SOUTHERN ILLINOIS LABORERS' & EMPLOYERS HEALTH & WELFARE FUND

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IMPORTANT INFORMATION ABOUT THE PLAN

PLAN NAME
Southern Illinois Laborers' & Employers Health & Welfare Fund.

PLAN TYPE
Death Benefits provided by Southern Illinois Laborers' & Employers Health & Welfare Fund effective 1/1/03.

Medical, dental, & vision benefits provided by the Trustees.

PPO/UR provider through HealthLink, Inc., 3/1/96.

Mail order, retail and specialty drug program sponsored by LDI, effective 1/1/05.

Member Assistance Program provided through Perspectives 5/1/99.

PLAN SPONSOR
Joint Board of Trustees of the Southern Illinois Laborers' & Employers Health & Welfare Fund.

CONTRIBUTIONS TO THE FUND
The sources of contributions to the Plan are employer and employee contributions. The funding medium used for the accumulation of assets is a trust.

Employers and employee organization contributions are based on the terms of the Collective Bargaining Agreement.

The Employee Retirement Income Security Act of 1974, as amended, requires that certain information be furnished to each participant (or eligible participant) in an Employee Benefit Plan. This is your Summary Plan Description. Contributions to this Plan are made by participating employers and under certain conditions by insured person. Contributions are based on the amount of monies necessary to provide the coverage required by the Plan.

PLAN IDENTIFICATION NUMBER

EIN	PN
37-1037101	501

PLAN YEAR
The plan year for this Plan commences on August 1 and consists of an entire year for the purpose of accounting and reporting to the United States Department of Labor and other regulatory bodies.

Relevant provisions of the Collective Bargaining Agreement, the names of the parties and its expiration date may be reviewed at the Southern Illinois Laborers' & Employers Health & Welfare Fund Office.

REVISION DATE: 1/1/05

BENEFITS SERVICE MANAGER
The benefit service manager is responsible for the processing and payment of claims and any other functions as may be delegated from time to time by the Plan Sponsor. The current Benefits Service Manager is **Southern Illinois Laborers' and Employers Health & Welfare Fund.**

INCEPTION DATE

The inception date of the life and health benefits was June 1, 1978.
The inception date of the vision benefits was June 1, 1979.
The inception date of the dental benefits was December 1, 1980.
The inception date of the dependent life benefits was December 1, 1985.
The inception date of the Preferred Provider/Utilization Review program was January 1, 1992.
The inception date of the Mail Order Drug Program was January 1, 1993.
The merger date of the Laborers' Industrial and Public Employees Health & Welfare Fund and the Southern Illinois Laborers' & Employers Health & Welfare Fund was January 1, 1995.
The inception of the Retail Drug Program was July 1, 1997.
The inception of the Member Assistance Program was May 1, 1999.
The inception of the Law America Program was January 1, 2001.
The inception of the Hearing Program was May 1, 2001.
The Life Insurance Contract (Members & Dependents) terminated January 1, 2003.
The inception date of Death Benefit (Employee Only) was January 1, 2003.
The inception date of Specialty Drug & Bio-Injectable Program was April 1, 2005.

LOSS OF BENEFITS

To determine if you are eligible for benefits, contact the Fund Office.

You must continue to be a member of the class to which the Plan pertains. Failure to do so may result in partial or total loss of your benefits.

The Trustees maintain the right to modify or terminate this Plan.

Relevant provisions of the Collective Bargaining Agreement, the names of the parties and its expiration date may be viewed at the Southern Illinois Laborers' and Employers Health and Welfare Fund Office.

