payable:

100% for covered dental charges for diagnostic oral examinations, cleaning and scaling of teeth, X-rays, fluoride applications, space maintainers and emergency treatment for relief of dental pain. (See pages 40 through 42 for more detailed information.)

50% for covered dental charges for crowns, fixed bridgework, inlays, gold fillings, full or partial dentures, other than charges incurred for repairs and additions to existing dentures, and covered orthodontia for Dependent Children under age 19 (see Orthodontia on the following page).

80% for all other covered dental charges.

Deductible Per Calendar Year:

No deductible is applied to covered dental charges for diagnostic oral examinations, cleaning and scaling of teeth, X-rays, fluoride applications, space maintainers and emergency treatment for relief of dental pain.

A $25 deductible per patient per calendar year is applicable to all other covered dental charges other than covered orthodontia (see the following page).

If two or more members of your family are injured in the same accident, only one deductible will be applied each year against all the covered dental charges incurred as a result of such accident.

Maximum Benefit Payable per Calendar Year – $600 (Not Applicable to Pediatric Services or Covered Orthodontia).

Orthodontia – For Dependent Children Under Age 19 Only:

Percentage Payable: 50%, up to the maximum lifetime benefit.

Maximum Benefit Payable Per Lifetime: $500

Additional Pediatric Dental Services:

The $600 calendar year maximum benefit will not apply to the following services when rendered to a covered person under 19 years of age, through the last day of the calendar month in which he or she attains age 19.

- Diagnostic oral examinations, cleaning and scaling of teeth, x-rays, and fluoride applications, payable at 100% after application of the deductible; and

- Amalgam and synthetic fillings and tooth extractions, payable at 80% after application of the deductible.

These pediatric dental services are not intended to duplicate the Dental Benefits outlined above or to increase the frequencies of covered services. They are intended only to provide additional payment, if needed, for these types of services, that are otherwise covered under the Dental Benefits but are in excess of the $600 calendar year maximum benefit.

Rules of Eligibility

Who Is Eligible

All employees who fulfill the eligibility rules specified below will be eligible for the benefits described in this booklet.

When Your Benefits Commence

You will be covered on the date you become eligible.

General Provisions

Eligibility is based on your work for which contributions are paid to the Railroad Maintenance and Industrial Health and Welfare Fund ("the Fund") by your employer as required by the collective bargaining agreements, acceptable to the Fund, entered into between your employer and the local unions, or as required by other written agreements between your employer and the Fund. Most employees that are covered under the Plan work under a collective bargaining agreement requiring a contribution to the Fund at either a fixed rate for each hour worked or a flat monthly rate. These rates are established under the applicable collective bargaining agreement.

In addition to collectively-bargained employees, the Fund covers certain non-collectively bargained employees who are affiliated with the Fund or with employers that contribute to the Fund for collectively bargained employees. The rules of participation of non-collectively bargained employees are defined in their participation agreements with the Fund. The rates are established by the Trustees.

It is expected that different employers participating in the Fund may negotiate different rates of contribution to the Fund subject to the approval of the Board of Trustees. Therefore, the Plan has been established to provide benefit programs supported by different contribution rates. The Plan of benefits for which an employee will qualify will be determined by the contribution rate paid to the Fund on his behalf due to his employment; an employee who meets the eligibility requirements as set forth on the following pages and who has contributions made to the Fund on his behalf at the contribution rate(s) required by the Trustees for Plan D benefits will be eligible for Plan D benefits.

Eligibility: Collectively Bargained Employees – Hourly Rate

Initial Eligibility

For you to become eligible for benefits, employer contributions must be paid to the Fund for at least 300 hours of your work within a three consecutive month period. Your benefits will become effective as of the first day of the second month following completion of this initial eligibility requirement. For example, if you are credited with at least 300 hours of contributions for your work in January, February, and March combined, you will be eligible for benefits in May; if you are credited with a least 300 hours of contributions for work in January and February, you will be eligible for benefits in April.

Continued Eligibility

Once you become eligible for benefits, your eligibility will continue from month to month as long as at least 100 hours of contributions are received on your behalf from a contributing employer for your work during the preceding month.

If you do not meet the requirement of 100 hours of contributions, you will continue to be eligible for benefit coverage if at least 1,000 hours of contributions are received on your behalf from a contributing employer for work performed in the preceding consecutive twelve month period. Your coverage will be continued for up to a maximum of four consecutive months based on the 1,000 hours rollback rule. This rollback rule does not apply to termination of collective bargaining units.

Eligibility Termination

Your eligibility will terminate on the last day of the second month following the month in which you no longer meet the Continued Eligibility requirement. For example, if you fail to receive credit for at least 100 hours of work in June and you failed to meet the 1,000 hour rule, your eligibility for benefits will end as of August 31.

Eligibility Reinstatement

If your eligibility terminates in accordance with these rules, you can again become eligible for benefits by meeting the requirements described under the "Initial Eligibility" section.

Termination of Plan Participation by Collective Bargaining Unit

When a collective bargaining unit terminates participation in the Railroad Maintenance and Industrial Health and Welfare Fund, the eligibility of any employee covered under the bargaining unit will terminate at the end of the month following the month in which the Fund first receives less than 100 hours of contributions for that employee.

If a collective bargaining unit terminates participation in the Fund, for any reason other than the employer's cessation of business, then the continued eligibility of the employer's employees under the 1,000 hour rollback rule will be determined without reference to any time worked for the terminated employer.

For this purpose, a bargaining unit will be considered terminated as of the last date of its collective bargaining agreement with the Union which requires employer contributions to the Fund.

This rule supersedes the Plan rules governing an individual's termination of participation in the Plan.

Eligibility: Collectively and Non-Collectively Bargained Employees – Flat Monthly Rate

Full-time employees of employers who have negotiated a flat monthly rate for the Fund coverage will be eligible for benefits under the Railroad Maintenance and Industrial Health and Welfare Fund if they work under the jurisdiction of the collective bargaining agreement, acceptable to the Fund, entered into between the employer and the Union, and the required contributions are made on their behalf.

Full-time non-collectively bargained employees of employers who have negotiated a flat monthly rate for the Fund coverage will be eligible for benefits under the Railroad Maintenance and Industrial Health and Welfare Fund if they participate under a participation agreement entered into between the employer and the Fund and the required contributions are made on their behalf.

The term "full-time" for collectively bargained employees is defined as working an average of at least 150 hours per month under the collective bargaining agreement. The term "full-time" is defined in the individual participation agreement for non-collectively bargained employees.

The following outlines the eligibility and participation requirements for collectively bargained and non-collectively bargained employees whose employer(s) contribute at a fixed monthly rate.

Initial Eligibility

A new collectively bargained employee and his eligible Dependents will become initially eligible on the first day of the second month following the first month of employment, provided the required monthly contribution has been received. For instance, if an employee starts to work in April and his contribution is received in the Fund office during May, eligibility begins June 1st.

A new non-collectively bargained employee and his eligible Dependents will become initially eligible on the first day of the month for which the initial contribution is paid to the Fund.

Continued Eligibility

For collectively bargained employees, once you are eligible, your eligibility will continue on a month to month basis, provided you work under the jurisdiction of the collective bargaining agreement and provided that the required monthly contribution is received by the first day of the second month following the month in which you worked. For instance, if an employee continues to work in May and his contribution is received in the Fund office during the month of June, eligibility will continue through July.

For non-collectively bargained employees, once you are eligible, your eligibility will continue on a month to month basis, provided the required monthly contribution is received by the first day of the month for which such coverage is to be provided. For example, in order to secure coverage for the month of June, contributions must be received by June 1st.

Eligibility Termination

For collectively bargained employees, if any employer does not make the required monthly contribution for an employee, eligibility will terminate on the last day of the month following the month for which the employer did not make a contribution. For example, if the monthly contribution for an employee's work in June is not received during July, his eligibility will terminate July 31st.

For non-collectively bargained employees, your eligibility will terminate on the last day of the month preceding the month for which contributions are not received. For instance, if the monthly contribution for June is not received on or before June 1st, eligibility will terminate May 31st.

Self-Payment Rules (Collectively Bargained Only)

If an employee's eligibility terminates, the employee may elect to continue benefits under the Plan by making up to six self-payments at the contractual rate. After making six self-payments, or in lieu of making self-payments, the employee may elect to continue benefits under the Plan in accordance with the Continuation of Coverage (COBRA) rules, described beginning on page 48.

Termination of Plan Participation by Collective Bargaining Unit

If a collective bargaining unit terminates participation in the Fund, all eligibility and benefits at the time the bargaining unit terminates participation will terminate and no voluntary eligibility will be allowed beyond the date participation is terminated. For this purpose, a bargaining unit will be considered terminated as of the last day of its collective bargaining agreement with the Union which requires employer contributions to the Fund.

If a collective bargaining unit terminates participation in the Fund for any reason other than the employer's cessation of business, then the continued eligibility of the employer's employees under the six month rollback rule will be determined without reference to any time worked for the terminated employer. For this purpose, a bargaining unit will be considered terminated as of the last day of its collective bargaining agreement with the Union which requires employer contributions to the Fund.

This rule supersedes the Plan rules governing an individual's termination of participation in the Plan.

Eligibility of Disabled Employees (Applicable to All Eligible Employees)

An employee who becomes disabled while eligible under the Plan and who was employed by a participating employer at the time such disability commenced may be entitled to a continuation of his eligibility for a maximum period of three months per period of disability, at no charge to the employee, provided he satisfies the requirements set forth below. An eligible employee who qualifies for such continuation and for whom contributions are paid into the Plan on an hourly basis will be credited with 100 hours per month of disability, such credit to be awarded in weekly increments for each week or partial week of disability. An eligible employee for whom contributions are paid based upon a flat monthly amount will be awarded such credits in monthly increments for each consecutive month in which the employee is continuously disabled for a period of not less than two weeks, but only if the employee's employer is not otherwise obligated to remit a contribution to the Plan for such month(s).

An eligible employee will be considered disabled for this purpose if he becomes continuously disabled while eligible because of an occupational or non-occupational accidental bodily injury or illness which prevents him from working at his regular occupation and which requires the regular care of a Physician. A determination of "disability" under this provision can only be made by a Physician or by a finding of disability by the Social Security Administration, subject to the provisions outlined in the previous sentence. Neither the Fund office nor the Board of Trustees can make a determination of disability. Successive periods of disability not separated by a return to active employment will be considered as one continuous period of disability.

Credits will be granted under this provision only for disabilities which continue for more than seven consecutive days. However, credits will be granted to employees who qualify beginning with the first day of disability. Such credits will be limited to three months for each continuous period of disability.

Military Service and Eligibility (Applicable to All Eligible Employees)

If you are inducted or enlist or are otherwise called to active duty in the uniformed services of the United States of America, you will be entitled to continued coverage or the right to make self-contributions for continued coverage as set forth below:

1. For active uniformed service of less than 31 days – your coverage will be continued without charge to you, provided you report to work no later than the first regularly scheduled working period one week after termination of active duty.

2. For active uniformed service of 31 days or more – all benefits for you and your Dependents will be terminated on the date you enter active uniformed service for a period of service of 31 days or more, except as follows:

    a. You may choose to continue coverage based on hours you have already worked. You may elect to use your accumulated eligibility to continue coverage under the Fund, or may elect to defer the use of your eligibility until your reemployment as described below. Failure to elect continued coverage under this provision will result in an automatic deferral of any accumulated eligibility.

    b. Upon termination of coverage as provided in this section, you may elect to continue coverage for the period of active uniformed service, not to exceed 24 months, by making COBRA continuation coverage payments. In order to be entitled to make COBRA payments, you must notify the Fund office in writing within 60 days following the date on which your coverage would otherwise terminate.

If you are discharged from active uniformed service of 60 months or less, you will be reinstated for benefits provided you submit an application for reemployment or seek reemployment through a participating local union within 14 days (if the active uniformed service is for 31 to 181 days) or 90 days (if the active uniformed service is more than 181 days) from the date of the discharge.

The time for reemployment application will be extended in the event of injury or hospitalization as further provided in the Uniformed Services Employment and Reemployment Rights Act of 1994.

If you have chosen to use your accumulated eligibility as explained above and, as a result, do not have enough hours accumulated to continue your coverage under the Fund upon reemployment, you will be required to make monthly self-payments to the Fund in order to regain and continue your coverage. Monthly payments will be required until you have worked enough hours to satisfy the requirements for Continued Eligibility.

The term active uniformed service includes active duty with the Armed Forces, the Army National Guard and the Air National Guard (when engaged in active duty training, inactive duty training or full time National Guard duty), the commissioned corps of the Public Health Service and any other category of persons designated by the President of the United States in the time of war or emergency.

