Beer Industry — Local Union No. 703
Health and Welfare Fund

Summary Plan Description

2017 Edition

Important Contact Information

The Plan is sponsored and administered by the Board of Trustees. However, the Trustees have delegated administrative responsibilities to other individuals or organizations. The list that follows provides the contact information for the various organizations that provide services to the Fund.

Organization	Responsibility	Contact Information
Fund Office (Call with Questions)	■ Maintains eligibility records ■ Maintains accounts for Employer and Self-Payment contributions ■ Administers Dental and Weekly Disability Benefit claims ■ Answers general inquiries ■ Updates personal information	312-829-6506 Fax: 312-829-0121 *Send claims to:* Beer Industry — Local Union No. 703 Health and Welfare Fund 300 South Ashland Avenue, Suite 201 Chicago, IL 60607-2764
BlueCross BlueShield of Illinois PPO Network	■ Provides access to network providers for medical care	800-810-2583 (BLUE) www.bcbsil.com *Send medical claims to:* BlueCross Blue Shield P.O. Box 805107 Chicago, IL 60680
OptumRx	■ Provides access to network pharmacies ■ Administers retail and mail order prescription drug programs	855-577-6319 800-850-2966 (Mail Order) www.optumrx.com
Briova Rx	■ Administers Specialty Pharmacy Services Program	800-850-9122
Med-Care Management	■ Provides pre-authorization for medical benefits and specialty drugs ■ Provides Disease Management Program	800-367-1934 866-844-4222
Absolute Solutions	■ Provides access to network providers for diagnostic imaging	800-321-5040 www.absolutedx.com
Guardian DentalGuard Preferred Select	■ Provides access to network providers for dental care	866-302-4542 www.guardianlife.com
United Healthcare	■ Provides access to network providers for vision care ■ Processes all vision claims	800-839-3242 www.myuhcvision.com *Send non-network vision claims to:* United Healthcare Vision Attn: Claims Department PO Box 30978 Salt Lake City, UT 84130
Amalgamated Life Insurance Company	■ Administers Death and AD&D Benefit claims	914-367-5000 www.amalgamatedlife.com For policy information contact the Fund Office at 312-829-6506
HearPO	■ Although the Plan does not provide benefits, this company provides access to a network of providers for discounts on hearing care expenses	888-HEARING www.hearpo.com

Table of Contents

Introduction

The Beer Industry — Local Union No. 703 Health and Welfare Fund provides health care coverage to you and your eligible Dependents. The Plan is periodically reviewed to ensure that benefits are being provided to meet your needs while still maintaining a financially stable Fund.

The Health and Welfare Fund offers:

- Medical Benefits;
- Prescription Drug Benefits;
- Dental Benefits;
- Vision Benefits;
- Weekly Disability Benefits (for Employee Participants only);
- Death Benefits; and
- Accidental Death and Dismemberment Benefits.

Benefits described in this booklet are available to eligible Employees and their eligible Dependents (see page 9 for more information about eligibility). However, please note that you must enroll your Dependents and make the required payments for them to be covered under the Plan.

Note: In this booklet, statements addressed to "You" are addressed to the employee participant.

Grandfathered Health Plan Statement

The Trustees of the Beer Industry — Local Union No. 703 Health and Welfare Fund have determined that the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the Affordable Care Act was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 312-829-6506. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This booklet is intended to give you an understanding of the benefits provided by the Health and Welfare Fund as of January 1, 2017. Information is organized in a way that will be useful to you. The booklet includes the following sections:

- **Important contact information** that provides you with phone numbers and addresses;
- **A Schedule of Benefits,** which gives you a brief overview of all the benefits available through the Fund;

- An **eligibility** section that tells you how you become eligible for benefits, who in your family is eligible for coverage, what you need to do to continue to be eligible, when coverage under the Plan ends, and what you need to do to reinstate your eligibility.
- A **life events and family status changes** section designed to show you how your benefits are affected by the different events that can occur in your life and how your benefits work, including information about what you need to do when those events occur.
- Several sections that provide **detailed information** about each of the different types of coverage provided through the Fund, as well as what is not covered under the Plan.
- **Claim filing** information, including what you need to do if a claim is denied.
- An **administrative information** section that includes general Plan information and your rights as a Participant in the Plan.
- A **glossary** that defines important words used throughout this booklet.

If you are not familiar with the terms used in this booklet, please check the glossary at the back. Terms defined in the glossary are capitalized throughout this booklet.

We urge you to read this information and, if you are married, share it with your spouse. In addition, we recommend that you keep this booklet with your important papers so you can refer to it when needed.

Contact the Fund Office at 312-829-6506 if you have any questions about the benefits described in this booklet.

Póngase en contacto con el Fund Office al numero 312-829-6506 si tiene alguna pregunta acerca de los beneficios que describen en este folleto.

This Summary Plan Description (SPD) describes the Beer Industry — Local Union No. 703 Health and Welfare Fund benefits for eligible Participants as of January 1, 2017. The Board of Trustees determines the benefits provided in accordance with all Plan provisions. Benefits provided to different classes of Participants may vary. In addition, any required self-payment amount may vary depending on the benefits provided and other factors. The Trustees reserve the right, by written amendment to this SPD, to change, add, or delete benefits, self-payment amounts, eligibility rules, or any other provisions relating to the operation of the Fund. The Trustees also reserve the exclusive right to interpret coverage and benefit provisions of the Fund. This SPD replaces and supersedes any prior SPD. If the Plan is amended or modified, you will receive written notice of such change.

Schedule of Benefits

The following chart highlights key features of the Plan. These benefits are described in detail throughout this booklet.

Medical Benefits	Coverage
Annual Maximum	Unlimited during and after calendar year 2014
Calendar Year Deductible	$500 per person; $1,500 per family maximum
Pre-Authorization Non-Compliance Penalty	$700 per occurrence (in addition to any deductible or coinsurance amounts)
Coinsurance (unless noted otherwise) PPO Provider Non-PPO Provider	After deductible (when applicable), Plan pays: 80% 65%
Calendar Year Out-of-Pocket Maximum PPO Provider Non-PPO Provider	You pay: $2,500 per person $4,375 per person Premiums, balance billing costs, and non-covered health care expenses are not included in the calendar year out-of-pocket maximum
Hospital Stay PPO Provider Non-PPO Provider	Plan pays: 80%, after deductible 65%, after deductible
Emergency Room/Urgent Care PPO Provider Non-PPO Provider Benefit Maximum Emergency Medical Transportation (PPO and Non-PPO)	Plan pays: 80%, after deductible 65%, after deductible Notification of emergency hospital admission required within 48 hours or $700 penalty is applied 80% after deductible
Physician/Surgeons PPO Provider Non-PPO Provider Benefit Limitation	Plan pays: 80%, after deductible 65%, after deductible 0% for any services performed at a non-PPO outpatient surgical facility or an unlicensed outpatient surgical facility, regardless of whether services are performed by a PPO provider or a non-PPO provider
Prenatal/postnatal care PPO Provider Non-PPO Provider	Plan pays: 80%, after deductible 65%, after deductible
Chiropractic Care PPO Provider Non-PPO Provider Benefit Maximum	Plan pays: 80%, after deductible 65%, after deductible $2,500 per calendar year; $100 per visit after the first visit
Physical Exams/Immunizations PPO Provider Non-PPO Provider Benefit Maximum	Plan pays: 80%, after deductible 65%, after deductible One physical exam per calendar year; immunizations covered for Dependent Children age 18 and under
Preventive Colonoscopy Screenings PPO Provider Non-PPO Provider Benefit Maximum	Plan pays: 80%, after deductible 65%, after deductible One screening every 10 years, starting from age 50 up to age 75

Home Health Care PPO Provider Non-PPO Provider Benefit Maximum	Plan pays: 80%, after deductible 65%, after deductible 30 visits per calendar year and 12 hours per 24-hour period for licensed nurse; 8 hours per 24-hour period for home health aide. Preauthorization required
Rehabilitation Services PPO Provider Non-PPO Provider Benefit Limitation	Plan pays: 80%, after deductible 65%, after deductible Preauthorization required
Speech Therapy PPO Provider Non-PPO Provider Benefit Limitations	Plan pays: 80%, after deductible 65%, after deductible Maximum 25 visits per calendar year - Preauthorization required
Physical Therapy PPO Provider Non-PPO Provider Benefit Limitation	Plan pays: 80%, after deductible 65%, after deductible Preauthorization required
Occupational Therapy PPO Provider Non-PPO Provider Benefit Limitation	Plan pays: 80%, after deductible 65%, after deductible Preauthorization required
Disease Management Program	Plan pays 100% of cost of program for Participants who enroll
Diabetic Education	Plan pays up to $300 per lifetime. Participant must be enrolled in the Disease Management Program
Nutritionist	Plan pays up to $300 per lifetime. Participant must be enrolled in the Disease Management Program
Skilled Nursing Facility PPO Provider Non-PPO Provider Benefit Limitation	Plan pays: 80%, after deductible 65%, after deductible Preauthorization required
Hospice Care PPO Provider Non-PPO Provider	Plan pays: 80%, after deductible 65%, after deductible
Durable Medical Equipment PPO Provider Non-PPO Provider Benefit Limitation Rental or purchase Replacement of purchased equipment Breast prostheses/surgical bras after mastectomy Other appliance to replace physical organs or parts	Plan pays: 80%, after deductible 65%, after deductible Pre-authorization required if total cost exceeds $500; covered expenses limited to the cost of conventional (non-microprocessor) mechanical prostheses. Limited to once every five years Up to one (or one pair) of prostheses and two surgical bras per 12-month period Only the initial charge for a prosthetic appliance is covered for adults; charges for replacement prosthetic device required due to growth is covered for a Child
Diagnostic Testing/Imaging Absolute Solutions PPO Network PPO Provider Non-PPO Provider	Plan pays: 100% per test, no deductible 80% per test, after deductible 65% per test, after deductible

Outpatient Surgical Facility PPO Provider Non-PPO Provider Benefit Limitation	Plan pays: 80%, after deductible 0% 0% for any services performed at a non-PPO outpatient surgical facility or an unlicensed outpatient surgical facility, regardless of whether services are performed by a PPO provider or a non-PPO provider	
Mental/Behavioral Health Treatment (Outpatient) PPO Provider Non-PPO Provider Benefit Limitation	Plan pays: 80% per office visit and 80% for other outpatient services, after deductible 65% per office visit and 65% for other outpatient services, after deductible Preauthorization required	
Mental/Behavioral Health Treatment (Inpatient) PPO Provider Non-PPO Provider Benefit Limitation	Plan pays: 80%, after deductible 65%, after deductible Preauthorization required	
Substance Abuse Disorder Treatment (Outpatient) PPO Provider Non-PPO Provider Benefit Limitation	Plan pays: 80% per office visit, after deductible 65% per office visit, after deductible Preauthorization required	
Substance Abuse Disorder Treatment (Inpatient) PPO Provider Non-PPO Provider Benefit Limitation	Plan pays: 80%, after deductible 65%, after deductible Preauthorization required	
Surgical Correction of Refractive Errors Benefit Limitation	Up to $1,000 per person, per lifetime Limited to Employee Participants	
Prescription Drug Benefits	**Retail Pharmacy (30-Day Supply)**	**Mail Order (90-Day Supply)**
Prescribed Medications	You Pay	You Pay
Generic Medication PPO Provider	$10 copay retail per 30-day supply	$20 copay mail order per 90-day supply
Non-PPO Provider	Major medical deductible and coinsurance will apply	Major medical deductible and coinsurance will apply
Preferred Brand Name Medication PPO Provider	$15 or 15% coinsurance, whichever is greater, up to a maximum of $40 per 30-day supply	$30 or 15% coinsurance, whichever is greater, up to a maximum of $80 per 90-day supply
Non-PPO Provider	Major medical deductible and coinsurance will apply	Major medical deductible and coinsurance will apply
Benefit Limitation*	If brand dispensed when generic is available, you pay the difference in cost, plus the brand copay or coinsurance	If brand dispensed when generic is available, you pay the difference in cost, plus the brand copay or coinsurance

Specialty Medication PPO Provider	$25 or 15% coinsurance, whichever is greater, up to a maximum of $50	$50 or 15% coinsurance, whichever is greater, up to a maximum of $100
Non-PPO Provider	Not covered	Not covered
Benefit Limitation	Preauthorization required	Preauthorization required

*When a generic is available but the pharmacy dispenses the brand name drug, you will pay the difference between the Plan's cost of the brand name drug and the generic drug, PLUS the brand copayment/coinsurance. However, if your Physician specifies the brand name drug and indicates "dispense as written" on the prescription, you pay only the brand name drug copayment/coinsurance. Refer to page 34 for details.

** Specialty Medications require preauthorization through Med-Care Management.

Dental Benefits	Coverage
Calendar Year Maximum	$1,000 for Employee Participants; $750 for Spouse and Dependent Child. Benefits paid for no more than two dental check-ups and cleanings for dependent children age 18 and younger do not apply toward the Dependent's annual maximum.
Calendar Year Deductible (for Class II and Class III dental benefits only)	$25 per person
Class I Coinsurance (Routine/Preventive Care/Oral Examinations) PPO Provider (adults) Non-PPO Provider (adults) Dependent Children (18 and under)	No deductible, cleanings limited to two per year; Plan pays: 100% 80% 100%
Class II Coinsurance (Basic and Major Dental Benefits) PPO Provider Non-PPO Provider	After deductible, Plan pays: 80% 70%
Class III Coinsurance (Denture Benefits) PPO Provider Non-PPO Provider	Limited to complete dentures only, once every five years. After deductible, Plan pays: 80% 70%
Vision Benefits	
Exam PPO Provider Non-PPO Provider	Limited to one eye exam every 12 months, Plan pays: 100% 100%, up to $40 maximum (no maximum for a Dependent Child age 18 and under)
Lenses PPO Provider Non-PPO Provider Single Vision Bifocal Trifocal or Lenticular	Limited to once every 12 months, Plan pays: 100% (for standard single vision or standard multifocal lenses) 100% up to: $40 maximum $60 maximum $80 maximum
Frames PPO Provider Non-PPO Provider	Limited to one pair of glasses every 12 months; Plan pays: 100% of covered frames ($130 allowance on non-covered frames) 100%, up to $45 maximum

Contact Lenses (instead of lenses and frames) Elective Medically Necessary PPO Provider Non-PPO Provider	Limited to once every 12 months, Plan pays: 100%, up to $105 (applied to fitting/evaluation fees and lenses) 100% 100%, up to $210

Weekly Disability Benefit	Employee Participants Only
Weekly Benefit	$250 ($50 per day)
Benefit Payable	13 weeks per disability
When Benefits Begin Injury/Hospital Confinement Illness	 First day Eighth day
Death Benefit	
Employee Participant	$25,000
Spouse or Dependent Child Age 14 days through age 25 Years	$5,000
AD&D Benefit	
Employee Participant – Full Amount	$25,000
Spouse or Dependent Child Age 14 days through age 25 Years – Full Amount	$5,000

Plan Eligibility

This section describes the Plan's eligibility provisions.

Initial Eligibility

You (an Employee Participant) are initially eligible for benefits on the first day of the month in which all four of the following requirements have been satisfied:

- You complete 90 calendar days of continuous employment with an Employer; and
- You are working in Covered Employment when you complete the 90-day period; and
- Contributions are received by the Fund from your Employer on your behalf; and
- You elect and pay the required contribution.

If you work in Covered Employment in the month that you complete the 90-day waiting period, but do not work enough days after your 90th day of employment so that your Employer is required to contribute to the Fund on your behalf for that month, you will become eligible on the first day of the following month, provided you are still working in Covered Employment and you and your Employer contributes for that month.

Example: Jose started working on January 5, and his 90th day in Covered Employment was April 5. His Employer is required to contribute to the Health and Welfare Fund for Employees who work 11 or more days in a month. If Jose works through the end of April, his initial eligibility date is April 1 since he worked 11 or more days that month after his 90-day waiting period ended.

Example: Anna started working for the same Employer on January 25, and her 90th day in Covered Employment was April 25. Her Employer is required to make contributions for April. Anna's initial eligibility date is April 1.

Dependent Eligibility

Your Dependents are not eligible to enroll in the Plan unless you are enrolled in the Plan. Generally, your Dependents are eligible for coverage on the date you become eligible, or, if later, on the date you acquire a Dependent, provided:

If your Dependent Spouse or Child is eligible for benefits as an Employee Participant under this Plan, he or she cannot be covered as your Dependent under the Plan.

- You enroll your Dependents (or if your Dependents are of legal age, they can enroll themselves);
- Your Dependents' enrollment is approved; and
- The required payment for Dependent coverage is received by the Fund.

To be eligible for coverage, your Dependents must also meet the Plan's definition of Dependent (see page 76).

If after you initially become eligible, enroll your Dependent(s) in the Plan, and make the required payment for Dependent coverage, you then acquire an additional Dependent(s) through *marriage, birth of a Child, adoption or placement for adoption of a Child*, or being designated a foster parent by a court or Child welfare agency, you must notify the Fund Office within 30 days of the date the event occurs for coverage to be effective. If you do not notify the Fund Office within 30 days, you will have to wait until the next open enrollment period. You will also have to enroll your newly acquired Dependent in

the Plan and make the required payment in order for him or her to be covered under the Plan.

Electing and Paying for Employee Participant and Dependent Coverage

There is a monthly charge for coverage. You must pay a monthly amount for yourself and each of your Dependents. Your Dependents are only eligible for coverage if a form electing Dependent coverage has been signed and the monthly contributions have been received for yourself and your Dependents. If your Employer has agreed to a payroll deduction procedure, your contributions can be withheld from your wages by your Employer and paid to the Fund. If your Employer does not have a payroll deduction procedure in effect, you are responsible for paying your contributions to the Fund no later than the 10th day of each month. Your and/or your Dependents' coverage will end if payment is not received on time. The Trustees reserve the right to change the contribution rates at any time. The costs are below:

Employee Participant Coverage	$50 per month
Working Spouse Dependent Coverage	An Additional $225 per month
Non-Working Spouse Dependent Coverage	An Additional $75 per month
All Child Dependent Coverage	An Additional $100 per month

There is a distinction between a Working Spouse and a non-working Spouse. A Working Spouse is a Spouse who:

- Is employed 30 or more hours per week; and
- Has a health plan available through his/her employment (regardless of whether the Spouse is enrolled under that health plan).

