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

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

PRE-MEDICARE RETIREES – 2016 EDITION

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

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT – PRE-MEDICARE RETIREES

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Dear Participant:

We are pleased to provide you with this new combination Plan Document and Summary Plan Description (Plan/SPD) booklet, which describes the non-grandfathered Welfare Benefits for Pre-Medicare Retirees "the Plan" for Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund "the Fund" as of January 1, 2016.

The Plan offers a comprehensive benefits program that is designed to protect you and your Dependent spouse. Whether you are getting married or divorced, suffering from an Illness or disability, or enjoying retirement, the Plan offers health care coverage that is designed to help meet you and your family's needs.

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

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

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

Sincerely,

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

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

Table of Contents

Plan Document and Summary Plan Description
Pre-Medicare Retirees Plan
Effective January 1, 2016

Table of Contents 2

Schedule of Benefits for Retirees 4

Important Contact Information 7
- Change of Address and Change in Family Status 7

Retiree Benefits 8
- Retired Employee Eligibility 8
- Dependent Eligibility under Retiree Benefits 10

Medical Benefit 14
- How the Medical Plan Works 14
- Covered Medical Expenses 18
- Expenses Not Covered 27

Prescription Drug Benefit 34
- Retail Pharmacy Program 34
- Mail Order Service 34
- Specialty Pharmacy Program 35
- Step Therapy Program 35
- Covered Expenses 37
- Expenses Not Covered 37

Health Reimbursement Account (HRA) 39
- HRA Highlights 39
- Eligibility 39
- Your HRA 39

Coordination of Benefits 44
- Coordination of Benefits with Medicare 45

Filing and Appealing Claims 47
- Filing Claims 47
- Appealing a Denied Claim 51
- External Review of Adverse Benefit Determination 55
- Medical Judgments 58
- Trustee Authority and Interpretation 59

Subrogation and Reimbursement 60
- Overpayment and Duty of Cooperation 62
- Misrepresentation or Falsification of Claims 62
- Wrongfully Paid Benefits 63

Administrative Information 64
- Plan Name 64
- Board of Trustees 64
- Administration of the Plan 64
- Plan Termination 65
- Plan Sponsor and Administrator 66
- Identification Numbers 66
- Plan Year 66

Agent for Service of Legal Process ... 66
Plan Description ... 66
Source of Contributions ... 66
Collective Bargaining Agreements ... 67
Workers' Compensation and the Plan ... 67
Welfare Trust's Assets and Reserves ... 67
Eligibility, Benefits and Discretionary Authority ... 67
Rescission of Your Coverage ... 68
Privacy Notice ... 68
Breach Notification Rights under HIPAA ... 69
Affordable Care Act ... 69

Your ERISA Rights ... 70
Receive Information about Your Plan and Benefits ... 70
Continue Group Health Plan Coverage ... 70
Prudent Actions by Plan Fiduciaries ... 71
Enforce Your Rights ... 71
Assistance with Your Questions ... 72

Definitions ... 73

Schedule of Benefits for Pre-Medicare Retirees

Comprehensive Medical Benefit (Retirees and their Dependent Spouse)	
Deductibles	
• Calendar Year Deductible	$500 per person
• Non-PPO Hospital Deductible	$500 per non-Medicare eligible person for each non-emergency admission to a non-PPO Hospital
Calendar Year Out-of-Pocket Maximums for Retirees and their Dependent Spouse	
PPO Maximum[1]	
– Major Medical	$2,500 per person/$5,000 per family
– Prescription Drug[2]	$4,350 per person/$8,700 per family
Additional Non-PPO Maximum	$1,000 per person/$2,000 per family
Calendar Year Plan Maximums	
• Chiropractic/Spinal Care	12 visits per person per calendar year
• Rehabilitative Speech Therapy (to restore normal speech)	30 visits per person
• Rehabilitative Physical Therapy	20 visits per person[3]
Special Benefit Maximums	
• Hospital Daily Room and Board	Single room rate
• Non-PPO Hospital Intensive Care	Three times semi-private room rate (three times single room rate if semi-private rooms unavailable)
• Infertility Treatment[4]	$10,000 per person per lifetime

Comprehensive Medical Benefit (Retirees and their Dependent Spouse)		
Type of Service	**PPO Provider**	**Non-PPO Provider**
• Outpatient Pre-Admission Tests	Plan pays 100%; no deductible	Plan pays 100%; no deductible
• Inpatient Hospital Services	Plan pays 80%	Plan pays 70%
• Outpatient Hospital Services	Plan pays 70%	Plan pays 70%
• Surgical Benefits (Inpatient and Outpatient)	Plan pays 80% (including surgeries during office visits)	Plan pays 70%

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1 Excludes amounts paid for non-covered expenses.

2 The prescription drug calendar year out-of-pocket maximum will be adjusted annually so that the combined out-of-pocket maximums for prescription drugs and major medical equal the maximum permitted under the Affordable Care Act (ACA).

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

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

• Overweight or Obesity Condition-Related Expenses[5]	Plan pays 50%	Not covered

Comprehensive Medical Benefit (Retirees and their Dependent Spouse)		
Type of Service	**PPO Provider**	**Non-PPO Provider**
• Preventive Services	Plan pays 100%; no deductible	Not covered
• Chiropractic/Spinal Care[6]	Plan pays 70% for up to 12 visits per person per calendar year	Plan pays 70% for up to 12 visits per person per calendar year
• Substance Abuse Treatment[7] – Inpatient – Outpatient	 Plan pays 80% Plan pays 80%	 Plan pays 70% Plan pays 70%
• Mental Health Treatment – Inpatient – Outpatient	 Plan pays 80% Plan pays 80%	 Plan pays 70% Plan pays 70%
• Ambulatory Surgical Center	Plan pays 80%	Not covered
• Other Covered Medical Expenses	Plan pays 70%	Plan pays 70%

Prescription Drug Benefits (Retirees and their Dependent Spouse)				
Calendar Year Deductible	$250 per person			
Coinsurance[8]				
• Participating Retail Pharmacy (up to 30-day supply)	You pay 25% up to $100 per 30-day supply; however, if you fill a maintenance medication at retail more than twice, you will pay a $5 surcharge for Generics and a $15 surcharge for Brand Name Drugs each time you fill the prescription at retail.			
• Mail Order Service		**1-30 Days Supply**	**31-60 Days Supply**	**61-90 Days Supply**
	Generics & Brand Single Source	25% with $100 max	25% with $200 max	25% with $300 max
	Brand Multi-Source	25% with $100 max + Penalty	25% with $200 max + Penalty	25% with $300 max + Penalty
• Diabetic Testing Supplies	The Plan pays 100%			

[5] Expenses for treatment rendered in connection with overweight or obesity conditions are covered in limited circumstances. Please see the Covered Medical Expenses subsection for further information about the circumstances in which such expenses are covered under the Plan.

[6] Chiropractic/spinal care includes all services and supplies for care of the back, neck, spine and vertebrae..

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

[8] Unless requested otherwise by your Physician, prescriptions will be filled with Generic Drugs. If you request a Brand Name Medication and a Generic Medication is available you may be required to pay the difference between the cost of the Generic Medication and the Brand Name Medication.

Vision Care Discount Program (Retirees and their Dependent Spouse)[9]		
	VSP Provider	**Non VSP Provider**
Complete Eyeglass Exam (One per calendar year)	$50 with purchase of prescription eyeglasses; 20% off without purchase of prescription eyeglasses	Not covered
Lenses and Frames when a complete pair of glasses are purchased	Frames subject to 25% discount, additional discounts for lenses available with frame purchase	Not covered
Contact Lense Exam (fitting and evaluation)	15% Discount, you pay 85%	Not covered

[9] The Plan does not pay vision benefits for Retirees or their Dependent spouse. The Plan offers you a discount program on vision expenses if you see a participating VSP provider.

Important Contact Information

Verification or prior authorization of coverage does not guarantee that services or charges will be paid for by the Plan.

If you have a question about:	Contact:
Eligibility for benefits or general questions about your benefits	Fund Office 1-708-482-0110 or toll-free at 1-800-704-6270 www.mech701-benefits.org
Participating PPO providers	BlueCross BlueShield of Illinois 1-800-810-2583 www.bcbsil.com
Pre-certification, Utilization Review, and Large Case Management	MCM 1-800-367-9938
Prescription drug benefits	
Retail	OptumRx 1-888-354-0090 www.optumrx.com
Mail order	OptumRx Home Delivery 1-800-881-1966 www.optumrx.com
Specialty Pharmacy Program	Briova Specialty Pharmacy Program 1-855-427-4682

Change of Address and Change in Family Status

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

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

Retiree Benefits

The following sections contain the Plan's eligibility rules for Retirees and their Dependent spouses. Children of Retirees are not eligible as a Dependent under the Plan. Retirees and their Dependent spouses are eligible for benefits under the Plan as of the date the conditions in the following sections are met.

Retired Employee Eligibility

Eligibility at Retirement

When you retire, you may be eligible for Retiree Benefits if you meet the following requirements:

- You were a collectively bargained participant in a welfare plan offered under the Automobile Mechanics' Local 701 Union and Industry Welfare Fund (as of May 1, 2012, this includes the Premier Plus, Premier and Classic Bargained Plans);
- You meet one of the two following years of coverage requirements:
    - You are eligible for an immediate, early, disability or normal retirement benefit from the Local 701 Pension Fund or the IAM National Pension Fund and have at least 10 years of eligibility in the Local 701 Welfare Fund with coverage in all of the 5 years immediately prior to Retirement. A participant will be considered to have had coverage in all of the 5 years immediately prior to retirement if he had at least 20 weeks of Covered Employment during each of such years; OR
    - You are at least age 55 and have 20 years of eligibility as a participant in the Local 701 Welfare Fund.
- You file a written application for Retiree Benefits and make the applicable required self-payment within 90 days of the date when your eligibility for Active Employee Benefits under the Premier Plus, Premier or Classic Bargained Plan terminates.

If you meet all of the conditions listed above, your eligibility for Retiree Benefits will begin on the first day of the month after your coverage as an Active Employee ends under the Premier Plus, Premier or Classic Bargained Plan of Benefits; provided that you submit your application and make the required self-payment within the 90-day timeframe stated above. **If you do not file your application or make the required self-payment within the 90-day timeframe, you will lose your eligibility for Retiree Benefits, with no possibility of reinstatement.**

Self-Payments and Continuing Eligibility

You will continue to be eligible for Retiree Benefits provided you make the required self-payments. The Trustees determine the amount of self-payments and the amount will change from time to time. Currently, the self-payment amounts are automatically adjusted each September 1st based upon Plan cost in accordance with the policy adopted by the Trustees. Please contact the Fund Office for information regarding current self-payment rates.