Eligibility Continuation Rules (Applicable to All Eligible Employees)

If eligibility terminates, you may elect to continue your benefits under the Plan in accordance with the Continuation of Coverage (COBRA) rules, described beginning on page 48.

Eligibility and Effective Date

You will be eligible for benefits on the date you become eligible according to the Rules of Eligibility. Your noncontributory Death Benefit, Accidental Death and Dismemberment Benefits, Medical Benefits and Dental Benefits will become effective on the date you are eligible.

Newborn or Adopted Children

A child born to or adopted by you or your Dependent spouse will automatically become covered as a Dependent for health benefits upon the completion of a Benefit Enrollment Form and presentation of the child's birth certificate. The effective date of benefits for the child will be the date of birth or the date of placement for the purpose of adoption. Coverage includes:

1. The necessary care and treatment of medically diagnosed congenital defects;

2. Birth abnormalities;

3. Prematurity;

4. Routine nursery charges;

5. Charges for routine well baby/child care from birth; and

6. Charges for childhood immunizations.

Send the Fund office a new, fully completed Benefit Enrollment Form whenever a child is born or placed for adoption. Provide the Fund office with a copy of the child's birth certificate or adoption papers. Call the Fund office at 1-800-258-6534 to request a new Benefit Enrollment Form. Claims for Dependents will not be paid until the Fund office receives the enrollment form.

Eligibility for Maternity Benefits

Generally, pregnancy-related benefits are payable only for eligible employees and Dependent spouses, as well as their newborn infants. However, a limited number of preventive services related to the pregnancy of Dependent children are covered as listed under the ACA Recommended Preventive Services (see pages 28 through 32).

Definitions

The following is a listing of important definitions:

Approved Clinical Trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

1. FEDERALLY FUNDED TRIALS – The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   a. The National Institutes of Health,

   b. The Centers for Disease Control and Prevention,

   c. The Agency for Health Care Research and Quality,

   d. The Centers for Medicare and Medicaid Services,

   e. A cooperative group or center of any of the entities described in a. through d. above or the Department of Defense or the Department of Veterans Affairs,

   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or

   g. Any of the following if the conditions described below are met:

      - The Department of Veterans Affairs
      - The Department of Defense
      - The Department of Energy

      The conditions for inclusion hereunder, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary of such Department determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and that assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

3. The study or investigation is a drug trial that is exempt from having such an investigation new drug application.

Child includes your children and those of your spouse as well as adopted children beginning on the date of placement for the purpose of adoption.

In addition, Child includes children who are listed in a Qualified Medical Child Support Order (QMCSO) for which you are obligated to provide medical coverage.

Dentist means a duly licensed dentist acting within the scope of his license. He may not be a family member.

Dependent means:

1. Your spouse to whom you are legally married in a marriage valid in the state where such marriage took place;

2. Your Children, through the last day of the calendar month in which they attain age 26;

3. Your unmarried Children age 26 or older who are not capable of self-sustaining employment by reason of mental or physical handicap, provided all of the following provisions are met;

   a. The incapacity must have begun prior to the date of coverage for the Child would have otherwise terminated;

   b. The Child must be chiefly dependent upon you for support and maintenance; and

   c. The Fund office must receive proof of the incapacity within 31 days of the date on which the Child's coverage would otherwise have terminated.

   As long as all of these conditions are satisfied, coverage for your Child described above will continue while your coverage remains in effect.

He or His means either a male or female unless a distinction is specified.

Hospital means an establishment which:

1. Is licensed to provide impatient care with 24 hour nursing and Physician services;

2. Provides facilities for diagnosis and surgery (except mental hospitals); and

3. Is not primarily a clinic, nursing, rest or skilled nursing home.

Hospital also includes a licensed ambulatory surgical center.

Injury means bodily injury caused by an accident. The accident must occur while coverage is in force. The Injury must result directly from the accident and must occur independently of all other causes.

Life-Threatening Emergency means a medical condition that manifests itself suddenly by symptoms of sufficient severity, including severe pain, that without immediate medical attention could reason-

ably be expected, by a prudent lay person who possesses an average knowledge of health and medicine, to result in:

1. Imminent serious jeopardy to the mental or physical health of the individual;

2. Danger of imminent serious impairment of the individual's body functions;

3. Imminent serious dysfunction of any of the individual's bodily organs; or

4. In the case of a pregnant woman, imminent serious jeopardy to the health of the fetus.

Necessary Treatment means medical treatment which is consistent with currently accepted medical practice. Any confinement, operation, treatment or service not a valid course of treatment recognized by an established medical society in the United States is not considered "Necessary Treatment." No treatment or service, or expense in connection therewith, which is deemed experimental or investigational in nature by any appropriate technological assessment body established by any state or federal government is considered "Necessary Treatment."

Peer Review Organizations or other professional medical opinions may be used to determine if health care services are:

1. Medically necessary;

2. Consistent with professionally recognized standards of care with respect to quality, frequency and duration; and

3. Provided in the most economical and medically appropriate site for treatment.

If services are not considered to be:

1. Medically necessary; or

2. Consistent with professionally recognized standards of care with respect to quality, frequency or duration;

expenses related to those services will not be deemed "Necessary Treatment."

Physician means a licensed practitioner of the healing arts acting within the scope of his license. He may not be a family member. Physician also includes a certified nurse midwife acting within that scope of the license.

Sickness means sickness or disease which causes loss covered by the Plan. Pregnancy is considered a sickness.

Death Benefits

A Death Benefit is payable if you die while eligible for benefits. Payment will be made in full to your designated beneficiary. If there is no living designated beneficiary, we will pay the death benefit to your estate. The benefit will be paid based on the latest beneficiary designation that has been received by the Fund office prior to your death. Beneficiary designations received after the date of your death will not be honored. In the event there is no designated beneficiary living at the time of your death, the benefit will be paid to your estate.

You or your beneficiary may elect to have the death benefit payable in one lump sum or in a fixed number of installments.

Continuation of Death Benefit

We will continue your death benefit without further cost to you while you are Totally Disabled, but not beyond the date of your retirement, if the total disability:

1. Begins while you are covered;

2. Begins before your 60th birthday;

3. Lasts for at least nine months; and

4. We receive due proof of the Total Disability within 12 months after it begins.

Total Disability means your inability to engage in any work for which you are reasonably qualified because of education, training or experience. A determination of "Total Disability" under this provision can only be made by a Physician or by a finding of total disability by the Social Security Administration, subject to the provisions outlined in the previous sentence. Neither the Fund office nor the Board of Trustees can make a determination of disability.

The required proof of Total Disability must be furnished to us by or on your behalf.

The amount of your death benefit which will be continued under this provision will be the amount which was in force on your life on the day before Total Disability began.

Beneficiary

Be sure you have named the person who is to be your beneficiary and that such person's name is on file with the Fund office. You may change your beneficiary by doing the following:

1. Obtain and fill out the required form furnished by the Fund office; and

2. Return the completed form to the Fund office.

Accidental Death and Dismemberment Benefit

If you suffer a loss described below, we will pay the amount shown if it:

1. Is incurred within 90 days after an accident; and
2. Is the result of an injury.

For Loss Of:	Benefit Amount
Life	The Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Foot and Sight of One Eye	The Principal Sum
One Hand and Sight of One Eye	The Principal Sum
One Hand or One Foot	1/2 Principal Sum
Sight of One Eye	1/2 Principal Sum

Loss, for hand or foot, means complete severance through or above the wrist or ankle joint. As used with reference to eyes, loss means the irrecoverable loss of entire sight.

No more than the maximum will be paid for losses you suffer due to the same accident.

Benefits for loss of life will be paid to the beneficiary you name, if living, otherwise to your estate. All other benefits will be paid to you.

The accidental death benefit will be paid based on the latest beneficiary designation that has been received by the Fund office prior to your death. Beneficiary designations received after the date of your death will not be honored. In the event there is no designated beneficiary living at the time of your death, the benefit will be paid to your estate.

Note that in the event of an accidental Injury that results in death, the Accidental Death and Dismemberment Benefit is payable in addition to the Plan's regular Death Benefit.

Limitations

No coverage is provided for:

1. Suicide, attempted suicide or self-inflicted injury while sane or insane;
2. Medical or surgical treatment of sickness or disease.
3. Bodily or mental infirmity; or
4. War or international armed conflict.

Preferred Provider Organization/Hospital Precertification

Generally, all inpatient hospital admissions must be precertified through United HealthCare. However, precertification is not required for maternity admissions for the first 48 hours following a normal vaginal delivery or 96 hours following a caesarean section. Maternity benefits are not provided for Dependent children other than those limited benefits outlined under the ACA Recommended Preventive Services.

Participating PPO Hospitals are responsible for precertifying your stay, but be sure to present your ID card and verify that the Hospital is a United HealthCare Choice Plus participating provider.

If you are admitted to a non-PPO Hospital, charges will be covered only for:

- Treatment of a Life-Threatening Emergency (see Definitions); or
- If you are outside the area covered by the PPO (See Out-of-Area Provision on page 2).

In such case, the non-PPO Hospital should precertify your stay, but it is ultimately your responsibility to see that your stay is precertified. **Failure to do so will result in benefits denied for your claim.**

An emergency Hospital Admissions must be precertified at least 24 hours prior to admission, while United HealthCare must be contacted within 24 hours after a Hospital admission for a Life-Threatening Emergency.

The information necessary for precertifying a Hospital admission is found on your Plan ID card. Be sure to present your card to your doctor as well as the Hospital. United HealthCare may be contacted at **1-877-211-6542**.

Preferred Provider Organization (PPO)

United HealthCare, a Preferred Provider Organization (PPO), has agreements nationally with a wide range of health care providers to provide comprehensive medical services at discounted rates to the Fund's covered persons. To locate a provider or to verify that the provider you have selected continues to participate in the United HealthCare Choice Plus network, visit www.welcometoUHC.com/uhss or call United HealthCare at **1-844-849-5748**. Because providers participating in the United HealthCare Choice Plus network change periodically, you are encouraged to make the determination regarding the provider you have selected immediately prior to your visit with the provider. Just to be sure, you may also wish to inquire of the selected provider whether they participate in the United HealthCare Choice Plus network at the time of your visit.

Generally, the Fund provides coverage only for services rendered by participating network providers. There are certain exceptions for Life-Threatening Emergencies, out-of-area services and ancillary providers. See the Schedule of Benefits for more detail.

Medical Care Management

The Fund's arrangement with United HealthCare also provides for a variety of Medical Care Management programs. These programs are designed to improve your health, help you access the right level of care, and help the Fund control future claims expenses. You may use the following services at no charge as the need arises:

- Organ Transplant Program. By contacting United HealthCare at **1-877-211-6542**, access can be gained to their program of voluntary Centers of Excellence should the need arise.

Case Management

Under Optum Healthcare Solutions Case Management Program, a Hospital Pre-Admission Certification Program is offered. **All** Hospital Admissions **must** be pre-certified with United HealthCare. One of your responsibilities prior to admission to a Hospital is to require the admitting Physician/Surgeon to contact United HealthCare at **1-877-211-6542** before the hospitalization commences. Once that contact is made with United HealthCare, the Case Management Program will automatically be alerted if it is determined that Case Management will be required. Once contact is made with United HealthCare, that organization will assume responsibility for making decisions about length of stay, discharge planning, obstetrical review and the necessity of a weekend admission. If the admission is of an emergency nature, contact must be made with United HealthCare within 24 hours of the admission in order for the stay to be treated as having been pre-certified.

Major Medical Benefits

If you or your Dependent incur covered expenses during a calendar year, the Fund will pay benefits as shown in the Schedule of Benefits beginning on page 1 of this booklet.

Covered Expenses

An expense will be considered to be a covered expense if it does not exceed the usual and customary charge for a medically necessary service or supply as listed below: (Coverage terms and limitations are more fully described in the pages that follow.)