A non-working spouse is Spouse who works less than 30 hours per week or who has no other employer-sponsored health plan available to him/her.

If you do not sign up for Employee Participant or Dependent coverage when you initially become eligible for coverage, you must wait for the next open enrollment period, unless you experience a special enrollment event. Generally, open enrollment is in March each year to schedule June payroll deductions for coverage effective August 1.

Special Enrollment

If you do not enroll yourself or your Dependents when initially eligible, you may be able to enroll later if you experience a special enrollment event.

If you are declining enrollment for yourself (or if you do not enroll) or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request

To request a special enrollment package or for more information, contact the Fund Office. You must notify the Fund Office in writing within 30 days of when you experience a special enrollment event.

enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage) and complete an enrollment card to enroll in this Plan. If you do not enroll within 30 days, you must wait until the next open enrollment period.

In addition, special enrollment is allowed under the Plan for you and/or your Dependent if:

1. You and/or your Dependent had coverage under Medicaid or the State Children's Health Insurance Program (SCHIP) and later lost eligibility for the coverage; or

2. You and/or your Dependent become eligible to participate in a financial assistance program through Medicaid or SCHIP for coverage under the Plan.

You and/or your Dependent must request enrollment within 60 days after losing eligibility or becoming ineligible for financial assistance under Medicaid or SCHIP.

Rescission of Coverage

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back in time. In general, the Plan will not rescind your coverage, except in the case of fraud or intentional misrepresentation of a material fact after you have been provided with 30 days advance written notice of the rescission of coverage. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days' advance written notice:

- When the Plan terminates your coverage retroactive to the date you lose eligibility, if there is a delay in administrative recordkeeping between your loss of eligibility for coverage and the date the Plan is notified of your loss of eligibility;
- When the Plan retroactively terminates your coverage because you fail to make timely self-payments; and
- When the Plan retroactively terminates your former Spouse's coverage back to the date of your divorce.

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

Continued Eligibility

Generally, once you are initially eligible, your coverage continues on a month-to-month basis provided you and your Employer make the required contributions.

A work month provides eligibility for coverage in the corresponding benefits month. The benefit month is separated from the work month by a lag month.

To allow the Fund time to receive Employer contributions, the Plan uses a lag month process for continuing eligibility. This means the Plan looks at:

- ***Work Month:*** The month for which contributions are required on your behalf.
- ***Lag Month:*** The month that the Plan actually receives the required contributions on your behalf.
- ***Benefits Month:*** The month in which you are eligible for coverage.

The following chart illustrates the Plan's continuing eligibility provisions:

If you work for an Employer required to make contributions on your behalf during this work month:	You will be eligible for coverage during this benefit month:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

Example:

Luke's Employer is required to contribute on Luke's behalf for July (work month). The Fund receives the contribution in August (lag month) for coverage in September (benefits month).

When Eligibility Ends

For You

In general, coverage ends two months after the last day of the month for which your Employer makes a required contribution on your behalf.

When you leave Covered Employment, your eligibility for benefits ends two months after the last day of the month for which your Employer makes a required contribution.

Example:

David stopped working on February 5, 2016. Under the collective bargaining agreement, David's Employer did not contribute on David's behalf for February, so the last month paid was January 2016. The lag month was February and the last benefit month was March and David remained eligible for benefits until March 31, 2016.

If your Employer withdraws from the Fund, but remains in business in the area, your benefits will end on the last day of the last month for which you and your Employer contributed to the Fund.

Example:

Bill works for XYZ Company, which ended its participation in the Fund, but retains its employees and continues its business operations. XYZ Company's last contribution to the Fund was for the month of March 2016. Because of XYZ's withdrawal, Bill's benefits ended on March 31, 2016. If XYZ Company had not withdrawn, but had stopped contributing to the Fund for another reason, such as going out of business, the prior eligibility rules would have applied and Bill would have remained eligible through May 31, 2016.

In addition to the above rules, your eligibility may end sooner if:

- You do not make a required payment, when applicable;
- The Plan terminates; or
- You enter the armed forces, subject to USERRA, as described on page 17.

However, your coverage will continue if your Employer is required, under the collective bargaining agreement, to contribute to the Fund during a workers' compensation disability and you are absent from work due to the workers' compensation disability.

For Your Dependents

Your Dependents' eligibility ends on the earliest of:

- The date your Spouse or Child no longer meets the Plan's definition of Dependent;
- The date your eligibility ends;
- The date the Plan terminates; or
- At the end of the period that any payment for Dependent coverage is due and unpaid.

The Plan covers your Dependent Child(ren) until he or she turns age 26, regardless of whether the Child is a student, lives with you, is married or unmarried, disabled, or is receiving continuation coverage under COBRA.

Reinstatement of Eligibility

Your eligibility may be reinstated as of the first day of a benefit month if:

- Your coverage ends because your Employer stops contributing to the Fund on your behalf without terminating your employment;
- You later return to work with the same Employer; and
- Your Employer resumes contributions to the Fund on your behalf.

This reinstatement rule only applies if you return to Covered Employment with the same Employer. If you return to work with another Employer, then you must meet the Plan's initial eligibility requirements to reinstate eligibility.

Changes in Eligibility Rules

The Trustees reserve the right, at their discretion, to change, modify, or discontinue all or part of the Plan's eligibility rules or the benefits provided under the Plan, at any time. The Trustees also establish the cost of Employee Participant and Dependent coverage and the cost of self-pay contribution rates and Self-Payment rules. The Trustees reserve the right to change the costs at any time.

When Coverage Ends

When your and/or your Dependent's coverage, including COBRA Continuation Coverage ends, you and/or your Dependent will be provided with a Certificate of Creditable Coverage, free of charge, that indicates the period you and/or your Dependent were covered under this Plan, including any additional information, as required by law.

In the event coverage ends for reasons other than a COBRA qualifying event, a Certificate will be sent within a reasonable time after coverage ends.

This Certificate may help reduce or eliminate any Pre-Existing Condition limitation under a new group medical plan. You or your Dependent may request a Certificate from the Fund Office at any time while covered under the Plan or within 24 months of the date coverage ends under the Plan.

When coverage under the Plan ends, no conversion privileges are available.

Life Events and Family Status Changes

At some point in your life, you will probably experience a change in family status that affects your welfare benefits. It is important that you understand what you or your Dependents need to do when you experience a change in family status.

Notify the Fund Office

Notify the Fund Office of any change in your family status.

You can help avoid delays in payment of benefits, by notifying the Fund Office:

- Of new Dependents; or
- When a Dependent is no longer eligible for coverage (you may want to continue his or her coverage through COBRA).

When you experience a change in family status, you should contact the Fund Office within 30 days of the event to provide any required information. It is important that you provide any requested information to the Fund Office because it helps ensure that the Fund Office has your correct address and family information on file. It also enables the Fund Office to keep updated information about your marital status, your Dependents, and whether you or your Dependents have other benefits coverage. This information helps in processing your claims quickly and accurately.

You should also contact the Fund Office to update your:

- Beneficiary information, if you experience a change in family status; or
- Address, if you move.

Adding a Dependent

You will need to contact the Fund Office to enroll your Dependents, and you must pay the required payment for their coverage. Adding a Dependent could result from any of the following:

- Having a baby;
- Adopting a Child or having a Child placed with you for adoption;
- Acquiring a Foster Child or a Stepchild; and
- Getting married.

If Your Dependent Loses Eligibility for Coverage

If your Dependent loses eligibility for coverage because of a loss of Dependent status under the Plan (for any reason other than non-submission of the required payment for Dependent coverage) and he or she wants to continue coverage under COBRA, you must notify the Fund Office within 60 days from the date your Dependent loses eligibility. See page 19 for more information about COBRA Continuation Coverage.

In the Event of Divorce or Legal Separation

If you divorce or legally separate and your once-covered ex-Spouse wants to continue coverage under COBRA, you or your ex-Spouse must notify the Fund Office within 60 days from the date of the divorce or legal separation in order to be eligible for COBRA Continuation Coverage. See page 19 for more information about COBRA Continuation Coverage.

Qualified Medical Child Support Order (QMCSO)

This Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and provides benefits for a Dependent Child(ren) as determined by a court order in the event of a divorce or other family law action. Orders must be submitted to the Fund Office to determine if the order is a QMCSO, as required under federal law. The Fund Office will provide you with a copy of the Plan's QMCSO procedures, free of charge, upon request.

If You Take Leave Under the Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks (or 26 weeks, if applicable) of unpaid leave during any 12-month period due to the:

- Birth, adoption, or placement with you for adoption of a Child;
- Care of a seriously ill Spouse, parent, or Child;
- Your serious Illness; or
- A qualifying urgent need for leave because your Spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation.

In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member. The service member must be:

- Your Spouse, son, daughter, parent, or next of kin;
- Undergoing medical treatment, recuperation, or therapy for a serious Illness or Injury incurred in the line of duty while in military service; and
- An outpatient or on the temporary disability retired list of the armed services.

The Fund will maintain your prior eligible status until the end of the leave, provided your contributing Employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

Call your Employer to determine if you are eligible for FMLA leave. During your leave, you will maintain all the coverage offered through the Fund, provided you pay any required contribution. Your Employer is required to make contributions during an FMLA leave.

How FMLA Works with COBRA

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

If you do not return from leave and lose coverage because you do not return to work, that is considered a qualifying event under COBRA Continuation Coverage, and there would be a termination of employment that would cause a loss of coverage. You will have up to 12 weeks (or 26 weeks, if applicable) of maintained health care coverage during FMLA leave and an additional 18 months (or 36 months, if applicable) of continued coverage under COBRA.

If You Enter Active Military Service

Note: This section applies to Employee Participants *only. A* Dependent who enters military service will continue to be treated as a Dependent under the Plan as long as he or she continues to meet the Plan's Dependent eligibility requirements.

If you are on active duty for 30 days or less, you will continue to receive health care coverage for up to 30 days, according to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on duty for more than 30 days, your coverage under this Plan will normally end. However, USERRA permits you to continue medical and prescription drug coverage for you and your Dependents at your own expense for up to 24 months. Your Dependent(s) may be eligible for military health care coverage under TRICARE.

Coverage under this Fund will not be offered for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

You have two options regarding payment for continuing coverage under USERRA. Under the first option, you may use any remaining eligibility to continue coverage at the time you enter military service, and then begin paying for coverage when that eligibility is exhausted; then upon reinstating coverage after service, you will need to pay for your coverage until you earn continuing eligibility from your work for a contributing Employer. Under the second option, you may pay for your continuing coverage under USERRA as soon as you enter service; then, upon your reinstatement after your discharge, the eligibility that you had remaining before entering military service will be used to reinstate coverage on the day you return to work with a Contributing Employer. To be eligible for reinstatement, you must receive a discharge that is not dishonorable, and report back to work or return to employment:

- Within 90 days from the date of discharge if your service lasted more than 180 days;
- Within 14 days from the date of discharge if your service lasted 30 days or more but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if your service lasted less than 30 days.

If you are hospitalized or convalescing from an Injury caused by active duty, these time limits can be extended for up to two years.

Your USERRA coverage may be terminated if:

- You do not pay any required self-payment;
- You exhaust the 24-month coverage period;
- The Plan ceases to provide group health coverage;
- You lose your rights under USERRA (for instance, for a dishonorable discharge); or
- You fail to return to work or apply for reemployment within the time required under USERRA.

If you enter the military, you should:

- Notify your Employer and the Fund Office if you want to elect COBRA Continuation Coverage for yourself and/or your family under the provisions of USERRA; and
- Make any required self-payments to the Fund Office to continue your coverage, if elected.

Reemployment

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

How USERRA Works with COBRA

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

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

If you have any questions about taking a leave, please speak directly with your Employer. If you have any questions about how a leave affects your benefits, please contact the Fund Office.

In the Event You Become Disabled

If you become disabled and begin receiving workers' compensation benefits, you and your Dependents are eligible to continue coverage under the Plan if your Employer is required, under the collective bargaining agreement, to contribute to the Fund during your disability.

In the Event of Your Dependent's Death

You should contact the Fund Office within 60 days of a Dependent's death. The Death Benefit is provided through an insurance company. The Fund Office will provide you with information on how to apply for the benefit.

In the Event of Your Death

In the event of your death, your surviving Dependent(s) should contact the Fund Office within 60 days for information on how to apply for the Death Benefit. Your Dependents may also be able to continue coverage by electing COBRA Continuation Coverage.

COBRA Continuation Coverage

You and/or your Dependents may be eligible to continue your coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) if your coverage under the Plan ends due to a qualifying event, as described below.

Qualifying Events

If you have questions about COBRA Continuation Coverage, contact the Fund Office To maintain your COBRA Continuation Coverage, you must make monthly payments to the Fund Office on time.

By making monthly payments, you and/or your Dependents may continue the same medical, vision, dental, and prescription drug coverage that was available to you before termination of your coverage. You may continue coverage under COBRA for up to 18, 29, or 36 months, depending on the qualifying event, as shown below:

Qualifying Event that causes a loss of Coverage	Who is Eligible	Maximum Coverage Period
Your termination or reduction in hours of employment (including retirement), unless due to gross misconduct	You, Spouse, and/or Dependent Children	18 months
Your termination or reduction in hours and, before the 60th day of your COBRA continuation period, you or your Dependent is disabled and entitled to Social Security Disability benefits	You, Spouse, and/or Dependent Children	29 months
Your entitlement to Medicare	Spouse and/or Dependent Children	36 months
Your death	Spouse and/or Dependent Children	36 months
Your divorce or legal separation	Spouse and/or Dependent Children	36 months
Your Child is no longer a Dependent as defined by the Plan	Dependent Child	36 months

When the qualifying event is the termination of employment or reduction of the Employee Participant's hours of employment, and the Employee Participant became entitled to (qualified for and enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA Continuation Coverage for the Qualified Beneficiaries other than the Employee Participant lasts up to 36 months from the date of the Employee Participant's Medicare entitlement. However, the Employee Participant's maximum coverage period is 18 months from the date of termination of employment or reduction in hours.

See page 23 for information on the COBRA provisions that apply in the event a second qualifying event occurs while you are covered under COBRA.

If your Employer withdraws from the Plan or stops making contributions on your behalf, but you do not suffer any of the qualifying events listed above, you are **not** eligible for COBRA.

Qualified Beneficiaries

Under the law, Qualified Beneficiaries are entitled to COBRA independent of your enrollment for COBRA Continuation Coverage. Qualified Beneficiaries include you, your Spouse, and your Dependent Child(ren) who were covered by the Plan on the day before the qualifying event.

It is a good idea to notify the Fund Office of any qualifying event. Failure to provide notice within 60 days of a qualifying event may prevent you and/or your Dependents from obtaining or extending COBRA Continuation Coverage.

If you marry, have a newborn Child, adopt a Child, or have a Child placed with you for adoption while covered under COBRA Continuation Coverage, you may enroll that Spouse or Child for coverage for the balance of the period of COBRA Continuation Coverage. You must enroll your new Dependent within 30 days of the marriage, birth, adoption, or placement for adoption.

In addition, if you are enrolled for COBRA Continuation Coverage and your Spouse or Dependent Child loses coverage under another group health plan, you may enroll that Spouse or Child for coverage for the balance of the period of COBRA Continuation Coverage within 30 days after the termination of the other coverage. To be eligible for this special enrollment right, your Spouse or Dependent Child must have been eligible for coverage under the terms of the Plan, but declined when enrollment was previously offered because they had coverage under another group health plan or had other health insurance coverage.

Contribution Month and Benefit Month are the same for COBRA coverage. There is NO lag month coverage for COBRA benefits.

Adding a Spouse or Dependent Child may cause an increase in the amount you pay for COBRA Continuation Coverage. To find out about COBRA rates, contact the Fund Office.

One or more of your family members may elect COBRA Continuation Coverage even if you do not. However, to elect COBRA, your family member must have been covered by the Plan on the date of the qualifying event. A parent may elect or reject COBRA Continuation Coverage on behalf of minor Dependent Children living with him or her.

If you change your marital status or add new Dependents, or if you or your Spouse or other Dependents change addresses, please notify the Fund Office immediately.

Electing COBRA Continuation Coverage

To elect COBRA Continuation Coverage, you (or your Employer) must notify the Fund Office within 60 days from the date the qualifying event occurs.

In some cases, your Employer will notify the Fund Office. In other cases, you or your Dependent must notify the Fund Office, as shown below:

Your Employer Should Notify the Fund Office of Your:	You (or your Dependent) Must Notify the Fund Office of:
■ Termination of employment ■ Reduction in hours ■ Retirement ■ Death	■ Entitlement to Medicare ■ Divorce ■ Legal separation ■ A Beneficiary ceasing to be covered under the Plan as your Dependent Child, for example because of reaching the age limit. ■ The occurrence of a second qualifying event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum of 18 (or 29) months. This second qualifying event could include an Employee Participant's death, divorce or legal separation or a Beneficiary ceasing to be covered under the Plan as your Dependent.

If you lose coverage due to a qualifying event:

- Inform the Fund Office of the qualifying event within 60 days and request a COBRA Continuation Coverage election form.
- Complete and return the election form within 60 days of the date you received it, or within 60 days of the date the qualifying event occurred, whichever is later.
- Make your first payment to the Fund Office within 45 days from the date you make your COBRA Continuation Coverage election.