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SCHEDULE OF BENEFITS – C

BENEFITS	TIER 1 HEALTHLINK CONTRACTED PROVIDER	TIER 2 HEALTHLINK CONTRACTED PROVIDER	TIER 3 OUT-OF-NETWORK PROVIDER
MAJOR MEDICAL LIFETIME MAXIMUM SEE ARTICLE 2, SECTION 1	UNLIMITED		
MAJOR MEDICAL ANNUAL MAXIMUM – ACTIVE MEMBERS	Plan Year Beginning August 1, 2011 - $1,000,000 Annual Maximum Plan Year Beginning August 1, 2012 - $1,250,000 Annual Maximum Plan Year Beginning August 1, 2013 - $2,000,000 Annual Maximum Plan Year Beginning August 1, 2014 and Subsequent Years – No Annual Maximum		
MAJOR MEDICAL ANNUAL MAXIMUM – RETIRED MEMBERS	Plan Year Beginning August 1, 2011 - $750,000 Annual Maximum Plan Year Beginning August 1, 2012 - $1,250,000 Annual Maximum Plan Year Beginning August 1, 2013 - $2,000,000 Annual Maximum Plan Year Beginning August 1, 2014 and Subsequent Years – No Annual Maximum		
CALENDAR YEAR DEDUCTIBLE PER PERSON SEE ARTICLE 2, SECTION 3	$500 – Active $1,000 – Retired	$500 – Active $1,000 – Retired	$1,000 – Active $3,000 – Retired
CALENDAR YEAR DEDUCTIBLE PER FAMILY SEE ARTICLE 2, SECTION 3	$1,500 – Active $3,000 – Retired	$1,500 – Active $3,000 – Retired	$3,000 – Active $6,000 – Retired
OUT-OF-POCKET PER PERSON PER FAMILY UNIT SEE ARTICLE 2, SECTION 5	$2,000 $6,000 DOES NOT INCLUDE DEDUCTIBLE	$2,000 $6,000 DOES NOT INCLUDE DEDUCTIBLE	$3,500 $10,500 DOES NOT INCLUDE DEDUCTIBLE
HOSPITAL SERVICES			
INPATIENT SEE ARTICLE 2, SECTION 4	85% AFTER DEDUCTIBLE	80% AFTER DEDUCTIBLE	60% AFTER DEDUCTIBLE
OUTPATIENT SEE ARTICLE 2, SECTION 4	85% AFTER DEDUCTIBLE	80% AFTER DEDUCTIBLE	60% AFTER DEDUCTIBLE
WRAP AROUND – If a member utilizes a PPO facility and a PPO physician and a PPO surgeon – charges incurred by a Non-PPO anesthesiologist or radiologist or pathologist or assistant surgeon will be paid at the PPO level. If a member utilizes a PPO emergency room – charges incurred by a Non-PPO physician will be paid at the PPO level.			
OUT-OF-AREA coverage will be available for emergency care needed for those members and/or dependents traveling for business or pleasure out of the PPO network or eligible children living outside of PPO area and for which the member is required to provide insurance coverage. The out-of-network deductible will apply. The coinsurance percentage will be 80/20. The out-of-network out-of-pocket will apply. Also, subject to emergency room co-pay.			
EMERGENCY ROOM SEE ARTICLE 2, SECTION 6	85% AFTER DEDUCTIBLE PLUS $150 PER OCCURRENCE CO-PAY FOR NON-ACCIDENT	80% AFTER DEDUCTIBLE PLUS $150 PER OCCURRENCE CO-PAY FOR NON-ACCIDENT	60% AFTER DEDUCTIBLE PLUS $150 PER OCCURRENCE CO-PAY FOR NON- ACCIDENT
PHYSICIAN SERVICES SEE ARTICLE 2, SECTION 4			
OFFICE VISITS SEE ARTICLE 2, SECTION 4	85% AFTER DEDUCTIBLE	80% AFTER DEDUCTIBLE	60% AFTER DEDUCTIBLE
SURGERY (INPATIENT OR OUTPATIENT) SEE ARTICLE 2, SECTION 4	85% AFTER DEDUCTIBLE	80% AFTER DEDUCTIBLE	60% AFTER DEDUCTIBLE
WELL-CARE IN PHYSICIANS OFFICE SEE ARTICLE 2, SECTION 25	$10 CO-PAY	$10 CO-PAY	$20 CO-PAY
CHIROPRACTIC CARE (EXCLUDING X-RAYS & LAB CHARGES) SEE ARTICLE 2, SECTION 7	85% AFTER DEDUCTIBLE $600 CALENDAR YEAR MAXIMUM PAID BENEFIT	80% AFTER DEDUCTIBLE $600 CALENDAR YEAR MAXIMUM PAID BENEFIT	60% AFTER DEDUCTIBLE $600 CALENDAR YEAR MAXIMUM PAID BENEFIT
MATERNITY(FEMALE EMPLOYEE & ELIGIBLE DEPENDENT SPOUSE) SEE ARTICLE 2, SECTION 13	85% AFTER DEDUCTIBLE	80% AFTER DEDUCTIBLE	60% AFTER DEDUCTIBLE
TEMPOROMANDIBULAR JOINT SYNDROME(TMJ) SEE ARTICLE 2, SECTION 24	85% AFTER DEDUCTIBLE $2,000 LIFETIME MAXIMUM	80% AFTER DEDUCTIBLE $2,000 LIFETIME MAXIMUM	60% AFTER DEDUCTIBLE $2,000 LIFETIME MAXIMUM

BENEFITS	TIER 1 HEALTHLINK CONTRACTED PROVIDER	TIER 2 HEALTHLINK CONTRACTED PROVIDER	TIER 3 OUT-OF-NETWORK PROVIDER
PHYSICAL/OCCUPATIONAL/ SPEECH THERAPY SEE ARTICLE 2, SECTIONS 22 & 23	85% AFTER DEDUCTIBLE 50 VISITS PER CALENDAR YEAR COMBINED	80% AFTER DEDUCTIBLE 50 VISITS PER CALENDAR YEAR COMBINED	60% AFTER DEDUCTIBLE 50 VISITS PER CALENDAR YEAR COMBINED
ORGAN/TISSUE TRANSPLANTS(DONOR CHARGES NOT COVERED) SEE ARTICLE 2, SECTION 17	85% AFTER DEDUCTIBLE	80% AFTER DEDUCTIBLE	60% AFTER DEDUCTIBLE
DURABLE MEDICAL EQUIPMENT SEE ARTICLE 2, SECTION 9	85% AFTER DEDUCTIBLE RENTAL UP TO PURCHASE PRICE	80% AFTER DEDUCTIBLE RENTAL UP TO PURCHASE PRICE	60% AFTER DEDUCTIBLE RENTAL UP TO PURCHASE PRICE
WHEELCHAIRS SEE ARTICLE 2, SECTION 23	50% AFTER DEDUCTIBLE RENTAL UP TO PURCHASE PRICE $1,000 PER WHEELCHAIR MAXIMUM BENEFIT	50% AFTER DEDUCTIBLE RENTAL UP TO PURCHASE PRICE $1,000 PER WHEELCHAIR MAXIMUM BENEFIT	50% AFTER DEDUCTIBLE RENTAL UP TO PURCHASE PRICE $1,000 PER WHEELCHAIR MAXIMUM BENEFIT
CONVALESCENT/SKILLED NURSING FACILITY CARE SEE ARTICLE 2, SECTION 8	85% AFTER DEDUCTIBLE 30 DAYS PER CALENDAR YEAR	80% AFTER DEDUCTIBLE 30 DAYS PER CALENDAR YEAR	60% AFTER DEDUCTIBLE 30 DAYS PER CALENDAR YEAR
HOME HEALTH CARE 4 HOURS = 1 VISIT SEE ARTICLE 2, SECTION 12	85% AFTER DEDUCTIBLE 100 VISITS PER CALENDAR YEAR	80% AFTER DEDUCTIBLE 100 VISITS PER CALENDAR YEAR	60% AFTER DEDUCTIBLE 100 VISITS PER CALENDAR YEAR
HOSPICE SEE ARTICLE 2, SECTION 12	85% AFTER DEDUCTIBLE 185 DAYS ANNUAL MAXIMUM	80% AFTER DEDUCTIBLE 185 DAYS ANNUAL MAXIMUM	60% AFTER DEDUCTIBLE 185 DAYS ANNUAL MAXIMUM
SLEEP STUDY SEE ARTICLE 2, SECTION 20	85% AFTER DEDUCTIBLE 1 PER LIFETIME	80% AFTER DEDUCTIBLE 1 PER LIFETIME	60% AFTER DEDUCTIBLE 1 PER LIFETIME