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

2. Intensive care at the full cost;

3. Charges made by a Hospital for medical services and supplies, operating room and recovery room;

4. Charges made by a Physician, to include in-network virtual (online) and telephone Physician visits and consultations.

5. Charges for diagnostic tests;

6. Charges for radiation and chemotherapy treatment;

7. Charges for anesthesia;

8. Charges for private duty nursing by an R.N. or L.P.N. when medically necessary;

9. Charges for prescription drugs purchased under the terms and conditions of the Prescription Drug Benefit Program (see pages 4 through 8);

10. Charges for rental (or purchase, if more economical) of durable medical equipment such as wheelchairs and hospital-type beds used in the patient's home;

11. Charges for artificial limbs and eyes, casts, splints, trusses, crutches and braces (except dental braces);

12. Charges for oxygen and rental of oxygen equipment;

13. Charges for voluntary sterilization;

14. Charges for physical therapy; speech therapy, and occupational therapy (see below and the following pages);

15. Charges for Home Health Care (as defined beginning on page 26);

16. Charges for local licensed ground ambulance service to transport a covered person from the place where he/she was injured by an accident or stricken by an illness to the nearest Hospital qualified to provide appropriate treatment; Charges for transportation by air ambulance are covered as well, subject to the same provisions, but only to the extent the service is medically necessary and only if the provider of the services agrees to accept the payment as payment in full, with no balance billing to the eligible employee or the patient, and subject to a maximum benefit per occurrence of $12,000;

17. Charges for blood and blood plasma, except when replaced;

18. Charges for reconstruction of the breast on which a mastectomy has been performed;

19. Charges for prostheses (implants, special bras, etc.) and treatment of physical complications for all stages of mastectomy, including lymphedema, in a manner determined in consultation with the attending Physician and the patient;

20. Charges for surgery and reconstruction of the other breast (see 18 above) to produce a symmetrical appearance;

21. Charges for items and services otherwise described in this section that are furnished in connection with participation in an Approved Clinical Trial. However, Covered Medical Expenses under this provision will not include:

    a. The investigational items, device or service itself,

    b. Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient, or

    c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

22. Preventative and wellness benefits as outlined in the Schedule of Benefits and as explained in greater detail on pages 28 through 32.

Physical Therapy

The plan provides benefits for physical therapy and requires that treatment be recommended by a Physician/surgeon and performed by a licensed physical therapist. The treatment must be designed to improve or restore the patient's functional level when loss of function is due to an illness or injury. Therapy that is performed concurrently with chiropractic therapy requires documentation of medical necessity and

is subject to review by the Executive Administrator and/or the Medical Consultant. Long term treatment of any type and treatment for chronic conditions are subject to review by the Executive Administrator and/or the Medical Consultant.

*Physical therapy **will not** be covered for:*

1. Services which are principally for the general good and welfare of the patient (e.g., developmental therapy, activities to provide general motivation, maintenance or preventative therapy).

2. Treatments that can easily and safely be performed at home, unless documentation of medical necessity for treatment being provided by a physical therapist exists. Specific examples include: moist or dry heat treatments, cold packs, exercise routines, use of exercise equipment, TENS therapy, and home traction.

Speech Therapy

The Plan provides benefits for speech therapy and requires that treatment be recommended by a Physician/ surgeon and performed by a licensed speech therapist to restore speech loss or correct an impairment which was due to:

1. A congenital defect for which corrective surgery has been performed; or

2. An accidental Injury or Sickness (except mental, psychoneurotic or personality disorder).

*Speech therapy expenses **will not** be covered for:*

1. Behavioral problems, developmental speech problems or in connection with or treatment of remedial reading, special education, self-care/self-help training, or supplies used in connection with such treatment;

2. Therapy provided by a therapist who is the claimant or a relative of the claimant to the following degree: parent, spouse of parent, spouse, child, spouse of child, or parent or child of spouse; or

3. Services available through the school system in the state of residence **will not** be covered by the Plan.

Occupational Therapy

The Plan provides benefits for occupational therapy and requires that treatment be recommended by a Physician/surgeon and performed by a licensed occupational therapist. The treatment must be designed to improve or restore the patient's functional level when loss of function is due to an illness or injury.

*Occupational therapy expenses **will not** be covered for:*

1. Behavioral problems, developmental speech problems or in connection with or treatment of remedial reading, special education, self-care/self-help training, or supplies used in connection with such treatment;

2. Therapy provided by a therapist who is the claimant or a relative of the claimant to the following degree: parent, spouse of parent, spouse, child, spouse of child, or parent or child of spouse; or

3. Services available through the school system in the state of residence **will not** be covered by the Plan.

Home Health Care

A home health care agency is an institution which is licensed as a home health care agency and which fully meets the following requirements:

1. Is operated and is duly licensed, if such licensing is required, by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services in a covered person's home for the treatment of sickness or Injury;

2. Services provided to a covered person are under the direction of a Physician;

3. Has at least one supervisory registered nurse on its staff;

4. Maintains a complete medical record on each patient; and

5. Has a full-time administrator.

Charges made by a home health care agency for care at home will be payable in accordance with a home health care plan which must meet the following criteria:

1. The attending Physician must establish the treatment plan in writing and the treatment plan must be approved prior to commencement of services; and the treatment plan must be certified every 60 days; and

2. It must be certified in writing by a Physician that the proper treatment of the illness or Injury would require continued confinement as a resident inpatient in a Hospital, in absence of the service provided as part of the home health care benefit.

Home health care expensed ***will*** include:

1. Part-time nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available;

2. Part-time home health aid services, consisting of primarily patient care of a medical or therapeutic nature, by other than a registered or licensed practical nurse;

3. Inhalation, physical, occupational or speech therapy provided by the home health care agency; and

4. Medical supplies prescribed by a Physician and laboratory services by or on behalf of a Hospital.

Home health care expenses ***will not*** *include* custodial care, housekeeping services, child care, cooking or laundry services.

All home health services must be ordered by a Physician and are subject to review and verification by the Plan's Executive Administrator.

Hospice Care

The hospice care plan must be submitted in writing by the attending Physician for home or in-patient hospice care which treats the special needs of the terminally ill patient and his/her family. The hospice care plan must be approved by the Fund Administrator as meeting established standards, including any legal licensing requirements of the state of locality in which it operates.

Covered charges made by a hospice care team under a hospice care plan for a terminally ill patient ***will*** include:

1. Charges for room and board, medications administered, durable medical equipment and general nursing care in freestanding or Hospital hospice; and

2. Charges for emotional support services provided in counseling sessions with the patient.

Charges will be considered at a daily flat rate for all services performed by the hospice care team under the hospice care plan, such rate to be negotiated by the Fund Administrator or Case Manager.

Chiropractic Treatment

The plan will pay 85% of the expenses incurred after satisfaction of the Major Medical deductible up to a maximum of $500 per calendar year for treatment by a chiropractor.

For purposes of this benefit, *Chiropractic Treatment* means the detection (including X-rays) or correction (by manual or mechanical means) of structural imbalance, distortion or subluxation to the body to remove nerve interference or its effects. The interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

No other benefits for Chiropractic Treatment will be paid under the Plan.

Foot Disorders

The Plan will pay expenses incurred for the examination, diagnosis, prevention, treatment and care of non-surgical conditions and functions of the foot.

Routine Drug Testing Benefit

In addition to the Plan's coverage for medically necessary lab tests performed to diagnose or treat a covered condition, the Plan will cover charges incurred for a routine blood test, urinalysis, or any other type of testing or screening performed solely to determine the presence of controlled substances or illegal substances, subject to the provisions outlined below. For this purpose, a drug test or drug screening is the full

series of tests performed in analyzing and assaying the single specimen provided by the patient, without regard to the number of tests performed.

- The maximum benefit per specimen drawn is $250.

- The benefit is payable at 85% after satisfaction of the Major Medical deductible.

Preventive/Wellness Benefits:

The Plan provides coverage for a wide range of preventative services as required by the Patient Protection and Affordable Care Act of 2010 (the "ACA") and which are outlined below. In addition to the ACA covered preventative services, the Plan provides expanded coverage for certain wellness services. Coverage is limited to participating PPO providers and is subject to a Fund payment percentage of 100%, with no deductible.

ACA Recommended Preventive Services:

ACA recommended preventative services generally include the following:

a. Evidenced-based items or services with a rating of A or B, that are considered to be current recommendations of the United States Preventative Services Task Force (USPSTF) for purposes of ACA;

b. Immunizations for routine use in children and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);

c. For infants, children and adolescents, evidence-informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

d. For women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA.

If preventative services are received from a non-PPO provider, they will not be covered. If Federal guidelines are unclear about which preventive benefits must be covered, the Trustees will determine whether a particular benefit is covered under this preventive services benefit. For recommendations in effect for less than one year, coverage of the newly recommended preventive service will become effective as of the first plan year (fiscal year) beginning at least one year after the effective date unless otherwise required by law. The following is intended to be a list of the recommended preventive services that are current as of the date this booklet was printed. However, this list will automatically be updated to include any applicable changes to recommended preventive services that the Plan is required to cover under ACA.

Covered Preventive Services for All Adults

Abdomina l Aortic Aneurysm	One-time screening for men ages 65-75 who have ever smoked
Alcohol Misuse	Screening and counseling to reduce alcohol misuse in primary care settings for adults (age 18 and older)
Aspirin Use	To prevent cardiovascular disease for adults ages 50 to 59
Blood Pressure	Screening for adults (age 18 and older)
Cholesterol Screening	For men age 35 and older; men age 20-35 if at increased risk for coronary heart disease; women age 45 and older; women age 20-45 if at increased risk for coronary heart disease
Colorectal Cancer Screening	Fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults age 50-75
Depression	Screening for adults
Abnormal Blood Glucose and Type 2 Diabetes	Adults age 40-70 who are overweight or obese
Diet	Counseling for adults who are overweight or obese and who have additional risk factors
Falls Prevention	Adults age 65 or older
Hepatitis B Screening	For persons at high risk of infection
Hepatitis C Screening	For persons at high risk of infection and adults born between 1945 and 1965
HIV Screening	Screening for adults ages 15-65, pregnant women and all adults at higher risk
HIV Preexposure Prophylaxis	Preexposure prophylaxis for persons at high risk of HIV acquisition effective May 1, 2021.
Immunization	Vaccines for adults – doses, recommended ages, and recommended populations vary: Hepatitis A Hepatitis B Herpes Zoster (Shingles) Human Papillomavirus Influenza (Flu Shot) Measles, Mumps, Rubella Meningococcal Pneumococcal Tetanus, Diptheria, Pertussis Varicella
Lung Cancer	Screening for adults age 55 to 80 who have smoked in the past 15 years
Obesity	Screening and counseling for adults with a BMI of 30 or higher
Sexually Transmitted Infections	Counseling for sexually active adolescents and women and for all adults at increased risk
Skin Cancer	Counseling to age 24 for individuals with fair skin
Statin Use	For adults age 40 to 75 with certain risk factors
Syphilis	Prevention counseling for persons at higher risk and for all pregnant women

Tobacco Use	Screening for all adults and cessation interventions for tobacco users
Tuberculosis	Screening for latent infection in populations at increased risk
Vitamin D and Calcium	Supplements for community-dwelling adults age 65 or older who are at increased risk for falls
Well Visits—To Obtain Recommended Preventive Services	

Covered Preventive Services for Women

Anemia	Screening on a routine basis for pregnant women
Aspirin Use to Prevent Morbidity and Mortality from Preeclampsia	Low-dose aspirin for pregnant women at high risk of preeclampsia
Bacteriuria	Urinary tract or other infection screening for pregnant women
BRCA	Counseling about genetic testing for women at higher risk
Breast Cancer Chemoprevention	Counseling for women at higher risk
Breast Cancer Screening	Screenings every 2 years for women ages 50 to 74
Breastfeeding	Support and counseling for pregnant and nursing women
Cervical Cancer	Screening for women ages 21 to 65
Chlamydia Infection	Screening for younger women and other women at higher risk
Contraception	Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
Domestic and Interpersonal Violence	Screening and counseling for all women
Folic Acid	Supplements for women who may become pregnant
Gestational Diabetes	Screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
Gonorrhea	Screening for younger women and women at higher risk
Hepatitis B	Screening for pregnant women at their first prenatal visit
Human Papillomavirus (HPV) DNA Test	High Risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
Intimate Partner Violence	Screening and support for women of reproductive age
Osteoporosis	Screening for women age 65 or older and younger women at increased risk
Perinatal Depression	Screening and counseling for pregnant and postpartum women
Preeclampsia	Screening for all pregnant women
Rh (D) Incompatibility	Testing for pregnant women
Well-Woman Visits to Obtain Recommended Preventive Services	

Covered Preventive Services for Children

Alcohol, Tobacco and Drug Use	Assessments for adolescents
Autism	Screening for children at 18 and 24 months
Behavioral	Assessments for children of all ages
Bilirubin Concentration	Screening for newborns
Blood Pressure	Screening for children
Blood	Screening for newborns
Cervical Dysplasia	Screening for sexually active females
Depression	Screening for adolescents ages 12 to 18
Developmental	Screening for children under age 3, and surveillance throughout childhood
Dyslipidemia	Screening for children at higher risk of lipid disorders
Fluoride Chemoprevention	Supplements for children without fluoride in their water source
Fluoride Varnish	For infants and children
Gonorrhea	Preventive medication for the eyes of all newborns
Hearing	Screening for newborns and children
Height, Weight, and Body Mass Index	Measurements for children
Hematocrit or Hemoglobin	Screening for children
Hemoglobinopathies or Sickle Cell	Screening for newborns
Hepatitis B	Screening for adolescents at high risk
HIV	Screening for adolescents at higher risk
Hypothyroidism	Screening for newborns
Immunizations	Vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis Haemophilus Influenzae type B Hepatitis A Hepatitis B Human Papillomavirus Inactivated Poliovirus Influenza (Flu Shot) Measles, Mumps, Rubella Meningococcal Pneumococcal Rotavirus Varicella
Iron	Supplements for children ages 6 to 12 months at risk for anemia
Lead	Screening for children at risk of exposure
Maternal Depression	Screening for mothers of infants
Medical History	For all children throughout development
Obesity	Screening and counseling for children age 6 or older
Oral Health	Risk assessment for young children (10 years and younger)

Phenylketonuria (PKU)	Screening for this genetic disorder in newborns
Sexually Transmitted Infection (STI)	Prevention counseling and screening for adolescents at higher risk
Tuberculin	Testing for children at higher risk of tuberculosis
Vision	Screening for children ages 3 to 5
Well Child Visits to Obtain Recommended Preventive Services	

Supplemental Wellness Benefits:

The Plan provides additional coverage as a supplement to those listed above, as follows:

- **Colonoscopies.** The ACA provides for coverage of routine colonoscopies and other colorectal cancer screenings at specified intervals for covered individuals ages 50 through 75. The Plan further provides that colonoscopies will be covered at five year frequencies, and provides for such coverage to continue after attainment of ages 75.