You may elect to make the required self-payments as follows:

- Monthly, due the first day of each month;
- Quarterly, due each January 1, April 1, July 1, and October 1;
- Annually, due each January 1; or
- Automatically deducted from your monthly pension benefit.

If you return to work for an Employer in Covered Employment, you do not need to make the required self-payments once you meet the initial eligibility requirements for Active Employee Benefits. **However, when you re-retire, you must submit an application for Retiree Benefits and make the required self-payment within 90 days of your Active Employee coverage ending or you will not be eligible for Retiree Benefits.**

When Retiree Coverage Ends

Generally, your coverage as a Retiree ends when the first of the following events occurs:

- The first day of the calendar month for which the required self-payment is not received by the Fund;
- On the date you become eligible for Medicare;
- On the date the Trustees terminate Retiree Benefits;
- On the date the Trustees terminate the Plan; or
- Upon your death.

There is no reinstatement of Retiree coverage if you fail to make a required self-payment. Additionally, the above listed events are not considered qualifying events as defined in COBRA. Accordingly, when your coverage ends due to one of the above listed events, you and your Dependent spouse will not receive or be eligible for COBRA continuation coverage. However, if your Dependent spouse may be able to continue coverage upon your death as explained on the following page.

Dependent Eligibility under Retiree Benefits

Initial and Continuing Eligibility for Dependents

Children of Retirees are not eligible as Dependents for coverage under Retiree Benefits. You may make a one-time election to cover your spouse as a Dependent, provided you are not divorced or legally separated and you make the applicable self-payment. Please note that in order to cover your spouse as a Dependent, you are required to make a self-payment on their behalf equal to the amount of the self-payment required to maintain your coverage. You must make the election to cover your spouse on your application for Retiree Benefits. As a result, your Dependent spouse will be eligible for Medical Benefits, Prescription Drug Benefits and discounts on vision services under Retiree Benefits on the date you are eligible for Retiree Benefits.

In the event that you are eligible for Medicare, but you and your Dependent spouse are ineligible to enroll in the Willis Towers Watson Post-Medicare Retiree Exchange Program ("Towers Watson" program), your Dependent Spouse is eligible for coverage under this Plan until s/he becomes eligible for Medicare, even if you are not enrolled in this Plan by virtue of your Medicare eligibility.

If you marry after you elect Retiree Benefits, you may submit a registered marriage license (with the state's registration number), your spouse's social security number and new history card to the Fund Office to elect coverage for your new spouse. However, you must notify the Fund Office and submit the required documentation and required self-payments within 90 days of the date your Dependent spouse first becomes eligible under the Plan to receive coverage as of that date. If you do not provide the required documentation within this 90-day period, coverage will begin as of the date the documentation and self-payment is submitted to the Fund Office.

When Dependent Coverage Ends under Retiree Benefits

Your Dependent spouse's coverage ends either on the day your coverage ends (except if you are Medicare-eligible, but both you and your spouse are ineligible to enroll in the Towers Watson program, as described above), on the day you legally separate or divorce, when the Plan discontinues benefits for Dependent spouses, when your Dependent spouse becomes eligible for Medicare, or when you fail to submit the required self-payment, whichever occurs first.

If Coverage Ends Due to Your Loss of Coverage or your failure to make a Self-Payment

In the event your Dependent spouse's coverage ends because you lose coverage as a Retiree or because you failed to make a required self-payment, no COBRA coverage is available for your Dependent spouse because there is no qualifying event as defined under COBRA.

If Coverage Ends Due to Divorce or Legal Separation

If you and your spouse legally separate or divorce, your spouse's loss of coverage is considered a qualifying event as defined under COBRA; however, you must notify the Fund Office within 60 days of a court entry approving or finalizing the legal separation or divorce. Failure to do so may

result in: (1) the loss of COBRA rights, (2) the Fund withholding future benefits and/or (3) the Fund seeking repayment of benefits paid on behalf of an ineligible individual.

If Coverage Ends Due to Your Death

If you die while you are covered under the Plan as a Retiree, coverage for your Dependent spouse will continue until he or she remarries or fail to make the required self-payment to continue coverage. This coverage is in lieu of COBRA coverage and an election to continue making self-payments under the Plan will constitute a waiver of COBRA coverage. Therefore, if your Dependent spouse elects to continue coverage under this provision, once he or she loses eligibility, COBRA continuation coverage is not available.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), is a federal law that requires plans to offer a temporary extension of benefits to employees and eligible dependents (qualified beneficiaries) who would otherwise lose coverage under a plan. Qualified beneficiaries include you and each Dependent who was covered under the Plan on the day before a qualifying event occurs (here your Dependent spouse) and who would lose coverage as a result of a qualifying event.

If you suffer a qualifying event as defined under COBRA, you may continue the benefits available to you prior to your loss of coverage for you and/or your Dependent spouse, without evidence of good health. As explained in the preceding pages, the failure to make self-payments, termination of Retiree Benefits by the Trustees, termination of Dependent spousal coverage by the Trustees or termination of the Plan by the Trustees are not considered qualifying events. Accordingly, COBRA coverage is not available for Retirees or generally for Dependent spouses. However, in the event of your divorce or your death, your Dependent spouse may be eligible to continue coverage as explained below.

Dependent Qualifying Events

Your Dependent spouse is eligible for COBRA continuation coverage in the event of:

- Your death*; or
- Your divorce or legal separation.

Your Dependent spouse may also include someone you marry during a period of continuation coverage after a loss of Retiree Benefits.

*In the event of your death, your Dependent spouse will be allowed to continue to make self-payments at a lower rate as described above in lieu of the higher self-payment rate established under COBRA.

Notification to the Fund Office

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

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

Retirees, Dependent spouses, or any representative acting on behalf of the Retiree or Dependent spouse may provide notice.

Electing COBRA Continuation Coverage

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

If the Fund Office does not receive a completed election form within the 60-day election period, coverage will automatically terminate for your Dependent spouse effective as of the original date coverage was lost. Failure to return the completed form within the time limit will also automatically terminate the right to continuation of benefits.

Type of Coverage

If your Dependent spouse is eligible for and elects COBRA continuation coverage after a loss of coverage under Retiree Benefits, the Plan will provide coverage for Medical and Prescription Drug coverage, both covered in the same rate.

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

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

COBRA Continuation Coverage Period

Generally, your Dependent spouse may continue coverage under COBRA for a period of up to 18 months from the date (or up to 29 months for disabled individuals, as described in the next section) of your legal separation or divorce.

Coverage for Disabled Individuals

If the Social Security Administration determines that your Dependent spouse was totally and permanently disabled on the day his or her coverage ended, or within 60 days after that, COBRA continuation coverage may be continued up to a maximum of 29 months, instead of 18 months for your Dependent spouse who elected COBRA continuation coverage. For coverage to continue, he or she must notify the Fund Office, in writing:

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

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

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

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

When COBRA continuation coverage Ends

Your Dependent spouse will lose his or her right to COBRA continuation coverage if:

- The Plan no longer provides medical and/or prescription drug coverage to any participants;
- He or she does not pay the required premium when due;
- He or she becomes covered under another group medical plan. Note however, that if he or she has a pre-existing condition not covered by the other plan, COBRA continuation coverage may be continued; or
- The period of time for COBRA continuation coverage has expired.

Medical Benefit

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

How the Medical Plan Works

Preferred Provider Organization (PPO)

You save money by using PPO providers. The Fund has contracted with a PPO to provide you and your Dependent spouse with health care services at preferred prices. When you or your Dependent spouse receives treatment from a Physician, Hospital, or Emergency Treatment Center that participates in the PPO, you save money for yourself and the Fund. In addition, when a PPO Hospital is used, benefits for Hospital ancillary providers (such as anesthesiologists, pathologists, radiologists, assistant Surgeons, or emergency room Physicians) will be paid at the PPO level of benefits where it is shown that the services were provided at a PPO Hospital.

You save money because:

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

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

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

For information about participating PPO providers:

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

Calendar Year Out-of-Pocket Maximum for Retirees and Dependent Spouses

If you have high medical expenses, the Plan protects you and your spouse by limiting the amount you have to pay out of your own pocket. This is called a calendar year out-of-pocket (OOP) maximum. When you and your spouse reach the OOP maximum set forth in the Schedule of Benefits, in any calendar year, the Plan pays 100% of any additional covered expenses, up to any specific Plan maximums, for that covered individual for the remainder of that year. There are separate OOP maximum amounts for major medical and prescription drug benefits, as set forth in the Schedule of Benefits. The OOP maximum applicable to your expense depends on whether it is a major medical expense or a prescription drug expense.

The family OOP maximum is satisfied when you and your Dependent Spouse, taken together, satisfy the family OOP maximum. Once the family meets the annual OOP maximum (PPO and Non-PPO, as applicable), the Plan pays 100% of any additional covered medical expenses, up to any specific Plan maximums, for the Retiree and Dependent spouse for the remainder of that year.

Amounts paid for non-covered expenses do not count toward the Plan's calendar year out-of-pocket maximum. See the notes following the Schedule of Benefits for more details or contact the Fund Office with questions.

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

Example: How the Out-of-Pocket Maximum Works assuming the OOP maximum is $2,500 for major medical expenses per person and the additional Non-PPO OOP maximum for major medical expenses is $1,000.
• **Scenario A:** Michael uses only PPO providers and pays $2,500 out of his pocket in covered medical expenses between January 1 and July 31. Provided he continues to use PPO providers, the Plan will pay 100% of most additional covered expenses he incurs for the remainder of the calendar year. • **Scenario B:** Michael uses both PPO and Non-PPO providers and incurs $2,500 in out-of-pocket expenses between January 1 and July 31. If he uses only PPO providers after July 31, the Plan will pay 100% of most covered expenses for the rest of the calendar year. However, if he uses Non-PPO providers after July 31, he will need to incur an additional $1,000 in out-of-pocket expenses before the Plan pays 100% of most covered services.

Calendar Year Deductible

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

Coinsurance

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

Please see below for an example of deductibles and coinsurance.

Example: How the Deductible and Coinsurance Work

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

Month	Covered Medical Expense Incurred For	Expense
March	Steve	$50
August	Liz	$350
September	Liz	$1,500
October	Steve	$450
November	Steve	$100
November	Liz	$100

Assuming the individual deductible is $500, and the Plan pays 80% of covered expenses after the deductible is met, here's how the deductible and coinsurance work:

- In March, Steve pays the entire $50, which is credited toward his individual $500 calendar year deductible.
- In August, Steve pays $350 of Liz's $350 expense which is credited towards her individual deductible.
- In September, when Liz incurs $1,500 in covered medical expenses, Steve pays $150, which satisfies her $500 calendar year deductible. The Plan then pays 80% of the remaining $1,350, which equals $1,080, and Steve pays the balance of $270, her coinsurance amount.
- In October, when Steve incurs $450, because his individual deductible has not been satisfied, he pays the entire amount and his deductible is now satisfied.
- In November when Steve and Liz both incur $100 in expenses, the Plan pays $80 (80% of $100) and Steve pays the $20 balance, his coinsurance amount, because both of their individual deductibles have been satisfied.