Notice of any of qualifying events or situations listed above must be provided in writing. You may use the Fund's *COBRA Continuation Coverage Election Notice* to provide notice to the Fund. You may also send a letter to the Fund including:

- Your name;
- The qualifying event or situations listed above under which you are providing notice; and
- The date of the event.

You, a Qualified Beneficiary, or any representative acting on your behalf may provide notice of a qualifying event. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same qualifying event. For example, if an Employee Participant, Spouse, and Child are all covered by the Plan, and the Child ceases to be a Dependent under the Plan, a single notice sent by the Spouse would satisfy this requirement.

When you or your Dependents have provided notice to the Fund Office of a divorce or legal separation, a Dependent ceasing to be covered under the Plan as a Dependent, or a second qualifying event, but are not entitled to COBRA Continuation Coverage, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA Continuation Coverage. This will be provided within 14 days of receiving your notice.

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

When the Fund Office receives notice of a qualifying event, you will be provided with a COBRA election form, information about COBRA, and the date on which your coverage will end. Under the law, you and/or your covered Dependents have 60 days from the later of the dates:

- You would have lost coverage because of the qualifying event; or
- You and/or your covered Dependents received the election form and COBRA Continuation Coverage information.

If you and/or any of your covered Dependents do not elect COBRA Continuation Coverage within 60 days of the qualifying event (or, if later, within 60 days after receiving that notice), you and/or your Dependents will not have any group health coverage from this Fund after coverage ends.

Each Qualified Beneficiary with respect to a particular qualifying event has an independent right to elect COBRA Continuation Coverage. For example, both you and your Spouse may elect COBRA Continuation Coverage, or only one of you. A parent or legal guardian may elect COBRA Continuation Coverage for a minor Child.

Paying for COBRA Continuation Coverage

You are responsible for the entire cost of COBRA Continuation Coverage. When you and/or your Dependents become eligible for this coverage, the Fund Office will notify you of the COBRA Continuation Coverage Self-Payment amount.

Your COBRA Continuation Coverage Self-Payment may be as much as 102% of the Plan's cost. If you are eligible for the 11-month extension due to a determination of disability by the Social Security Administration, your COBRA Continuation Coverage premiums may be as high as 150% of the Plan's cost for the additional 11 months.

You must make Self-Payments so that your COBRA Continuation Coverage is continuous. To prevent a lapse in coverage, you must send the first COBRA Continuation Coverage Self-Payment to the Fund Office within 45 days from the date on which you or your Dependent make your COBRA Continuation Coverage election, as determined by postage cancellation. Payments for subsequent months are due on the first day of the month for which COBRA Continuation Coverage is provided. You will have a 30-day grace period to submit payments. If you make a monthly COBRA payment later than the first day of the month for which it is due, but before the end of the grace period for the coverage, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you do not make payment by the end of the grace period, your COBRA Continuation Coverage will end, retroactive to the last day of the previous month, and you will lose all rights to COBRA Continuation Coverage under the Plan.

If you choose COBRA Continuation Coverage within the election period but after the date your eligibility ended, you must pay the required COBRA Continuation Coverage Self-Payment retroactive to cover the elapsed period. There can be NO lapse in payment for coverage from the time your regular coverage terminated and the date your COBRA payments begin.

Disability COBRA Continuation Coverage

If you are covered under COBRA Continuation Coverage for 18 months, and at the time of the qualifying event or within the first 60 days of coverage you (or your covered Dependent) are determined to be disabled, you (or your Dependent) may be eligible to continue COBRA Continuation Coverage for an additional 11 months for a total of 29 months.

To be eligible, the Social Security Administration must make a formal determination that you (or your Dependent) are disabled and therefore entitled to Social Security Disability benefits. If you are providing notice of a Social Security Administration determination of disability, the notice must be sent to the Fund Office within 60 days and before the end of the 18-month COBRA Continuation Coverage period.

This extended period of COBRA Continuation Coverage will end on the earlier of:

- The last day of the month that occurs 30 days after the Social Security Administration has determined that you and/or your Dependent(s) are no longer disabled;
- The end of the 29 months of COBRA Continuation Coverage;
- For the disabled person, the date the disabled person becomes entitled to Medicare.

If you recover from your disability before the end of the initial 18 months of COBRA Continuation Coverage, you will not have the right to purchase extended coverage. You must notify the Fund Office within 30 days of:

- The date that you receive a final Social Security determination that you and/or your Dependent(s) are no longer disabled; or
- The date that the disabled person becomes entitled to Medicare.

Additional Qualifying Events While Covered Under COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is 36 months, even if you experience another qualifying event while you are already covered under COBRA Continuation Coverage. If you are covered under COBRA Continuation Coverage for 18 months because of your termination of employment or reduction in hours, your Spouse and/or Dependent may extend coverage for another 18 months if:

Continuation Coverage under USERRA will run concurrently with COBRA Continuation Coverage.

- You get divorced or legally separated;
- You become entitled to Medicare and drop Plan coverage;
- You die; or
- Your Child no longer meets the Plan's definition of Dependent.

You, as an Employee Participant, are not entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage because of a disability). Therefore, if you experience a reduction in hours followed by a termination of employment, the termination of employment is *not* treated as a second qualifying event and you may not extend your coverage.

When COBRA Continuation Coverage Ends

COBRA Continuation Coverage will end on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- The required COBRA Continuation Coverage Self-Payment is not made by the due date;
- The person receiving the coverage becomes covered by another group health plan that does not contain any exclusion or limitation with respect to Pre-Existing Conditions;
- The person receiving the coverage becomes entitled to Medicare; or

- The Plan terminates and no longer provides group health insurance coverage.

If COBRA Continuation Coverage ends before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable following the determination that COBRA Continuation Coverage will end. The notice will explain why coverage will end early, the date it will end, and your rights, if any, to alternative individual or group coverage.

Medical Benefits

The Plan offers comprehensive health care coverage to help you and your family stay healthy and provide you with financial protection against catastrophic health care expenses. The decisions about how and when you receive medical care are up to you and your Physician — not the Plan. The Plan determines how much it will pay; you and your Physician must decide what medical care is best for you.

How the Medical Benefits Work

To help manage certain health care expenses, the Plan contains a cost management feature – a Preferred Provider Organization (PPO). A PPO is a network of Physicians and Hospitals that have agreed to charge discounted rates for their services and/or supplies. The Plan pays a different percentage of your medical costs based on whether you use a PPO network provider or a non-PPO network provider, as explained below and shown on the *Schedule of Benefits*. Refer to the *Important Contact Information* list for information on how to find a network provider.

Each year between January 1 and December 31, the Plan pays benefits as follows:

- **Covered Charges:** The Plan pays for medical Covered Charges, in accordance with the limits and conditions established under the Plan. Medical Covered Charges are expenses for services, treatments, and supplies that are Medically Necessary and not Experimental or investigational. In general, Medically Necessary services, treatments, and supplies are only those ordered by a Physician, which are essential to treat an Injury or Illness.
- **Deductible:** The deductible is the amount you and your family pay each calendar year toward the cost of your medical care before the Plan begins to pay toward Covered Charges.
  - If you incur expenses toward your individual deductible in October, November, or December of one year, those expenses will also be applied toward your deductible for the following year. Expenses towards reaching the family deductible that are incurred in October, November or December are NOT applied to meeting the following year's family deductible.
  - You are responsible for meeting the individual or family deductible. No one family member can apply more than the individual deductible amount toward meeting the family maximum. However, payments toward the individual deductible are limited to the family maximum; so once payments toward the individual deductible for all family members reach the family maximum, individual deductibles for all family members will automatically be satisfied for that year.
  - If two or more covered family members incur Covered Charges due to the same accident, only one deductible applies to those expenses.
- **Coinsurance:** Once you (or your family) meet the annual deductible, the Plan pays a percentage of Covered Charges and you pay the rest. The amount the Plan pays varies depending on whether you use PPO or non-PPO providers, as explained below:
  - When you use a PPO provider, the Plan pays a percentage of the Covered Charges, up to the discounted rate the PPO has negotiated with its network providers for their services and supplies. The percentage that the Plan pays of the Covered Charges is higher when care is provided by a PPO provider than when care is provided by a non-PPO provider, as shown on the *Schedule of Benefits*.

If you need to see a Physician…

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

- When you use a non-PPO provider, the Plan pays a percentage of the Covered Charges, up to the maximum amount ordinarily charged by most providers in the same geographic area for comparable services and supplies. In determining whether the billed charges are Covered Charges, consideration is given to the nature and severity of the Injury or Illness being treated and any medical complications or unusual circumstances that require additional time, skill, or experience. The Plan pays a lower percentage of Covered Charges billed by non-PPO providers, as shown on the *Schedule of Benefits*. In addition, because non-PPO providers have not agreed to discount their services, their costs are, most likely, higher than that of PPO providers, which will affect the amount you pay out-of-pocket.

- **Annual Out-of-Pocket Maximum:** The Plan limits the amount you pay out-of-pocket in a calendar year toward medical Covered Charges. Once you reach your individual maximum out-of-pocket, the Plan pays 100% of most of your remaining charges for the remainder of the calendar year.
- **Annual Maximum:** The Plan pays a majority of your and your family's medical costs. The Plan no longer has an overall annual maximum; however, the Plan may still apply an annual maximum to any non-essential benefit (as defined under the Affordable Care Act), as shown on the *Schedule of Benefits*.

The deductible and out-of-pocket maximum do not apply to every covered service, as shown on the *Schedule of Benefits*. Some expenses may be covered differently or are subject to benefit maximums.

Maximizing Your Medical Benefits

The Plan's Medical Benefits are provided through programs designed to help manage certain health care costs. They include a:

- Preferred Provider Organization (PPO);
- Diagnostic Imaging Provider; and a
- Utilization Review Provider.

PPO

A network of Hospitals, Physicians, and other providers that have agreed to charge negotiated rates. Since PPO providers have agreed to these negotiated rates, you help control health care costs for yourself and the Plan when you use PPO providers.

The Preferred Provider Organization (PPO)

When you use a provider that participates in the PPO network, you save money for yourself and the Plan because PPO providers have agreed to charge negotiated rates. In addition, you pay less when you use a PPO provider because the Plan pays a higher percentage of Covered Charges billed by PPO providers. However, it is your decision whether to use a PPO or non-PPO provider. You always have the final say about the providers you and your family use.

If you or your Dependents are confined in a PPO Hospital but incur Covered Charges for charges made by a non-PPO radiologist, pathologist, and/or anesthesiologist, these Covered Charges will be paid at the PPO provider rate.

Example: How Using PPO Providers Saves Money

Let's compare what Joe pays when using a PPO provider versus a non-PPO provider (this assumes Joe has met his deductible):

	PPO Provider	*Non-PPO Provider*
Covered Charges	*$4,000*	*$5,000*
Percent Joe Pays	*x 20%*	*x 35%*
Amount Joe Pays	*$800*	*$1,750*
Covered Charges	*$4,000*	*$5,000*
Percent Plan Pays	*x 80%*	*x 65%*
Amount Plan Pays	*$3,200*	*$3,250*

Joe saves $950 by using a PPO provider; and the Plan pays less as well.

This example, which is for illustrative purposes only, assumes a PPO savings of 20% (charges of $4,000 versus $5,000 for non-PPO charges).

For the most up to date list of PPO providers, or to find out if your provider is in the PPO network, contact the PPO (see the *Important Contact Information* list).

Diagnostic Imaging (X-rays, MRIs, Other)

The Plan provides diagnostic imaging benefits through a provider network, currently the Absolute Solutions PPO nationwide network. When you use this program, the Plan pays 100% of your diagnostic imaging expenses, with no deductible required. If you do not go through this provider network, you must meet the deductible and pay your coinsurance amount, as listed on the *Schedule of Benefits*. Refer to the *Important Contact Information* list for information on how to find a network provider.

Diagnostic imaging includes:

- Magnetic Resonance Imaging (MRI);
- Computerized Tomography (CT)
- Position Emission Tomography (PET) Scans;
- X-Rays; and
- Mammograms.

When your Physician prescribes one of these diagnostic imaging services, contact Absolute Solutions to schedule an appointment. A representative will work with you to identify the most convenient facility for you.

Utilization Review (Pre-authorization)

The Utilization Review (UR) Program helps ensure that you receive quality care in a way that uses valuable health care resources as wisely as possible. However, to make it work, you need to become involved in the decisions regarding your care, which is why the Plan includes the UR Program. The UR Provider, currently Med-Care Management, provides pre-authorization services.

Pre-authorization is not a guarantee of payment. Your eligibility for Plan benefits, and benefit payment, is subject to all the terms and conditions of the Plan.

Under the UR Program, you are required to get pre-authorization for:

- **Hospital admissions.** If it is a(n):
  - Non-Emergency admission, you or your Physician must call for pre-authorization **at least 48 hours before** the admission.
  - Emergency admission, you or someone acting on your behalf must call for pre-authorization **within 48 hours of admission**.

  For extended Hospital stays, if Medically Necessary to stay in the Hospital longer than originally expected, have your Physician coordinate your care with the UR Provider.
- **Non-Emergency outpatient surgery.** You or your Physician must call for pre-authorization **at least 48 hours before** the surgery. Any surgical procedure performed on an Emergency basis does not need to be pre-authorized unless the procedure results in a Hospital Confinement, in which case you must call for pre-certification within 48 hours of the admission.
- **Home health care services or Durable Medical Equipment.** You or your Dependents should contact the UR Provider when you need home health care services or Durable Medical Equipment. The UR Provider will work with your Physician to determine whether to rent or purchase the necessary equipment and will coordinate obtaining the equipment.

If pre-authorization is not requested for a hospital admission as required, you will be subject to a pre-authorization non-compliance penalty of $700 per occurrence. This penalty amount is in addition to any other amounts you are responsible for paying, such as amounts you must pay to meet your deductible. In addition, this amount does not apply toward meeting your deductible or out-of-pocket maximum.

Disease Management

The Plan also provides a disease management (DM) program**,** called the "*Living Well Health Management Program,"* to help Participants with certain medical conditions improve their quality of life. The DM program is administered by Med-Care Management, the same organization that administers the Medical Review Program.

If you or one of your eligible Dependents has diabetes, coronary artery disease (heart or cardiovascular conditions), or are coping with managing your weight (Weight Management), you are eligible to enroll in the DM program and learn self-management tools for care and management of your medical condition. ***You pay nothing to enroll and participate in the DM Program and the program is voluntary—in other words, you decide whether you want to participate***.

While the *Living Well Health Management Program* is not meant to provide a cure or treatment for an individual's medical condition(s), the free informational assistance you can receive may be invaluable to you if you have diabetes or coronary artery disease, or you are struggling with obesity.

You must be enrolled in the Disease Management Program to utilize the Diabetic Education and Dietician/Nutritionist coverage available under the Plan. To participate, call the number shown on the *Important Contact Information* list and a nurse will enroll you in the program. ***All of the information you share with the nurse will be kept confidential.***

Covered Medical Charges

Covered Medical Charges include the following expenses. Plan provisions relating to Covered Medical Charges, including any benefit limitations, are listed on the *Schedule of Benefits:*

1. Hospital charges, including:
    a. Hospital room and board, including any flat daily charge for routine Hospital services.
    b. Intensive Care Accommodation.
    c. Services and supplies provided during a Hospital Confinement.
    d. Emergency treatment charges.
    e. Surgery charges.
    f. Pre-admission testing performed on an outpatient basis.
2. Physician charges for:
    a. Surgical services.
    b. Radiotherapy procedures.
    c. Professional medical services.
3. Professional care and attendance by a registered nurse, nurse practitioner, and licensed physical therapist.
4. Professional ambulance service for necessary transportation to the nearest Hospital equipped to furnish treatment for an Injury or Illness.
5. Outpatient surgery, including the following related expenses incurred on the day of surgery:
    a. Hospital outpatient department charges or other facility charges.
    b. Surgeon and anesthetist fees.
    c. Lab tests, x-rays and supplies.

    The surgery may be performed in a Physician's office, ambulatory surgical center, clinic, or Hospital outpatient facility. For Outpatient Surgical Facilities, only treatment provided at a PPO facility is covered under the Plan. Treatment provided at a non-network Outpatient Surgical Facility is not covered.
6. Prescription drugs and medicines properly identified and ordered in writing by a Physician and dispensed by a licensed pharmacist or Physician.
7. Anesthesia and its administration.
8. Diagnostic imaging, including x-ray and laboratory examinations in connection with therapeutic treatment.
9. Diagnostic testing of Infertility (male or female) problems and surgical or medical treatment of the physical cause of Infertility. However, the following procedures are **not** covered for males or females:
    a. Prescription drugs or medications to promote conception, including hormone treatments.
    b. Artificial intrauterine insemination.

c. Implantation of a fertilized egg, whether by in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, or any similar procedure, regardless of whether the treatment is applied to a male or female.

The foregoing exclusions also apply to in vitro fertilization and similar procedures that apply to Infertility.

10. X-ray, radium, and radioactive isotope therapy.
11. Oxygen and its administration.
12. Blood and blood plasma.
13. Casts, splints, trusses, braces, and crutches.
14. First pair of glasses or contact lenses placed after cataract surgery.
15. Surgical correction of refractive errors of the eye if Medically Necessary, limited to $1,000 per Employee Participant per lifetime.
16. IUD insertion and removal and birth control implants.
17. Pregnancy, childbirth, and related conditions, under the same terms and conditions as any other medical Covered Charge.
18. Examinations performed on a newborn while Hospital confined, which will be paid under the newborn Dependent Child's coverage, subject to the deductible and coinsurance.
19. Routine medical examinations; childhood immunizations for Dependent Children are covered from birth to age 18.
20. One routine physical examination per person during any calendar year. Covered Charges include the following, if ordered on the day of the physical examination:
    a. Physician charges.
    b. Urinalysis.
    c. Complete blood chemistry.
    d. Electrocardiogram.
    e. X-rays.
    f. Any other special examination or test deemed necessary by the Physician performing the examination, which are ordered on the same day.
21. Routine pap test and office visit to obtain pap smear. These costs do not apply toward the routine physical examination maximum.
22. Mammography benefits, which include screenings for the presence of occult breast cancer in women ages 35 and older. Screenings are limited to once every calendar year.
23. Reconstructive surgery following mastectomy, as required by the Women's Health and Cancer Rights Act of 1998, which includes:
    a. All stages of reconstruction of the breast on which the mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

The Plan does not restrict benefits for any covered Hospital length of stay in connection with childbirth for the mother and/or newborn Child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. The Plan does not require a health care provider to obtain pre-authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours, or 96 hours, as applicable.

c. Prosthetic devices and treatment of physical complications at all stages of the mastectomy, including lymphedema (swelling associated with removal of lymph nodes).