- **Mammograms.** The ACA requires that routine mammograms must be covered every other year for women ages 50 through 74. The Plan expands that coverage so that a single baseline routine mammogram is covered between ages 35 and 40. Upon attainment of age 40, mammograms are then covered annually, and such coverage does not cease after attainment of age 74.

- **Pap Smears.** The ACA generally requires that Pap Smears must be covered once every three years for women aged 21 to 65 years. The Plan expands that benefit by providing coverage regardless of age, and at more frequent intervals as medically appropriate.

- **Hearing Tests.** The ACA requires that hearing screenings be provided for all newborns. The Plan provides coverage for audiograms for all covered persons at reasonable intervals.

- **PSA Tests.** The ACA does not require any coverage for prostate-specific antigen (PSA) tests. The Plan however does cover such tests, in conjunction with a DRE, after age 50, or earlier with a family history of prostate cancer, at reasonable intervals.

Exclusions and Limitations

Individual benefit provisions have exclusions and limitations which apply only to those benefits. The following exclusions and limitations apply to the Basic Accident Benefit, the Major Medical Benefits and the Prescription Drug Benefit Program.

No benefit will be payable under this Plan for:

1. Treatment of infertility or the promotion of fertility, including the reversal of surgical sterilization, and any attempts to cause pregnancy by hormone therapy, artificial insemination, embryo transfer, or any other treatment method;

2. Expenses covered in the past unless specifically identified as covered benefits in this Summary Plan Description;

3. Charges made by medical personnel or "stand by" services when no care was actually rendered;

4. An inpatient hospital admission that began prior to the patient's effective date;

5. Injuries caused by, or contributed to by, committing or attempting to commit an assault, battery, felony, or misdemeanor (except misdemeanors that are traffic offenses) or while participating in a riot or civil insurrection, except in cases of domestic violence. Such exclusions and limitations also apply while charges are pending. Further, the lack of a conviction or the failure to issue a citation by a law enforcement agency does not mean or conclude that the Injury was not caused by, nor contributed to by, committing or attempting to commit an assault, battery, or felony, or misdemeanor;

6. Injury or Sickness resulting from declared or undeclared war or any act of war;

7. Injury or Sickness arising out of employment or for which you or your Dependent are entitled to receive benefits under any Worker's Compensation or Occupational Disease Law;

8. Services or supplies which are not recommended by a Physician and which are not considered to be medically necessary;

9. Induced abortions unless necessary to avert the death of the woman or to terminate a pregnancy caused by rape or incest;

10. Confinement in a United States government or agency hospital. However, this limitation does not apply to those expenses otherwise covered under the Plan and incurred by the United States or one of its agencies for inpatient medical care if the care is given by a Hospital of the uniformed services and provided to a member of the armed services or the family member of an active, retired or deceased member of the uniformed services;

11. Expenses incurred for which a Covered Person is not legally required to pay except for those expenses otherwise covered under the Plan and incurred by the United States for treatment given by the United States or one of its agencies to a veteran for a disability which is not "service-related;"

12. Charges for education, training or room and board if the covered person is confined in an institution which is primarily a school, an institution for training, a place for rest, a place for the aged or a nursing home;

13. Rest cures, domiciliary care, convalescent care or custodial care, which is care provided primarily for convenience, or to assist the patient in the activities of daily living, or custodial in nature when the constant attention of trained medical personnel is not required;

14. Cosmetic surgeries and procedures performed mainly to improve or alter a person's appearance, including body piercing and tattooing. For purposes of this exclusion/limitation, the term "cosmetic surgery or procedure" does not include a surgery or procedure required to correct a deformity caused by disease, trauma or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures required to correct congenital abnormalities that cause functional impairment. No type of procedure, therapy or medication required for the treatment of acne and scarring caused by acne will be covered by the Plan;

15. Transsexual surgery, including any hormone therapy or other related treatment, procedures or therapy;

16. Penile implants and care for and/or related to sexual dysfunction, including prescription drugs for the treatment of sexual dysfunction;

17. Charges related to sleep therapy and/or sleep clinics, unless pre-authorization for the treatment is obtained from the Executive Administrator and/or Medical Consultant;

18. Charges for acupuncture, acupressure or hypnosis;

19. Charges for the treatment of temporomandibular joint syndrome (TMJ);

20. Eye exams (other than covered vision screenings for children), glasses, or contact lenses except contact lenses required as a result of a covered surgical procedure;

21. Hearing aids and related evaluations;

22. Custodial care;

23. Dental care and treatment, unless within six months of an injury or for cutting procedures in the month (but see the Dental Benefits on pages 40 through 42);

24. Charges for Injuries or Sickness of children of Dependent children.

25. Charges related to the pregnancy or childbirth, or any complications of pregnancy or childbirth, of a Dependent daughter, except as required by the Patient Protection and Affordable Care Act.

26. Injuries or Sickness for which a third party may be liable or legally responsible except as provided in the Subrogation and Right of Reimbursement Section.

27. Services required for the treatment of obesity or morbid obesity, including surgery therefor, and treatment for medical complications arising from non-covered services for obesity and morbid obesity.

28. Any loss due to an intentionally self-inflicted injury, unless the self-inflicted injury is the result of a medical condition, including a previously diagnosed mental or nervous disorder;

29. Services that are of the nature of stress management, family planning, marital counseling, social counseling, educational or vocational testing or training and the treatment of learning disabilities, behavioral problems and behavioral modification therapy, biofeedback and other forms of self-care or self-help training;

30. Care and treatment for the reversal of surgical sterilization;

31. Care and treatment for hair loss unless caused by an underlying medical condition. Male pattern baldness is not considered an underlying medical condition;

32. Travel and lodging for the treatment of any condition, whether or not recommended by a Physician;

33. Neuromonitoring services other than such services when administered by an in-network hospital or surgical facility;

34. Any portion of an expense for care and treatment that is considered by the Trustees to be in excess of Usual, Customary and Reasonable (UCR) charges. For purposes of this section, a UCR charge is a charge which, in the opinion of the Trustees, does not exceed the usual charge made for the care, treatment or supply by most providers in the same geographical area as the provider administering the service. The nature and severity of the condition being treated, as well as any complications or unusual circumstances that require more time, skill or experience will be considered in determining the UCR value of the treatment and charges. The Trustees' decision on what constitutes UCR will be conclusive and binding;

35. Exercise programs;

36. Gene therapy, regardless of its intended use or stated purpose; and

37. Charges for services administered by an assistant surgeon for medically necessary treatment which exceed fifty percent (50%) of the amount paid by the Fund to the primary surgeon.

Supplemental Family Medical Benefit

If you or any of your eligible Dependents should incur expenses for Necessary Treatment which are not otherwise covered by and reimbursed by this Plan, the Plan will cover and reimburse you for those expenses in an amount not to exceed $300 per eligible family per calendar year. In order for such expenses to be covered by the Plan, the following guidelines and restrictions must be satisfied for each and every such expense:

Eligible Expenses

For purposes of this benefit, the following eligible expenses incurred for Necessary Treatment will be covered, but only if they are not otherwise covered by the Plan, they have been incurred for medical, dental or vision care treatment, and they are deductible for federal income tax purposes:

1. Medical supplies required for the treatment of a covered Sickness or Injury;

2. Any type of dental care or vision care not otherwise covered by the Plan, including orthodontia care for Dependent children and prescription eyeglasses or contact lenses;

3. Any type of medical expense incurred for a Sickness or Injury otherwise covered by the Plan but not payable because of the application of a Plan benefit maximum;

4. Hearing examinations and hearing aids; and

5. Expenses otherwise covered by the Plan but not paid in full, provided such expenses will exclude those used to satisfy a Plan deductible or the Plan's Full Payment Provision.

PLEASE NOTE: Regardless of any other provisions, no charges will be covered for services rendered, or items purchased, at a Wal-Mart store, a Wal-Mart pharmacy or affiliated pharmacy, or at a Wal-Mart vision center.

Ineligible Expenses

For purposes of this benefit, the following expenses will be excluded from coverage and will not be eligible for reimbursement by the Plan:

1. Expenses used to satisfy a Plan deductible;

2. Expenses used to satisfy the Plan's out-of-pocket payment maximum;

3. Plan co-payment amounts;

4. Expenses otherwise covered by the Plan;

5. Expenses that are not deductible for federal income tax purposes;

6. Expenses listed under the Major Medical Exclusions and Limitations section of this Plan, other than those set forth as eligible expenses above, to include the following specific exclusions and limitations.

    - Treatment of infertility;
    - Cosmetic surgery except as otherwise provided;
    - Transsexual surgery;
    - Treatment of sexual dysfunctions, including any hormone therapy or other related treatment, procedures or therapy;
    - Acupuncture, acupressure and hypnosis;
    - Treatment of temporomandibular joint syndrome (TMJ); and
    - Custodial care and education.

7. Expenses incurred for diets and other weight loss programs;
8. Expenses incurred for smoking cessation programs not otherwise covered by the Plan;
9. Expenses incurred for exercise programs, health club dues and membership fees;
10. Expenses incurred for the treatment of an eligible Dependent child's behavioral problems not otherwise covered by the Plan;
11. Expenses incurred for the purchase of hot tubs and jacuzzis and any other durable equipment not specifically covered by the Plan;
12. Premiums paid for the purchase of spousal group health coverage; and
13. Expenses filed more than twelve months following the date the expense is incurred.

Claims Filing Procedures

Reimbursements for Covered Expenses payable under this Supplemental Family Medical Benefit will be paid only if the following requirements are satisfied:

1. The expense must be first paid by the eligible employee and reimbursement sought in writing from the Fund office;
2. Any claim for the payment of Covered Expenses must be filed with the Fund office in the manner prescribed by the Trustees and on such forms as may be made available by the Fund office; and
3. Any claim for the payment of Covered Expenses must be filed with the Fund office no later than twelve months following the date on which the claim is incurred.

This page is intentionally left blank

This page is intentionally left blank

Dental Benefits

If you or your Dependent incur any of the covered dental expenses outlined below, the Plan will make payment in accordance with the Schedule of Benefits and the provisions outlined in this section. Payment is subject to the following:

1. If there is a lesser charge for an appropriate alternative treatment of service, we will consider that to be the covered charge;

2. Covered charges must be incurred while eligible for benefits; and

3. Benefits for orthodontic services will be paid in, and up to, eight quarterly installments over the course of treatment.

A charge will be deemed incurred as of the date the service is rendered or the supply is furnished, except that such charge will be deemed incurred:

1. With respect to fixed bridgework, crowns, inlays or gold restorations, on the first date of preparation of the tooth or teeth involved;

2. With respect to full or partial dentures, on the date the impression was taken; and

3. With respect to endodontics, on the date the tooth was opened for root canal therapy.

Deductible Per Calendar Year (Not Applicable to Covered Orthodontic Services)

The deductible applies separately to you and each of your Dependents for dental benefits in each calendar year, except that if two or more members of your family are injured in the same accident, only one cash deductible will be applied each year against all the covered dental charges incurred as a result of such accident.