Non-PPO Hospital Deductible

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

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

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

Calendar Year Maximum Benefit

The Plan does not impose overall lifetime or calendar year maximums for benefits deemed to be essential health benefits. The Plan pays up to the calendar year plan maximums for certain other benefits that are not deemed to be essential health benefits (as listed in the Schedule of Benefits in the front of this booklet).

Case Management, Pre-certification and Utilization Review

The Plan offers pre-certification, case management and utilization review to work with you and your Physician to keep your Medical Care costs as low as possible and consistent with good Medical Care. In many instances, review of the need for hospitalization and exploration of available alternatives will indicate that admission to the hospital may be avoided and that quality treatment is better provided in a less stressful environment. To ensure you receive the maximum benefits available under the Plan, you should ask your Physician to contact MCM, the case management and utilization review company selected by the Trustees, within 5 days prior to a scheduled inpatient admission, or when your Physician refers you to physical therapy, chiropractic care, hospice, skilled nursing, home health care, orders Durable Medical Equipment (DME) for you or your Dependent, or before you incur expenses related to transplant procedures.

The Plan requires pre-certification for the following services:

- Inpatient admissions;
- Outpatient surgery;
- Out-of-network procedures;
- Within 48 hours of treatment in an emergency room if admitted;
- Bariatric surgery; and

- All transplant procedures.

Covered Medical Expenses

The Plan will pay benefits as listed in the Schedule of Benefits in the front of this Plan/SPD up to the Reasonable and Customary charges for covered Medically Necessary expenses (subject to the terms and conditions of the Plan). However, such benefits are only payable if you or your Dependent is under the care of a Physician and the covered medical expenses are ordered or provided by a Physician for the treatment of a non-occupational Illness or accidental Injury. Covered medical expenses include the following services and supplies:

- Hospital room and board charges, including:
  - Hospital charges for a private room for contagious or communicable diseases or when private rooms are only available; and
  - Intensive care units.

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

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

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

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

- » Damage to nerves in the oral cavity suffered at the time of the Injury that required time to heal or regenerate;
- » Care of a fractured jaw(s) that required immobilization of the bone structure that prevented other treatment;
- » Additional time required for stabilization of the Injury; or
- » A delay in the healing process that is demonstrable by x-ray.

- Removal of impacted teeth.

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

➢ Charges for the services of a Nurse, acting within the scope of his or her license.

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

➢ Necessary pre-admission tests (x-ray examinations and/or laboratory tests) made before Hospital admission. Payment for such tests will be made in accordance with the following provisions:

- The tests must be ordered by the attending Physician or surgeon.
- The tests must be performed in the Outpatient department of the Hospital to which the eligible individual is being admitted.
- The Hospital confinement must begin within 10 days after the tests are performed.
- The tests must be medically valid at the time of the Hospital admission.
- No payments will be made for charges incurred for diagnoses, research, case of findings, or surveys.

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

➢ Home health care rendered in an eligible individual's home, if the Home Health Agency is licensed by the state, primarily engaged in providing skilled nursing care in patients' homes, operated under professionally developed policies and under the supervision of a Physician or registered nurse, and eligible for Medicare. Benefits are subject to the following provisions:

- The plan of home nursing care must be established and approved in writing by the patient's Physician within seven days following termination of an Inpatient Hospital confinement.
- The Physician must certify that the care is for the same or related condition for which the patient was hospitalized and that proper treatment of the patient's condition would require Hospital confinement in the absence of the services and supplies provided as part of the home plan of care.

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

➢ Physiotherapy rendered in or out of a Hospital, by a Physician or a registered physical therapist rendering treatment under the direction of a licensed Physician, subject to the following provisions:

- There must be an active written treatment regimen designed by the Physician or registered physical therapist;
- The services must be of such a level of complexity that the judgment, knowledge, and skills of a qualified physical therapist are required and he or she must be on the premises when services are rendered.
- The services must be provided with the expectation, based on the Physician's assessment of the patient's restorative potential that the patient will improve significantly in a reasonable, generally predictable, period of time.
- The services must be reasonable and necessary to the treatment of the condition and considered to be within the accepted standards of medical practice as specific and effective treatment for the patient's condition.

➢ Transportation services, including:

- Emergency local transportation by a professional Ambulance Service, limited to the first trip to and/or from a Hospital for any one Illness or for all Injuries sustained in any one accident; payable at the PPO coinsurance percentage, even in the event that the services are provided by a non-PPO provider.
- If a Physician certifies that an individual's disability requires specialized or unique treatment that is not available in a local Hospital, charges incurred for transportation for such treatment will also be considered covered medical expenses, provided:

- The transportation is by regularly scheduled commercial airlines or railroad or by professional air ambulance in an Emergency situation.
- The transportation is only from the city or town where the Injury or Illness occurred to the nearest Hospital qualified to render the special treatment.
- Only charges incurred for the first trip to and/or from the Hospital for any one Illness or for all injuries resulting from any one accident will be considered covered medical expenses.
- The transportation is only within the continental limits of the United States and Canada, including the geographical boundaries of Puerto Rico and Hawaii.

➢ Anesthetics and their administration.

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

➢ The following medical supplies:

- Drugs and medicines administered while an Inpatient or during surgery at a PPO Outpatient surgical facility, Hospital Outpatient department, Physician's office, or clinic.
- Whole blood (if not replaced or donated) or blood plasma and the administration of such substances.
- Surgical supplies including appliances to replace physical organs or parts of organs. These include such items as artificial limbs, eyes, and larynxes. In addition, the first charge incurred for surgical supplies required to aid any impaired physical organ or part of an organ in its natural body function will be a covered medical expense. Adjustments, repairs, and replacement of covered prosthetic devices and surgical implants are covered when required because of wear or when the current device has become non-functional due to a change in a patient's status and an improved functional status is expected to be achieved with the replacement.
- Oxygen and the rental of the equipment for the administration of oxygen.
- Rental of Durable Medical Equipment (DME), as defined by the Plan unless purchase is determined to be more cost effective by the Plan Administrator, the Trustees or their designees. Repair and adjustment of rented or purchased DME is covered under the Plan when Medically Necessary. Replacement rental or purchase of DME is covered when the unit cannot be repaired or when the current unit has become non-functional due to a change in a patient's status and an improved functional status is expected to be achieved with a replacement unit.
- Casts, splints, braces, crutches, and trusses pursuant to a Physician's prescription.
- Wigs/cranial prostheses when necessitated due to hair loss following medical treatment due to chemotherapy up to a limit of two wigs/cranial prostheses per lifetime per person while covered under the Plan.

- Hospice Care program covered expenses.
- Services and supplies provided during an approved confinement in a Skilled Nursing Facility. An approved confinement is one that meets all of the following criteria:
  - The attending Physician must certify that such confinement and nursing care is essential for recuperation from an Injury or Illness and that it is not, other than incidentally, for Custodial Care.
  - The attending Physician must continue treatment of the individual and personally see the individual at least once each 14 days and must certify that continuation of such confinement is necessary for continued treatment of the Injury or Illness requiring the confinement.
- Services and supplies rendered for the purpose of obtaining a voluntary second surgical opinion.
- Services and supplies provided in a PPO Outpatient surgical facility, Hospital Outpatient department, Physician's office, clinic, or elsewhere, as a result of a surgical procedure performed other than in a Hospital. Benefits paid by the Plan include charges directly related to the surgery within the following time limits:
  - The day of surgery for surgeon, consultations, and anesthesia; and
  - Within 10 days either before or following the date of surgery for Outpatient services and supplies, x-rays and tests, laboratory procedures, and services and supplies provided by the facility.
- Services and supplies provided for pregnancy and pregnancy-related conditions, including but not limited to Hospital charges, delivery fees, prenatal laboratory and x-ray examinations, home birth delivery by a Physician or Nurse Midwife, sonograms and ultrasound testing (except if performed solely to determine fetal age or fetal sex), prenatal office visits, anesthesia and its administration, and tubal ligations.
- Services of a registered occupational therapist for Occupational Therapy recommended by a Physician due to a qualified non-occupational Injury or Illness. Supplies are not covered.
- Services and supplies for certain transplant procedures, as determined by Medicare guidelines. Please note that you or your Physician should contact MCM prior to incurring expenses related to transplant services.
- Pursuant to the Women's Health and Cancer Rights Act, reconstructive breast surgery following a mastectomy will be provided on the same basis as other surgical procedures covered by the Plan and include:
  - Reconstruction of the breast on which a mastectomy is performed;
  - Reconstructive surgery on the other breast to produce a symmetrical appearance;
  - Prostheses and surgical bras following a mastectomy; and
  - Physical complications of any stage of mastectomy, including lymphedemas.

- Services of a surgical assistant provided that:
  - The surgeon and surgical facility participate in the PPO network;
  - The surgical assistant is performing his or her duties under the supervision of a licensed surgeon; and
  - Payment is in accordance with the established PPO recommended payment schedule.
- Services of a physician assistant provided that:
  - The Physician and affiliated facility participate in the PPO network;
  - The physician assistant is performing his or her duties under the supervision of a Physician; and
  - Payment is in accordance with the established PPO recommended payment schedule.
- Orthotics coverage is limited to one pair of orthotics every 24 months for you and your Dependents. Orthotics are medical devices that support and gently reposition the heel, arch, muscles, ligaments, tendons, and bones in the feet (i.e., they are not shoe inserts sold over the counter).
- Respiratory assistance devices (such as CPAPs) and replacement of supplies once every six months.
- Supplies and services rendered by a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic Medicine, Naprapath, or a Registered Physical Therapist (under the direction of a Physician) for treatment of the back, neck, spine, and vertebra for conditions due to subluxation, strains, sprains, and nerve root problems (chiropractic/spinal care) as shown in the Schedule of Benefits.
- Charges for services rendered for treatment of a Mental Health Illness and/or substance abuse. Treatment may be rendered as an Inpatient, Outpatient or through an Intensive Outpatient Plan or Partial Hospitalization program. Covered charges include treatment provided at a Residential Treatment Facility. When treatment is provided on an inpatient basis, the confinement is subject to utilization management review. Please refer to the section titled Case Management, Pre-certification and Utilization Review for Plan requirements. Coverage does not include treatment that is considered custodial. Professional services are limited to only those providers listed as covered Physicians or Mental Health/Substance Abuse Providers under the “Definitions” section.
- Infertility Treatment for you and your Dependent spouse (except for the services of or coverage for a third-party surrogate not otherwise eligible for coverage under the Plan). Covered Infertility services include, but are not limited to:
  - Evaluation.
  - In vitro fertilization.