HEARING PROGRAM MUST USE PROVIDERS ON PROVIDER LIST SEE ARTICLE 2, SECTION 10	NO DEDUCTIBLE – ONCE EVERY FIVE YEARS EVALUATION $60 RESTOCKING $100 $500 PER DEVICE/EAR

SMOKING CESSATION PROGRAM SEE ARTICLE 2, SECTION 21	80% NO DEDUCTIBLE – OVER THE COUNTER 6 MONTH LIFETIME

VISION BENEFITS SEE ARTICLE 2, SECTION 26	100% NO DEDUCTIBLE - $200 PER CALENDAR YEAR/PER PERSON INCLUDES EYE EXAM, LENSES, FRAMES, AND/OR CONTACTS PEDIATRIC VISION CARE INCLUDES ONE ROUTINE EYE EXAM EACH PLAN YEAR. UP TO AGE 19. STANDARD FRAMES, LENSES, AND CONTACTS ARE COVERED TO A MAXIMUM OF $150. LOST OR BROKEN FRAMES AND LENSES ARE NOT COVERED. **WAL-MART IS NOT A COVERED VISION PROVIDER**

DENTAL BENEFITS – SEE ARTICLE 2, SECTION 27	
DEDUCTIBLE	$50 FOR CATEGORIES B,C,D OR ANY COMBINATION THEREOF
PERCENTAGE PAYABLE	80% CATEGORIES A & B 50% CATEGORIES C & D
MAXIMUMS	$1,000 PER PERSON/PER CALENDAR YEAR CATEGORIES A,B, & C (combined) $1,000 LIFETIME MAXIMUM CATEGORY D (Eligible dependents age 6-18)

	PEDIATRIC ORAL CARE INCLUDES ORAL EXAMS AND CLEANINGS EVERY CONSECUTIVE SIX MONTHS UP TO AGE 19. PEDIATRIC ORAL CARE IS NOT SUBJECT TO THE ANNUAL BENEFIT MAXIMUM. ALL OTHER DENTAL CARE IS SUBJECT TO THE MAXIMUM LIMITATIONS.

POLICY EXCLUSIONS & LIMITATIONS SEE ARTICLE 8

DEATH BENEFITS **(not available to COBRA participants)** SEE ARTICLE 2, SECTION 28	EMPLOYEE - $12,000 The amount of death benefit will be reduced as shown below: 1. Upon attaining age 65 to 65% of death benefit 2. Upon attaining age 70 to 45% of death benefit 3. Upon attaining age 75 to 30% of death benefit

PHARMACY BENEFITS	LDI 3 TIER FORMULARY	ANY OTHER STORE
RETAIL (LDI) 30 DAY SUPPLY INITIAL PRESCRIPTION & TWO REFILLS SEE ARTICLE 2, SECTION 8	$5.00 PER PRESCRIPTION GENERIC $20.00 PER PRESCRIPTION FORMULARY $35.00 PER PRESCRIPTION NON-FORMULARY	NONE
MAIL ORDER (LDI) **MAINTENANCE MEDICATIONS** 90 DAY SUPPLY SEE ARTICLE 2, SECTION 18	$10.00 PER PRESCRIPTION GENERIC $40.00 PER PRESCRIPTION FORMULARY $70.00 PER PRESCRIPTION NON-FORMULARY	NONE
SPECIALTY MEDICATIONS & BIO-INJECTABLES OBTAINED THRU LDI PHARMACY OR MAIL ORDER SEE ARTICLE 2, SECTION 19 & ARTICLE 9, SECTION 47	$100 CO-PAY	NONE
SPECIALTY MEDICATIONS & BIO-INJECTABLES PROVIDED BY AND/OR ADMINISTERED BY PHYSICIAN OR AT A FACILITY SEE ARTICLE 2, SECTION 19 & ARTICLE 9, SECTION 47	$100 CO-PAY REMAINING LDI DISCOUNTED AMOUNT SUBJECT TO PLAN'S REGULAR CALENDAR YEAR DEDUCTIBLE AND CO-INSURANCE	NONE

WAL-MART IS NOT A COVERED PROVIDER OF PRESCRIPTION BENEFITS

SEE ARTICLE 2, SECTION 18 FOR A LIST OF COVERED/NON-COVERED DRUGS

FOR ALL PRESCRIPTIONS OBTAINED THRU DRUG CARD PROGRAM WITH LDI, THE FIRST $10,000 OF PHARMACY BENEFIT EACH CALENDAR YEAR IS SUBJECT TO THE CO-PAYS LISTED ABOVE. FOR PRESCRIPTIONS ABOVE THE FIRST $10,000 OF BENEFIT, YOU WILL BE SUBJECT TO 50% CO-INSURANCE FOR THE REMAINDER OF THE CALENDAR YEAR. THIS DOES NOT INCLUDE BIO-INJECTABLE OR SPECIALTY MEDICATIONS OBTAINED THRU THE DRUG PROGRAM

MANDATORY GENERIC SUBSTITUTION – IF GENERIC IS AVAILABLE AND BRAND NAME IS DISPENSED MEMBER PAYS BRAND CO-PAY PLUS COST DIFFERENTIAL

WHENEVER THERE IS A NEED FOR BIO-INJECTABLE OR SPECIALTY MEDICATION, CONTACT LDI AT 1-866-516-4121 OR FUND OFFICE AT 1-618-734-0773

FIRST DIALYSIS TREATMENT OF EACH MONTH THAT INCLUDES BIO-INJECTABLE OR SPECIALTY MEDICATION WILL BE SUBJECT TO $100 CO-PAY