These benefits are subject to the same deductibles and coinsurance applicable to other Plan medical and surgical Covered Charges.

24. Purchase or rental of Durable Medical Equipment that:

    a. Is used for therapeutic treatment.

    b. Serves as a prosthetic device for initial replacement of natural limbs or eyes. Covered expenses are limited to the cost of conventional (non-microprocessor) mechanical prostheses.

    This includes necessary supplies to operate the equipment (for examples of covered and non-covered Durable Medical Equipment, refer to page 77). The equipment must be ordered by a Physician who certifies the need for the equipment in the medical management of the Participant, and specifies how long the equipment will be needed. If the total cost of renting or purchasing Durable Medical Equipment exceeds $500, the rental or purchase of the equipment must be pre-authorized. Replacement of purchased equipment is limited to once every five years.

    For breast prostheses and surgical bras following a mastectomy, up to one (or one pair) of prostheses per 12-month period and two surgical bras per 12-month period are covered. For other appliances to replace physical organs or parts, only the initial charge for a prosthetic appliance will be a Covered Charge for adults. For Children, charges for a replacement prosthetic device required due to growth will also be covered.

25. Hospice care.

26. Home health care, which includes:

    a. Licensed Nurse services to provide part-time or intermittent nursing care, not to exceed 12 hours during any 24-hour period.

    b. Home Health Aide services to provide part-time or intermittent personal health care of a medical or therapeutic nature, not to exceed 8 hours during any 24-hour period.

    c. Licensed therapist services to provide physical, occupational or speech therapy.

    d. Total payments for each covered person for home health care services will not exceed 30 days during any calendar year. This limitation does not apply to Hospice care.

    The following Home Health Care procedures are **not covered** and no benefits will be payable for:

    a. Services not included in the Home Health Care Plan.

    b. Home health care expense to the extent benefits are payable for such expense under any other portion of this Plan.

    c. Custodial Care not performed by a Home Health Aide.

    d. Transportation services.

    e. Expense incurred while not under the continuing care of a Physician.

    f. Any period during which confinement in a Hospital or other institution would not be required in the event home health care benefits were not provided.

g. Charges incurred after seven days have elapsed, during which time the Participant received no home health care services when the care was not re-certified by a Physician.

h. Services or supplies that are listed under *General Plan Exclusions and Limitations* on page 47.

27. Speech therapy for Dependent Children ages 18 months through 18 years, up to the maximum listed on the *Schedule of Benefits*.

28. Human Organ Transplants - coverage does not include donor expenses related to human organ transplants.

29. Mental/Behavioral Health Disorder treatment.

30. Substance Abuse Disorder treatment.

31. Chiropractic care, up to the maximum listed on the *Schedule of Benefits*.

32. General anesthesia, hospital, or PPO outpatient surgical center charges for Dependent Children age five and under who need extensive dental treatment that requires general anesthesia. The dental treatment is covered under the Dental Benefit, subject to the usual limits.

33. Non-emergency care when traveling outside the United States (unless related to your occupation).

34. Routine foot care.

35. Preventive care colonoscopy screenings once every 10 years starting from age 50 up to age 75. Coverage may be provided to individuals with certain risk factors at an earlier age and more frequency than average risk individuals, as may be recommended by the American Cancer Society (ACS).

36. Genetic Testing covered only as follows:
    a. oncotype testing of breast cancer when the result of the test will impact the clinical treatment of the person's breast cancer; and
    b. prenatal testing to analyze fluid and tissue obtained as a result of amniocentesis or chorionic villus sampling ("CVS") in a covered pregnant Participant as follows:
        i. regardless of Participant's age (tests performed via CVS or amniocentesis):
            1. Cystic fibrosis;
            2. Sickle cell anemia;
            3. Down syndrome;
            4. Neural tube defects, including spina bifida
            5. Hemophilia.
        ii. For pregnant Participants age 35 and older (test performed via CVS or amniocentesis), in addition to the above:
            1. Chromosomal microdeletions
            2. Aneuploidy disorders (Trisomy 21 and monosomy)
            3. Trisomy 9 and 16.

    If the prenatal testing is billed as "panel" for several diseases at once and includes test that are covered and not covered under the Plan only the Reasonable and Customary Charge for the covered tests will be covered under the Plan.

Behavioral Health Disorder Treatment

You or your Dependents should contact the UR Provider before beginning any behavioral health treatment. However, there is no penalty if you do not.

Expenses Not Covered Under Medical Benefits

Not all expenses are covered under the Plan's Medical Benefits. Refer to the *General Plan Exclusions and Limitations* section on page 47 for information on what is not covered under the Plan's Medical Benefits.

The Plan pays benefits only for those expenses expressly described as coverage; any omission will be presumed to be an exclusion.

Prescription Drug Coverage

Prescription drug expenses are rising faster than most other health care expenses, and can be a significant expense for you and your family. Recognizing this, the Fund offers prescription drug benefits to you and your Dependents.

How the Prescription Drug Benefit Works

The Fund has contracted with a pharmacy benefit manager, currently OptumRx, to provide you with access to:

- A retail pharmacy program, for your short-term prescription needs; and
- A mail order program, for your long-term needs.

You save money for yourself and the Plan when you have your prescriptions filled at a participating retail pharmacy or through the mail order program. Refer to the *Important Contact Information* for information on how to find a network provider.

Amounts you pay for covered prescription drug expenses through the retail pharmacy or mail order program do not count toward meeting your medical annual deductible or out-of-pocket maximum, which means that prescription drug expenses are never paid at 100%.

When you have a prescription filled at a participating pharmacy:

- Present your ID card.
- Pay your copayment, as shown on the *Schedule of Benefits* on page 3.

If you have a prescription filled at a non-participating pharmacy, the prescription may be covered under the Plan's Medical Benefits and will be subject to the provisions of the Plan's Medical Benefits (such as being paid at the non-PPO rate after you meet your deductible).

Generic Medication Requirement

Many prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. However, on average, generic medications cost less than their brand name alternatives. This can be a significant source of savings for you and the Plan.

While the Plan covers generic and brand name medications, you pay more when you receive a brand name medication. If you have a prescription filled with a brand name medication when a generic alternative is available and appropriate, you will be required to pay the difference in cost between the generic medication and the brand name medication – in addition to your copayment for the brand name medication.

A generic equivalent is a copy of a brand name medication that is no longer protected by a patent. A generic medication usually serves the same purpose as the original (brand name) medication and costs less.

If your Physician writes a prescription for a brand name medication that has a generic equivalent available and indicates "dispense as written," ("DAW") you will not be penalized for purchasing the brand name drug.

Example: Jerry purchased a 30-day supply of a brand name medication at a network retail pharmacy. The retail price of the brand name medication was $100, but there was a generic alternative available that retailed at $40. Since Jerry purchased the brand name medication when there was a generic alternative available and appropriate, Jerry had to pay his copay, plus the difference in cost between the brand name medication and the generic medication ($15 + $60)—a total of $75.

If Jerry's Physician had written "DAW" on the prescription, Jerry would only have had to pay the brand name copay in the amount of $15.

Retail Pharmacy Program

You can use a participating retail pharmacy to fill your prescription for a 30-day supply. If you are taking a prescription on a long-term basis, you should have your prescription filled through the mail order program. When you use the mail order program, you can have prescriptions filled for up to a 90-day supply.

You will receive a prescription drug ID card when you are eligible for coverage. When you have a prescription filled at a participating retail pharmacy and present your ID card, you pay your copayment when you pick it up and the Plan pays the rest. The amount you pay varies depending on the type of medication, as shown on the *Schedule of Benefits*.

If you fill a prescription at a non-participating retail pharmacy or you do not have your ID card with you when purchasing a prescription, you must pay the full cost of the prescription when you have it filled. You will then need to submit a reimbursement form, along with a receipt, to the Fund Office. Claims for prescriptions filled at a non-participating retail pharmacy may be covered under the Plan's Medical Benefits, which means they are subject to your medical deductible and coinsurance provisions. Non-covered prescriptions are not covered under the Prescription Provider Organization and are also not covered under your major medical coverage. Specialty Drugs are ONLY covered under the Specialty Provider Service.

Mail Order Program

You should use the mail order program when you need to have prescriptions filled for maintenance medications. Maintenance medications are prescription drugs that are used on an on-going basis. These prescriptions can be used to treat chronic Illnesses such as:

- Arthritis;
- Diabetes;
- Emotional distress;
- Heart disorders;
- High blood pressure; or
- Ulcers.

When you use the mail order program, you can get a larger quantity of medication at one time – up to a 90-day supply – for less than you would pay at a participating retail pharmacy. The amount you pay varies depending on the type of medication (generic or brand name), as shown on the *Schedule of Benefits.*

When you need to reorder medication through the mail order program:

- Ask your Physician to prescribe a 90-day supply, with refills if applicable.
- Mail the original prescription along with the appropriate form and your copayment to the mail order drug program.
- Allow about 14 days from the time you mail in your order to receive your prescription(s).

Example of How Using the Mail Order Program Can Save Money: Jill has a prescription for a generic medication. Assuming she needs a 90-day supply, Jill can have her prescription filled:

- *Once through the mail order program and pay $20; or*
- *Three times at a retail pharmacy and pay $30 (that's $10 each time she goes to the pharmacy).*

By having her prescription filled through the mail order pharmacy, Jill saves $10. In addition, she has her medications delivered right to her home.

Specialty Pharmacy Service Program

The Fund currently contracts with OptumRx for the provision of a Specialty Pharmacy Services program. Specialty medications are considerably more expensive than traditional prescription drugs, partly due to their specialized use and the manner in which they are administered, manufactured, handled, and distributed:

- Specialty drugs are designed to target and treat specific diseases, such as arthritis, asthma, cancer, diabetes, hemophilia, hepatitis, HIV, and multiple sclerosis.
- Specialty drugs are primarily self-injectable medications requiring patient training and education.
- Their unique manufacturing and distribution process limits the number of pharmacies that are capable of effectively purchasing, storing, and distributing the medications.

To ensure that you are prescribed the right medication at the right dosage, you are required to obtain prior authorization before a specialty medication can be dispensed. Before using OptumRx for your specialty medical prescriptions, **you or your doctor will need to call Med-Care Management to obtain a prior authorization**. Refer to the *Important Contact Information* list for information on how to contact Med-Care Management.

Med-Care Management will coordinate with the Fund Office and OptumRx in order to fill your prescription and send your medication directly to you or your doctor's office, whichever you prefer**.** The amount you pay varies depending on the type of medication (generic or brand name) as shown on the *Schedule of Benefits*.

Note: Oncology or other Physician-administered medications will continue to be covered under your Major Medical Benefit.

If you have questions about OptumRx's Specialty Pharmacy services, or you'd like a list of the specialty pharmaceuticals covered under the program, contact OptumRx at the number shown on the *Important Contact Information* list.

SECURE Compound Program

The Fund has implemented the SECURE Compound Program provided by OptumRx. "SECURE" stands for "Safe & Effective Compound Use Reassurance Effort." This program excludes coverage for compound kits and bulk chemicals. In addition, compound medications that cost more than $300 require prior approval by OptumRx.

Covered Prescription Drug Charges

Covered Charges include:

1. Legend medications that are required under federal law to bear the legend, "Caution: federal law prohibits dispensing without a prescription."
2. Insulin, by prescription.
3. Disposable insulin needles, syringes, lancets and test strips.
4. Compound medications of which at least one ingredient is a prescription legend drug as a condition of the SECURE Compound Program under the Plan.

5. Any other drug that under applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.
6. Levonorgestrel (Norplant).
7. Tretinoin topical (e.g., Retin-A) for individuals through age 25.
8. Legend contraceptives (injectable contraceptives may be dispensed in up to a 90-day supply).

Prescription Drug Charges Not Covered

Not all expenses are covered under the Plan's Prescription Drug Benefits. In addition to any *General Plan Exclusions and Limitations* (see page 47), Prescription Drug Benefits are not paid for the following expenses:

1. Retin-A for Participants age 26 and older.
2. Non-legend medications other than insulin.
3. Therapeutic devices or appliances, including needles, syringes (other than for use with insulin), support garments, and other non-medicinal substances, regardless of intended use.
4. Drugs labeled "Caution: Limited by federal law to investigational use," or Experimental medications, even though a charge is made to the individual.
5. Immunization agents, biological sera, blood, and blood plasma (e.g., hepatitis vaccination, adult chicken pox vaccine).
6. Medication to be taken by or administered to an individual, in whole or in part, while a patient in a licensed Hospital, rest home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals. However, the prescription may be covered as any other Covered Charges under the Plan's Medical Benefits; subject to the Plan's Medical Benefit provisions (see page 25).
7. Any prescription refill in excess of the number specified by the Physician, or any other refill dispensed after one year from the Physician's original order.
8. Growth hormones (e.g., Humatrope, Protropin).
9. Minoxidil (e.g., Rogaine) for the treatment of alopecia.
10. Any prescription or prescription refill that is obtained from a pharmacy that is not in the Plan's participating retail pharmacy network or through the mail order program. However, the prescription may be covered as any other Covered Charges under the Plan's Medical Benefits; subject to the Plan's Medical Benefit provisions (see page 25).
11. Anti-wrinkle agents (e.g., Renova).
12. Smoking deterrent medications, all dosage forms, containing nicotine or any other smoking cessation aids.
13. Impotence medications (e.g., Viagra), unless Medical Necessity has been established.
14. Charges for medicines, drugs, or nutritional supplements that can be obtained without a prescription (over-the-counter).
15. PCSK-9 Inhibitors (e.g. Praluent and Repatha) compound kits and bulk chemicals.

Limits

The Plan limits the amount of prescription Proton Pump Inhibitor drugs and non-sedating antihistamines to a quantity of 30 for a 30-day supply through retail pharmacy or a quantity of 90 for a 90-day supply through mail order.

Proton Pump Inhibitor drugs, which include Nexium and Prilosec, are used to block the production of stomach acid. Non-sedating antihistamines include drugs such as Zyrtec and Allegra, which are used to treat allergies.

Dental Benefits

Timely, preventive dental care plays an important role in your overall health. To help you meet the cost of routine and unexpected dental care, the Fund provides comprehensive dental benefits for you and your family.

How the Dental Benefits Work

When you or your Dependent need dental care:

- Choose any Dentist.
- Make an appointment.
- Ask your Dentist to submit the claim to the address on the back of your ID card.

- **Network Providers:** The Plan provides Dental Benefits through a preferred provider network of Dentists, currently Guardian DentalGuard Preferred. Dentists that participate in the dental network have agreed to provide dental care at negotiated rates. When you or your family needs dental care, you can choose any Dentist. However, when you choose a network Dentist, you maximize your Plan Dental Benefits.
  - When you receive care from a network Dentist, be sure to show your ID card so your provider knows that you are covered under the network. Network Dentists will file claim forms for you. Refer to the *Important Contact Information* list for information on how to find a network provider.
- **Covered Charges:** Covered Charges are the costs for dental services and supplies listed as covered under the Plan, which are provided on the recommendation and approval of a Dentist.
- **Calendar Year Deductible:** The calendar year deductible is the amount you and your family pay each calendar year before the Plan begins to pay toward dental Covered Charges. A deductible applies for basic dental benefits (Class II dental benefits) and for dentures (Class III dental benefits). There is no deductible for routine oral exams in Class I dental benefits. You and each covered Dependent are responsible for meeting the deductible. If you incur expenses towards your deductible in October, November, and December, those expenses will NOT be applied to the following year.
- **Coinsurance:** Once the applicable annual deductible is met, the Plan pays a percentage of Covered Charges and you pay the rest. Dentists that do not participate in the network usually charge more because they have not agreed to negotiated rates. Therefore, you may pay more coinsurance because you are paying a percentage of a higher cost.
  - To encourage you to use network Dentists and save money, the Plan pays a higher coinsurance percentage, as shown on the *Schedule of Benefits,* when you use network Dentists.
  - The Plan pays a lower coinsurance percentage when you use non-network Dentists, as shown on the *Schedule of Benefits*. In addition, when you receive care from a non-network Dentist, you may be responsible for submitting claim forms.
- **Calendar Year Maximum:** Each year, Covered Charges for you and each covered eligible Dependent are payable up to the calendar year maximum listed on the *Schedule of Benefits*.

Network Dentist

A Dentist or other dental specialist who agrees to negotiated rates. You save money for yourself and the Plan when you use a network Dentist.

Covered Dental Charges

Class I – Routine/Preventive Examinations (No Deductible)

Dental Benefits are designed to pay a portion of the cost for routine oral examinations. Covered Charges for check-up examinations and examinations due to Injury, dental defects, or disease include:

- Oral examinations performed by a Dentist;
- Prophylaxis performed by a Dentist or Dental Hygienist (limited to two cleanings per calendar year);
- Necessary x-rays;
- Fluoride treatments; and
- Diagnosis.
- Routine Exams/Cleanings Limited to 2 per year for Dependents age 18 and under.