- Uterine embryo lavage.
- Embryo transfer.
- Artificial insemination.
- Gamete intrafallopian tube transfer.
- Zygote intrafallopian tube transfer.
- Low tubal ovum transfer.
- Prescribed drugs and medicines.
- In vitro expenses must be medically necessary and performed by a facility licensed by the state to perform in vitro services.

➢ Speech therapy services to aid in the restoration of normal speech lost due to Illness, Injury or surgical procedure, or to correct dysphagia or swallowing defects and disorders.

➢ Charges for cochlear implant devices, including the placement thereof. Benefits will also include charges for repair and maintenance. Replacement of cochlear implant devices are covered when the device cannot be repaired or when the current device has become non-functional due to a change in a patient's status and an improved functional status is expected to be achieved with a replacement unit. Covered charges do not include expenses incurred for replacement batteries.

➢ Preventive Services as required by the Affordable Care Act, including well adult care, routine physical exams, mammograms and colon cancer screenings. For an up-to-date list of Preventive Services covered by the Plan, please contact the Fund Office or visit https://www.healthcare.gov/coverage/preventive-care-benefits/.

- If a Preventive Service item is billed separately from an office visit, the Plan will impose cost sharing with respect to the office visit. If such services are not billed separately, then whether or not the Plan imposes cost sharing for the office visit will depend on if the primary reason for the visit was the delivery of the Preventive Service.
- PPO-covered provider restrictions apply to all preventive services as stated on the Schedule of Benefits (with the exception of breast pumps for the purpose of breastfeeding, which do not have to be purchased through a PPO-covered provider). The Plan will reimburse 100% of the cost of a reasonably priced electric breast pump, up to the Reasonable and Customary amount, for the purpose of breastfeeding, but not all breast pump models are required to be covered. The Reasonable and Customary amount allowable for breast pump coverage is $275. Please verify coverage of a particular model with the Plan and the current Reasonable and Customary amount allowable prior to your purchase.

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

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

- Rehabilitative and restorative Physical, Speech and Occupational Therapy will be covered if all of the following criteria are met:

   - The treatment is ordered by a Physician after the Retiree or Dependent suffers from an Illness or Injury;

   - The treatment is provided pursuant to a treatment plan that requires the services of a licensed and skilled therapist specializing in the area of services provided;

   - There is an expectation that treatment will result in measurable improvement in a reasonable and predictable period of time for the particular diagnosis and phase of recovery; and

   - There is a demonstration of measurable, objective, and functional progress as a direct result of treatment.

- Charges incurred for removal of tumors in the oral cavity.

- Charges by a Hospital or an outpatient facility (including anesthesia) when treatment at the facility is Medically Necessary for the Dental treatment.

- Routine patient costs for items and services furnished in connection with participation in a clinical trial. For purposes of this Plan provision, "routine patient costs" refer to all items and services that are Medically Necessary and consistent with the coverage provided in this Plan that are typically covered for an eligible individual who is not enrolled in a clinical trial. "Routine patient costs" do not include:

   - The investigational item, device or service being studied in the approved clinical trial;

   - Items and services that are provided solely to satisfy the clinical trial's data collection and analysis needs that are not used in the direct clinical management of the patient; and

  A service that is clearly inconsistent with widely accepted standards of care for a particular diagnosis, or would otherwise be considered Experimental or Investigative, as defined by the Plan.

- Expenses for services and supplies provided in connection with an overweight or obesity condition, including gastric band and bariatric surgery, if you fulfill, to the Trustees' satisfaction, all of the requirements set forth below, and any additional requirements maintained by the Fund's case manager as updated and amended from time to time:

   - You are age 18 or older;

- You suffer from clinical obesity. For purposes of this coverage, you suffer from clinical obesity if your body-mass index is:
  - greater than or equal to 40; or
  - greater than or equal to 35 but less than 40, and you also suffer from one or more obesity-related co-morbidities, such as osteoarthritis, sleep apnea, high blood pressure, high cholesterol, heart disease, coronary artery disease, heart failure, stroke, Type 2 diabetes, venous diseases, gastroesophageal reflux disease, pseudotumor cerebri, and soft tissue infections;
- You supply documentation to support previous Physician-supervised weight loss attempts. This includes a complete history and physical examination, weight loss record, diet(s), nutritional counseling/programs, exercise programs/regime, and contemporaneous progress notes indicating adherence to at least 2-3 weight loss programs for a total duration of 6 consecutive months;
- You have no medical contraindications to surgery (e.g. significant heart, lung, liver or kidney disease, or a history of cancer other than skin cancer);
- You have no untreated physiological condition that may contribute to the morbidly obese condition (e.g. hypothyroidism);
- You have undergone a cardiac and pulmonary evaluation;
- Endocrinopathy has been excluded;
- Active peptic ulcer disease has been excluded by testing, including negative results for the *helicobacter pylori* bacteria;
- You have no history of drug or alcohol abuse, and are not currently using drugs (except as directed by a physician), alcohol, or tobacco;
- You have undergone psychiatric or psychological consultation, and do not suffer from severe psychosis, a personality disorder, or a mood or anxiety disorder;
- You have demonstrated reliable participation in a pre-operative weight-loss program that is multidisciplinary (e.g. low-calorie diet, supervised exercise, and behavior modification);
- You obtain pre-certification of the requested services or supplies; and
- You certify that you understand the risk associated with the requested services or supplies, and the required post-service compliance and follow-up.

Additional requirements not listed above for coverage of such service or supplies may be maintained by the Fund's case manager, as updated and amended from time to time.

Repeated gastric band and bariatric surgery is not covered under the Plan regardless of whether the above criteria are met.

Expenses Not Covered

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

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

- Any expense that, in the opinion of the Trustees, is not Medically Necessary.
- Any Injury or Illness for which the individual is not under the regular care of a Physician.
- Any care, treatment, service, surgical procedure, supply, or Hospital confinement that is rendered by or received from or on the recommendation of a Physician who does not meet this Plan's definition of a Physician or that is received from or in a Hospital that does not meet this Plan's definition of a Hospital.
- Any care, treatment, service, surgical procedure, supply, or Hospital confinement that is not recommended or approved by the attending Physician.
- Any care, treatment, service, surgical procedure, supply, or Hospital confinement that is not rendered for the treatment or correction of, or in connection with, a specific non-occupational accidental bodily Injury, Illness, or congenital defect, unless specifically identified as being covered under the Plan.
- Care or treatment of an eligible individual where the person providing the care or treatment is related by blood or marriage to the employee or to any of their Dependents or who ordinarily lives in the Retiree's or Dependent's home.
- Any type of Custodial Care (care that is designed primarily to assist an individual in meeting the activities of daily living, i.e., milieu therapy), regardless of what the care is called.
- Any special education rendered to any individual, regardless of the type of education, purpose of the education, recommendation of the attending Physician, or the qualifications of the individual(s) rendering the special education.

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

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

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

- Any accidental bodily Injury, Illness, or disease sustained while, or resulting from, performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit, including self-employment, or for which benefits are or may be paid in whole or in part under any workers' compensation, employer liability, occupational diseases, or similar law.

  - Excluded charges include expenses for which benefits are available under any workers' compensation coverage provided by the Employer for their employees. However, if benefits are denied under such coverage, expenses may be eligible for coverage under the Plan.

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

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

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

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

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

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

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

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

condition, except as expressly provided under Covered Medical Expenses, and as required under applicable law.

- Any treatment, service, supply, Hospital confinement, or surgical procedure that is of an elective nature, which includes any non-emergency plastic or cosmetic surgery on the body (including but not limited to such areas as the eyelids, nose, face, breasts, or abdominal tissue).

  Exception: This exclusion does not apply to:

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

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

  Exception:

  - This exclusion does not apply to BRCA testing or tests listed as a Preventive Service under the Affordable Care Act.
  - When genetic testing is Medically Necessary, in the judgment of the Trustees, for the treatment or management of one or more actual manifested medical symptoms or conditions and that the service or care provided is the most efficient and economical service which can safely be provided.

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

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

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

  Exception: This exclusion does not apply to benefits for outpatient psychiatric treatment by a Licensed Clinical Social Worker or Licensed Clinical Professional Counselor.

- Charges incurred for or in connection with acupuncture, if performed without the recommendation of or approval by a Medical Doctor (MD), Doctor of Osteopathic

Medicine(DO), Doctor of Chiropractic (DC), or Doctor of Naprapathy (DN) or when performed by an individual not licensed to provide such services under applicable state law.

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

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

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

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

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

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

- Dental implants.

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

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

- Non-PPO Ambulatory surgical center charges.

- Orthoptics or vision training.

- Unlicensed facilities or providers.

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

- Any of the following items for any condition or indication, including for supplementation of an inadequate diet, replacement of foods due to intolerances, to provide nutritional alternatives, or for weight loss or maintenance:

  - Standardized or specialized infant formula for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-

sensitive enteropathy/celiac disease; milk allergies; sensitivities to intact protein; protein or fat maldigestion; or intolerances to soy formulas or protein hydrolysates;

- Food thickeners;
- Dietary and food supplements;
- Lactose-free products and products to aid in lactose digestion;
- Gluten-free food products;
- Weight-loss foods and formula and products to aid weight loss;
- Normal grocery items;
- Low carbohydrate diets;
- Baby food;
- Grocery items that can be blenderized and used with an enteral feeding system;
- Nutritional supplement puddings;
- High protein powders and mixes; and
- Oral vitamins and minerals.

➢ Expenses for any medical services, supplies, or drugs or medicines that are determined to be Experimental or Investigative.

➢ Expenses for children of Retirees.

➢ Hearing aid and exam expenses for Retirees and their Dependent spouse.

➢ Expenses which are not specifically listed as covered under the Plan.

➢ Habilitative or developmental therapy.

➢ Any supplies or equipment that do not meet the Plan's definition of Durable Medical Equipment (DME) or that the Trustees determine is not DME, and is not otherwise covered under the Plan.

➢ Casts, splints, braces, crutches, and trusses purchased without a Physician's prescription.

➢ Any and all expenses incurred by a person covered under this Plan in connection with service as a surrogate (whether traditional or gestational) in exchange for something of value (except for de minimis reimbursements for incidental surrogacy-related expenses), including but not limited to:

- Expenses for pre-gestational and pre-pregnancy testing, office visits, evaluation (including psychological), laboratory, and x-ray examination;
- Sonograms and ultrasound testing;
- Coverage for complications and pregnancy-related conditions arising before, during, or after the pregnancy;

- Anesthesia and its administration;
- Tubal ligations;
- Home birth delivery;
- Emergency expenses;
- Delivery expenses; and
- Maternity expenses.