CANCER RELATED DRUGS ARE EXCLUDED FROM THE BIO-INJECTABLE OR SPECIALTY MEDICATION $100 CO-PAY

MENTAL HEALTH SUBSTANCE ABUSE	TIER 1 – HEALTHLINK CONTRACTED PROVIDER PERSPECTIVES/MAP CERTIFIED	TIER 2 – HEALTHLINK CONTRACTED PROVIDER PERSPECTIVES/MAP CERTIFIED	PERSPECTIVES/MAP
HOSPITAL/FACILITY IN-PATIENT OR OUT-PATIENT SEE ARTICLE 2, SECTION 14	80% AFTER DEDUCTIBLE	80% AFTER DEDUCTIBLE	NONE
PHYSICIANS OFFICE VISITS IN-PATIENT OR OUT-PATIENT SEE ARTICLE 2, SECTION 14	80% AFTER DEDUCTIBLE	80% AFTER DEDUCTIBLE	NONE
PRESCRIPTION DRUGS- PSYCHOTROPHIC DRUGS MUST BE CERTIFIED (APPROVED) BY PERSPECTIVES/MAP CAN BE OBTAINED RETAIL OR MAIL ORDER			
RETAIL (LDI) 30 DAY SUPPLY SEE ARTICLE 2, SECTION 14	$5.00 PER PRESCRIPTION GENERIC $20.00 PER PRESCRIPTION FORMULARY $35.00 PER PRESCRIPTION NON-FORMULARY	$5.00 PER PRESCRIPTION GENERIC $20.00 PER PRESCRIPTION FORMULARY $35.00 PER PRESCRIPTION NON-FORMULARY	NONE
MAIL ORDER (LDI) MAINTENANCE DRUGS 90 DAY SUPPLY SEE ARTICLE 2, SECTION 14	$10.00 PER PRESCRIPTION GENERIC $40.00 PER PRESCRIPTION FORMULARY $70.00 PER PRESCRIPTION NON-FORMULARY	$10.00 PER PRESCRIPTION GENERIC $40.00 PER PRESCRIPTION FORMULARY $70.00 PER PRESCRIPTION NON-FORMULARY	NONE
MANDATORY GENERIC SUBSTITUTION – IF GENERIC IS AVAILABLE AND BRAND IS DISPENSED MEMBER PAYS CO-PAY PLUS COST DIFFERENTIAL **WAL-MART IS NOT A COVERED PROVIDER OF PRESCRIPTION DRUGS**			

ARTICLE 2 - SUMMARY OF BENEFITS

SECTION 1

Medical Benefits -

Active Members - $250,000 Annual Major Medical Max with a $1,000,000 Lifetime Max
Retired Members - $100,000 Annual Major Medical Max with a $500,000 Lifetime Max*

***If at the time of retirement, a participant or any of his eligible dependents has exceeded the $500,000 overall Retiree Lifetime Maximum, this participant will be granted an additional $100,000 within the calendar year of retirement. No further medical benefits are available thereafter.**

SECTION 2

PREFERRED PROVIDER ORGANIZATION (PPO)
The Trustees have entered into a contract with a Preferred Provider Organization to provide comprehensive medical services at discounted rates. The current PPO is HealthLink. An eligible person can choose any covered provider. However, if a provider in the PPO network is used, the Plan will pay a higher percentage (80%) of the covered charges. See Article 6 for important information about Preferred Provider Organizations and Utilization Review.

It is the patient's responsibility to verify the current PPO status of the provider of service. Call the PPO network direct at 1-800-624-2356or visit their web-site at www.healthlink.com .

BENEFITS WILL BE REDUCED BY $500 FOR FAILURE TO PRE-CERTIFY ANY INPATIENT HOSPITAL ADMISSION, EXCEPT AS NOTED BELOW (SEE ARTICLE 6, SECTION 1).

HOSPITAL ADMISSIONS MUST BE PRE-CERTIFIED WHETHER YOU USE IN-NETWORK OR OUT-OF-NETWORK PROVIDERS.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996
HEALTH PLANS AND INSURANCE ISSUERS MAY NOT RESTRICT A MOTHERS' OR NEWBORNS' BENEFITS OR A HOSPITAL LENGTH OF STAY THAT IS IN CONNECTION WITH CHILDBIRTH TO LESS THAN 48 HOURS FOR A NORMAL VAGINAL DELIVERY OR 96 HOURS FOLLOWING A DELIVERY BY CAESAREAN SECTION.

SECTION 3

CALENDAR YEAR DEDUCTIBLE:	In PPO Network	$ 500 per person 3 individual deductibles per family
	Out of Network	$ 1,000 per person 3 individual deductibles per family

Any covered charges incurred toward the deductible in the last three months of a calendar year may be carried over and combined with subsequent covered charges to satisfy the deductible for the following year.

SECTION 4

PERCENTAGE PAYABLE:	In PPO Network	80% of eligible discounted charges
	Out of Network*	60% of eligible reasonable/customary
	Out of Area**	80% of eligible reasonable/customary

*NOTE 1: Out-of-Network expenses negotiated by a Case Manager are eligible under the plan at the in-network level. Wrap Around - If a member utilizes a PPO facility and PPO physician and PPO surgeon, then charges incurred by a non-PPO anesthesiologist or radiologist or pathologist or assistant surgeon will be paid at PPO level. As of 7/1/05 , if a member utilizes a PPO emergency room - charges incurred by a non-PPO physician will be paid at the PPO level.

** NOTE 2: Out-of-Area coverage will be available for emergency care needed for those members/dependents traveling for business or pleasure out of the PPO network area or those full-time students attending school out of the PPO area or eligible children living outside the PPO area and for which the member is required to provide insurance coverage. The out of network deductible will apply. The coinsurance percentage will be 80/20. The out of network out-of-pocket maximum will apply. Also subject to emergency room co-pay.

SECTION 5

OUT-OF-POCKET MAXIMUM: (in addition to deductible)	In PPO Network	$2,000 per person $6,000 per family unit
	Out of Network	$3,500 per person $10,500 per family unit

SECTION 6

EMERGENCY ROOM:	In PPO Network	80% after deductible ***Plus*** $150 per occurrence co-pay For non-accident claim*
	Out of Network	60% after deductible ***Plus*** $150 per occurrence co-pay For non-accident claim*

* Co-pay will waived if patient is admitted or in the case of a true accident.