Class II – Basic and Major Dental Benefits (Deductible Applies)

Covered Charges for an actual or suspected dental disease, defect, or Injury include:

- Tooth extractions;
- Oral surgery;
- Fillings;
- Periodontal treatment;
- Crowns;
- Partial dentures and bridges; and
- Anesthesia.

Class III – Denture Benefits (Deductible Applies)

- Initial Complete Dentures
- Replacement dentures every five years.

Dental Charges Not Covered

Not all expenses are covered under the Plan's Dental Benefits. In addition to any *General Plan Exclusions and Limitations* (see page 47), Dental Benefits are not paid for the following expenses:

1. General anesthesia and facility charges (however, these may be covered under the Plan's Medical Benefits).
2. Any replacement of a denture previously covered under this Plan, either as an initial complete denture or as a replacement, that is not separated from prior treatment by five years.
3. Orthodontic care, treatment, services, and/or supplies.
4. Expenses incurred before the Participant was covered under the Plan, including expenses that are part of a course of treatment.
5. Replacement of lost dentures.

Vision Benefits

The Plan provides Vision Benefits for you and each of your enrolled Dependents.

How the Vision Benefit Works

- **Vision Preferred Provider Network:** The Board of Trustees has contracted with a vision preferred provider network, currently United Healthcare. Network providers have agreed to charge negotiated fees, which are usually less than what non-network providers charge.

  To receive the financial advantages of the network, you must use network providers. However, the Plan gives you flexibility – each time you seek care, you have the choice of using a network or non-network provider. Refer to the *Important Contact Information* list for information on how to find a network provider.

- Covered Charges: The Plan covers the expenses for Medically Necessary vision services and supplies, which are the Covered Charges listed below and shown in the *Schedule of Benefits*.
  - When you use network providers, the Plan pays 100% of the cost of discounted vision Covered Charges, except as specified below and listed on the *Schedule of Benefits*.
  - When you use a non-network provider, the Plan pays 100% of the cost of vision Covered Charges, up to the specific limits listed on the Schedule of Benefits. This includes services and supplies provided by an optometrist or ophthalmologist. Vision providers that do not participate in the network usually charge more because they have not agreed to negotiated fees. The Plan will cover costs that do not exceed the amount ordinarily charged by most vision providers in the same geographic area for comparable services and supplies. **In addition, you are responsible for submitting claims to the PPO Vision Provider Service Network when you receive services or supplies from non-network providers. You will first have to pay the full cost of the services and supplies you receive at the time of purchase and then submit a claim for reimbursement**. Refer to the *Important Contact Information* list for information on where to submit non-network claims.

Your Dependents are only eligible for Vision Benefits if they are enrolled and the required payment is made for their coverage.

Covered Vision Charges

Vision Covered Charges include:

- One exam every 12 months; and
- One pair of single vision or multi-focal lenses (with standard scratch-resistant coating) and frames from the provider's selection (up to a frame allowance) every 12 months; or
- Contacts once every 12 months (this includes the fitting/evaluation fees and up to two follow-up visits). If you choose disposable lenses, the Plan covers up to the Plan maximum listed on the *Schedule of Benefits*.

When you use a network provider, you may receive discounted prices on services and materials not covered by the Plan.

Note that you can receive either lenses and frames or contact lenses in any 12-month period, but not both.

In addition, when you use network providers, other lens options may be available at a discount. If you choose frames or contact lenses outside of the network provider's covered selection, you will only receive an allowance up to the limits shown in the *Schedule of Benefits*.

There are instances where contact lenses may be necessary, such as following cataract surgery, to correct extreme vision problems that cannot be corrected with spectacle lenses, or with certain conditions of anisometropia or keratoconus. If your contact lenses are Medically Necessary (as determined by a non-network provider), the Plan pays a higher percentage, as shown on the *Schedule of Benefits*. You should have your non-network provider contact the Network Administrator before you purchase Medically Necessary contact lenses.

Vision Charges Not Covered

Not all expenses are covered under the Plan's Vision Benefits. In addition to any *General Plan Exclusions and Limitations* (see page 47), Vision Benefits are not paid for the following:

1. Post cataract surgery lenses.
2. Non-prescription items.
3. Medical or surgical treatment for eye disease that requires Physician services.
4. Services or materials that the patient, without cost, obtains from any governmental organization or program.
5. Services or materials that are not specifically listed as covered.
6. Replacement or repair of lenses and/or frames that have been lost or broken.
7. Cosmetic extras, except as specifically listed as covered.
8. Vision therapy.
9. Orthoptics or vision training and any associated supplemental testing.

In the Event of Disability or Death

To help provide financial protection for you and your family, the Plan provides benefits to you in the event of your disability or your Dependent's death and to your Beneficiary in the event of your death. This section describes these benefits.

Weekly Disability Benefit (Employee Participants Only)

Contact the Fund Office if you become disabled. To be eligible for benefits, you must provide written proof of your disability.

The Plan provides a Weekly Disability Benefit, which is available to you if you are:

- Wholly and continuously disabled because of an Injury or Illness which is not related to any occupation or activity undertaken for wage or profit;
- Unable to perform the duties of your occupation due to the disability; and
- Not engaged in any other occupation for wage or profit.

The amount of the benefit is shown on the *Schedule of Benefits*. Weekly Disability Benefits begin on the:

- First day of disability due to Injury or Hospital Confinement (including outpatient surgery); or
- Eighth day of disability due to Illness.

Benefits continue for up to a maximum of 13 weeks during any one period of disability, but will end earlier upon retirement or death. Two or more periods of disability are considered as one unless, between periods of disability, you returned to active full-time work for at least 30 days.

Weekly Disability Exclusions and Limitations

Spouses and Dependent Children are not eligible for Weekly Disability Benefits.

No benefits will be payable for a disability:

- Resulting from travel or flight in any kind of aircraft except as a fare-paying passenger in an aircraft operated on a regular schedule by an incorporated common carrier for passenger service over its established air route.
- For which you are not under the care of a licensed Physician or surgeon.
- If the disability is due to a work-related injury or illness.
- If you are covered under COBRA Continuation Coverage, you will not be entitled to Weekly Disability Benefits.

Death Benefits

The Plan provides a non-taxable Death Benefit in the event of your death or the death of your Beneficiary. All of your eligible Dependent Children who are older than 14 days and younger than age 26 are covered under the Death Benefit.

Death Benefits are provided through an insurance company, currently Amalgamated Life Insurance Company. If you would like a copy of the full terms of the policy, please contact the Fund Office to request a free copy of the Certificate of Insurance.

In the event that you or your designated Beneficiary is eligible to receive a Death Benefit, proof of the death must be provided to the insurance company before the benefit will be paid. The Death Benefit cannot be assigned and is not subject to the claims of creditors.

Your Spouse and Dependent Children are not allowed to name a Beneficiary for Death and AD&D Benefits because you (the Employee Participant) are the sole Beneficiary.

For Employee Participants

In the event of your death, your designated Beneficiary will receive a lump sum benefit. The amount of the benefit is listed on the *Schedule of Benefits*.

For Dependents

The Plan provides a Death Benefit to you in the event of the death of your Spouse or Dependent Child (age 14 days but less than 26 years). The amount of the Dependent Death Benefit is listed in the *Schedule of Benefits*.

Generally, benefits are paid to you. However, in the event you are not living, this Death Benefit is paid to your estate or Designated Beneficiary.

Death Benefits Exclusions and Limitations

No benefits will be paid if death results from:

1. Service in the armed forces of any country.

2. Aviation other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Also, if you are covered by COBRA Continuation Coverage, you will not be entitled to Death Benefits.

Additional limitations and exclusions under the Death Benefits are governed by the Certificate of Insurance.

Additional Coverage Under Insured Policy for Death Benefits

Any and all additional terms of the insured policy for Death Benefits are contained in the Certificate of Insurance. If you would like a copy of the full terms of the policy, please contact the Fund Office for a free copy of the Certificate of Insurance.

Accidental Death and Dismemberment (AD&D) Benefits

The Plan provides a non-taxable Accidental Death and Dismemberment (AD&D) Benefit for you and your Dependents. All of your eligible Dependent Children who are older than 14 days and younger than age 26 are covered under the AD&D Benefit.

AD&D Insurance benefits are provided through an insurance company, currently Amalgamated Life Insurance Company. If you would like a copy of the full terms of the policy, please contact the Fund Office to request a free copy of the Certificate of Insurance.

A work-related death or Injury is covered under the AD&D policy on the same basis as a non-work-related death or Injury. Therefore, in the event of an accidental death, even if work-related, the AD&D benefit would be paid to your Beneficiary or estate, in addition to the Death Benefit.

The AD&D benefit is payable for the loss of life and limb(s), or the entire and irrecoverable loss of sight in one or both eyes. The loss must be due to an accidental Injury and occur within 90 days of and as the direct result of that accident, and must be independent of all other causes.

In the event of your death, benefits are paid to your designated Beneficiary. For all other losses, benefits are paid to you. The full amount of the AD&D benefit is listed on the *Schedule of Benefits* and is paid as follows:

For Loss of:	Benefit
▪ Life; ▪ Two hands; ▪ Two feet; ▪ Sight of two eyes; Any two or more of the following: ▪ One hand; ▪ One foot; ▪ Sight of one eye.	100% of full amount
▪ One hand; ▪ One foot; ▪ Sight of one eye.	50% of full amount

If more than one loss is sustained as the result of the same accident, benefits will be paid only for the loss with the greatest benefit amount. Benefits will be made only for the loss that results from the accident without regard to any former loss.

Loss of:

- Hand(s) means severance at or above the wrist joint.
- Foot or feet means severance at or above the ankle joint.
- Sight of eye(s) means the total and irrecoverable loss of sight.

Additional losses, if any, as provided by the Certificate of Insurance, are payable in accordance with the provisions of the Certificate of Insurance.

AD&D Benefits Exclusions and Limitations

No benefits are paid for losses resulting from or caused directly or indirectly by:

1. War or any act of war, whether declared or undeclared, terrorism, insurrection, rebellion, or participation in a riot or civil commotion.
2. Illness, disease, or bodily infirmity (this does not include bacterial infection, which results from an accidental cut or wound, or accidental ingestion of a poisonous food substance).
3. Taking a poison or asphyxiation from or inhaling a gas, or intentionally taking narcotics, drugs, barbiturates, hallucinogenic drugs, alcohol or any combination of these when not part of a professional medical treatment.
4. Intentionally self-inflicted Injury, while sane or insane.

5. Suicide or attempted suicide, while sane or insane.
6. Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft, except while a fare-paying passenger in any aircraft then licensed to carry passengers.
7. The insured's committing or attempting to commit an assault or felony. Commission of or participation in a crime.
8. Service in the armed forces of any country.
9. Travel or flight as a pilot or crewmember in any kind of aircraft including, but not limited to, a glider, seaplane, or hang kite.

If you are covered by COBRA Continuation Coverage, you will not be entitled to Accidental Death and Dismemberment Insurance.

Additional exclusions and limitations, if any, are administered in accordance with the provisions of the Certificate of Insurance.

Designating Your Beneficiary

The Beneficiary(ies) you designate for your Death Benefit will be the same for your AD&D Benefit (if applicable). You can designate any person or persons as your Beneficiary by completing and submitting a written form to the Fund Office. If you want to designate more than one Beneficiary, be sure to allocate the percentage to be paid to each Beneficiary; otherwise, Beneficiaries will share equally. You can change your Beneficiary(ies) at any time, without the consent of the previously named Beneficiary. To change a Beneficiary(ies), you need to file a form with the Fund Office. Be sure to list your Beneficiary's full name and his or her relationship to you. Your Beneficiary designation will be kept on file with the Fund Office.

It is important that you designate a Beneficiary(ies). If you do not, or your designated Beneficiary(ies) does not outlive you, your benefit will be paid to your:

- Surviving Spouse; or if none,
- Surviving Children in equal shares; or if none,
- Surviving parent(s) in equal shares; or if none,
- Surviving brothers and sisters in equal shares; or if none,
- Executor or Administrator of your estate.

The insurance company may rely on an affidavit from any individual listed above to determine who is entitled to the Death Benefit. If the insurance company pays the benefit based on this affidavit, it will be discharged of its liability for the amount paid unless written notice of claim by another individual listed above is received before payment is made.

If the Beneficiary is a minor or someone not able to give a valid release for payment, the insurance company will pay the benefit to the Beneficiary's legal guardian. The insurance company will be fully discharged of its liability for any amount of benefit paid in good faith.

General Plan Exclusions and Limitations

The Plan provides coverage for many health care expenses; however, not all expenses are covered. In addition to any specific exclusions and limitations listed throughout this booklet, Plan benefits will be neither paid or payable for any item listed in this section.

1. Expenses in connection with **cosmetic surgery**, unless:
    a. The surgery is performed to repair injuries sustained in an accident.
    b. The surgery corrects a congenital anomaly in a Child.
    c. The surgery is reconstructive and incidental to or following surgery for a mastectomy or any other covered Illness.
2. Expenses in connection with **dental work**, except as specifically covered under the Plan's Dental Benefits. This exclusion does not apply to treatment of Injuries sustained in an accident that damages the natural teeth, if the treatment is provided by a Physician or a Dentist within 90 days after the accident. Covered treatment then includes the initial replacement of damaged teeth and the setting of a jaw fractured or dislocated in the accident. This exclusion also does not apply to expenses in connection with general anesthesia and facility charges, subject to a maximum benefit of $2,000, for Children age five and under who require general anesthesia and/or treatment in a Hospital or surgical center for dental work.
3. Expenses in connection with any Injury or Illness caused by any **act of war**, whether declared or undeclared.
4. Expenses in connection with treatment provided to a person **outside the United States** and Canada during an absence from the United States and Canada for a period of 60 days or more, if the absence is related to the business, occupation, or profession of the Participant.
5. Expenses for flu shots and immunizations for children and adults traveling outside of the United States.
6. Expenses in connection with **mental/behavioral health disorders**, except charges made by a licensed clinical psychologist, licensed clinical social worker, or a Physician for treatment (including diagnosis) of Behavioral Health Disorder conditions.
7. Expenses incurred as a result of participation in or attempt to commit a crime that may be punishable as a **felony**, except that expenses for injuries or illnesses incurred during incidents of domestic violence will be covered by the Plan.
8. Expenses or supplies that are not provided in connection with, or as treatment for, a **specific Injury or Illness**, unless specifically covered under the Plan.
9. Expenses, supplies, or treatments that are **preventive** in nature, unless specifically covered under the Plan.
10. Hospital expenses, unless the hospitalization is **recommended and approved** by a Physician.
11. Expenses for medicines or nutritional supplements that can be obtained **without a Physician's prescription** or that have not been legally dispensed by a pharmacist upon a Physician's prescription.

12. Expenses for **eyeglasses** or contact lenses, except as specifically covered under the Plan's Vision benefit or elsewhere under the Plan (for example, the first pair of glasses or lenses placed following cataract surgery).
13. Expenses for hearing aids.
14. Expenses associated with **failure to keep a scheduled visit** or the completion of a claim form.
15. Supplies or equipment for personal hygiene, **comfort, or convenience**, such as, but not limited to, air conditioners, humidifiers, and physical fitness equipment.
16. Expenses for services provided by a person who ordinarily resides in the Participant's home or is a member of the Participant's **immediate family**.
17. Medical expenses of a person enrolled in and **covered by an HMO**, whether or not that person utilized HMO providers.
18. Services or supplies for which the person is **not required to make payment** or would have no obligation to pay if not for this coverage.
19. Services or supplies that are **Experimental,** investigative, or do not meet accepted standards of medical practice.
20. Expenses for **Custodial Care**, convalescent care, domiciliary care, or rest cures.
21. Expenses in excess of **Covered Charges**.
22. Expenses for treatment leading to or in connection with **sex reassignment surgery**.
23. Expenses in connection with the purchase or fitting of appliances or implants relating to **sexual dysfunction** or impotence.
24. Expenses for **transportation** to a place of treatment (except for transportation by ambulance when Medically Necessary) and expenses for room and board incurred in connection with travel for medical treatment.
25. Services and supplies provided for treatment of **obesity**, including bariatric surgery.
26. Expenses for which a claim is not received by the Fund **within one year** of the date the claim was incurred.
27. Expenses related to any Injury, Illness, or dental treatment for which a Participant has received or is entitled to receive benefits under workers' compensation or similar law or that arises out of or in the course of any **occupation or employment**.
28. Expenses for a consultation with a Physician or medical professional by **e-mail**.
29. All expenses incurred at a **Non-PPO Outpatient Surgical Facility**.
30. **Infertility** treatment and procedures (limited).
31. Expenses for **acupuncture**.
32. Expenses for **long-term care**.
33. Expenses for **private-duty nursing**.
34. Expenses for **weight loss programs**.
35. Expenses for **orthodontia** (braces).
36. Expenses for reversal of tubal ligation and vasectomy.
37. Charges for **genetic testing**, except to the extent set forth in Paragraph 36 of the list of Covered Medical Charges on Page 32

Hearing Benefits

While the Plan does not provide for hearing aids, the Fund does provide information on non-Plan programs, which provide discounts on hearing aids. Refer to the "Important Contact Information" list.

38. Expenses for the following listed Durable Medical Equipment. The following list is not all-inclusive and is subject to change.
    a. Bathroom equipment
    b. Batteries
    c. Biofeedback equipment
    d. Blood pressure cuff
    e. Blood pressure monitors
    f. Breast pump
    g. Chairs (except wheelchairs)
    h. Colonic irrigation unit
    i. Communication devices
    j. Diabetic shoes and inserts
    k. Environmental equipment, including air cleaner, air filter, humidifier, air conditioner, dehumidifier, or precipitator
    l. Exercise equipment
    m. Food blender
    n. Gravetonic traction device
    o. Handrails
    p. Hearing masker
    q. Heating pad
    r. Hot tub
    s. Hydraulic lift
    t. Incontinence supplies
    u. Massage devices
    v. Nocturnal enuresis devices
    w. Sauna bath
    x. Sitz baths
    y. Sleep warm electric comfort units
    z. Stair lifts
    aa. Treadmill walker
    bb. Water Pik
    cc. Whirlpool equipment
    dd. Wigs

Claim and Appeal Procedures

Definitions

The following definitions apply in these Claim and Appeal Procedures. Words that are defined in this section are capitalized throughout these procedures so, when you see a capitalized word, look in this section for the definition.