The Plan Administrator has the discretion, subject to review by the Board of Trustees, to determine whether reimbursements for incidental surrogacy-related expenses provided to the surrogate are of *de minimis* value. If the Plan Administrator and/or Board of Trustees determine that such reimbursements are of *de minimis* value, the surrogate is eligible for coverage in accordance with the Plan's coverage of pregnancy and pregnancy-related conditions.

An individual may petition the Board of Trustees for pre-approval of coverage of pregnancy medical expenses incurred as a result of a surrogacy arrangement. If the Trustees pre-approve coverage for a surrogacy arrangement, such arrangement must be carried out in a manner consistent with, to the Trustees' satisfaction, the arrangement proposed to the Trustees at the time of pre-approval in order to retain eligibility for coverage under the Plan. The Trustees have the power to revoke pre-approval of a surrogacy arrangement at any time.

- Any care, treatment, service, surgical procedure, supply, or Hospital confinement provided to a third-party surrogate who is not otherwise eligible for coverage under the Plan.

- Charges for services received where the Trustees or their delegee determine that a contributing cause of the Injury or sickness was engaging in conduct that would constitute an illegal occupation or a felony in the State where the conduct occurred regardless of whether: (1) charges are filed, (2) a conviction is obtained or (3) the legal process has concluded. This exclusion does not apply if the Injury or medical condition (including both physical and mental health) resulted from an act of domestic violence.

- Charges incurred for treatment of an Illness or Injury sustained while a covered individual is incarcerated, or in the custody of any Federal, State, or Local authority.

- Charges for treatments, services, supplies, and substances that are illegal under federal law or the law of the state in which they are provided.

- Charges for treatments, services, supplies, and substances related to temporomandibular joint dysfunction (TMJ).

- Charges for alternative therapies including but not limited to aromatherapy, light therapy, rolfing, homeopathy, hydrogen peroxide, magnetic, naturopathic, or chelation therapy (except for the extraction of heavy metal poisoning) or any other treatments that are not conventional or the treatment of choice by mainstream medicine.

- Charges for counseling for social maladjustment, pastoral issues, financial issues, behavioral issues, or lack of discipline or other antisocial action, except when specifically required to treat a Mental Health Illness Condition.

- Charges incurred for participation in exercise programs, including Phase III cardiac rehabilitation programs, except as expressly provided under Covered Medical Expenses, and as required under applicable law.

- Charges resulting from the treatment of weak, unstable or flat feet, bunions (unless an open cutting procedure is performed), corns, calluses, toenails (unless part of the nailb ed or nail root is removed), orthopedic shoes, modative inlays or inserts.

- Charges for failure to keep a scheduled visit, for completion of a claim form or for preparation of report(s) to other Physicians, or late payment fees assessed by the Physician.

- Charges for services related to non-organic sexual dysfunctions or inadequacies. Implants and sexual counseling are excluded under the Plan regardless of the cause.

- Charges for any examination or procedure performed for screening, surveys, research or an examination rendered in connection with a physical examination ordered or required for the use of a third party, educational testing or training, including Intelligence Quotient testing, or court-ordered evaluations or programs (unless Medically Necessary).

- Charges for ultrasounds or other tests performed solely to determine fetal age or fetal sex.

- Charges for vocational or training services. This exclusion does not apply to education services rendered for diabetic counseling, peritoneal dialysis, or any other educational service otherwise covered or deemed to be Medically Necessary, or required under applicable law.

- Charges for weekend admissions, including Friday, except for accidents, life-threatening conditions, maternity, or when surgery is scheduled on that day or before 10:00 a.m. the following day.

- Charges that are incurred:
  - For which the covered individual is not, in the absence of this coverage, legally obligated to pay;
  - That would be covered by a grant; or
  - For which a charge would not ordinarily be made in the absence of this coverage.

  This exclusion does not affect the Plan's liability as outlined in the section entitled Coordination of Benefits.

Prescription Drug Benefit

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

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

Retail Pharmacy Program

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

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

Mail Order Service

Maintenance medications (i.e., for conditions such as high blood pressure or asthma), should be filled through the mail order service program. However, the Plan allows two initial fills of a maintenance medication to be filled at any participating network retail pharmacy. Thereafter, if you have your maintenance medication filled at a participating network retail pharmacy, you will be charged a $5 surcharge for refills of Generic Medications and $15 for each brand medication not filled through the mail order service.

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

The first time you have a prescription filled through the mail order pharmacy, you will need to submit a copy of your prescription, and the appropriate copayment along with an order form. The amount of you copayment depends on whether you receive a Generic Medication, single source brand medication or multi source brand medication as shown in the Schedule of Benefits in the front of this booklet.

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

Specialty Pharmacy Program

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

You can initiate a request to fill a specialty medication by calling a Briova Care Coordinator at 1-855-427-4682.

Step Therapy Program

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

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

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

The Step Therapy Program was expanded to include the following five drug classes and medications:

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

Does this change affect my prescriptions?

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

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

Step Therapy

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

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

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

Covered Expenses

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

- Medications that by federal law can be dispensed only pursuant to a prescription and that are required to bear the legend, "Caution, Federal Law Prohibits Dispensing without Prescription."
- Compounded medications (except compound kits) of which at least one ingredient is a prescription legend drug, provided that compounded medications that cost more than $300 require prior authorization for coverage.
- Insulin.
- Insulin syringes/needles.
- OTC medications prescribed by a Physician under the Step Therapy Program or identified under the Affordable Care Act.

Expenses Not Covered

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

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

- Birth control drugs except as required by the Affordable Care Act.
- Rogaine.
- Smoking cessation drugs, including patches, gum, and lozenges except as required under the Affordable Care Act.
- Fluoride supplements except as required under the Affordable Care Act.
- Weight loss medications.
- Vitamin or mineral supplements (except pre-natal vitamins, or as required under the Affordable Care Act).
- Anabolic steroids.
- Viagra and similar drugs for impotence, unless Medically Necessary.
- Bulk chemical kits.
- Compound kits.
- Compounded medications that cost more than $300 for which prior authorization is not obtained.
- Any drugs or medications that are otherwise specified by the Plan as not covered.
- Treatment rendered outside the United States, unless you or your Dependent is traveling for pleasure or is a registered full-time student in a foreign country.
- Drugs or medications that are not Medically Necessary, except as required by law.
- Expenses that are excluded from coverage elsewhere in this booklet.

Health Reimbursement Account (HRA)

The Health Reimbursement Account (HRA) is designed to reimburse Active Employees covered under a CBA and Retirees for qualified medical expenses under §213 of the Internal Revenue Code incurred by themselves, or on behalf of their Dependents, tax free.

The following are the Plan rules that apply to HRA benefits. In the event that the Plan contracts with a third party vendor to administer HRA benefits, the rules of the third party vendor will control. You will be separately advised of these rules if a third party vendor is retained.

HRA Highlights

The Trustees have established a Health Reimbursement Account benefit (HRA). If you were an Active Employee covered under the Premier Plus, Premier or Classic Bargained Plan prior to your Retirement and you have a balance in an HRA account established on your behalf under one of those Plans, you can utilize contribution credits in your individual HRA accounts to cover specified expenses that have been incurred by you or your Dependent spouse that are related to, but not payable under the regular provisions of the Plan. You may not receive cash from your HRA account under any other circumstances.

An HRA is not a savings account. You cannot deposit money in it or withdraw money from it and you do not receive interest or earnings on it. Your HRA account is an unfunded bookkeeping account. When your Employer makes contributions for your HRA, it is not a vested benefit and the Trustees reserve the right to discontinue contributions to or benefits from your HRA at any time.

Eligibility

You are eligible to receive reimbursements from the HRA account established on your behalf while you were eligible under the Premier Plus, Premier or Classic Bargained Plans when you retire as long as a balance remains in your account.

Your HRA

Your HRA Balance

- Your HRA balance is the total of Employer HRA contributions made on your behalf while you were an Active Employee as required under a CBA minus the reimbursements you request from the HRA. You will not receive interest or earnings on your HRA account.
- If the Fund Office issues you a HRA reimbursement check for an Eligible Expense, your HRA account balance will be reduced by the amount of such reimbursement. If you are issued a debit card and use your debit card to pay for an Eligible Expense at the point of

service, your HRA account balance will be reduced by the amount of such payment. Any remaining balance at the end of a calendar year is carried forward from year to year, except as specified below.

Expenses Eligible for Reimbursement

Eligible expenses are "qualified medical expenses" under Section 213(d) of the Internal Revenue Code that you and/or your Dependent spouse incur provided that the expense is:

- Incurred on or after the first day you are covered under the Plan;
- Incurred while you and/or your Dependent spouse were covered under Active Employee Benefits, Retiree Benefits or COBRA continuation coverage (provided you had an HRA account prior to becoming covered under COBRA);
- One that you or your Dependent spouse are required to pay or have already paid;
- Not taken as a tax deduction; and
- Not payable by another source, including under another provision of the Plan.

For a complete list of eligible expenses, please see Publication 502 as prepared by the Internal Revenue Service. Common examples of eligible expenses include the following:

- Payments for coverage including COBRA continuation coverage self-payments, Retiree self-payments, and premiums your spouse pays for other coverage.
- Out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance.
- Healthcare expenses not covered, or only partially covered, under the Plan, such as LASIK surgery or orthodontia and expenses that exceed benefit maximums.
- Eye surgery, including laser eye surgery (e.g., cataracts, radial keratotomy, etc.)
- Smoking-cessation programs, including prescribed medications designed to help with stopping smoking.
- Massage therapy provided by a state licensed massage therapist.
- Premiums paid for disability, or long-term care insurance.

Expenses not Eligible

Any expense for an item that does not constitute "medical care," as defined in Internal Revenue Code §213 is not eligible for reimbursement or payment from your HRA.

Common expenses that are not eligible for reimbursement from the HRA include, but are not limited to:

- Automobile insurance.
- Bottled water.
- Controlled substances (such as marijuana) that are in violation of federal laws.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal injury resulting from an accident or trauma, or disfiguring disease. Cosmetic surgery means any procedure that is directed at improving the patient's appearance and does not fully promote the proper function of the body or prevent or treat illness or disease.
- Cosmetics, toiletries, toothpaste, etc.
- Custodial Care.
- Dental bleaching.
- Diapers or diaper service.
- Expenses incurred before eligible to participate in the Plan.
- Funeral or burial expenses.
- Health club or fitness program dues, even if necessary to alleviate a specific medical condition (such as obesity).
- Home or automotive improvements.
- Household and domestic help.
- Long-term care services.
- Nurse expenses to care for a healthy newborn at home.
- Over-the-counter items, drugs, or medications.
- Social activities (such as dance lessons).
- Transportation expenses (such as, but not limited to, transportation to receive Medical Care).
- Uniforms or special clothing (such as maternity clothing).
- Weight loss programs for general health or appearance.