SECTION 7

CHIROPRACTIC BENEFITS:	In PPO Network	Subject to calendar year deductible 80% up to a maximum payment of $600 per person, per calendar year
	Out of Network	Subject to calendar year deductible 60% up to a maximum payment of $600 per person, per calendar year

SECTION 8

CONVALESCENT/ SKILLED NURSING FACILITY CARE

Benefits are limited to 30 days per individual, per calendar year, and care is limited to a total of 60 days per lifetime for the same or related cause. Charges incurred for care provided in a skilled nursing facility or through a home health agency for the treatment of alcoholism, drug addiction, chemical dependency and mental illness are **not** covered.

Convalescent/skilled nursing facility is a legally operating institution or a distinct part of one which:

1. Is supervised by a resident physician or resident registered graduate nurse;
2. Requires that health care of each patient be under the supervision of a physician;
3. Requires that a physician be available to furnish necessary medical care in emergencies;
4. Provides 24-hour nursing services;
5. Is approved or qualified to receive approval for Medicare benefits; and
6. Keeps clinical records on all patients.

Covered charges made by a convalescent facility immediately following a hospital confinement and starting within 7 days after the confinement will include:

1. Room/board not to exceed 50% of the semi-private room rate of the hospital of prior confinement;
2. General nursing care; and
3. Medical services and supplies.

SECTION 9

DURABLE MEDICAL EQUIPMENT

Benefits will be payable for the rental (up to the purchase price) of hospital-type bed, iron lung, kidney dialysis equipment, or other durable medical equipment which meets all of the following tests:

1. Can withstand repeated use;
2. Is mainly used for a medical purpose;
3. Is not useful except to treat sickness/injury; and
4. Is essential for a treatment plan that is medically reviewed on a regular basis.
5. $5,000 per lifetime for purchase/rental of wheelchair, paid at 50%.

SECTION 10

HEARING BENEFIT

For eligible members and their eligible dependents:

A routine hearing evaluation in connection with the possible placement of a hearing device will be allowed under the Plan. The maximum payment for all services will be:

...$60 for hearing evaluation
...$100 restocking fee (in event member is not satisfied)
...$500 per device/ear

This benefit is not subject to the calendar year deductible and is paid at 100% up to the above maximum once every (5) years. Benefits will be assigned.

IN ORDER TO RECEIVE THIS BENEFIT, THE PARTICIPANT MUST RECEIVE SERVICES FROM A PARTICIPATING PROVIDER IN THE HEARING CARE NETWORK. CONTACT THE FUND OFFICE FOR THE LIST OF PARTICIPATING PROVIDERS.

SECTION 11

HOME HEALTH CARE

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

1. Is operated mainly for the purpose of providing skilled nursing care and therapeutic services in a covered person's home for the treatment of sickness or injury;
2. Maintains clinical records on each patient;
3. Services provided to a covered person are under the direction of a physician;
4. Has at least one supervisory registered nurse on its staff; and
5. Has an administrator.

Charges made by a home health care agency for care in accordance with the home health care plan must meet the following criteria:

1. The care must start within 7 days following the end of a hospital stay as a bed-patient;
2. The attending physician must establish the treatment plan in writing and the treatment plan must be approved prior to commencement of services; and the treatment plan must be certified every 60 days;
3. The care must be provided for the same or a related injury or illness which caused the hospital stay;
4. Each 4 hours of service by a home health care aide equals one visit. Each visit by any other member of the home health agency equals one visit within a 24-hour period; and
5. The amount payable for all such services and supplies will not exceed the amount that is shown under the maximum payment.

Home health care expenses will include:

1. Part-time nursing care by or under the supervision of a registered nurse or licensed practical nurse if registered nurse is not available;
2. Part-time home health aide services;
3. Inhalation, physical, occupational or speech therapy provided by the home health care agency;
4. Medical supplies prescribed by a physician and laboratory services by or on behalf of a hospital; and
5. Nutrition services, including special meals.

The maximum payment is limited to 100 visits per person/per calendar year.
Home health charges **will not** be covered for care provided in a skilled nursing facility or through a home health agency for the treatment of alcoholism, drug addiction, chemical dependency, and/or mental illness.

SECTION 12

HOSPICE CARE

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

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

1. Charges for room and board and general nursing in a freestanding or hospital hospice;
2. Charges for emotional support services provided in counseling sessions with the patient; and
3. Nutrition services, including special meals.

Care is limited to 185 days per person/lifetime.

SECTION 13

MATERNITY BENEFITS - Female Employee and Eligible Dependent Spouse Only

Maternity Benefit coverage of at least 48 hours of inpatient care after normal childbirth and 96 hours after a Caesarean section delivery. Shorter stays are permissible, if the attending physician consents to the shorter stay and after consultation with the mother and provided notification is given to both the Fund Office and HealthLink. In which case the Plan will allow two post-discharge visits; at least one of the visits will be provided at home.

Maternity Limitations

1. The female employee or dependent spouse must be eligible for benefits at the time of delivery;
2. One amniocentesis will be allowed per pregnancy for the following reasons:
   A. Mother's blood type is Rh negative;
   B. In late pregnancy to determine maturity of lungs of fetus; or
   C. If baby is post mature, to determine if needs of fetus are being adequately met in utero or if Caesarean section is necessary;
3. Benefits will be payable for one ultrasound during a normal pregnancy; and
4. Benefits will be payable for hospital room and board expenses only for a newborn child during the period that the mother is confined as a result of giving birth to the child. (See Article 3 for eligibility and enrollment information)

Benefits **will not** be payable for:

1. An elective abortion, but will be payable for any complication which is the result of an elective abortion. Elective abortion means any other than one where the mother's life would be endangered if the fetus were carried to term;
2. Any expense or charge for the promotion of fertility, including (but not limited to) fertility tests, hormone therapy, artificial insemination, in vitro fertilization and embryo transfer; and
3. Genetic counseling (including genetic amniocentesis and chronic villus sampling).