Covered Dental Procedures

The following procedures are subject to the $600 calendar year maximum benefit for all covered persons:

Preventive Care Services (100%)

Oral exams, 1 per 6 months
X-Rays, including bitewing films, 1 per 6 months
Full mouth X-rays, 1 per 6 months
Prophylaxis (cleaning of teeth), 1 per 6 months
Fluoride applications, 1 per calendar year for children under 14
Space maintainers
Emergency visits for pain

Basic Services (80%)

Diagnostic casts and biopsies
Extractions
Oral surgery
Periodontics
Injectible antibiotics
General anesthesia for oral surgery
Endodontics
Root canals
Amalgam and Synthetic restorations (fillings)

(Continued on next page)

Major Services (50%)

Inlays and onlays
Crowns
Pontics
Removable bridges, unilateral
Occlusal guards
Repairs to crowns and bridges
Dentures and partial dentures

Basic Services (80%)

Denture repairs (acrylic)
Recementation of inlays, crowns and bridges and adjustments
Denture relinings and rebasings, 6 months or more after installation
Partial denture repairs
Adding teeth to partial dentures

Covered Orthodontic Procedures

The following services are covered for Dependent children under age 19 only, and are not subject to the deductible. These procedures are limited to a lifetime maximum benefit of $500 and are payable at 50%.

Radiographs
Minor tooth guidance
Interceptive orthodontic treatment
Treatment of transitional and permanent dentition

Additional Pediatric Dental Services

The following additional dental benefits are provided to covered persons under age 19, through the last day of the calendar month in which they attain age 19.

Preventive Care Services (100%)

Oral exams, 1 per 6 months
X-rays, including bitewing films, 1 per 6 months
Full mouth X-rays, 1 per 6 months
Prophylaxis (cleaning of teeth), 1 per 6 months
Fluoride applications, 1 per calendar year for children under 14

Basic Services (80%)

Extractions
Amalgam and Synthetic restorations (fillings)

These pediatric dental services are not intended to duplicate the Dental Benefits outlined above or increase the frequencies of covered services. They are intended only to provide additional payment, if needed, for these types of services that are otherwise covered under the Dental Benefits but are in excess of the $600 calendar year maximum benefit.

Dental Benefits Exclusions and Limitations

No coverage is provided for:

1. A service for cosmetic purposes, unless needed because of Injury;

2. Replacement of lost or stolen appliances;

3. Appliances, restorations or procedures to alter vertical dimension, restore or maintain occlusion, or replace tooth structure lost as a result of abrasion or attrition, or for TMJ or splinting;

4. A service not furnished by a dentist, except by a dental hygienist or for X-rays;

5. A person's first denture or bridge that replaces teeth lost before becoming covered, unless it also replaces teeth extracted after becoming covered;

6. The replacement of any appliance, crown, restoration or bridge within five years of the date of the last placement, unless needed because of Injury;

7. Orthodontic services if an active appliance has been installed prior to becoming covered; and

8. Dietary counseling and training in oral hygiene and plaque control, including supplies used.

Extension of Dental Benefits

If yours or your Dependent's dental coverage terminates, certain dental benefits shown below may still be payable for up to 90 days if the preliminary work occurred before coverage terminated:

1. For an appliance (except orthodontic appliances), if a master impression was made;

2. For a crown, bridge, onlay or inlay, if a tooth was prepared; and

3. For a root canal, if a pulp chamber was opened.

Benefits for orthodontic work in progress will be payable through the end of the month in which coverage terminates.

Successive Periods of Disability

Successive periods of Hospital confinement and successive surgical procedures will be considered as occurring during one period of disability unless you or your Dependent have completely recovered from the Injury or Sickness causing the earlier confinement or surgical procedure, or in the case of pregnancy-related conditions, the later confinement or procedure is due to a different pregnancy, or;

1. For you only, you have returned to active work with a contributing employer for at least one full day before the later confinement or procedure; or

2. For your Dependent only, the later confinement or procedure is due to an Injury or Sickness entirely unrelated to the causes of the earlier confinement or procedure or unless your Dependent has returned to the full-time duties of his regular occupation of normal activity.

Coordination of Benefits

When you or your Dependent(s) are covered under more than one group plan, the total benefits payable to you or your Dependent(s) under this Plan in a calendar year will be reduced to the extent necessary so that the sum of the benefits payable by this Plan and any other plan will not exceed 100% of the "allowable expenses."

In the event that an employer provides fully paid group health coverage for you and such coverage is not accepted by you or your Dependent, you or your Dependent will be presumed to be covered by the available "other" group plan, and the benefits otherwise payable under such "other" group plan will be taken into account to determine the amount of benefit payable under this Plan, in accordance with these Coordination of Benefits ("COB") provisions. In the event that an employer provides group health coverage for a Dependent spouse and such spouse does not elect this "other" coverage, this Plan will still provide only those benefits payable under the COB provisions between such spouse's "other" group plan and this Plan.

To the extent allowed by the Patient Protection and Affordable Care Act and the regulations thereunder, no coverage of any kind will be afforded under this Plan to an eligible employee's Dependent who has, or has available, medical coverage of any kind under his or her employer's plan unless the employer's plan provides the same maximum benefits to all its employees irrespective of the coverage the employee (or the person of whom he or she is a dependent) may be entitled to in another plan. Any Dependent of an eligible employee adversely affected by this provision will be entitled to appeal to the Board of Trustees for determination of hardship acceptance based upon circumstances beyond the control of said Dependent and the assignment, by the Dependent to the Board of Trustees, of available remedies against the Dependent's employer and/or the employer's plan or insurer.

A Covered Employee Must Report Any Other Group Health Coverage Which Covers the Employee or Eligible Dependent(s) on the Claim Form He Submits to the Fund Office.

The important thing to remember is that Coordination of Benefits is designed for just one purpose – to conserve your health care dollars. This protects the entire Plan from unnecessary increases in cost. Benefits are reduced only to the extent necessary to prevent an individual from recovering more money than he was charged and required to pay.

Allowable Expense

Allowable Expenses are any medically necessary, reasonable and customary items of expense for medical treatment or supplies incurred by an eligible person during a calendar year and while eligible under this Plan for medical care or treatment, part or all of which are covered under any of the other plans covering the person for whom claim is made. When benefits from a plan are in the form of services, not cash payments, the reasonable cash value of each service is both an allowable expense and a benefit paid. Allowable Expenses do not include any expenses listed in the Exclusions and Limitations.

Other Plan

Other Plan refers to any of the following plans which provide full or partial health benefits for services on an insured or self-funded basis:

1. Group practice, group Blue Cross or group Blue Shield, individual practice offered on a group basis or any other group HMO or prepayment coverage;

2. Labor-management trusteed plans, union welfare plans, employer organizations plans or employee benefit organization plans or any other arrangement of benefits for individuals of a group;

3. Governmental programs or coverage required or provided by any statue. However, "other plan" does not include no-fault or under-insured insurance coverage, and further, does not include any governmental program coverage which is not allowed by law to coordinate. When medical payments are available under vehicle insurance, this Plan will pay excess benefits only. This Plan will always be the secondary carrier;

4. Medicare, to the extent permitted by law; and

5. This Plan when an individual is covered as both an employee and a Dependent, and when a child is covered as a Dependent of more than one employee.

"Other Plan" will apply separately:

1. To each policy, contract, agreement or other plan for benefits or services; and

2. To that part of such policy, contract, agreement, or plan which reserves the right to consider the benefits or services of other plans in determining its benefits and to that part which does not.

Which Plan Pays First

The plan under which benefits are payable first is the primary plan. All other plans are called secondary plans. The secondary plans pay any remaining unpaid allowable expenses. No plan pays more than it would have paid without this provision.

The rules below determine which plan's benefits are payable first:

1. A plan which does not have a COB provision is always primary and pays its benefits first;

2. If the individual is covered as a participant under two plans, the plan which has covered him the longer is primary;

3. A plan which covers the individual as an active participant pays before a plan which covers the individual as a laid-off employee or as a retiree; or

4. A plan which covers the individual as a participant pays before a plan which covers the individual as a dependent.

The rules below determine which plan's benefits are payable first, if a Dependent child is covered under two or more plans.

1. If the parents are not divorced or separated:

The plan that covers the parent whose date of birth occurs earlier in the calendar year, excluding the year of birth, pays first. If the birthday of both parents occurs on the same date, the plan which has covered the parent for the longer period of time pays first.

2. If the individual is a Dependent child of separated or divorced parents, the "order of payment" used to determine the primary plan is as follows:

   a. The plan of the natural parent with custody of the child pays first.

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

   c. If a court order makes one parent financially responsible for the health care expenses of the child, that parent's plan will pay first.

If a covered employee or any one of his eligible Dependents elects to be covered by an employer sponsored Health Maintenance Organization (HMO) which is determined to be the primary payor, no benefits are payable under this Plan. Also, if the participant or any one of his eligible Dependents violates the provisions of the HMO (e.g. neglecting to utilize the facilities of the HMO), no benefits will be payable under this Plan.

In the event that an employer provides group health coverage for a newborn baby of a Dependent spouse at no additional cost or at nominal cost by enrolling said newborn baby within a time limit so as to render said coverage by the other plan primary and render coverage by the Railroad Maintenance and Industrial Health and Welfare Fund as secondary, then the failure to so enroll said newborn baby within said time limit shall result in the Railroad Maintenance and Industrial Health and Welfare Fund providing only those benefits payable under the COB provisions between such other plan and our Plan.

If the Fund office has made payment of any amount that is in excess of that permitted by these COB rules, the Fund office has the right to recover such amount from any party that has received such overpayment.

Information necessary to the administration of this COB provision will be required at the time a claim is submitted.

Termination of Benefits

Employees

Your benefits will terminate on the earliest of:

1. The last day of the last period for which you made any required contribution.

2. The date you enter the armed forces of any country, except as otherwise provided on page 14; or

3. The date you are no longer eligible for benefits according to the Rules of Eligibility.

Dependents

Your Dependent's benefits will terminate on the earliest of the following:

1. The date your benefits terminate;

2. The date he/she enters the armed forces of any country; or

3. The date your Dependent ceases to be a Dependent as defined in this booklet.

You and your Dependents have certain rights to continue your benefits if your benefits are terminated. Refer to the Continuation of Coverage section beginning on page 48 of this booklet or contact the Fund office for more details.

Important rules concerning rights to continue benefits are contained on the next five pages.

Continuation Coverage Rights under COBRA

Introduction

This section contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under Federal law, you should contact the Fund office.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower-out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced; or
- The child stops being eligible for coverage under the Plan as a "Dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to a contributing employer and that bankruptcy results in loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or commencement of a proceeding in bankruptcy with respect to a contributing employer, the employer must notify the Fund office of the qualifying event. However, it may be in the best interest of qualified beneficiaries to contact the Fund office as well in the event of the death of an employee so that notification can be given as timely as possible.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a Dependent child), you must notify the Fund office in writing within 60 days after the qualifying event occurs. You must send this notice to the Fund office at the address listed on page 52. In the event of divorce, you must also furnish a copy of the divorce decree. In the event of a child ceasing to qualify as a covered dependent, you must furnish a copy of the dependent's birth certificate or other proof of date of birth.

How is COBRA Coverage Provided?

Once the Fund office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have the right to elect

COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

How Long Does COBRA Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, divorce or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan are determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Fund office in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Fund office is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation. You must send this notice and proof of determination of disability to the Fund office at the address listed on page 52.

Maximum period of 24 months for service in the armed forces

As explained on page 14, if you enter active duty in the Uniformed Services of the United States of America for a period of 31 days or more, the maximum period of COBRA coverage which you may elect is 24 months, provided you notify the Fund office within 60 days of your entry into active service.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a combined maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies or gets divorced. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Fund office is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund office along with proof of divorce or date of birth of the dependent child.

Procedure for Obtaining Continuation Coverage

Once the Fund office knows that an event which qualifies you or a covered dependent for continuation coverage has occurred, the Fund office will send an election notice to your last known address or to the address of your dependent, as applicable. You will have sixty days after the date on the election notice in which you or your dependent must notify the Fund office of an election to continue coverage. If you or your dependent do not elect coverage within the sixty-day time period, the right to continue group health coverage will end. A period of forty-five days will be allowed from the date of an election of continued coverage in which to remit any retroactive payment due under this provision. Each employee, or each covered dependent if electing separately, will be required to make monthly payments in an amount and manner which will be determined by the Trustees in accordance with applicable law. The monthly amount of each payment will be established no more than once each year.

Type of Coverage Extended

The benefits provided under COBRA will be the same as those provided to active employees and their dependents, except that no Death Benefits or Accidental Death and Dismemberment Benefits will be extended.