Debit Cards

You, and upon your request, your Dependent spouse, may receive a debit card to pay for eligible expenses. If you are issued a debit card, you may not use the debit card for any purpose other than to pay for eligible expenses. Refer to the materials issued with your card for instructions and limitations for its use. Please be aware that if you use an issued debit card for an ineligible expense, you may have to repay the money to the Fund and it may be subject to taxes in certain circumstances.

Reimbursements

Reimbursements from your HRA account are subject to the following provisions:

- The minimum amount of an HRA reimbursement payment is $50. Claims less than $50 should be bundled together and submitted once their combined total exceeds $50. Claims for reimbursement must be received by the Fund Office no later than one (1) year following the date on which the expense was incurred.

- You must submit an HRA reimbursement request with a properly completed request form to the Fund Office. Reimbursement requests must include a copy of the explanation of benefits (EOB), itemized bills or any other documentation as required by the Trustees.

- HRA reimbursement requests can only be submitted by you or by your spouse pursuant to your written authorization on file at the Fund Office or in the event you are deceased, by your surviving spouse. HRA reimbursement requests may not be submitted by a former spouse and an HRA balance is not subject to division pursuant to a domestic relations order under the preemption provisions of ERISA Section 514.

Upon receipt of an HRA reimbursement request for an Eligible Expense that has been submitted in accordance with the provisions of this Section, the Fund will issue you a reimbursement check. This check will be issued within 30 days of your request for the amount of the eligible expense, up to, but not to exceed the amount of your HRA balance. Once the check has been issued, the Fund will deduct the amount of such reimbursement from your HRA balance. If your HRA account balance is less than the amount of your request, the Fund will issue you a reimbursement check for the amount in your HRA account at the time of the request. Any excess not reimbursed should be re-submitted with your next reimbursement request.

Forfeiture of your HRA once You Terminate your Employment

Once you are no longer eligible for coverage, any unused balance in your HRA will be permanently forfeited if at any time you have not been eligible for coverage for a 12-month period and your account is inactive (no contributions or claims) for a 12-month period. Any forfeited amounts revert to the Plan's general assets and are used for administrative expenses. In no event will permanently forfeited amounts be paid in cash to any person.

Your HRA In the Event of Your Death

If you die and there is a balance in your HRA account, your surviving spouse may use your account balance provided that they continue to be eligible through self-payments of benefits. Any remaining HRA account balance not reimbursed to your surviving spouse will be forfeited if they have not been eligible for coverage for a 12-month period. Your HRA balance is Trust Fund property, is not inheritable, and will not become part of your estate.

Coordination of Benefits

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

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

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

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

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

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

- A plan that covers a covered individual as an employee is primary over a plan that covers the covered individual as a dependent.
- A plan that covers a covered individual as an employee is primary over a plan that covers the covered individual as a laid off or retired employee.
- A plan that covers a covered individual as an employee, member, or subscriber (that is, other than as a dependent) is primary over a plan that provides coverage pursuant to a right of continuation under federal or state law.
- In the event that both spouses are covered under this Plan as employees, benefits will be coordinated for the two spouses.

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

Coordination of Benefits with Medicare

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

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

When a member becomes eligible for Medicare, regardless of whether the member actually enrolls in Medicare, s/he is no longer eligible for benefits under this Plan. Upon a member's Medicare eligibility, the member will automatically be transitioned onto the Towers Watson program, and the HRA for Medicare Eligible Retirees. Accordingly, be sure that you enroll in Medicare when you are first eligible to do so.

Rules for Spouses of Pre-Medicare Retirees

If your spouse is eligible for Medicare, but you are not (and you are eligible for benefits under the Plan), Medicare will have primary payment responsibility for your spouse and the Plan will pay second. Your spouse's eligibility under this Plan will end when you also become eligible for Medicare. The Plan will pay its normal Plan benefits or the balance due after Medicare payments, whichever is less.

The Plan considers payments from Medicare Part A, Part B, and Medicare Advantage Part C whether or not your spouse is enrolled in these programs. **Accordingly, be sure that your spouse enrolls in both Medicare Part A and Medicare Part B when s/he is first eligible to do so.**

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

End Stage Renal Disease (ESRD)

There are special rules that apply to the first 30 months if you have ESRD, (the initial 30-month period). The primary/secondary rules depend on whether the covered individual is eligible for Medicare due to age or disability as of the beginning of the initial 30-month period. After the 30-month period, Medicare is always primary. There are different rules for Pre-Medicare Retirees (members) and their spouses, as described below.

Rules for Pre-Medicare Retirees (Members) with ESRD

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

Rules for Spouses with ESRD

If your spouse is not otherwise eligible for Medicare at the time s/he becomes entitled to Medicare ESRD benefits, the Plan will have primary payment responsibility during the initial 30-month period and Medicare will pay second. After the initial 30-month period, Medicare will pay primary and the Plan will pay secondary.

If your spouse is already eligible for Medicare at the time s/he becomes entitled to Medicare ESRD benefits, Medicare will have primary responsibility for ESRD during the initial 30-month period and this Plan will pay second. After the initial 30-month period, Medicare continues to pay primary and the Plan will pay secondary.

Individual Policies of Insurance

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

Filing and Appealing Claims

Filing Claims

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

What is a Claim

A claim for benefits is a request for Plan benefits that you make in accordance with the Fund's reasonable claims procedures. Health claims can be filed for medical and prescription drug expenses.

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

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

How to File Health Care Claims

- Generally, your provider will file a claim on your behalf. To request a claim form, contact BMGI at the telephone number listed below.

- Complete the employee portion of the claim form in its entirety. Attach an itemized bill(s) to the claim form. Remember that all itemized bills must contain the following information:
  - Retiree's name and social security number and/or member ID;
  - Patient's name, social security number, and relationship to member;
  - Date(s) of service;
  - Description of service;

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

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

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

- Return the completed and signed claim form to Professional Benefit Administrators (PBA) for processing. PBA's address is:

Professional Benefit Administrators, Inc. (PBA)
900 Jorie Blvd, Suite 250
Oak Brook, IL 60523

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

Types of Health Care Claims

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

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

- Pre-Service — A claim where pre-certification is required before you obtain care. The Plan requires pre-certification of certain services, as listed above in the section titled Case Management, Pre-certification and Utilization Review.

- Concurrent Care — A claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits or a termination of benefits (other than by Plan amendment or termination).

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

Claim Determinations

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

The chart below describes the timeframes for claim determinations.

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

If a Claim Is Denied

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

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

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

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on:

  - A determination of an individual's eligibility to participate in the Plan; or
  - A determination that a benefit is not a covered benefit;

- A reduction in a benefit resulting from the application of any utilization review decision, preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate; or

- Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

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

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

- The specific reason(s) for the determination, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;

- Reference to the Plan provision(s) on which the determination was based;

- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;

- A copy of the Plan's internal claims review procedures, and external review processes, along with the time limits and information regarding how to initiate an appeal of your Claim;

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

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

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

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

Examples of When a Claim May Be Denied

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

- The individual on whose behalf the claim was filed was not covered under the Plan on the date the expenses were incurred.
- The claim was not filed within the Plan time limits.
- The claim was not for covered expenses under the Plan.
- The claim was for expenses that were not actually incurred.
- The individual for whom the claim was filed already received the maximum allowable under the Plan for the type of expense.
- Another plan was primarily responsible for paying benefits for the covered expense.
- No payment was made, or a reduced payment was made, because some or all of the expenses for which the claim was filed were applied against a particular deductible or copayment.
- A third party was responsible for paying the expenses and the individual on whose behalf the claim was filed did not submit the required subrogation agreement that would permit the Plan to process the claim and recover payment from the third party or his insurance company.
- Plan eligibility rules or benefits were amended.
- An eligible individual's future benefits were reduced or temporarily suspended to recover an overpayment of benefits previously made.
- Hospital benefits were reduced by the amount of the Non-PPO Hospital deductible.
- The Plan was terminated.

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

Appealing a Denied Claim

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

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

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

Appeal Determinations

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

We will provide you (automatically and free of charge) any new or additional evidence or rationale used or generated in connection with your appeal if such evidence or rationale was not used or generated in the initial claim denial or adverse benefit determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date that a final decision on your appeal is made in order to give you an opportunity to respond regarding such evidence or rationale.

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

Appeal Determination Timeframes

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

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

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

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

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

Appeal Determination Notice

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

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

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

- A statement explaining the external review process, along with any time limits and information regarding how to initiate the external review of your claim;

- A statement that you have a right to bring a civil action under ERISA §502(a) following the denial of your claim;

- The specific reason(s) for the determination, including the denial code and its corresponding meaning, and a discussion of the decision, as well as any Plan standards used in denying the claim;

- Reference to the Plan provision(s) on which the determination was based;

- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

- If your claim is denied based on:

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

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

Authorized Representatives

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

Authorized representatives may include a:

➢ Health care provider that has knowledge of the condition in an emergency situation;

➢ Legal spouse;

➢ Dependent child age 18 or over;

➢ Parent or adult sibling;

➢ Grandparent;

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

➢ Other adult.

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

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

Elimination of Conflict of Interest

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

External Review of Adverse Benefit Determination

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

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

External Review Filing Deadline

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

Determination of Eligibility for Review

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

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

Within one business day after the completion of this review, the Plan must notify you (or your authorized representative) whether the request is complete and is eligible for review. If the request is not complete, the Plan must provide notice of what information or materials are needed and allow you to perfect the request within the four-month filing period or 48 hours

following receipt of the notification, whichever is later. If the request is not eligible for external review, the notice must include the reason(s) for ineligibility and contact information for the Employee Benefits Security Administration.

Referral to an Independent Review Organization (IRO)

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

- The IRO will timely notify you of receipt of assignment of the external review and such notice will inform you that you may provide additional information within ten business days following receipt of the notice. The IRO is not required, but may, accept and consider additional information submitted after ten business days.

- The Plan must provide the claim file and any information considered in making the Adverse Benefit Determination within five business days after the date of assignment to the IRO. Failure by the Plan to submit the information to the IRO may result in an immediate reversal of the adverse benefit determination. The IRO must send notice of such to you and the Plan within one business day.

- The IRO must forward any additional information received from you to the Plan within one day of receipt and the Plan may reconsider and reverse its decision, terminating the external review. The Plan must provide notice within one business day of such a decision to you and the IRO.