SECTION 14

MENTAL HEALTH and/or SUBSTANCE ABUSE TREATMENT

A Member Assistance Program (MAP) is provided for access to mental health and/or substance abuse treatment. To be eligible for benefits, you must call the MAP service provider(Perspectives) before any non-emergency treatment is provided, and within 24-hours of an emergency hospital admission. The MAP's(Perspectives) toll-free telephone number, 1-800-456-6327, is listed on the back of your identification card.

The Member Assistance Program or "MAP"(Perspectives) will be the ***only access*** to cover mental health and/or substance abuse treatment for plan participants.

Eligible plan participants (members and eligible dependents) can call the MAP during regular business hours to schedule an appointment with a counselor. For emergencies members can call the MAP 24 hours a day, 7 days a week, 365 days a year at 1-800-456-6327 to speak with a crisis counselor. The MAP counselors are available to provide professional and confidential assistance for various types of issues for up to 5 in-person sessions, such as:

Problem drinking and DWIs
Illegal drug use
Drug testing concerns
Prescription drug misuse
Stress and anxiety
Depression or mood swings
Managing anger
Loss of a loved one
Disability adjustment
Jobsite conflicts
Sexual harassment
Family/Parent-child conflicts
Serious illness of family member
Aging parents
Single parents
Child care
Separation/Divorce
Communication problems
Pre-retirement concerns
Legal issues
Household finances
Over-extended credit

In addition, the MAP will serve as your "gateway" to all mental health and/or substance abuse treatment. They will do this by arranging to meet privately with you at a convenient local office and discuss your concerns. The MAP may then schedule you for additional counseling with the MAP counselor for up to four additional sessions. If mental health or substance abuse treatment is warranted, the MAP will identify the best possible treatment provider to refer you to.

ALL MENTAL HEALTH AND/OR SUBSTANCE ABUSE TREATMENT, EITHER INPATIENT OR OUTPATIENT, MUST BE PRE-CERTIFIED BY THE MAP OR CLAIMS WILL NOT BE PAID BY THE FUND. IN THE CASE OF EMERGENCY MENTAL HEALTH AND/OR SUBSTANCE ABUSE HOSPITALIZATION, CONTACT WITH THE MAP MUST OCCUR IN FIRST 24 HOURS OF TREATMENT OR THE CLAIM WILL BE DENIED.

Mental Health and/or Substance Abuse
All care, including prescriptions drugs, must be pre-certified by the Perspectives/MAP.

HOSPITAL EXPENSES

In-patient Hospital Facility	MAP certified	Subject to PPO deductible paid at 80%
	Not MAP certified	Not covered

Limits:

30 days in-patient care per calendar year or 60 days out-patient partial hospitalization care
(1 in-patient = 2 out-patient)
All care and treatment of substance abuse is further limited to a maximum lifetime payment of $50,000 whether in-patient or out-patient or any combination of charges.

In-patient Physician Visits	Map certified	Subject to PPO deductible paid at 80%
	Not MAP certified	Not covered

OUT-PATIENT EXPENSES

Out-patient Hospital Facility	Map certified	Subject to PPO deductible paid at 80%
	Not MAP certified	Not covered

Limits:

30 days in-patient care per calendar year, or 60 days outpatient partial hospitalization care
(1 in-patient = 2 out-patient days)
All care and treatment of substance abuse is further limited to maximum lifetime payment of $50,000 whether in-patient or out-patient or any combination of charges.

Out-Patient Physician Office	MAP certified	Subject to PPO deductible paid at 80%
	Not MAP certified	Not covered

SECTION 15

MOUTH CONDITIONS
The Plan will pay for the following:
1. The dentist's fee for removing fully or partially bony impacted wisdom teeth, including anesthesia;
2. Treatment of injuries to natural teeth sustained in an accident, but only to the extent that such treatment is received within six months after the accident;
3. Room and board, miscellaneous charges made by the hospital when treatment for dental care is documented as medically necessary prior to the services actually being rendered; and
4. Care/treatment of pain in the temporomandibular joint (TMJ) not associated with acute trauma, whether medical or dental in nature, up to a maximum lifetime payment of $2,000 per person.

The Major Medical coverage does **not** cover any confinement, treatments, care or service to diagnose, prevent or correct the following:
1. Periodontal disease (disease of the surrounding and supplemental tissue of the teeth);
2. Deformities of the bone/jaw surrounding the teeth;
3. Malocclusion (abnormal positional and/or relationship of the teeth);
4. Ailments or defects of the teeth and supporting tissues and bone/jaw (excluding appliances used to close an acquired or congenital opening); or
5. Tooth extractions or other dental care or surgery, except as outlined under Mouth Conditions.

SECTION 16

MULTIPLE SURGICAL PROCEDURES
If during a single surgical setting, two or more operations are performed, covered charges for the services of the physician for each procedure that is clearly identified and defined as a separate procedure will be based on:
1. 100% of reasonable and customary charges for the first or primary operation;
2. 50% of reasonable and customary charges for the second operation; and
3. 25% of reasonable and customary charges for each of the other operations.

SECTION 17

ORGAN TRANSPLANT

Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

1. The transplant must be performed to replace an organ or tissue.
2. There is no coverage under the Plan for charges incurred in obtaining donor organs or tissues. This includes charges for:
   A. Evaluation of the organ or tissue;
   B. Removing the organ or tissue from the donor; and
   C. Transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

SECTION 18

PRESCRIPTION DRUG CARD PROGRAM

3 tier Formulary Plan - Retail - LDI; Mail Order - LDI
Web-site www.ldipbm.com

Retail at LDI Pharmacy - 30 day supply - Initial prescription and 2 refills

Participant co-pay:
$ 5.00 per prescription generic
$20.00 per prescription formulary
$35.00 per prescription non-formulary

Mail Order at LDI - 90 day supply

Participant co-pay:
$10.00 per prescription generic
$40.00 per prescription formulary
$70.00 per prescription non-formulary

RETAIL DRUGS FROM OUT-OF-NETWORK PHARMACY ARE NOT CONSIDERED AN ELIGIBLE EXPENSE UNDER THE MEDICAL PLAN.