Cancellation of COBRA Coverage

Continued coverage will be cancelled by the Fund upon the occurrence of any of the following events:

- You do not make the required monthly payment by the due date, including the allowable 30 day grace period;
- The Plan terminates;
- You become covered under any other group health care plan; or
- You become covered by Medicare.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Childrens' Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of those options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

[1]https://medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

- The month after your employment ends; or

- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund office at the address listed below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPPA) the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov.ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Fund office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund office.

Plan Contact Information

Information about the Plan and about your rights and obligations under COBRA can be obtained at the Fund office by writing or calling:

Railroad Maintenance and Industrial Health and Welfare Fund
2725 West Monroe Street
Springfield, IL 62704
(217) 787-2923
(800) 258-6534

Subrogation and Right of Reimbursement

Third party means a person or organization other than the covered person who suffers loss.

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

1. Any claim arising, or arguably arising, from a work-related cause shall be first submitted by the claimant or his representative to, and administered through, the workers' compensation administration of the jurisdiction in which the claim occurred. No benefits shall be paid regarding said claim unless, and to the extent, the workers' compensation claim is disproved and denied by the Industrial Commission. Further, no benefits regarding said claim shall be paid until disposition of the workers' compensation claim; provided, however, that in cases of hardship or extenuating circumstances, the claimant and/or this representative may request relief from these guidelines through the Appeal Procedure of the Fund, and as a condition of granting said relief, the claimant and/or his representative must execute and submit to the Fund a Subrogation Agreement in a form prescribed by the Fund.

2. Any claim arising, or arguably arising, from circumstances for which a third party (including uninsured and under insured carriers) may be liable, shall be first submitted by the claimant and/or his representative to the insurance carrier responsible therefore or shall be first pursued by the claimant in an appropriate third-party action. No benefits shall be paid regarding said claim unless, and to the extent, third-party liability is disproved and denied. Further, no benefits regarding said claim shall be paid until disposition of the third-party action; provided, however, that in cases of hardship or extenuating circumstances, the claimant and/or his representative may request relief from these guidelines through the Appeal Procedure of the Fund, and as a condition of granting said relief, the claimant and/or his representative must execute and submit to the Fund a Subrogation Agreement in a form prescribed by the Fund.

Should the claimant present to the Trustees, or their committee, a hardship or extenuating circumstances which is subsequently granted by the Committee, or should the Plan mistakenly provide benefits for which a third party may be liable or legally responsible, any benefits paid will be paid according to the terms of the Plan regardless of whether a Subrogation Agreement is signed as follows:

1. As a condition to receiving medical, dental or any combination of benefits under this Plan, covered person(s), including all dependents, upon request of the Fund, agree to transfer to the Plan their rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person.

2. Alternatively, if a covered person or a dependent receives any recovery by way of judgement, settlement or otherwise, from another person or business entity, the covered person or dependent agrees to hold such sum in trust for the benefit of the Fund and to reimburse the Plan in full, in first priority, for any medical, dental or any combination of expenses paid by it (*i.e.*, the Plan shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the Plan member).

3. If a covered person or dependent receives any recovery, by way of judgement, settlement or otherwise, from any other person or business entity, the covered person or dependent agrees to reimburse the Plan in full, in first priority, regardless of whether the settlement or judgement specifically designates the recovery, for any medical or disability expenses paid by it (*i.e.*, the Plan shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the Plan member).

4. If a repayment/reimbursement agreement is required to be signed, and if, for any reason, said repayment/reimbursement agreement is not signed and a claim is paid, then the Fund shall be entitled to repayment/reimbursement regardless of whether the agreement was signed.

5. The Plan's right of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person, dependent or guardian receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medial payments, no-fault or school insurance coverage which are paid or payable.

6. The Plan may enforce its reimbursement or subrogation rights by requiring the employee, dependent or guardian to assert a claim to any of the foregoing coverages to which he/she may be entitled.

7. The Plan will not pay attorney fees or costs associated with the Plan member's claim/lawsuit without express written authorization.

8. The Plan's right to recovery as set forth herein shall survive the death of the participant, dependent and beneficiary and shall automatically bind the decedent's successors, assigns, executor or estate.

9. Acceptance of benefits under this Plan signifies acceptance of these terms and conditions.

10. Neither the "make whole" doctrine nor the "common fund" doctrine will be applicable to reduce the Fund's rights to recovery and reimbursement.

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

Moreover, no claim arising from a work-related injury or third-party liability circumstance will be paid unless relief is specifically granted through the Fund's Appeal Procedure.

Right of Recovery/Reimbursement of Overpayment and Offset of Future Benefits

Whenever payments have been made by the Plan with respect to changes in total amount at any time in excess of the maximum amount of payment required under the provisions of this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: (1) any persons to, or for, or with respect to whom such payments were made; (2) any insurance companies; and (3) any other organizations.

Further, in the event you receive an overpayment of benefits, on your behalf or on behalf of your dependent, you are obligated to refund the overpayment to the Plan immediately. In the event you fail to refund any overpayment, then the Plan can offset the overpayment against future benefits until the overpayment is fully recouped, or suspend your benefits until the said overpayment is paid in full. Such offset and/or suspension can be applied to your benefits or your dependent's benefits regardless of who received the overpayment. The Plan may also initiate an action on the court of competent jurisdiction and obtain any and all appropriate relief (including equitable relief).

Procedures Under a Qualified Medical Child Support Order (QMCSO)

Pursuant to Federal law, group health plans must provide coverage for any participant's child (known as an "alternate recipient") who is recognized under a Qualified Medical Child Support Order ("QMCSO") as having the right to enroll under the Plan for benefit coverage when a court of competent jurisdiction issues a judgement, decree or order (including approval of a settlement agreement).

A QMCSO is a "Medical Child Support Order" made pursuant to state law or enforces a law relating to medical child support described in section 1908 of the Social Security Act as added by section 13822 of the Omnibus Budget Reconciliation Act ("OBRA") of 1993 that is qualified by the Fund pursuant to the procedures summarized below.

The following procedures are hereby adopted as the Plan's procedures for determining the qualified status of Medical Child Support Orders, for administering benefits under such Orders and for providing notifications to participants and alternate recipients:

1. The Board of Trustees shall delegate to the Fund Executive Administrator, in consultation with Fund Counsel as needed, the authority to determine whether a Medical Child Support Order is qualified pursuant to OBRA '93.

2. Any Medical Child Support Order or proposed Order which creates or recognizes an alternate recipient's right to receive medical benefits under the Plan shall be forwarded to the Fund Administrator by the participant, alternate recipient or their representative(s), with a request that a determination of qualification be made.

3. Upon receipt of any Medical Child Support Order or proposed Order involving the participation of an alternate recipient in the Plan, the Fund Administrator shall promptly notify the participant and alternate recipient or their representative(s) of such receipt. A copy of these procedures for determining the qualified status of the Medical Child Support Order shall be attached to the Fund Administrator's notification letter.

4. Within a reasonable period of time, the Fund Administrator shall review the Order for its compliance with OBRA '93 and these procedures. If the Order is not in compliance with OBRA '93 or these procedures, the Fund Administrator shall attempt to resolve the existing issues which prevent qualification of the Order with the participant and each alternate recipient and/or their representatives. The Fund Administrator shall notify the participant and each alternate recipient and/or their representative of its final determination regarding the Fund Administrator's review of the Order submitted.

5. If the participant or alternate recipient disagrees with the determination of the Fund Administrator, an appeal may be processed in accordance with the Fund's Appeal Procedures as provided beginning on page 64 of this booklet.

6. A Medical Child Support Order shall meet the following requirements in order for it to be a Qualified Medical Child Support Order:

a. The Order shall be a judgement, decree or order (including approval of a property settlement agreement) which relates to the provision of child support, with respect to a child of a participant under this Plan, which is made pursuant to a State's domestic relations law (including community property law) and which relates to medical benefits under this Plan.

b. The Order shall recognize an alternate recipient as having the right to enroll under this Plan. The term "alternate recipient" means any participant's child who is recognized by a Medical Child Support Order as having a right to enroll under the Plan with respect to such participant.

c. The Order shall also meet the requirements outlined below:

- The Order shall specify the name, social security number and mailing address of each alternate recipient covered by the Order. The alternate recipient or alternate payee's guardian shall be responsible for notifying the Fund Administrator of any change in address;

- The Order shall reasonably describe the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such coverage is to be determined. Such coverage and benefits will be the coverage and benefits in effect under the Plan at the time a covered medical expense is incurred;

- The Order shall specify the period of time to which the Order applies. Any alternate recipient who is eligible to participate in the Plan under a QMCSO shall be entitled to the same coverage and benefits as any other eligible dependent under this Plan;

- The Order shall state the proper legal name of such plan (or predecessor plan) to which such Order applies; and

- The Order shall not require the Fund to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

7. An alternate recipient, or the alternate recipient's custodial parent or legal guardian, may designate a representative to receive copies of any notices or other communications sent by the Plan to the alternate recipient. Such representative shall be responsible for notifying the Fund Administrator of the representative's current address and any change of address.

8. Any medical expense incurred by an alternate recipient will be processed and paid in accordance with the Plan's normal claims procedures. If a medical expense is to be paid directly to an alternate recipient, the Plan may reimburse either the alternate recipient or the alternate recipient's custodial parent or legal guardian for such medical expense.

9. An alternate recipient(s) will be eligible for benefits under the Plan only if the participant named in the QMCSO is eligible for benefits under the Plan. Consequently, if the participant named the QMCSO loses eligibility, the alternate payee(s) also loses eligibility. If the participant later regains eligibility, the alternate payee(s) will correspondingly regain eligibility consistent with the terms of the QMCSO.

10. For purposes of the reporting and disclosure requirement of ERISA, part 1, an alternate recipient shall be treated as a participant.

11. For purposes of COBRA continuation coverage, an alternate recipient shall be eligible independently to elect continued coverage, in accordance with the Plan's provisions for such coverage, upon the termination of the coverage of the participant identified in the QMCSO due to a qualifying event. In addition, the alternate recipient (or his/her designated representative) shall be provided independent notification of any COBRA continuation rights.

How to File Your Claims or Obtain Pre-Approval When Required

Certain rules and procedures have been established by the Trustees which must be followed by you when you or an eligible Dependent incur a claim, or when you expect to incur a claim which requires prior approval. These rules and procedures are explained below. You are encouraged to become familiar with them before you or an eligible Dependent incur a claim which you anticipate will be covered by the Plan.

Pre-Approval Required for Certain Claims – Your Responsibilities

Under some circumstances it is necessary for you to obtain approval for coverage of a claim in advance of the treatment being provided and the charge being incurred. This type of approval is generally required in three different instances, as follows:

1. As explained on page 21, all inpatient hospital admissions must be precertified through United HealthCare. Participating PPO hospitals are responsible for precertifying your stay, but be sure to present your ID card and verify that the hospital is a United HealthCare Choice Plus participating provider.

   If you are admitted to a non-PPO hospital, charges will be covered only for:

   - Treatment of Life-Threatening Emergency (see Definitions); or
   - If you are outside the area covered by the PPO (see Out-of-Area Provisions on page 2).

   In such case, the non-PPO hospital should precertify your stay, but it is ultimately your responsibility to see that your stay is precertified. Failure to do so will result in benefits being denied for your claim.

   All non-emergency hospital admissions must be precertified at least 24 hours prior to admission, while United HealthCare must be contacted within 24 hours after a hospital admission for a Life-Threatening Emergency.

   The information necessary for precertifying a hospital admission is found on your Plan ID card. Be sure to present your card to your doctor as well as to the hospital. United HealthCare may be contacted at **1-877-211-6542**.

   Pre-admission review gives the hospital and your physician the opportunity to not only review the need for your hospitalization, but to review your continuing stay requirements as well. As part of that process, your physician and United HealthCare will review and discuss the medical necessity and appropriateness of treatment as you or your eligible Dependent remain hospitalized.

   Coverage will not be provided under the Plan for a hospital admission which begins on Friday, Saturday or Sunday unless the confinement is for a medical emergency or if surgery is performed within 24 hours of the admission.

2. **Necessary Treatment Approval** – As explained on page 18 of this booklet, a charge must be for *Necessary Treatment* to be covered by the Plan. In most instances your doctor can make this determination. In other cases, the Fund office staff can assist you with this decision. However, in some circumstances the opinion of an independent professional organization will be required. If you believe it is necessary or helpful for a decision to be made in advance as to whether expected treatment is *Necessary Treatment*, you should call for assistance.

   The same company selected to provide Pre-Admission Certification services to the Fund, United HealthCare, was also chosen to provide utilization and quality review services, including determining whether proposed treatment is *Necessary Treatment*. United HealthCare is available at **1-877-211-6542** to review the appropriateness and quality of a person's care. In addition to Pre-Admission Certification, United HealthCare also offers pre-procedure review, continued stay review, discharge planning and obstetrical review, services they will perform at the request of and in cooperation with your health care provider. Of course, the Fund office staff can answer routine questions about coverage and even tell you in a general way if some treatment is *Necessary Treatment*.