- The IRO will review all information received anew. In addition to all information provided, the IRO may consider the following information, if the IRO deems it appropriate:

    - the claimant's medical records;

    - the attending health care professional's recommendation;

    - reports from appropriate health care professionals and other documents submitted by the Plan, claimant or treating provider;

    - the terms of the Plan;

    - appropriate practice guidelines, which must include all evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

    - any applicable clinical review criteria developed and used by the Plan, unless the criteria is inconsistent with the terms of the Plan or applicable law; and

    - the opinion of the IRO's clinical reviewer or reviewers after considering the information described in this section to the extent the information or documents are available and the clinical reviewer or reviewers consider it appropriate.

Request for an Expedited External Review

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

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

Timing of Notice of Decision on External Review

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

Content of Notice of Decision on External Review

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

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

Payment of Claims

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

Medical Judgments

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

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

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

Deemed Exhaustion

If the Plan Administrator fails to adhere to the claims and appeals procedures set forth herein, you are deemed to have exhausted the Plan's claims and appeals procedures, and may initiate external review of your claim (as provided above), or file a legal action regarding your claim, unless the Plan Administrator's violation(s) of its claims and appeals procedures are *de minimis*, i.e. the violation(s) do not cause, and are not likely to cause, prejudice or harm to you (the claimant). The Plan's violation(s) of its claims and appeals procedures are considered *de minimis* if the Plan demonstrates that the violation(s) (1) were for due cause, or due to matters beyond the Plan's control; and (2) occurred in the context of an ongoing, good faith exchange of information with you. You may request a written explanation of the violation(s), which we will provide you within ten (10) days of your request. Such written explanation will include a specific description of the Plan's basis, if any, for asserting that the violation(s) should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or court of law rejects your request for immediate review on the basis that the Plan has met the standards for the *de minimis* exception described above, you have the right to re-submit and pursue the claim pursuant to the Plan's internal claims and appeals procedures. The Plan will provide you with notice regarding the opportunity to re-submit your

claim. Your time period for re-submitting the claim will begin to run upon your receipt of such notice.

Trustee Authority and Interpretation

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

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

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

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

Subrogation and Reimbursement

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

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

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

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

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

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

- You and/or your Dependent spouse must cooperate with the Fund by providing information requested by the Fund concerning subrogation or reimbursement. This includes providing the Fund Office with (1) a signed subrogation and reimbursement agreement if requested; (2) the names and addresses of all potential third parties and their insurer, adjusters and claim numbers; (3) any accident reports; (4) a signed Medical Authorization; and (5) any other information the Fund Office requests, including contact information of an attorney representing you in your claim against a third party.

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

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

If you fail to meet your responsibilities, the Fund may withhold future benefit payments for both you and your Dependent spouse until you comply with these requirements. In addition, the Fund may deny or reduce any future benefits covered under this Plan.

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

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

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

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

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

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

If you and/or your Dependent(s) retain your own attorney, you are wholly responsible for all attorney's fees or other expenses incurred to obtain the third party recovery. If the attorney(s) that you and/or your Dependent(s) retain in relation to an injury or illness brings a separate claim or lawsuit against the Fund to recover his/her attorney's fees under the Common Fund Doctrine, quantum meruit, unjust enrichment or other similar state laws, you and/or your Dependent(s) are required to reimburse the Fund from the money you and/or your Dependent(s) recover from any third party for (i) any money judgment entered against the Fund in the lawsuit brought by the attorney and (ii) the Fund's attorney's fees and costs defending the lawsuit, regardless of whether the Fund prevails or loses. You and/or your Dependent(s) shall fully indemnify, hold harmless and defend the Fund and its Trustees, employees and agents from and against any such claims or lawsuits. The Fund shall have the right to appoint counsel.

To the extent the Fund is required to initiate a formal proceeding against you and/or your Dependent(s) to enforce its reimbursement rights, you and/or your Dependent(s) shall also be responsible for the Fund's attorney's fees and costs incurred. In addition, to the extent the expenses, including but not limited to attorney's fees and costs, incurred by the Fund exceed the amount you and/or your Dependent(s) recover from any third party or you and/or your Dependent(s) refuse or fail to reimburse the Fund from any third party recovery, the Fund shall have the right to withhold benefits to you and/or your Dependent(s) until such time that the Fund is reimbursed in full for all expenses, including but not limited to attorney's fees and costs.

You and/or your Dependent(s) grant the Fund a lien on the monies recovered from any third party in the amount of (i) all medical and short term disability claims paid on your and/or your Dependent's behalf, (ii) any money judgment entered against the Fund in the lawsuit brought by the attorney, and (iii) the Fund's attorney's fees and costs in defending the lawsuit, regardless of whether the Fund prevails or loses.

Overpayment and Duty of Cooperation

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

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

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

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

Misrepresentation or Falsification of Claims

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

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

Wrongfully Paid Benefits

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

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

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

Assignment of Claims

As an Active Employee or Dependent participating in this Plan, your right to receive benefit payments, appeal a claim, or bring a cause of action against the Plan is personal to you. Any claim or rights under the Plan, which includes but is not limited to any right to appeal a claim under the procedure set forth in the Plan document, any right to bring a cause of action against the Plan in any forum, or any right to receive benefits or benefit payments from the Plan, is not assignable or transferrable in whole or in part to any other person, Hospital, health care provider, or other entity (collectively a “Provider” for purposes of this paragraph) at any time. Any assignment or transfer of a claim or other rights to receive benefit payments is void unless you receive written consent from the Board of Trustees. This anti-assignment provision is not waivable. Direct payments to a Provider may be made for convenience only and do not constitute a waiver of this anti-assignment provision. Under no circumstances is a Provider a Participant or a beneficiary.

Administrative Information

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

Plan Name

The name of the plan is Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund – Pre-Medicare Retirees Plan.

Board of Trustees

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

Board of Trustees
Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund
361 S. Frontage Road, Suite 100
Burr Ridge, Illinois 60527
Telephone: 1-708-482-0110 or toll-free at 1-800-704-6270

The present Trustees are:

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

Administration of the Plan

The Board of Trustees makes the rules and regulations to administer your Plan. By amendment, the Board of Trustees may change the terms, conditions, or benefits of the Plan. Only the Board of Trustees can make a final decision regarding any question, interpretation, or application of any part of the Plan. No employer or Union or any representative of any employer or Union, is authorized to interpret the Plan. The Trustees will make every effort to interpret Plan provisions

in a consistent and equitable manner, and the Trustees decisions will be awarded judicial deference. Benefits under this Plan will be paid only when the Board of Trustees (or persons delegated by the Trustees) decides, in their discretion, that the eligible individual is entitled to benefits in accordance with the Plan's terms.

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

The provisions of the Plan may be amended from time to time by a majority vote of the Trustees. Amendments may include increases, modifications, reductions, or the elimination, in whole or in part, of certain benefits.

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

Plan Termination

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

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

However, any remaining surplus will, in accordance with the terms of the Trust Agreement, be used in such manner as the Trustees believe will best effectuate the purpose of the Plan, subject to the requirement that no part of the corpus may be diverted to any purpose other than the exclusive benefit of participants and beneficiaries and payment of the administrative expenses of the Plan. Upon termination, no part of the assets of the Plan will revert or accrue, directly or indirectly, to the benefit of an Employer or the Union.

Plan Sponsor and Administrator

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

Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund
361 S. Frontage Road, Suite 100
Burr Ridge, Illinois 60527
Telephone: 1-708-482-0110 or toll-free at 1-800-704-6270

Identification Numbers

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

The Plan number is 501.

Plan Year

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

Agent for Service of Legal Process

If legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees or the Administrative Manager, Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund, 361 S. Frontage Road, Suite 100, Burr Ridge, Illinois 60527.

Plan Description

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

All benefits described in this booklet are self-funded by the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund.

Source of Contributions

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

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

Collective Bargaining Agreements

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

Workers' Compensation and the Plan

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

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

Welfare Trust's Assets and Reserves

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

Eligibility, Benefits and Discretionary Authority

The Plan's requirements for eligibility for benefits are shown in this booklet. Circumstances that may cause you to lose eligibility are also explained. You are not vested in the benefits described in this booklet. All Plan benefits are made available to you and your Dependent spouse by the Plan as a privilege and not as a right.

Eligibility and benefit coverage under this Plan are limited to and controlled by the terms of this written Plan Document/Summary Plan Description. This written Plan Document/Summary Plan Description is the only instrument on which you can rely. You cannot rely on any other oral or written statements by any person or entity regarding coverage and eligibility terms under this

Plan. Fund Office employees, employers, union representatives, individual Trustees and individuals or entities other than the Board of Trustees acting in accordance with the Trust Agreement are not authorized or empowered to make representations, certify or guarantee eligibility or coverage, or interpret or change the terms of the Plan. If you would like to confirm eligibility or coverage you must file an official claim for benefits pursuant to the Plan's claim filing procedures.

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

Rescission of Your Coverage

The Plan may rescind your coverage for fraud or intentional misrepresentation of a material fact. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan.

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

Privacy Notice

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

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

Your rights under HIPAA include the right to:

- Receive confidential communications of your health information, as applicable;

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

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

Breach Notification Rights under HIPAA

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

If your unsecured PHI is breached, the Fund Office will notify you without unreasonable delay and in no case no later than 60 calendar days after 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.

Affordable Care Act

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

Your ERISA Rights

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

Receive Information about Your Plan and Benefits

You have the right to:

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

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

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

Continue Group Health Plan Coverage

You may also have the right to:

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

- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:

  - You lose coverage under the Plan;
  - You become entitled to elect COBRA continuation coverage; or
  - Your COBRA continuation coverage ends.