There are different time limits for Claimant Extensions and Plan Extensions.

- **Claimant** - The person who has incurred the claim is called the "Claimant" except that, if the claim is incurred by a Dependent Child, then the adult who files the claim on behalf of the Child is the Claimant.

- **Concurrent Care Claim** - A "Concurrent Care Claim" is a special type of Pre-service Claim. A Concurrent Care Claim is a claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits, an extension of benefits, or a termination of benefits.

- **Disability Claim** - Any Plan benefit that is conditioned on a finding of disability is a "Disability Claim." A claim for Weekly Disability Benefits is a Disability Claim.

- **ERISA** - "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

- **Extension** - An "Extension" extends the time for processing a claim. If there are circumstances beyond the control of the Plan that cause the Plan to need an Extension of time to process a claim, the Plan may take an Extension.

- **Medical Provider** - "Medical Provider" includes all providers of treatment or services that are covered under the Plan, whether such treatment or services are medical, dental, vision, or other types of covered expenses.

- **Plan** - "Plan" means the Beer Industry Local Union No. 703 Health and Welfare Fund and its Plan of Benefits.

- **Post-service Claim** - A claim is a "Post-service Claim" if the Claimant has already received the treatment or service and the claim consists of asking the Plan for payment. A claim is also a Post-service Claim if the treatment or service has not yet been provided but the Plan does not require the Claimant to obtain approval before receiving the treatment or service. In general, any claim that is not a Pre-service Claim or a Disability Claim is a Post-service Claim.

- **Pre-service Claim** - A claim is a "Pre-service Claim" only if the Plan specifies that benefits will not be paid unless the claim is approved before care is provided. In addition to normal Pre-service Claims, there are two special types of Pre-service Claims, that is, Urgent Care Claims and Concurrent Care Claims.

- **Review Committee** - The Board or Committee or person who decides the outcome of an appeal is the "Review Committee."

- **Urgent Care Claim** - An "Urgent Care Claim" is a special type of Pre-service Claim. A claim is an Urgent Care Claim if applying the claim processing time limits for a non-urgent Pre-service Claim could jeopardize the life or health of the patient or subject the patient to severe pain that could be managed with care or treatment. The Trustees expect that there will be few, if any, Urgent Care Claims because there are few circumstances in which the Plan conditions eligibility for a benefit on prior approval of the treatment.

There will be few, if any, Urgent Care Claims because there are few circumstances in which the Plan conditions eligibility for a benefit on pre-authorization of Emergency treatment.

Filing a Claim

In order for the Plan to pay benefits, a claim must be filed with the Plan, under the procedures described below. A claim can be filed by you, by your eligible Dependent or by someone authorized to act on behalf of your eligible Dependent, or by the Medical Provider. In these Claim and Appeal Procedures, "you" means the Claimant.

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

- A claim for a benefit is considered to have been filed on the date it is received at the Fund Office. Even if a claim is incomplete–for example, the Fund Office has received a medical bill but has not received a claim form–the claim is considered to have been filed on the date the Fund Office first receives notice of the claim.

- You may obtain claim forms by telephoning or writing the Fund Office at 300 S. Ashland, Suite 201, Chicago, Illinois 60607, telephone (312) 829-6506. You can also visit the Fund Office to obtain claim forms.

- If you incur a medical expense and ask the Plan to pay benefits, that is considered a claim. However, a request for confirmation of Plan coverage is not a claim if you have not yet incurred the medical expense (except in the case of a Pre-service Claim). The following are examples of situations that do not constitute a claim: an inquiry about general benefit eligibility; a dispute concerning a Plan finding that you or a Dependent is not eligible for benefits, where no medical costs have been incurred; presenting a prescription to a pharmacy, whether or not the pharmacy is a prescription network provider.

If you or a Dependent has coverage under more than one health care plan, benefits are coordinated (see page 59).

- A claim must be filed within one year of the date the claim was incurred.

- You may designate another person as your authorized representative for purposes of filing a claim or an appeal. Except in the case of an Urgent Care Claim, such designations must be made in writing on a form provided by the Plan. Please contact the Fund Office if you need a form to designate an authorized representative.

  When you designate a person as your authorized representative, it allows that person to deal with the Plan on your behalf but it does not mean that the Plan will send your benefit payments to that person. When you designate an authorized representative, all notices regarding your claims will be sent to your authorized representative and not to you. Designating an authorized representative is different from assigning benefits to a Medical Provider. (See "Limitation on Assignments" on page 57.)

Where to file claims:

- All medical claims (both from Medical Providers who are in the PPO network and from those who are not) should be sent directly to the PPO, following the instructions on your Plan identification card.

- Dental claims are to be sent to the Fund Office.

- Vision claims (whether in the vision network or outside of it) are filed with the Vision Service Provider. The name and telephone number of the Vision Service Provider are shown on your Plan identification card.

- Prescription drug claims can be made at a retail pharmacy that is in the prescription network, or they can be mailed to the Pharmacy Benefit Manager. See your prescription drug card for details. Finally, in the case of any claim that is received at the Fund Office and should have been sent elsewhere, the Fund Office will forward the claim to the proper location.

- If you or your Beneficiary need to file a Death Benefit or Accidental Death and Dismemberment (AD&D) Benefit claim, you or your Beneficiary should contact the Fund Office. Written proof of a dismemberment or death will need to be provided to the insurance company before benefits are paid. Dismemberment proof must be provided within 90 days of your loss.

Appeals (see below) of vision and prescription drug claims are handled by the Plan under the same procedures as other appeals.

Time Periods for Processing Claims

The amount of time that the Plan can take to process a claim depends on the type of claim.

- **Post-service Claims:** Approval or denial of a Post-service Claim will normally be made within 30 days of the date the claim is received by the Plan.

- **Pre-service Claims:** Approval or denial of a normal Pre-service Claim (not an Urgent Care or Concurrent Care Claim) will ordinarily be made within 15 days of the date the claim is received by the Plan. If an Extension is necessary, the Plan can extend the 15-day time period by another 15 days. Before the end of the original 15-day period, you will be notified in writing of the circumstances requiring an Extension and the date by which the Plan expects to make a final decision on the claim.

- **Urgent Care Claims:** For Pre-service Claims that are also Urgent Care Claims, the Plan or its representative will advise you whether or not the treatment or service is approved within 24 hours of the Plan's receipt of the Urgent Care Claim. This notice may be given by telephone or in writing but, if the notice is by telephone, a written confirmation will follow within 3 days. If the Plan cannot process the claim without additional material or information from you or your Medical Provider, the Plan may take an Extension and request the necessary material within 24 hours of receipt of the claim. You will be given no less than 48 hours to provide the needed information. Once the Plan has received a response to its request, the Plan will make a determination on your claim within 48 hours of the time the additional information is received or, if no information is provided, within 48 hours of the expiration of the time period within which a response was to be made.

For Urgent Care Claims, a medical professional with knowledge of your medical condition can act as your authorized representative. The Plan will not require the medical professional to show that you have designated him/her as your authorized representative.

- **Concurrent Care Claims:** For Pre-service Claims that are also Concurrent Care Claims, the same time limits that govern normal (non-urgent) Pre-service Claims will apply, unless the Concurrent Care Claim is also an Urgent Care Claim. The following additional rules apply to Concurrent Care Claims:

  - If the Plan has approved coverage for a specified period of treatment and you request an extension of that period, the request for an extension is treated as a new Pre-service Claim. However, if the extension request is an Urgent Care Claim, the Plan will notify you of its decision within 24 hours of the Plan's receipt of the request, provided that the request for an extension is received more than 24 hours before the end of the originally approved period of treatment. Otherwise, the time periods for processing an Urgent Care Claim will apply.

  - If you have a Concurrent Care Claim and the Plan terminates or reduces a previously approved period of treatment, you will have the right to appeal that termination or reduction. (The rules governing appeals are explained below.) The Plan will give you 10 days' advance notice of such a termination or reduction. If you appeal the termination or reduction within the 10-day period, the Plan will not implement the termination or reduction before you are given notice of the outcome of the appeal. This rule, allowing the course of treatment to continue pending an appeal, does not apply if your benefits terminate because you have lost eligibility under the Plan or if the termination or reduction of benefits is the result of a Plan amendment.

- **Disability Claims:** Approval or denial of a Disability Claim will normally be made within 45 days of the date the claim is received by the Plan. If an Extension is necessary, the Plan can extend the 45-day time period by 30 days. If one 30-day Extension is not sufficient, the Plan can apply a second 30- day Extension. Before the end of the original 45-day period (or, for a second Extension, before the end of the first 30-day Extension), you will be notified in writing of the circumstances requiring an extension of time and of the date by which the Plan expects to make a final decision on the claim.

Denial of Claims

If your claim is denied, in whole or in part, the Plan will send you a written notice stating the specific reason or reasons for the denial, making reference to pertinent Plan provisions on which the denial was based. A notice of claim denial will also include:

- A summary of the Plan's appeal procedures;

- If applicable, a description of any additional material or information necessary to process your claim, along with an explanation of why such material or information is necessary;

- If applicable, a statement that, upon written request, you will be furnished with a copy of any internal rule, guideline or policy that the Plan relied on in processing your claim;

- If applicable, a statement that, upon written request, you will be furnished with an explanation of any scientific or clinical judgment used by the Plan in denying your claim if the Plan found that the treatment was experimental or not medically necessary; and

- A statement that Section 502(a) of ERISA provides that a participant or beneficiary of an employee benefit plan may file suit to recover benefits due under the terms of the plan, to enforce the terms of the plan or to clarify the person's right to future benefits under the plan.

Appealing the Denial of a Claim

If your claim has been denied in whole or in part, you may request a full and fair review (referred to in these Procedures as an "appeal") by filing a written notice of appeal with the Plan.

- A notice of appeal must be received at the Fund Office not more than 180 days after you receive the written notice of denial of the claim. Your appeal is considered to have been filed on the date the written notice of appeal is received by the Fund Office.

- For Post-service Claims and Disability Claims, the Review Committee will be a committee of the Board of Trustees. For Pre-service Claims, the Review Committee will be a Plan fiduciary(ies) selected by the Board of Trustees. The Review Committee will not include the person, or a subordinate of the person, who made the original claim denial. You (and your authorized representative, if any) may appear before the Review Committee for an informal hearing on your appeal (except that there will be no hearing on the appeal of a Pre-service Claim).

- In deciding your appeal, the Review Committee will consider all comments and documents that you submit, regardless of whether that information was available at the time of the original claim denial. In addition, the Review Committee will not presume that the original denial was correct.

- If an appeal involves a medical judgment, such as whether treatment is medically necessary, the Review Committee will consult with a medical professional who is qualified to offer an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the Review Committee will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.

- If you wish, another person may represent you in connection with an appeal. If another person claims to be representing you in your appeal, the Trustees have the right to require that you give the Plan a signed statement, advising the Trustees that you have authorized that person to act on your behalf regarding your appeal. Any representation by another person will be at your own expense.

- In connection with your appeal, you or your authorized representative may review pertinent documents and may submit issues and comments in writing, as follows:

    - Upon written request, the Plan will provide reasonable access to, and copies of, all documents, records or other information relevant to your claim.

- If the Plan obtained an opinion from a medical or vocational expert in connection with your claim, the Plan will, on written request, provide you with the name of that expert.

- The Plan will not charge you for copies of documents you request in connection with an appeal.

Denials Based on Missing Information or Documents

If your claim was denied *because the Plan did not have information or documents* necessary to process the claim and if, on appeal, you submit information or documents that respond to the reason for denial, then, in place of the appeal procedures described above, the Plan has the right to simply reopen and reprocess the claim. In this case, you will be sent a new Explanation of Benefits form, advising of the determination of the claim upon reprocessing. If, on reprocessing, your claim is denied in whole or in part, you will have a new right of appeal with respect to the reprocessed claim.

Time Periods for Processing Appeals

■ **Post-service Claims and Disability Claims:** The Review Committee meets four times per year. If your appeal is received more than 30 days prior to a regular meeting of the Review Committee, your appeal will be decided at that meeting unless special circumstances require an extension of time for processing, in which case a decision will be made on your appeal at the next following meeting of the Review Committee.

If a Claimant whose Pre-Service Claim was denied obtains the service or treatment that had been denied, the claim is no longer a Pre-Service Claim and any appeal of the claim will be handled under the rules for Post-Service Claims.

- If your appeal is received within the 30-day period immediately preceding a regular meeting of the Review Committee, the appeal will not be decided at that meeting but will be decided at the next following meeting, unless special circumstances require an extension of time for processing. In that case, a decision will be made on your appeal at the third meeting following the date your appeal was filed.

- Whenever there are special circumstances that require that the decision be delayed until the next following meeting, you will be advised in writing of why the extension of time was needed and when the appeal will be decided.

- When the Review Committee, in its discretion, determines that it can decide an appeal sooner than the time limits stated above, the Committee will do so.

- Once the Review Committee has decided your appeal, the Plan will send you a written notice of that decision. The notice will be mailed within five days of the Review Committee's decision.

■ **Pre-service Claims:** For a Pre-service Claim that is not an Urgent Care Claim, the Plan will notify you of the decision on appeal within 30 days of the Plan's receipt of the appeal.

- For an Urgent Care Claim, the Plan will notify you of the decision on appeal within 72 hours of the Plan's receipt of the appeal. In addition, for appeals of Urgent Care Claims, the notice of appeal can be oral instead of in writing, and the Plan may notify you of its decision by telephone or facsimile ("fax").

- If a Claimant whose Pre-service Claim was denied obtains the service or treatment that had been denied, the claim is no longer a Pre-service Claim and any appeal of the denial of the Pre-service Claim will be handled under the rules that apply to Post-service Claims.

Advisory Appeals

Ordinarily, in order to have the right to appeal a claim denial, you must have incurred a claim and that claim must have been denied (in whole or in part) by the Plan. An "advisory appeal" is permitted for certain types of requests (described below) where a claim has not yet been incurred but the Plan nevertheless allows you to use a modified appeal process to challenge a Plan decision. Advisory appeals are permitted in two situations:

- If you, or a Medical Provider on your behalf, has submitted a written request for a predetermination of benefits payable for a certain procedure, and if the Plan has responded in writing that the procedure is not eligible for reimbursement under the Plan, you can file an advisory appeal. **Please note**, if pre-approval of a procedure is *required* by the Plan, then a request for predetermination *is* a claim and you have the right to appeal an adverse determination under the Plan's regular (non-advisory) appeal procedures. However, there are few (if any) claims for which preapproval is required by the Plan, so most predetermination requests are advisory and an appeal from such a denial is an advisory appeal.

- If you have received a letter from the Plan denying you the right to self-pay under COBRA, or denying you the right to pay for Dependent coverage, you can file an advisory appeal. If you have already incurred a claim that was denied because you are not eligible to self-pay, that would be a regular (non-advisory) appeal, rather than an appeal of the right to self-pay, which is an advisory appeal.

When you file an advisory appeal, the appeal is not about a claim you have actually incurred; it is about a claim you have not yet incurred – either a procedure you plan to have performed or a claim you might incur and submit if you have the right to extend your eligibility by making self-payments. Advisory appeals are processed exactly like regular (non-advisory) appeals, including the applicable time limits for filing appeals, with two exceptions. First, if, after an advisory appeal is decided, you incur a claim and that claim is denied, in whole or in part, you **still** have the right to file a regular (non-advisory) appeal. Also, while a Claimant ordinarily has the right to file a lawsuit if an appeal is denied (subject to certain requirements such as timeliness and exhaustion of administrative remedies), you do not have the right to sue the Plan based on the denial of an advisory appeal because no claim has actually been incurred

Decisions on Appeal

A notice that the Review Committee has decided your appeal will state the specific reason or reasons for the decision, making reference to pertinent Plan provisions on which the decision was based. If applicable, the notice will also include:

- A statement that, upon written request, you will be furnished with a copy of any internal rule, guideline or policy that the Plan relied on in processing your claim; and

- A statement that, upon written request, you will be furnished with an explanation of any scientific or clinical judgment used by the Plan in denying your claim if the Plan found that the treatment was experimental or not medically necessary.

If your appeal is denied, you are entitled to receive, upon written request and at no cost, copies of documents and information that the Plan relied on in denying your claim.

If the Review Committee upholds the denial of your claim, you will then have the right to file suit, under the authority of ERISA, subject to the Limitations Period described below.

A Claimant may not file suit against the Plan until the Claimant has exhausted all of the procedures described in these Claim and Appeal Procedures. However, this rule is subject to the following:

- If the Plan does not process a claim within the time limits stated in these Procedures, the Claimant has the immediate right to file an appeal under these Procedures.

- If a decision on an appeal is not furnished within the time limits stated in these Procedures, this requirement to exhaust Plan remedies will not apply.

Limitations Period

The Plan provides for a "limitations period," which is the period of time within which any lawsuit must be filed. The limitations period is three years from the date of the Plan's notice advising you of the determination of your claim. If you file a timely appeal, the limitations period is three years from the date of the Plan's notice advising you of the determination of your appeal. Also, if your claim is denied and you fail to file a timely appeal, a lawsuit, even if filed within the limitations period, will be subject to dismissal because, as explained above, the Plan requires you to use the appeal process before filing a lawsuit. Finally, if the Plan fails to send a notice advising you of the determination of your claim, the limitations period is three years from the date a determination was due under these Claim and Appeal Procedures.