3. **Compliance with the Plan Provisions, Exclusions and Limitations** – In an effort to help control the cost of providing benefits under the Plan and limiting coverage to benefits for treatment of a medical nature, various Plan provisions, exclusions and limitations have been adopted and are included in the Plan. These are very specific and are fully described in this booklet. Sometimes, however, questions arise as to whether a particular provision, exclusion or limitation applies to a specific condition or treatment.

   The Fund office staff can help you answer most of these questions. If they cannot, they will secure an answer for you from the Plan's Trustees in accordance with the procedures in this booklet. Sometimes the Fund's Executive Administrator, in consultation with a Medical Consultant, if required, will be able to respond to your inquiry. The Fund office staff will always be responsible for providing answers to all of your inquiries.

The Plan's Responsibilities Regarding Your Requests for Pre-Approval

You have the right under the Plan to request pre-approval of all treatment which may be covered by the Plan. As explained in the preceding sections, pre-approval is sometimes required. At other times, the proposed treatment may be of a non-routine nature and you would like assurances that related expenses will be covered by the Plan or you may simply prefer to secure pre-approval.

The Fund office staff or, if applicable, United HealthCare will respond to all such requests in a timely manner, as follows:

1. **Urgent Care Claims** – If proposed treatment is determined to be **urgent** in nature, as defined on the following page, a decision on your request for pre-approval will be made and communicated to you within 72 hours of receipt of your request. If it is determined that additional information is necessary to make a decision on your claim, you will be notified as soon as possible, but in no instance more than 24 hours after receipt of your request. You will then be given not less than 48 hours to provide the required information.

An Urgent Claim is a claim which, if treated as a claim for non-urgent care:

a. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

b. In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. **Non-Urgent Care Claims** – If proposed treatment is determined to be of a non-urgent nature, a decision on your request for pre-approval will be made and communicated to you within 15 days of receipt of your request. If it is determined that additional information is necessary to make a decision on your claim, the Plan may require up to an additional 15 days to make a decision on your request. If such an extension is required, you will be notified within 15 days of receipt of your request regarding the extension and a decision will be made as soon as possible. If the extension is required because it is necessary for you to provide additional information, you will be given at least 45 days to provide the requested information.

These procedures for processing requests for pre-approval of both urgent and non-urgent care claims have been adopted solely as guidelines and to assure compliance with applicable Federal Law. It will continue to be the practice and intent of the Trustees, as the Plan Administrator, the Fund office staff, the Executive Administrator and United HealthCare to timely process all requests for pre-approval review and to respond to all such requests immediately where possible, but always within the time periods described above.

Filing All Other Claims – Your Responsibility

If you or an eligible Dependent incur charges for which a claim will be filed with the Plan, you must contact Fund Office at 2725 West Monroe Street, Springfield, IL 62704, Phone 800-258-6534. Your work history will be reviewed, and if you are eligible for benefits, a claim form will be mailed to you promptly.

A Medical Claim Statement (claim form) signed by you is required with:

1. Each family member's first claim of the calendar year; and

2. Every claim for an injury (cuts, broken bones, burns, etc.). You will also be asked to complete an Accident or Injury Report.

The forms provided to you must be completed by you where indicated and returned to the Fund office at the address shown on the forms. If you fail to include ***all*** requested information, the form will be returned to you as soon as a determination has been made that requested information is missing, but in no event more than 30 days after the claim form was initially received from you.

It is also your responsibility to provide the attending physician/surgeon, the hospital and any other medical service providers with information about your coverage with the Plan. The information they require for this purpose is provided on the reverse side of the identification card which has been provided to you.

A fully completed claim form should be sent to the Fund office for each family member's first claim of the calendar year.

Payment of Claims by Fund Office

All claims received by the Fund office will be processed for payment as soon as possible after their receipt. **However, no claim can be paid until information necessary to determine if it is covered by the Plan has been received by the Fund office. This includes the Medical Claim Statement (claim form).** Sometimes claims must also be received from more than one medical service provider before any claims can be paid. For example, it may be necessary to receive a claim from the attending physician before a hospital claim is paid so one or more diagnoses can be confirmed, or so other information necessary to pay the claim can be obtained.

Once the information required to make a determination as to whether a claim is payable has been received, a decision will be promptly made by the Fund office staff and you will be notified regarding any payment made. However, in no event will the decision regarding payment be made more than 30 days after the claim has been fully and properly filed.

Time Limit for Filing Claims and Responding to Requests

No claim for reimbursement of medical expenses filed with the Fund office more than one year after the date the expense was incurred will be paid by the Plan. As explained above, no claim will be considered properly filed until information necessary to determine coverage has been provided to the Fund office. If a claim is received within the last 45 days of the one year filing period, and additional information is necessary to determine coverage, the filing deadline will be automatically extended for 45 days beyond the one year filing period.

Assignment of Benefits

The benefits in this Plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer or grant is not enforceable against the Fund and imposes no duty or obligation on the Fund. The Fund will not honor and such purported sale, assignment, pledge, transfer or grant.

You Must Notify the Fund Office About Changes

It is a very important requirement of the Plan that you immediately notify the Fund office whenever you:

1. Change your home address;
2. Wish to change your beneficiary;
3. Receive Workers' Compensation Benefits;
4. Return to work after disability ceases;
5. Get married or divorced; or
6. Gain a dependent or your dependent is no longer eligible as a Dependent.

Claims Provisions

Death Benefits and Accidental Death and Dismemberment Claims

The death benefit will be paid in full in accordance with the terms of the Plan upon receipt of satisfactory proof of death.

Health and Medical Benefit Claims

Written notice of claim for benefits must be given to the Fund office in Springfield, Illinois, within twelve months after the date of the event. Upon receipt of such notice, forms will be furnished for filing proof of claim.

Written proof of the occurrence and loss herein referred to must be furnished to the Fund office in Springfield, Illinois, on the Plan's forms within twelve months after the date of such loss for which claim is made.

Legal Proceedings

No action at law or in equity will be brought to recover under the Plan prior to the expiration of sixty days after proof of claim has been furnished in accordance with the requirements of the Plan, nor will any such action be brought at all unless started within three years from the expiration of the time within which such proof of claim is required by the provisions hereof. Further, no legal action may be commenced or maintained unless such action is filed in the appropriate court no later than one year following the exhaustion of such procedures.

Facility of Payment

If an eligible person is, in the opinion of the Trustees, legally incapable of giving valid receipt of any payment due him, the Trustees reserve the right, in the absence of the appointment of a legal guardian, to make payment to the party who, in its opinion, is entitled to such payment. Payment so made will discharge the Trustee's obligation with respect to the amount so paid.

If a beneficiary is designated, the consent of the beneficiary will not be required to change the beneficiary, or to make any other changes in the Plan, except as may be specifically provided. If any beneficiary dies before the eligible participant, the interest of such beneficiary designated by the eligible participant, or surviving at the death of the eligible participant, payment will be made in a single sum to the first of the following beneficiaries: the participant's widow or widower; surviving children, surviving parents, surviving brothers and sisters, executors or administrators.

Examinations

The Fund will have the right and opportunity through its medical representative to examine any eligible person, while living, when and so often as it may reasonably require during the pendency of a claim.

Claims Must Be Filed Within 12 Months of the Date of Service.

Appeal Procedures

A participant whose claim for benefits has been denied under the terms of the Plan is entitled to certain rights, including the right to receive a full explanation of the denial and an opportunity to appeal the denial. The following procedures have been adopted by the Board of Trustees as the Plan Administrator explaining those rights:

Notice of Adverse Benefit Determination (Notice of Denial)

Upon the determination that a claim submitted by or on behalf of a participant or an eligible dependent is not covered under the Plan, the participant will be notified in writing within the time frame set forth on pages 64 through 74 of this booklet regarding the adverse benefit determination. This notice will set forth, in a manner calculated to be understood by the claimant, all of the following information:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provisions on which the determination is based;

3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to such procedures. Including a statement of the claimant's right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review;

5. If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, practice or procedure will be provided free of charge to the claimant upon request;

6. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limitation, an explanation that the claimant will be provided free of charge upon request an explanation of the scientific or clinical judgement applied to the terms of the Plan with respect to the claimant's medical circumstances used in making the determination;

7. If the claim involves urgent care, a description of the expedited review process applicable to such claims. If an adverse benefit determination involves an urgent claim, the contents of this notice may be provided orally to the claimant. However, in such instances this written notification will be furnished to the claimant not later than three days after the oral notification;

8. Information sufficient to identify the claim involved, including:

    a. The date of service,

    b. The health care provider,

    c. The claim amount (if applicable), and

d. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and

9. If the claim is contingent on the covered employee's determination of disability for purposes of granting continuation of eligibility under the Plan, and the claimant has filed to establish proof of disability:

    a. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

        - The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who elevated the claimant,

        - The view of medical or vocational experts whose advise was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

        - A disability determination presented by the claimant to the Plan made by the Social Security Administration;

    b. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

The notification will be provided in a culturally and linguistically appropriate manner.

Claimant's Right to Internal Review of an Adverse Benefit Determination

A claimant whose claim for benefits has been denied under the terms of the Plan and to whom a notice of adverse benefit determination has been issued in accordance with the preceding section shall have the right to appeal the adverse benefit determination and shall be entitled to a full and fair review of the decision by the Board of Trustees, or a committee appointed by them, that will take into account all comments, documents, records and all other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial denial. The procedures by which the claimant may appeal the adverse benefit determination and receive a full and fair review of the claim are as described below. The procedures will:

1. Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination;

2. Provide for an independent review by the Board of Trustees, or their committee. The review shall not be done by the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual;

3. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgement, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees, or their committee, shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement;

4. Provide, upon request from the claimant, for the identification of medial or vocational experts whose advise was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

5. Provide that the health care professional engaged for purposes of this appeal is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

6. Provide in the case of a claim involving urgent care, for an expedited review process pursuant to which –

    a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant, and

    b. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method; and

7. In the event of a claim for benefits contingent on the covered employee's determination of disability for purposes of granting continuation of eligibility under the Plan, and the claim is denied due to failure to establish proof of disability, the Trustees, or a committee appointed by them, will:

    a. Provide that before the Plan can issue an adverse benefit determination on review, the Plan will provide to the claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. The evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant reasonable opportunity to respond prior to that date, and

    b. Provide that, before the Plan can issue an adverse benefit determination on review based on a new or additional rationale, the Plan will provide the claimant, free of charge, the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant reasonable opportunity to respond prior to that date.

Notice of Appeal Decision

The Board of Trustees, or their committee, will review all appeals in accordance with the following and will notify the claimant as indicated:

1. **Urgent Care Claims** – When the appeal of a claim involving urgent care, as that term is defined on page 61 of this booklet, is received as provided by the Plan, a decision on the appeal will be made and communicated in writing (and otherwise as appropriate) within 72 hours of receipt of the claimant's request for review of an adverse benefit determination. Appeals of adverse benefit determination involving urgent care will be addressed promptly by the Trustees, or their committee, taking into account the urgent nature of the claim, but in no instance will the decision be made later than 72 hours after receipt of the claimant's request.

2. **Non-Urgent Care Claims** – Appeals of adverse benefit determinations received from claimants which are of a non-urgent care nature will be reviewed by the Trustees, or their committee, in accordance with the following guidelines, and notification of the decision will be communicated in writing to the claimant within the time period prescribed:

    a. **Pre-Service Claims** – If the appeal involves a request for review of an adverse benefit determination for medical services which have not yet been provided, the Trustees, or their committee, will make a decision on the appeal and the decision will be communicated in writing to the claimant not later than 30 days after receipt of the claimant's request for review.

    b. **Post-Service Claims** – If the claimant's request for review of an adverse benefit determination involves a claim for medical services which have already been provided, a decision on the claimant's appeal will be made by the Trustees, or their committee, and communicated in writing to the participant within five days of the decision. The appeal will be reviewed at the meeting of the Trustees, or their committee, which immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of the request for review, but in no instance more than 120 days following receipt of the appeal. The time periods described in this section also apply to requests for review of adverse benefit determinations involving claims for benefits contingent on the determination of disability and where the claim was denied for failure to establish proof of disability.

3. Notwithstanding the requirements set forth above, notice of every appeals determination will be given to the claimant within five days of the determination.

Access to Plan Documents

At any time during the course of these appeal proceedings, a claimant will be granted access to, and be provided copies of documents, records and other information relevant to the claimant's claim for benefits or relied upon by the Trustees, or their committee, in making its decisions, as requested by the claimant.