  You must request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject

to preexisting condition exclusions for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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

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

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

Definitions

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

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

Covered Employment	Covered Employment is work performed by an employee for an Employer for which contributions are required pursuant to a CBA and/or participation agreement and are actually made to the Plan.
Creditable Coverage	Coverage under a nationally recognized group health plan, Medicare or Medicaid programs.
Custodial Care	Any services or supplies provided primarily for personal comfort or convenience that provide general maintenance, preventive, and/or protective care without any clinical likelihood of condition improvement. Custodial Care also means those services that do not require the technical skills, professional training, and/or clinical assessment ability of medical and/or nursing personnel to be safely and effectively performed.
Dependent	For purposes of the Plan a Dependent is the spouse of a Retiree who is not divorced or legally separated from the Retiree, and is of a marriage that was legally entered into in a jurisdiction that recognizes said marriage. A same sex spouse legally married to a Retiree in a jurisdiction that recognizes same-sex marriage shall also be considered a Dependent under this Plan.
Durable Medical Equipment (DME)	For purposes of the Plan, Durable Medical Equipment (DME) means equipment that: ➢ Is long-lasting and can withstand repeated use by successive patients; ➢ Is primarily and customarily used for a medical purpose; ➢ Generally is not useful to a person in the absence of an Illness or Injury; ➢ Is appropriate for use in your home; ➢ Is used solely for the care and treatment of the patient; and ➢ Is not commonly available over-the-counter (e.g. items such as ice and heating packs, bandages, support hose, compression socks, and shoe inserts are NOT considered DME under the Plan); The Board of Trustees and their designees have full authority and discretion to determine what constitutes Durable Medical Equipment (DME) for purposes of the Plan.
Emergency or Emergency Medical Condition	A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including extreme pain) such that the absence of immediate medical attention could reasonably be expected to result in: ➢ Placing the patient's health in serious jeopardy, ➢ Serious impairment to bodily functions, or ➢ Serious dysfunction of any bodily organ or part.
Emergency Services	Services for an Emergency Medical Condition, including medical screening exam and treatment to stabilize the patient.
Emergency Treatment Center	A free-standing facility that is engaged primarily in providing minor emergency and episodic Medical Care.
Employer	For the purposes of the Plan Employer includes: ➢ Any person, firm, association, partnership, or corporation that enters into a CBA with the Union requiring contributions to be made to the Fund on behalf of full-time employees;

	➢ The Union, which is required to make contributions to the Fund for its full-time employees under the terms of a participation agreement; ➢ The Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund and Pension Fund with respect to its full-time employees; and ➢ Any employer that is required to make contributions to the Fund under the terms of a participation agreement for its full-time employees whose employment is not subject to a CBA.
Experimental or Investigative	Applies to a service, procedure, drug, device, or treatment modality for a specific diagnosis (referred to herein as such treatment or procedure) that meets one of the following criteria: ➢ Such treatment or procedure has failed to obtain final approval for a specific diagnosis from the appropriate governmental body; ➢ Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of such treatment or procedure on health outcomes for a specific diagnosis; ➢ Such treatment or procedure, or the patient-informed consent document utilized with such treatment or procedure was reviewed and approved by the treating facility "institutional review board" or other body serving a similar function, or if federal law requires such review or approval; ➢ Reliable evidence shows that such treatment or procedure is (1) the subject of ongoing phase I or phase II clinical trials, (2) the subject of on-going phase III clinical trials or (3) otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or ➢ Reliable evidence shows that the prevailing opinion among experts regarding such treatment or procedure is that further studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Reliable evidence means only: published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure. Note: The Trustees have the authority to determine whether a service, procedure, drug, device or treatment modality is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device or treatment does not, in itself, make it eligible for payment.
Generic Drug or Medication	A drug with the same or bio-equivalent of a Brand Name Drug in the following respects: the active ingredients (those that are responsible for the drug's effect); the dosage amount, the way in which the drug is taken; the safety; and the amount of time it takes to absorb into the body. A Generic Drug has been approved by the U.S. Food and Drug Administration (FDA) and is basically a "copy" of a Brand Name Drug. Generic Drugs may have different names, shapes, colors and inactive ingredients than the Brand Name Drug.
Hospice Care	Palliative and supportive care designed to provide for the physical and psychological well being of dying persons and their families.

Home Health Agency	A program of care provided by a public agency or private organization, or a subdivision of such agency or organization that: ➢ Is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients; ➢ Has established policies for governing the services that it provides; ➢ Provides for the supervision of its services by a Physician or registered professional nurse; ➢ Maintains clerical records of all patients; ➢ Is licensed according to the applicable state laws and of the locality in which it is located or provides services; and ➢ Is eligible to participate under Medicare.
Hospital	A lawfully operated institution that has permanent and full-time facilities for bed care of five or more resident patients; has a doctor in regular attendance; and provides 24-hour nursing services rendered by registered nurses.
Illness	A disease, disorder, or condition (including pregnancy, childbirth, and any related conditions) that requires treatment by a Physician.
Infertility	The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy, as certified by your Physician.
Injury	Physical damage or hurt caused by a sudden unforeseen event resulting from an external source.
Inpatient	A registered bed patient receiving treatment at a Hospital or other healthcare facility.
Intensive Outpatient Plan or Partial Hospitalization	A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care specifically designed for the diagnosis and active treatment of a Mental Health Illness or Substance Abuse when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization. Programs must provide diagnostic services; services of social workers; psychiatric nurses and staff trained to work with psychiatric patients; individual, group and Family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes. The facility providing the Intensive Outpatient Program or Partial Hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a Physician.
Medical Care	The ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an Illness or Injury.
Medically Necessary or Medical Necessity	Services, treatments, or supplies ordered by your Physician that: ➢ Are required to identify or treat an Injury or Illness; ➢ Are appropriate and consistent with the symptoms, diagnosis, or treatment of the condition, disease, Illness, or Injury; ➢ Do not involve unnecessary or repeated tests; ➢ Are not of an Experimental, Investigational or educational nature; ➢ Are furnished by a provider with appropriate training and experience, acting within the scope of his or her license; ➢ Are the most appropriate that can be safely provided under the circumstances on a cost-effective basis; and

	➢ Meet the following definition of standard of care: Standard of care refers to an acceptable level of patient care provided by a medical practitioner. It considers how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances. Standard of care is sometimes referred to as "standard therapy" or "best practice" and is generally satisfied by any medicine or treatment that experts agree is consistent with generally accepted standards of medical practice, is appropriate, accepted, and widely used for a certain type of patient, illness, or clinical circumstance. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.
Medicare	Medicare is a social insurance program administered by the United States government, providing health insurance coverage to people who are aged 65 and over; to those who are under 65 and are permanently physically disabled or who have a congenital physical disability; or to those who meet other special criteria.
Mental Health; Mental or Nervous Disorder	A disorder classified in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or a neurosis, psychoneurosis, psychopathy or psychosis or a mental or emotional disease of any kind.
Mental Health/Substance Abuse Provider	A legally licensed psychiatrist, psychologist, licensed or certified social worker, clinical psychiatric counselor or psychiatric nurse clinician, or a licensed or certified mental health/substance abuse provider to the extent they are performing services within the scope of their license. In states where licensing and certification are not available, this Plan will recognize a provider that holds a Masters level degree in the field of mental health or substance abuse.
Nurse	Nurse means any of the following: 1. Certified Registered Nurse Anesthetist (C.R.N.A.). 2. Certified Nurse of the Operating Room (C.N.O.R.). 3. Certified Surgical Technologist (C.S.T.). 4. Certified First Assistant (C.F.A.). 5. Licensed Nurse Practitioner (L.N.P.). 6. Licensed Practical Nurse (L.P.N.). 7. Nurse Midwife (N.M.). 8. Registered Nurse (R.N.).
Occupational Therapy	Therapeutic use of self-care, work, and recreational activities to increase independent function, enhance development, and prevent disability; may include adaptation of tasks or environment to achieve maximum independence and optimal quality of life.
Outpatient	Treatment received while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room, diagnostic laboratory tests and X-rays, medications, and supplies.
Ophthalmologist/ Optometrist	A person legally qualified and licensed to practice such profession by the appropriate governmental authority.
Physical Therapy	Services and providers that are expected to address specific clinical and functional restrictions by applying skilled physical therapy techniques and utilizing appropriate physical therapy modalities, therapeutic exercise, manipulative techniques and soft tissue care with concurrent initiation of a progressive exercise and stabilization program. Additionally, emphasis of treatment is expected to be self-symptom management and an independent home or community-based exercise program.
Physician	A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (D.P.M.) and authorized to practice medicine, perform surgery, and to

	administer drugs under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.
Premier Participant	An Active Employee who meets the Premier Plan's eligibility rules and whose Employer signed a CBA designating that the Employee will be covered under the class of benefits known as Premier Benefits.
Premier Plus Participant	An Active Employee who meets the Premier Plus Plan's eligibility rules and whose Employer signed a CBA designating that the Employee will be covered under the class of benefits known as Premier Plus Benefits.
Preventive Services	➢ Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, except as provided below; ➢ Immunizations for routine use in adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention); ➢ With respect to women, to the extent not described above, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. ➢ Where the federal guidelines are unclear regarding whether an expense is considered a Preventive Service, the Trustees will decide whether such expense is a Preventive Service under the Plan. For a complete up-to-date list of Preventive Services under the Affordable Care Act, please visit: http://www.healthcare.gov/coverage/preventative-care-benefits/.
Reasonable and Customary	With regard to medical expenses Reasonable and Customary means: ➢ With respect to a PPO provider, the charge set forth in the PPO agreement, unless the provider's actual charges are less; ➢ With respect to a non-PPO provider, Reasonable and Customary means the lowest of: o No more than 80% of the prevailing charge which amount may be based on industry standard provider reimbursement data provided to the Plan or the maximum amount allowable by Medicare; or o The amount payable to a similarly-situated PPO provider in the nearest geographic area; or o The provider's actual charges. ➢ With respect to non-PPO Emergency Services, Reasonable and Customary means the greatest of the following amounts (adjusted for PPO cost-sharing): o The median amount negotiated with PPO providers for the Emergency Service;

	○ The amount for the Emergency Service calculated using the same method used to determine payments for non-PPO non-Emergency Services (see above); or ○ The amount that would be paid under Medicare for the emergency service Reasonable and Customary shall not exceed the charges actually incurred. Verification or prior authorization of coverage does not guarantee that services or charges will be paid for by the Plan. Any dispute regarding the determination of the Plan's definition of Reasonable and Customary described herein shall be resolved solely at the discretion of the Board of Trustees.
Residential Treatment Facility	A facility which provides a program of effective treatment for a Mental Health Illness or Substance Abuse and which meets all of the following requirements: 1. It is licensed by the state in which it operates and is operated in accordance with applicable state law for residential treatment programs. 2. It provides a program of treatment under the active participation and direction of a Physician. 3. It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient. 4. It provides all of the following basic services 24-hours per day: a. Room and board. b. On-site nursing services. c. Evaluation and diagnosis. d. Counseling. e. Referral and orientation to specialized community resources. 5. It is accredited by one of the following: the Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities, Accreditation Association for Ambulatory Health Care, or as required under applicable law. A Residential Treatment Facility does not include half-way houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities.
Retiree	A former Employee who retires while covered under the Plan's Active Employee Benefits and is covered under the Retiree Benefits.
Retirement	Retirement means that the Employee ceases employment from an Employer and intends to abstain from actively working.
Skilled Nursing Facility	A licensed institution that has a transfer agreement with a Hospital, that provides 24-hour Inpatient nursing services under the supervision of a Physician or registered nurse, is eligible for Medicare, has a utilization review plan in place, is not an institution that is primarily for the care and treatment of mental diseases, and every patient must be under the supervision of a Physician.
Speech Therapy	Speech–language pathology services for the treatment of disorders of speech, language, voice, communication and auditory processing.
Union	Automobile Mechanics' Local No. 701, affiliated with the International Association of Machinists, AFL-CIO.

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