WAL-MART IS NOT A COVERED PROVIDER OF PRESCRIPTION DRUGS.

$10,000 ANNUAL MAX ON ALL PRESCRIPTIONS OBTAINED THRU DRUG CARD PROGRAM WITH LDI. THIS DOES NOT INCLUDE BIO-INJECTABLE OR SPECIALTY MEDICATIONS OBTAINED THRU THE DRUG CARD PROGRAM.

MANDATORY GENERIC SUBSTITUTION - IF GENERIC IS AVAILABLE AND BRAND DISPENSED MEMBER PAYS BRAND CO-PAY PLUS COST DIFFERENTIAL.

PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS WILL BE COVERED ONLY IF THE TREATMENT PROVIDED BY THE PRESCRIBING PHYSICIAN/PROVIDER IS AUTHORIZED THROUGH THE MEMBER ASSISTANCE PROGRAM/PERSPECTIVES (MAP). THESE PRESCRIPTIONS (IF APPROVED BY MAP) MAY BE OBTAINED RETAIL OR MAIL ORDER.

MANDATORY MAIL ORDER

A prescription can be filled at the retail pharmacy for maintenance medication three times (the initial prescription plus two (2) refills). After the second refill, all other prescriptions of this medication must be obtained through mail order. Additional refills at a retail pharmacy will not be covered.

COVERED PRESCRIPTION ITEMS:

Federal legend drugs
Compounded prescriptions
Needles and Syringes
Prenatal vitamins - maternity
Imitrex
Diabetic supplies
State restricted drugs
Insulin on prescriptions
Immune altering drugs
Bee sting kits
Imitrex auto injector
Nicotine cessation products (except over-the-counter and transdermal patches)
Federal legal oral, implanted or injectable contraceptives

NON-COVERED PRESCRIPTION ITEMS:

Items lawfully obtained without prescription
Allergy serums
Injectables - See Prior Authorization
Federal legend vitamins
Ostomy Supplies and Products
Fertility Drugs
Rogaine
Diet Medications
Devices and Applications - unless otherwise stated as covered
Growth hormone drugs - See Prior Authorization
Viagra or any sexual dysfunction drugs
Prescriptions covered without charge under the Federal, State or local programs, to include Worker's Compensation
Any charge for the administration of a drug or insulin
Investigational or experimental drugs
Unauthorized refills
Immunization agents, biological sera, blood plasma
Medication for an eligible member/dependent confined to a rest, nursing home, sanitarium, extended care facility, hospital or similar entity
Any charge above the usual and customary, advertised or posted price, whichever is less than the scheduled amount.

PRIOR AUTHORIZATION

Medical necessity must be determined and prior written authorization must be obtained before dispensing of these drugs–
Retin A - over age 25
Accutane - over age 25
Growth Hormones
All Mental Health drugs (Must be certified(approved) by Perspectives/MAP)
Injectables (other than insulin and allergy) and genetically engineered drugs unless otherwise stated as covered
Lupron
Beta Seron
Epogen
Enbrel
Rebetron
Referon-A
Alferon-A
Intron-A
Avonex
Copaxone

SECTION 19

SPECIALTY MEDICATIONS & BIO-INJECTABLES

Effective April 1, 2005, the Plan instituted a Specialty Medication Bio-Injectable Program. Coverage for prescription drugs at discounted rates is provided through LDI Pharmacy, the Drug Benefit Service Manager for the Fund.

This program is for those participants with specific chronic or rare diseases requiring bio-injectable or specialty drugs.

The bio-injectable and specialty drug program utilizes LDI's Case Management services to help those participants receive the proper therapies and correct education to assist in improving their quality of life. Because most of these medications can be given either in your Doctor's office or obtained from a pharmacy and self-administered, the creation of this new benefit will consolidate the delivery of these medications. Your Specialty coordinator and assigned case manager will help guide you through the process to fill your medication.

How will these bio-injectable and specialty drug charges be paid —

1. The LDI allowed amount is subject to a separate co-payment of $100 per script. This $100 co-payment does not accumulate to the plan's regular out-of-pocket maximum.
2. The remaining charge (LDI discounted amount) is subject to the plan's regular calendar year deductible and co-insurance, if not previously met.
3. Then the remaining amount is paid at the appropriate co-insurance level.
4. The amount that is payable will accumulate to the plan's overall lifetime and/or calendar year maximum benefit.
5. Cancer related drugs are excluded from the $100 co-pay.
6. The first dialysis treatment each month, that includes bio-injectable or specialty medications, will be subject to a $100 co-pay.

In those few cases where a bio-injectable or specialty medication is needed right away, your doctor can administer the medication and then before the next dose have your doctor contact the Fund Office so an LDI case coordinator can make the proper arrangements to provide the medication.

MEDICATIONS SUCH AS INSULIN AND INJECTABLE MIGRAINE THERAPY ARE EXCLUDED FROM THIS PROGRAM AND CAN BE PURCHASED AT YOUR LOCAL RETAIL PHARMACY OR THE LDI MAIL SERVICE

See the Grid Sheet (page 3) for co-payment that is effective April 1, 2005 and how these drugs are paid. Any questions on this program, please contact the Fund Office 1-800-327-4532 or 1-618-734-0773, extension 17, or you can contact LDI's Specialty Pharmacy Services at 1-866-516-4121. **Website**

SECTION 20

SLEEP STUDY

Charges in connection with one (1) sleep study in the participant's lifetime.

SECTION 21

SMOKING CESSATION COVERAGE

For information on smoking cessation programs and initiatives, contact the Fund Office at 1-800-327-4532 or 1-618-734-0773.

Nicotine Replacement Therapy - One course of treatment per person lifetime; maximum six months; cash register receipt required and should be mailed direct to the Fund Office.