Notification of Appeals Decision

Each claimant whose adverse benefit determination has been appealed to the Trustees, or their committee, will receive notification in writing, within the time periods outlined above, of the Committee's decision. Such notification will set forth, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provision on which the benefit determination is based;

3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

4. A statement describing any additional voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, should the Board of Trustees adopt such procedures, and a statement of the claimant's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended;

5. The following information where applicable –

    a. If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that such rule, guideline, practice or procedure was relied upon in making the adverse determination and that a copy of the rule, guideline, practice or procedure will be provided free of charge to the claimant upon request,

    b. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request, and

    c. A statement that you and your 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. While the Plan does not currently offer voluntary alternative dispute resolution options to the procedures set forth above, you may contact the local U.S. Department of Labor Office and your State Insurance Regulatory Agency to determine what options might be available to the you, and

6. If the claim is contingent on the covered employee's determination of disability for purposes of granting continuation of eligibility under the Plan, and the claim was denied because the claimant failed to establish satisfactory proof of disability:

    a. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

        - The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant,

        - The views of medical or vocational experts whose advise was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

        - A disability determination presented by the claimant to the Plan made by the Social Security Administration;

    b. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and

c. The statement required under 4. above will also describe any contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the limitations period expires.

The notification will be provided in a culturally and linguistically appropriate manner.

Claimant's Right to External Review of an Adverse Benefit Determination

1. Claims Subject to Review

   Those claims involving medical judgement (see page 66) which have either been denied or otherwise not acted upon are eligible for external review, including only:

   a. Claims for urgent care that have not been acted upon within 72 hours of receipt of the claim/request;

   b. Other claims for which the Plan fails to act within the time limits applicable to other pre-service and post-service claims, or where the claim procedure has not been followed by the Plan;

   c. Claims for which the internal review process (including the Trustee's, or their committee's, review) has been exhausted; and

   d. Claims involving rescission of coverage.

2. Claims Not Subject to Review

   Claims not eligible for external review include:

   a. Claims relating to your failure to meet the requirements for eligibility (such as insufficient hours worked, failure to self-pay, classification of employment, failure to meet the definition of Dependent, etc.)

   b. Claims incurred while you are not eligible for benefits.

   c. Claims incurred for health care service that is not a covered service under the Plan.

   d. Claims for which the internal review process has not been exhausted, except as outlined under 1. above.

   e. Claims incurred for other than medical expenses.

   f. Claims denials not involving medical judgement.

3. Standard External Review

   This paragraph sets forth procedures for standard external reviews. Standard external review is external review that is not considered expedited as described in 4. below.

a. Request for external review. You may file a request for an external review if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal Holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal Holiday.

b. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether;

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

- The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan or does not relate to a decision made solely on a legal or contractual interpretation of the Plan's terms;

- You have exhausted the Plan's internal appeal process; and

- You have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to you. If the request is complete but not eligible for external review, the notification will include the reason for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number **866-444-EBSA (3272)**. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the Plan will allow you to perfect the request for external review within the four-month filing period or within the 48 hour period following receipt of the notification, whichever is later.

c. Referral to Independent Review Organization. The Plan will refer the review to an Independent Review Organization (IRO).

- Within five business days after the date of assignment of the IRO, the Plan will provide to the IRO the documents and any information it considered in making the adverse benefit determination or final adverse benefit determination.

- Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final adverse benefit determination. The external review may be terminated as a result of the reconsideration if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final adverse benefit determination and provide coverage or payment. The assigned IRO

will then terminate the external review upon receipt of the notice from the Plan. If upon reconsideration, the Plan reverses its adverse determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision.

- The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to you and to the Plan.

- The Plan will rotate review referrals among the IROs with which it contracts.

- The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim. Such additional information must be submitted within ten (10) business days. Information submitted after ten (10) business days may not be considered by the IRO.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

- The IRO's decision will contain:

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

    - The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;

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

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

    - A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;

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

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

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

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

4. Expedited External Review

a. Request for expediated external review. The Plan will allow you to make a request for an expedited external review at the time you receive:

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

- A final adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

b. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the requirements for standard external review. The Plan will immediately send a notice that meets the requirements for standard external review to you of its eligibility determination.

c. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other similar method.

d. Notice of final external review decision. The IRO must provide notice of the final external review decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and to the Plan.

5. Payment of Claims

    a. 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

6. Definitions

    a. "Adverse benefit determination" means any claims denial, or partial denial, as determined by the Plan.

    b. "Final adverse benefit determination" means any claims denial, or partial denial, upheld by the Board of Trustees, or their committee, upon appeal.

    c. A claim denial involving "medical judgement" is a claim that involves medical judgement as determined by the external reviewer, including, but not limited to, those claims denials based on the Plan's requirement for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefits, or the Plan's determination that a treatment is experimental or investigational.

Appointment of Authorized Representative

Pursuant to Department of Labor Regulations, an authorized representative of a claimant is not precluded from acting on behalf of a claimant in pursuing a benefit claim or appeal of an adverse benefit determination. In order to assure that the person purporting to be an authorized representative has been and continues to be authorized to act on behalf of the claimant, with respect to the particular benefit claim or appeal, any written benefit claim or appeal or an adverse benefit determination must bear the notarized signature of the claimant. (A general appointment is insufficient; the specific claim or appeal must bear the notarized signature of the claimant.) If evidence is presented that the claimant is disabled and/or incompetent to the extent that the signature of the claimant cannot be obtained, then such benefit claim or appeal shall bear the notarized signature of the spouse of the claimant, a health care surrogate of the claimant or a person holding a plenary power of attorney for the claimant. A copy of the documents establishing the health care surrogate or power of attorney shall be furnished.

A general appointment of a health care provider, as representative, prior to the rendering of services that are the subject of the benefit claim or appeal of an adverse benefit determination will not be considered as a satisfactory appointment of an authorized representative in pursuing a benefit claim or appeal of an adverse benefit determination.

Nothing in the foregoing provision would limit the ability of a health care professional, with knowledge of the claimant's medical condition, from acting as the authorized representative of the claimant in the case of a claim involving urgent care without such a notarized signature.

Rights Are Limited to One Appeal

In appealing an adverse benefit determination under these procedures, the claimant may choose to make a written appeal and submit comments, documents, records and other information relating to the claim, in which event the Plan's Executive Administrator will present the appeals and all comments, documents and records in the claimant's behalf, or the claimant may choose to personally appear before the Board of Trustees, or their committee, for the purpose of presenting an appeal, or designate a representative to appear in his behalf. Claimant appeals rights are limited to one written or personal appeal per denied claim.

Compliance with Appeal Procedures

The claimant may at his own expense have legal representation at any stage of these appeal procedures. The Board of Trustees, or their committee, will interpret Plan provisions in a consistent and equitable manner. The claimant will be required to exhaust these appeals procedures before proceeding to litigation.

Limitation of Actions

No legal action may be commenced or maintained against the Fund or Trustees by any claimant prior to the claimant exhausting the administrative procedures established herein. Further, no legal action may be commenced or maintained unless such action is filed no later than one year following the exhaustion of such procedures. Any such lawsuit shall be filed in a court of competent jurisdiction that is located in Sangamon County, Illinois.

Impartiality in Adjudication

The Trustees will ensure that all claims for benefits, and appeals thereof, that are contingent on the determination of disability of an employee are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any employee of the Plan will not be made based upon the likelihood that the employee will support a denial of benefits.

Important Information About the Plan

Name of Plan

The Plan for which this Summary Plan Description is provided is known as the Railroad Maintenance and Industrial Health and Welfare Fund Benefit Plan.

Maintenance of Plan

The Plan is maintained by the Board of Trustees, and is located at 2725 West Monroe Street, Springfield, Illinois 62704.

Employer Identification Number and Plan Number

The employer identification number (EIN) assigned by the Internal Revenue Service is 37-1023648.

The Plan number assigned to the Plan by the Board of Trustees pursuant to instruction of the Internal Revenue Service is 501.

Type of Welfare Plan

The Plan is maintained for the purpose of providing Death, Accidental Death and Dismemberment, Medical and Dental benefits for eligible employees and their dependents in accordance with the benefit specifications and eligibility rules described in this booklet.

Plan Sponsor and Administrator

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

Agent for Service of Legal Process

Ms. Dora L. Crenshaw is the Plan's agent for service of legal process. If legal disputes involving the Plan arise, any documents may be served upon Ms. Crenshaw at 2725 West Monroe Street, Springfield, Illinois 62704.

Service of legal process may also be made upon any of the Plan Trustees individually.

Trustees

The name and address of each Trustee of the Plan is shown in the front of this booklet.

Collective Bargaining Agreements

The Plan is maintained pursuant to collective bargaining agreements. A copy of such agreement(s) may be obtained upon written request to the Executive Administrator, who may make a reasonable charge for the copies, and is available for examination by participants and beneficiaries at the Fund office, 2725 West Monroe Street, Springfield, Illinois 62704.

Eligibility and Benefits

The Plan's requirements respecting eligibility for participation, the condition pertaining to eligibility to receive benefits, and a description or summary of the benefits are contained in this booklet.

Circumstance Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits are contained in this Plan booklet.

Sources of Plan Contributions

Contributions to the Plan are made by the contributing employers. The amount of employer contributions is based on a fixed rate per hour worked or a flat monthly rate which is determined by the applicable provision of the collective bargaining agreements or participation agreements. The Fund office will provide you, upon written request, information as to whether a particular employer is contributing to this Fund on behalf of employees working under the collective bargaining agreements. Under certain circumstances, the Fund allows an employee to self-contribute on his own behalf in accordance with the Eligibility Rules.

Date of End of Plan's Fiscal Year

The date of the end of each year for purposes of maintaining the Plan's fiscal records in April 30.

Claim Procedures

The procedures to follow for filing a claim for benefits are set forth beginning on page 59 of this booklet. If all or any part of your claim is denied, you may appeal that decision. To make an appeal, contact the Fund office at the address shown in the front of this booklet within one hundred eighty (180) days. You will be advised further on how the appeal will be considered. (See page 64 of this booklet.)

Termination of Plan

The Plan may be terminated under the following circumstances:

1. In the event the Trust Fund becomes inadequate to meet its financial obligations or to carry out the intent and purpose of the Trust Fund;

2. In the event there are no employees eligible under the Plan;

3. In the event the Plan is terminated by the union and employers who established the Trust Fund; or

4. In the event the Plan is terminated as otherwise provided by law.

If the Plan is terminated, the Trustees will:

1. Pay the final expenses of the Plan;

2. Arrange for a final audit;

3. Distribute any remaining assets in accordance with the established purpose of the Trust Fund; and

4. Give any notices and file any reports which may be required by law.

Statement of Rights Under the Employee Retirement Income Security Act of 1974

As a participant in the Railroad Maintenance and Industrial Health and Welfare Fund Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), ERISA provides that all Plan participants shall be entitled to:

Receive Information about your Plan and Benefits

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

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

3. Receive a summary of the Plan's annual financial report. The Executive Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of 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 Executive 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 Executive Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the 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 claims is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Executive 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 Executive Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Plan.

The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever, in their judgment, conditions so warrant. Notwithstanding any language contained in this Summary Plan Description, this booklet and SPD is automatically amended to the extent mandated by law should any applicable statute be enacted rendering any such benefit, limitation or exclusion illegal or against the Public Policy of the People of the United States. Participants will be notified of any Plan changes.

Subject to the stated purposes of the Fund and the provisions of the Agreement, the Trustees shall have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They shall have full power to construe the provisions of the Agreement, the terms used herein and the by-laws and regulations issued thereunder. Any such determination and any such construction adopted by the Trustees in good faith shall be binding upon all of the parties hereto and the beneficiaries hereof. No matter respecting the foregoing or any difference arising thereunder or any matter involved in or arising under the Trust Agreement or this Summary Plan Description shall be subject to the grievance or arbitration procedure established in any collective bargaining agreement between the Association and the Union, provided, however, that this clause shall not affect the rights and liabilities of any of the parties under any of such collective bargaining agreements.

It is the intent of the drafters of this Summary Plan Description that the Trustees possess the discretion to determine eligibility for benefits and to construe the terms of the Trust and/or Plan governing benefits. It is also the intent of the drafters of the Trust and Summary Plan Description, by adopting the discretionary power specified above, that the decisions of the Trustees as to the granting or denial of benefits and the construing of terms of the Trust and benefit plan, are reviewed pursuant to an "arbitrary and capricious" standard by a reviewing court, as enunciated by the United States Supreme Court in Firestone Tire and Rubber Company et al. v. Richard Bruch, 57 LW 4194 (Feb. 21, 1989).