Plan Benefits Payable to Medical Provider

When you receive treatment for services that are covered under the Plan, the Plan will pay its benefits directly to the provider of that treatment or service. This rule applies whether or not you have assigned Plan benefits to the Medical Provider (see next paragraph). However, the Plan will make payment directly to the Plan participant if either you or the Medical Provider has advised the Plan in writing that the Medical Provider has already been paid or will be paid from another source.

Limitation on Assignments

An "assignment of benefits" is a written statement, signed by you, that gives a Medical Provider the right to receive Plan benefits for services provided to you. When benefits have been assigned to a Medical Provider, the Medical Provider will also have certain rights, such as the right to file an appeal. Under the Plan, benefits may be assigned **only** to a Medical Provider who participates in the Plan's PPO. **The Plan will not recognize an assignment of benefits to a non-PPO Medical Provider**. However, as explained in the preceding paragraph, an assignment is not needed in order for the Plan to pay benefits directly to a Medical Provider.

Plan Benefits Payable to You or Your Dependents

Benefits are payable only if you submit timely and adequate proof of your claim.

If any individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed for that individual, the Trustees may, at their discretion, make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of such individual. If the individual should die before all amounts due and payable have been paid, the Trustees may, at their option, make such payment to the executor, administrator or personal representative of his or her estate or to his surviving Spouse, parent, Child or Children, or to any other person or persons who are entitled to such payment, in the Trustees' opinion.

Any payments made by the Trustees in accordance with these provisions will fully discharge the liability of the Trustees to the extent of such payment.

Please call the Fund Office if you have any questions about these procedures.

Coordination of Benefits

The Plan has been designed to help you meet the cost of Illness or Injury. It is not intended, however, that you receive greater benefits than your actual health care expenses. The amount of medical and/or dental benefits payable under this Plan will take into account any medical or dental coverage you or a Dependent has under other plans.

Specifically, in a calendar year, this Plan will always pay to you either its regular benefits in full, or a reduced amount that, when added to the benefits payable to you by the other plan or plans, will equal the total Allowable Expenses. However, no more than the maximum benefits payable under this Plan will be paid.

If you or your Dependents are covered under another plan, you must report such duplicate group health coverage to the Fund Office to secure reimbursement of Allowable Expenses incurred.

Another plan means any plan providing benefits or services for medical or dental care that are provided by:

- Group insurance coverage (including college plans);
- Any group hospital service prepayment plan, group medical service prepayment plan, or other prepayment coverage;
- Any coverage under a labor-management trusteed plan or employee benefit organization plans; and
- Any coverage under governmental programs or required or provided by any state, except the Plan will always pay primary to Medicaid.

Order of Payment

If you or your Dependent are covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan.

The Fund will work with another plan to coordinate benefits based on this Fund's rules. The first of the following rules that apply establish the order of payment:

- **Non-Duplication.** A plan that does not have a coordination of benefits (non-duplication) provision is primary and will pay benefits first.
- **Non-Dependent/Dependent.** A plan that covers an individual as other than a Dependent (for example, as an employee or retiree) is primary and will pay benefits first before a plan covering the individual as a Dependent.
- **Length of Coverage.** The plan covering an individual for the longer period is primary and will pay benefits first before a plan covering the individual for the shorter period.
- **Continuation Coverage.** If an individual is covered under this Plan's COBRA Continuation Coverage and another plan, the other Plan is primary and will pay first before this Plan's COBRA Continuation Coverage.

If a Dependent Child is covered under more than one plan and the parents are:

- Not divorced or legally separated, the plan that covers the parent whose day of birth occurs earlier in the calendar year is primary and will pay first. If the birthday of both parents occurs on the same day, the plan that has covered the parent for the longer period is primary and will pay first.
- Divorced or legally separated, then:
  - Where there is a court decree that establishes financial responsibility for expenses, the plan covering the Dependent Child of the parent who has financial responsibility will pay first; or
  - Where there is no court decree or a court order does not specify which plan is primary, the plan that covers the parent whose day of birth occurs earlier in the calendar year is primary and will pay first. If the birthday of both parents occurs on the same day, the plan that has covered the parent for the longer period is primary and will pay first.

For Coordination of Benefits purposes, this Plan:

- May, subject to the Plan's privacy rules, release to or obtain from any other insurance company or other organization or person, any claim information. Any person claiming benefits under the Plan will furnish any information that the Plan may require.
- Has the right, if an overpayment is made, to recover the overpayment from any other person or insurance company or organization.
- Has the right to pay to any other organization an amount it determines to be warranted, if payments that should have been made by the Plan have been made by the organization.

Coordination of Benefits with Medicare

The Medicare Coordination of Benefits (COB) rules take effect before any other Plan COB rules. Medicare is a multi-part program:

- **Medicare Part A:** Primarily covers hospital benefits, although it also provides other benefits.
- **Medicare Part B:** Primarily covers Physician's services, although it, too, covers a number of other items and services.
- **Medicare Part C:** Called *Medicare Advantage,* is a Medicare managed care offering. If you are covered by an HMO, the Plan will presume that you have complied with the HMO rules necessary for your expenses to be covered by the HMO.
- **Medicare Part D:** Called *Medicare Prescription Drug Coverage,* is Medicare's prescription drug coverage that is offered through private companies to all Medicare-eligible individuals.

For Participants enrolled in or eligible for Medicare, this Plan has primary responsibility for your claims if the Participant is:

- At least age 65;
- Eligible for Medicare Part A solely because of age; and
- Actively employed by an ADEA Employer that pays all or part of the required contributions for eligibility.

If a covered person is eligible for Medicare but is not actively employed by an ADEA Employer, then this Plan has secondary responsibility for claims.

When Medicare coverage is based on end-stage renal disease, this Plan has primary responsibility for the first 30 months of Medicare eligibility; thereafter, this Plan's coverage is secondary.

When Medicare coverage is based on disability, this Plan has primary responsibility for the Participant if he or she is receiving Social Security disability benefits.

If, based on these rules, this Plan is primary over Medicare, then this Plan pays benefits first. When this Plan is not primary over Medicare, then Medicare benefits are determined and paid first. After that, the Plan pays benefits so that combined Medicare and Plan benefits do not exceed 100% of the expense incurred.

If a Participant is eligible for Medicare and it is determined that this Plan has secondary responsibility, benefits will be paid on that basis even if the Participant has not enrolled in Medicare Part A and/or B. Therefore, it is very important to enroll in Medicare Parts A and B when you become eligible for Medicare.

Privacy Rules

These rules describe how medical information about you may be used and disclosed and how you can have access to this information. Please review it carefully.

The Health and Welfare Fund exists for one purpose—to provide health and welfare benefits to Participants in the Fund. In the course of providing benefits, the Fund receives and maintains information that constitutes "protected health information," as defined in federal privacy rules. This section describes the Fund's policies that protect you from the unnecessary disclosure of your health information and give you certain rights regarding your health information.

If you need a copy of the Privacy Notice, please contact the Fund Office.

In this section, "you" means any person whose health information is received by the Health and Welfare Fund. These rules apply to you whether you are an Employee Participant or Dependent. Privacy rights can be exercised either by you or your Personal Representative (defined below). For a minor Child, the parent is the Personal Representative.

Circumstances Where the Fund Uses or Discloses Health Information

- **To Process and Pay Claims.** The Fund may use or disclose your health information to process and pay benefit claims. Claim processing includes all aspects of the process including, for example:
  - Determining benefit eligibility or Plan coverage;
  - Reviewing health care services for Medical Necessity, reasonableness of charges, and duration of Hospital stays;
  - Providing information regarding coverage or health care treatment to another health plan to coordinate payment of benefits;
  - Processing claim appeals;
  - Calling you (or in your absence, a member of your household) to obtain information needed to process a claim; and
  - Answering claim and benefit questions from you, your family members, or other relatives or close friends, if such person is involved with your health care or the payment of your claim.
- **To Collect Contributions for Coverage.** The Fund may use or disclose your health information in the process of collecting any payments, such as COBRA Continuation Coverage or Dependent coverage self-payments.
- **For Administrative Purposes.** The Fund may use or disclose health information for its own operations. Some examples are:
  - Quality assessment and improvement activities.
  - Activities designed to improve health or reduce health care cost.
  - Underwriting, premium rating, or related functions to create, renew, or replace Plan benefits.
  - Review and auditing, including compliance reviews, medical reviews, legal, services, and compliance programs.
  - Business planning and development, including cost management and planning related analyses.

- General administrative activities of the Fund, including customer service and resolution of internal grievances.

- **To Provide You with Health-Related Information.** The Fund may use and disclose your health information to tell you about or recommend possible treatment options or alternatives or to advise you of health-related benefits and services that may be of interest to you.
- **When Legally Required.** The Fund will disclose your health information when it is required to do so by any federal, state, or local law, including, for example:
  - When the Fund receives an order, issued by a court or a state agency, to disclose your health information.
  - When the Fund receives a subpoena or discovery request in a lawsuit or workers' compensation case. In the case of a subpoena or discovery request that has not been issued under a court order, the party requesting the information should notify you of the request so that you will have an opportunity to obtain a court order protecting your health information.
- **To Conduct Health Oversight Activities.** The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensing, or disciplinary action.
- **For Law Enforcement Purposes.** As permitted or required by state law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, reporting a crime in an Emergency or if the Fund has reason to believe that your death was the result of criminal conduct.
- **For Specified Government Functions.** In certain circumstances, federal regulations require the Fund to use or disclose your health information to facilitate specified government functions, for example those related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.
- **In the Event of a Serious Threat to Health or Safety.** The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

Persons Who Will Use Your Health Information

Claims adjusters and other Employees in the Fund Office will use your health information to process benefit claims. The Fund Administrator and other supervisory personnel may use your health information for claim payment, training, and administrative purposes, among others. The Board of Trustees, in its capacity as administrator of the Fund, may have access to your health information for appeals or other administrative or supervisory purposes.

Releasing Health Information with Your Authorization

The categories above (Circumstances Where the Fund Uses or Discloses Health Information) describe when the Fund will use or disclose your health information without your authorization. Other than as stated above, the Fund will not disclose your health information, except with your written authorization. The following rules apply to authorizations to release health information:

- Authorizations will be in writing, signed by you or your Personal Representative.
- You or your Personal Representative will receive a copy of the authorization form.
- Authorizations have an expiration date that is stated on the authorization form.
- You or your Personal Representative can revoke the authorization at any time. The revocation must be in writing, and delivered to the Fund Office.

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information that the Fund maintains:

- **Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. The Fund is not required to agree to your request but the Fund will ordinarily honor any request that the Fund communicate only with you (that is, refrain from disclosing your claim or benefit information to your relatives, friends, or members of your household). If you wish to make a request for restrictions, please contact the Fund's Privacy Coordinator.
- **Right to Receive Confidential Communications.** You have the right to request that the Fund communicate with you in a certain way. The Fund is not required to honor such requests but the Fund will do so if it can be done without interfering with the Fund's normal operations or if you believe that the disclosure of your health information could endanger you. If you wish to receive confidential communications, please make your request in writing to the Fund's Privacy Coordinator. Here are some examples of requests for confidential communications:
  - A request that the Fund communicate only with you (that is, refrain from disclosing your claim or benefit information to your relatives, friends, or members of your household). The Fund will routinely grant this request.
  - A request that the Fund only communicate with you at a certain telephone number or send written communications to a P.O. Box instead of your home.
- **Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Fund's Privacy Coordinator. If you request a copy of your health information, the Fund will charge you $0.25 per page for copying, plus actual mailing costs.
- **Right to Amend Your Health Information.** If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing to the Fund's Privacy Coordinator. The Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to

inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

- **Right to an Accounting.** You have the right to request a list of certain disclosures of your health information for which the Fund is required to keep a record under the federal privacy rules, such as disclosures for public purposes, disclosures authorized by law, or disclosures that are not in accordance with the Fund's privacy policies or applicable law. The request must be made in writing to the Fund's Privacy Coordinator. The request should specify the period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods in excess of six years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests will be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable
- Right to a Copy of the Fund's Privacy Notice. You have a right to request and receive a copy of the Fund's Privacy Notice at any time, even if you have received the Notice previously. To obtain a copy, please contact the Fund's Privacy Coordinator or any Employee at the Fund Office.

Your Personal Representative

If you are of legal age, you can exercise the privacy rights explained in this section. Your rights can also be exercised by your Personal Representative. A Personal Representative is:

- The parent of a minor Child.
- The person designated in a Health Care Power of Attorney (limited to the rights stated in the Power of Attorney).
- The legal guardian of a mentally incompetent adult.
- The administrator or executor of your estate or your next of kin.

Fund Obligations

The Fund is required by law to maintain the privacy of your health information, as described in this section and to provide to you with the Privacy Notice outlining the Fund's duties and privacy practices. The Fund is required to conform to the terms of these rules. The Fund reserves the right to change the terms of the Notice at any time. If that happens, the Fund will revise the Notice and will provide you with a copy of the revised Notice within 60 days of the change. Any change in the Fund's privacy practices will apply to all health information that the Fund has, regardless of whether the information was obtained before or after the change in privacy practices. You have the right to submit any complaints regarding privacy issues to the Fund's Privacy Coordinator. If you believe that your privacy rights have been violated, you have the right to report any violations to the Secretary of the Department of Health and Human Services. The Fund encourages you to express any concerns you may have regarding the privacy of your information. The Fund, your Employer, and your Union are not permitted to retaliate against you in any way for filing a complaint.

Contact Person

The Fund has a designated Privacy Coordinator. The Privacy Coordinator is the contact person for all issues regarding patient privacy and your privacy rights. You may contact the Privacy Coordinator at 300 South Ashland Avenue, Suite 201, Chicago, IL 60607, 312-829-6506.

Breach Notification Rights for Unsecured Protected Health Information under HIPAA

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

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

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

Subrogation

The Plan's Subrogation rules apply when you or your eligible Dependent are injured and, because of that Injury, you or your Dependent become entitled to reimbursement from Another Source. However, the Plan's Subrogation rules do not apply to benefits paid under another employer-sponsored group health plan if that coverage is subject to coordination of benefits.

In any case in which you or a Dependent may be able to recover money or benefits from Another Source, the injured Participant's entitlement to benefits from the Plan is conditioned on compliance with the Plan's Subrogation Rules, as described in this section, and upon the signing of a Reimbursement Agreement.

If a Participant or his or her representative does not make a claim against a person or insurer that is liable, the Plan is entitled to do so in the name of the injured Participant to recover amounts due under the Plan's Subrogation Rules. In this instance, the Fund's expenses, costs, and attorney's fees will be paid out of any recovery or settlement.

Plan benefits are not payable for any claims related to a Compensated Injury, unless the total Covered Charges arising out of or related to the Compensated Injury equals or exceeds the gross amount of the Plan recovery paid to or on behalf of the injured person. In this instance, the Plan considers only the amount of claims that exceeds the amount of the gross recovery. This applies regardless of who makes the claim against the responsible party and who pays the recovery. The Plan also has Subrogation rights with respect to any benefits paid before the injured Participant recovers money from Another Source for the Injury.

Reimbursement Agreement

The Reimbursement Agreement is an agreement by which the injured Participant, and his attorney (if applicable), agree to reimburse the Plan from any money recovered from Another Source. If the injured Participant is a minor, the Reimbursement Agreement must be signed by a person legally authorized to act on behalf of the minor. The Reimbursement Agreement must be on a form approved by the Trustees. It requires the injured Participant to repay the Plan for the amount of all benefits paid on account of the Injury, whether or not the recovery is sufficient to fully reimburse the Participant for his or her losses. However, no person is required to repay to the Plan more than the:

- Amount of benefits the Plan paid on the claim; or
- Gross amount the injured Participant (or his or her representative) received in recovery.

The Plan is not responsible for legal fees and expenses incurred in obtaining a recovery from Another Source, unless the Fund has agreed in writing to assume a share of those fees and expenses.

The Plan is also entitled to a lien on the proceeds of any recovery from Another Source, to the extent of the full amount of benefits paid for the Injury in question. This lien arises under both the Reimbursement Agreement and the Plan itself. In addition, the lien applies even if a Reimbursement Agreement is not signed or is invalid for any reason.

The injured Participant is obligated to do everything that is necessary to enable the Plan to bring about a recovery of the amount of benefits paid. Neither the injured Participant nor his or her representative may assign to another person the right to recover money from Another Source. The injured Participant (or his or her representative) is not permitted to compromise the Plan's Subrogation claim and lien and is required to obtain the Fund's consent before releasing another person from liability for any Injury. If the injured Participant recovers compensation from another party for the Injury, the injured Party agrees to hold such funds in trust for the benefit of the Fund.

If you do not reimburse the Plan as required by the Reimbursement Agreement, or if you otherwise violate the Plan's Subrogation Rules, the Plan has the right, in addition to any other legal rights it may have, to reduce future benefits on claims made by the Participant or any covered Dependent, until the full amount of the repayment has been received by the Plan.

Definitions

For the Plan's Subrogation Rules, the following terms have the specific meanings listed below:

- **Another Source or Other Source:** Any third party, including an insurance company that is obligated to pay claims due to acts of a third party. The other source can also be your own insurance carrier.
- **Injury:** Any Injury, Illness, or condition.
- **Subrogation:** The Plan's right, which is the same right as the injured Participant, to make a claim against Another Source to recover the amount of benefits paid.
- **Compensated Injury:** Any occurrence taking place at any time or over a period of time from which any settlement, award or recovery is or was granted to an eligible individual. It includes a single act, or number of acts occurring over a period of time which result in injury to the eligible individual (such as, but not limited to, continued exposure to a harmful agent, prolonged misdiagnosis of a condition, etc.).

Administrative Information

Plan Name

Beer Industry — Local Union No. 703 Health and Welfare Fund.

Plan Numbers

The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 36-6051305. The Plan number assigned to this Plan by the Board of Trustees per Internal Revenue Service instructions is 501.

Plan Year

The accounting records of the Plan are kept on a Plan Year basis beginning each January 1 and ending the following December 31.

Plan Sponsor and Plan Administrator

A Board of Trustees is responsible for the operation of this Plan. Although the Trustees are legally designated as the Plan Sponsor and Plan Administrator, they have delegated certain administrative responsibilities to other organizations, as outlined on the *Important Contact Information* list. For example, the Fund Office, under the direction of the Fund Manager, is responsible for maintaining eligibility records, accounts for Employer contributions, answering Participant inquiries, processing certain claims, and handling other routine administrative functions.

The Board of Trustees consists of Employer and Local Union representatives selected by the Employers and Local Union who have entered into collective bargaining agreements that relate to this Plan. If you want to contact the Board of Trustees, you may use the address and phone numbers below:

Beer Industry — Local Union No. 703 Health and Welfare Fund
300 South Ashland Avenue, Suite 201
Chicago, IL 60607-2764
Phone: 312-829-6506
Fax: 312-829-0121

If you want to inspect or receive copies of additional documents relating to this Plan, contact the Board of Trustees. You may be charged a reasonable fee to cover the cost of any document you request.

The Trustees of this Plan are:

Local Union Trustees	*Employer Trustees*
Patrick R. Bruno Teamsters Union Local No. 703 1333 Butterfield Road, Suite 110 Downers Grove, IL 60515	DeVon Robertson Lakeshore Beverage 400 North Elizabeth Street Chicago, IL 60642
David McLin Teamsters Union Local No. 703 1333 Butterfield Road, Suite 110 Downers Grove, IL 60515	John M. Holland Town & Country Distributors, Inc. 1050 Ardmore Avenue Itasca, IL 60143
Howard C. Murdoch Teamsters Union Local No. 703 1333 Butterfield Road, Suite 110 Downers Grove, IL 60515	Eugene Jacobs Seyfarth Shaw LLP 131 South Dearborn Street, Suite 2400 Chicago, IL 60603
Thomas W. Stiede Teamsters Union Local No. 703 1333 Butterfield Road, Suite 110 Downers Grove, IL 60515	Donna L. Spagnola Beer Industry — Local Union No. 703 Health and Welfare Fund 300 South Ashland Ave, Ste. 201 Chicago, IL 60607

Fund Manager

Sherryl Reeves
Beer Industry — Local Union No. 703 Health and Welfare Fund
300 South Ashland Avenue, Suite 201
Chicago, IL 60607-2764
Phone: 312-829-6506
Fax: 312-829-0121

Fund Counsel

Asher, Gittler, & D'Alba, Ltd.

Fund Auditor

Bansley & Kiener, LLP

Fund Consultant

The Segal Group

Collective Bargaining

This Plan is maintained pursuant to collective bargaining agreements between Employers and the Local Unions. Upon written request, the Fund Office will provide you with a copy of the collective bargaining agreement under which you are covered. The Fund Office will also provide, upon written request, information as to whether a particular employer is participating and, if so, the name and address of the Employer. The collective

bargaining agreements specify the amount of contributions, due date of Employer contributions, and type of work for which contributions are payable.

Plan Funding

This multiemployer Plan is not an insurance policy and no benefits are provided by or through an insurance company except Death Benefits and Accidental Death and Dismemberment (AD&D) Benefits, which are provided through Amalgamated Life Insurance Company. All other benefits are self-funded from accumulated assets and are provided directly from the Trust Fund. Employer contributions and Employee Participant self-payments finance the benefits. All Employer contributions are paid to the Trust Fund subject to provisions of the collective bargaining agreements between the Local Union and those Employers that enter into an individual collective bargaining agreement with the Local Union. The Board of Trustees holds all assets in trust. Benefits and administrative expenses are paid from the Plan and a portion of Fund assets is allocated for reserves to carry out the objectives of the Plan.

Plan Type

This Plan is a welfare plan maintained to provide medical, prescription drug, dental, vision, and disability benefits for Participants who meet the eligibility requirements described in this booklet.

Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits are described in this Summary Plan Description ("SPD"). Circumstances that may cause a Participant to lose eligibility are also explained. Your coverage by this Plan does not constitute a guarantee of employment and you are not vested in the benefits described in this booklet.

Legal Process

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the entire Board of Trustees or any individual Trustee at the address of the Beer Industry — Local Union No. 703 Health and Welfare Fund.

Plan Amendment and Termination

The Board of Trustees expects that the Fund will be permanent. However, the Trustees have the right to change, modify, or terminate all or any part of the Plan at any time, in accordance with the Trust Agreement and the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Board of Trustees will notify you in writing if the Plan is amended or terminated. If all or a part of the Plan is terminated, the Trustees will provide for payment of expenses incurred up to the date of termination, arrange for a final accounting of the Plan, and distribute the balance of the assets in a manner consistent with the purpose of the Fund.

Board of Trustees' Discretion and Authority

The Trustees or, where Trustee responsibility has been delegated to others, the other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of the Plan. Decisions of the Trustees or their delegates are final and binding. The Trustees or their delegates have broad discretion to determine

eligibility for benefits and to interpret Plan language and their decisions will be accorded judicial deference in any subsequent action at a court or administrative proceeding.

Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them, decide, in their discretion, that you or a Beneficiary is entitled to benefits in accordance with the terms of the Plan.

In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure adopted by the Trustees. The decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that the decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over the matter.

You or any other Claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. You may, at your own expense, have legal representation at any stage of the review process.

If a provision of the Trust Agreement or the Plan, or any amendment made to the Trust Agreement or the Plan, is determined or judged unlawful or illegal, the illegality will apply only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan.

Your ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. ERISA provides that you are entitled to the rights described in this section.

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. The Fund Office will provide you with 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 the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

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

Assistance with Questions

If you have any questions about the Plan, you should contact the 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) at:

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

Nearest Regional Office
Employee Benefits Security Administration
Chicago Regional Office
200 West Adams Street, Suite 1600
Chicago, IL 60606
312-353-0900

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the website of the EBSA at www.dol.gov/ebsa.

Glossary

Terms defined in this section are used throughout this Summary Plan Description. For your convenience, these defined terms are capitalized in the text of this booklet.

ADEA Employer

An employer that:

- Is subject to the U.S. Age Discrimination in Employment Act (ADEA); and
- Has 20 or more Employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

Allowable Expense

Any necessary, reasonable, and customary expense, wherein at least a portion is covered under at least one of the plans covering the person for whom a claim is made.

Child

A Child includes your Biological Child, your Adopted Child, your Stepchild or your Foster Child, as long as the Child is under age 26. Eligibility of a Child will not be dependent on school attendance, marital status, residency or support.

- "Biological Child" means a Child to whom you (the Employee Participant) are the biological parent, as shown by a birth certificate or paternity order.
- "Adopted Child" means a legally Adopted Child, or a Child placed with you pending legal adoption.
- "Stepchild" means a Child who is the Biological or Adopted Child of your current Spouse.
- "Foster Child" means a Child who has been placed in your care by a court or a child welfare agency, but excluding a Child for whom a state or private agency pays any compensation to you or a member of your household for the support of the Child.

Chiropractic Care

Treatment performed through the manipulation of the spine or spinal adjustment.

Covered Charges

The Medically Necessary expenses incurred for services, treatments, and/or supplies, which are listed as covered under the Plan and that are provided on the recommendation and approval of a Physician (for medical benefits), a Dentist (for dental benefits), or an optometrist or ophthalmologist (for vision benefits).

- For network services—The Plan will pay toward the cost of Covered Charges, up to the negotiated discounted amount, upon payment of any applicable deductibles.
- For non-network services—The Plan will pay toward the cost of Covered Charges, up to the maximum amount ordinarily charged by most providers for the same services, treatments, and/or supplies received within the same geographic area. In determining whether the billed charges are Covered Charges, consideration will be given to the nature and severity of the Injury or Illness being treated and any medical

complications or unusual circumstances that require additional time, skill, or experience.

Covered Employment

Employment for which your Employer is required to contribute to the Fund on your behalf under a Collective Bargaining Agreement, Participation Agreement, or other written agreement with the Local Union.

Custodial Care

Care comprised of services and supplies that are provided to you or your Dependent primarily to assist in the activities of daily living.

Deductible

The amount you and your family pay each calendar year toward the cost of your medical care before the Plan begins to pay toward Covered Charges.

Dentist

A person licensed to practice Dentistry by the governmental authority having jurisdiction over the licensure and practice of Dentistry.

Dental Hygienist

A person licensed to practice dental hygiene by the governmental authority having jurisdiction over the practice of Dentistry who works under the supervision of a Dentist.

Dependent

Dependents include your:

- Spouse, if your marriage to that person is recognized by the laws of the state or country where your marriage took place; and
- Child, as defined on page 75.
- A Child who is named in a Qualified Medical Child Support Order (QMCSO) with which you or your Spouse and the Fund are obligated to comply.

Disabled Dependents—In addition, your unmarried Child may be covered at and beyond age 26 if your Child:

- Is dependent on you for at least one-half of his or her support during the calendar year;
- Lives with you for at least one-half of the calendar year; and
- Became disabled before age 26, which means that the Child is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more.

If an unmarried permanently and totally disabled Child does not live with the Employee Participant, the Child will be a Dependent Child, provided that:

- The Child's parents are: 1) divorced or legally separated under a decree of divorce or separate maintenance; 2) separated under a written separation agreement; or 3) live apart at all times during the last six months of the calendar year;
- The Child's parents provide over one-half of the Child's support for the calendar year;
- The Child is in the custody of one or both of his or her parents for more than one-half of the calendar year; and
- The Child is not the qualifying Child or qualifying relative of any other person.

The Trustees may require you to furnish proof of the Child's continued disability from time to time, but not more often than once in a 12-month period. Coverage will end if the Trustees determine, based upon medical evidence, that the Child is no longer disabled or if the Child does not undergo an examination or furnish proof required by the Trustees.

Your Child is not an eligible Dependent under the Plan if he or she is eligible for benefits under the Plan as an Employee Participant.

Durable Medical Equipment

Equipment that:

- Can withstand repeated use;
- Is not a consumable or disposable item;
- Is exclusively and customarily used to serve a medical purpose;
- Is appropriate for use in the home; and
- Is not useful to a person in the absence of Injury or Illness.

Emergency

- Any medical condition (including mental and substance abuse conditions) that, if immediate medical attention is not provided, can reasonably be expected to lead to death, serious dysfunction of any bodily organ or part, or other serious medical consequences. These conditions must be severe, sudden in onset, and involve one or more of the major organ systems of the body, such as the cardiovascular, metabolic, respiratory, nervous, gastrointestinal, or urinary system. In no event will a condition be considered an Emergency if the first treatment by a Physician is provided more than 24 hours after the onset of symptoms.
- If symptoms exist that reasonably may have been interpreted as an Emergency under the above definition, that condition will be considered an Emergency even if the final diagnosis is of another condition. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an Emergency even if a final diagnosis of a heart attack is not made.
- Conditions that result from accidents that appear to be serious and so threatening to a body part that emergency room treatment is indicated. These conditions will be considered Emergencies, even though they do not otherwise meet the definition of Emergency.
- Transportation to the nearest Hospital or trauma center by police, fire department, or ambulance, when the transportation is made under circumstances over which the person has no control.

Employee Participant

An individual who is working in Covered Employment and is eligible for benefits under this Plan's rules.

Employer

An association, individual, partnership, or corporation that has a Collective Bargaining Agreement with the Local Union, if that Agreement requires the employer to pay contributions to the Fund. The Fund, Local Union, other signatories to Collective Bargaining Agreements and Participation Agreements, as well as pension funds associated with the Local Union are also considered Employers with regard to their Employees.

Enrollment Date

For:

- An Employee Participant, the date the Employee Participant begins the waiting period for initial eligibility; and
- Dependents, the date the person is added as a Dependent.

Experimental

Services, supplies, and/or procedures that require approval by an agency of the U.S. Government that has not yet been received. Experimental treatments, services, and supplies are also those that have largely been confined to laboratory or research settings. The Trustees have the authority to determine whether a treatment, service, or supply is Experimental. The fact that a Physician has prescribed, ordered, recommended, or approved the treatment, service, or supply does not in itself make it eligible for payment.

Fund

The Beer Industry — Local Union No. 703 Health and Welfare Fund, as established under the Amended Agreement and Declaration of Trust.

Home Health Agency

- A Hospital possessing a valid operating certificate authorizing the Hospital to provide home health services; or
- A public or private health service or agency licensed as a Home Health Agency by the state in which it operates to provide coordinated home care.

Each visit from a Home Health Agency of four hours or less is considered a single visit.

Home Health Aide

A health worker other than a Physician, nurse, or professional therapist, who is on the staff of a Home Health Agency and performs personal health care services, such as helping the patient to bathe, helping the patient in and out of bed to exercise, helping the patient with medications that are ordinarily self-administered, and other services that are intimately related to the health care of the patient and have been specifically ordered by a Physician.

A Home Health Aide does not include a person who ordinarily resides in your home or is your Spouse, Child, son-in-law, daughter-in-law, brother, brother-in-law, sister, sister-in-law, parent, father-in-law, or mother-in-law.

Home Health Care Plan

A program for care and treatment established and approved, in writing, by a Physician, together with the Physician's certification that the proper treatment of the Injury or Illness would require confinement as an inpatient in a Hospital or other institution in the absence of the services provided as part of the Home Health Care Plan.

Hospice

A manner of providing care for terminally ill patients, either in their home or in a special care facility. Hospice care allows terminally ill individuals to live their final days in as natural and comfortable a setting as possible.

Hospital

A facility that:

- Has received accreditation from an accreditation organization approved by the Centers for Medicare & Medicaid Services;
- Operates lawfully in the jurisdiction where it is located;
- Maintains permanent and full-time facilities for bed care of five or more resident patients;
- Has a Physician in regular attendance;
- Continuously provides 24-hour a day nursing service by Registered Nurses; and
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical surgical care and mental and substance abuse disorders (either on the premises or by formal arrangement with an acceptable institution) of injured and ill persons on a basis other than as a rest home, convalescent home, or place for the aged.

Hospital Confinement

A confinement in a Hospital for which you are charged for room and board by the Hospital. Successive periods of Hospital Confinement are considered one confinement, unless:

- Due to entirely different causes; or
- With respect to an Employee Participant's eligibility, unless the later period of confinement begins after the Employee Participant has returned to active work on a full-time basis for two weeks; or
- With respect to a Dependent's eligibility, unless the later period of confinement is separated from the previous confinement by a period of at least three months.

Illness

A disease (including pregnancy) or bodily Injury.

Infertility

The inability, as certified by the covered individual's Physician, to:

- Conceive after one year of unprotected sexual intercourse; or
- Sustain a successful pregnancy.

Injury

Any damage to a body part resulting from trauma from an external source.

Intensive Care Accommodation

A section, ward, or wing in a Hospital that:

- Is operated exclusively for critically ill patients; and
- Provides special supplies, equipment, and constant supervision and care by a Registered Nurse (RN).

This does not include any Hospital facility maintained for the purpose of providing normal post-operative recovery, treatment, or service.

Licensed Nurse

A professional nurse legally entitled to use the title of Registered Nurse (RN) or Licensed Practical Nurse (LPN).

Local Union

Local No. 703, I. B. of T.

Medically Necessary or Medical Necessity

Any service, supply, or treatment that:

- Is essential for the diagnosis or treatment of the Injury or Illness for which it is prescribed or performed;
- Meets generally accepted standards of medical practice; and
- Is ordered by a Physician.

Mental/Behavioral Health Disorder

Any Illness that is defined in the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and /or physiological dependence or addiction to alcohol, psychiatric drugs, or medications regardless of any underlying organic cause. This includes, among other things, autism, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods. Substance abuse means a psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the DSM.

Non-PPO

Any provider who is not in the PPO network. See "PPO" below.

Outpatient Surgical Facility

A health care facility where the primary function is performing surgery on an outpatient basis and patients are typically admitted and discharged within 24 hours. A Hospital is not considered an Outpatient Surgical Facility, nor is an office maintained by a Physician or a Dentist for the practice of medicine or Dentistry. Also, a facility whose primary function is performing eye surgery or terminating pregnancies is not an Outpatient Surgical Facility.

Participant

Any one of the following individuals:

- An Employee of an Employer who is or may become eligible to receive Plan benefits upon meeting the applicable eligibility requirements ("an Employee Participant"); or
- A Dependent of an Employee Participant who is or may become eligible to receive Plan benefits by meeting the Plan's definition of Dependent (a "Dependent").

Physician

A medical practitioner licensed under the Illinois Medical Practice Act or under a comparable law in another state.

Plan

The health and welfare benefits provided under the Beer Industry — Local Union No. 703 Health and Welfare Fund, as described in this Summary Plan Description or subsequently provided.

Pre-Admission Review

An evaluation of the number of days of Hospital Confinement to be authorized as Medically Necessary for the treatment of a Participant's Injury or Illness.

PPO

Preferred Provider Organization (PPO). A PPO is a network of Physicians and Hospitals that have agreed to charge discounted rates for their services and/or supplies. The Plan pays a different percentage of your medical costs based on whether you use a PPO network provider or a non-PPO network provider, as shown on the *Schedule of Benefits*.

Qualified Medical Child Support Order

A court order that requires the Fund to cover a Child under the Plan. The requirements for a Qualified Medical Child Support Order are stated on page 16.

Spouse

A person who is married to you, provided your marriage is recognized by the laws of the state or country where your marriage took place. If you marry a person of the same sex in

a state where the marriage is legal, the Plan will recognize your Spouse as an eligible Dependent, even if you live in a state that does not recognize your marriage.

Trust Agreement

The Agreement and Declaration of Trust establishing the Beer Industry — Local Union No. 703 Health and Welfare Fund, as amended from time to time.