SECTION 22

SPEECH THERAPY
The Plan provides benefits for speech therapy when rendered by a qualified speech therapist to restore speech loss or correct an impairment which was due to:
1. A congenital defect for which corrective surgery has been performed; or
2. An accidental injury or sickness (except a mental, psychoneurotic or personality disorder).

Covered speech therapy expenses are limited to the lessor of:
1. The doctor's charges; or
2. $50 per session, limited to 50 sessions per calendar year, subject to the deductible and co-insurance.

Speech therapy expense **will not** be covered:
1. Behavioral problems, developmental speech problems or in connection with or treatment of remedial reading, special education, self-care/self-help training, or supplies used in connection with such treatment; or
2. Therapy provided by a therapist who is the claimant or a relative of the claimant to the following degree: parent, spouse of parent, spouse, child, spouse of child, or parent or child of spouse.

SECTION 23

PHYSICAL/OCCUPATIONAL THERAPY
Charges for Physical/Occupational Therapy are limited to 40 visits per calendar year.

SECTION 24

TMJ (TEMPOROMANDIBULAR JOINT) DYSFUNCTION
A jaw/joint disorder causing pain, swelling, clicking and difficulties in opening and closing the mouth; and complications including arthritis, dislocation and bite problems of the jaw. Treatment includes any services, not associated with acute trauma, rendered to the teeth, jaw or jaw joints, head bones, nerves and muscles of the face, head, neck and back to alleviate pain attributed to a dysfunction of the jaw joint and/or associated structures including nerves and chewing muscles; and treatment performed for the purpose of diagnosis or prevention for the conditions above including orofacial muscle disorders and/or facial-cranial pain syndromes.
$2,000 per lifetime will be covered for the care/treatment of pain in the temporomandibular joint (TMJ), not associated with acute trauma, whether medical or dental in nature.

SECTION 25

WELLNESS BENEFIT - ANNUAL PREVENTIVE CARE
Maximum payment of $250 per eligible person, per calendar year. Charges in excess of the $250 maximum payment are not covered by the Plan.

Services must be rendered in a physician's office and are subject to a $10 co-pay if a PPO provider is utilized and $20 co-pay for a non-PPO provider. Ancillary services rendered in connection with a well-care visit are paid at 100% up to the maximum payment.

Benefits include, but are not limited to:
1. Medical exams not required for treatment of illness or injury;
2. Routine well baby care;
3. Immunizations; and
4. Routine physical examinations.

SECTION 26

VISION BENEFITS

The eligible participant and/or dependent will be reimbursed 100% of the amount incurred up to a maximum payment of $200 per year. This includes eye examinations, lenses, frames, and/or contact lenses.

WHAT IS NOT COVERED BY THE PLAN?

1. Medical or surgical treatment of the eyes; and
2. Services or materials provided as a result of any Workers Compensation law or similar legislation or obtained through or required by any government, agency or program whether federal, state or any subdivision thereof.

THERE IS NO COORDINATION OF BENEFITS FOR VISION

HOW TO OBTAIN VISION BENEFITS

When filing a vision claim submit an itemized bill to:

Southern Illinois Laborers' & Employers Health & Welfare Fund
Claims Department
2035 Washington Ave.
Cairo, IL 62914

SECTION 27

DENTAL BENEFITS

Covered dental expenses are the expenses incurred by covered individuals for charges made by a dentist for any dental service provided for in the schedule of dental benefits. The dental service must be performed by or under the direction of a dentist, essential for the necessary care of the teeth, and begin while the individual is covered for dental expenses.

Covered dental expenses **will not** include:

1. Any expenses incurred for a dental service completed after the individual's dental expense benefits are terminated; or
2. Any charges which exceed the reasonable and customary charge for dental service.

CLASSIFICATION OF DENTAL SERVICES

Dental calendar year deductible	$50 deductible per person per calendar year for Categories B, C, or D or any combination thereof
Dental percentage payable:	80% category A (Diagnostic/Preventive) 80% category B (Basic Restorative Endodontics/Periodontics **)** 50% category C (Major Restorative/Prosthodontics) 50% category D (Orthodontia)
Dental maximums:	$1000 per person per calendar year for categories A, B, & C $1000 per person per lifetime for category D (ages 6-18)

Category A -Diagnostic/Preventive

1. Routine examinations	Once in any period of six (6) consecutive months.
2. Teeth cleaning	Once in any period of six (6) consecutive months.
3. Space maintainers	To replace prematurely lost teeth for dependent children under age 19.
4. Topical fluoride/sealants application	Once in any period of twelve (12) consecutive months for dependent children under age 19.
5. Emergency treatment for temporary relief of pain	
6. Dental x-rays including full mouth	Once in any period of thirty-six (36) consecutive months.
7. Supplementary bitewing	Twice in any period of six (6) consecutive months.

Category B - Dental Services -Basic Restorative - Endodontics/Periodontics

1. Fillings	Amalgam, silicate, acrylic, synthetic porcelain or composite fillings.
2. Extractions and Oral Surgery	
3. General Anesthetics	When medically necessary and administered in connection with oral or dental surgery.
4. Periodontal treatment of gums	
5. Endodontic treatment of the dental pulp, including root canal therapy.	
6. Drugs for treatment of dental disease/injury when administered by the attending dentist.	

Category C -Major Restorative/Prosthodontics

1. Repair or recementing of crowns, inlays, onlays, bridgework, or dentures	No earlier than (6) months after the installation.
2. Relining or rebasing dentures	When performed more than six (6) months after the installation, but not more than once in twenty-four (24) months.
3. Inlays, onlays, gold fillings or crown restoration	Only when the tooth cannot be restored with type of fillings described above.
4. Prosthodontics Initial installation of fixed bridgework (including inlays and crowns as abutments or removable dentures).	Includes attachments and adjustments during the six months following installation.
5. Replacement of or addition to existing bridgework or dentures	Only if the replacement of a bridge or denture is made more than five years after the date of original installation unless: (a) replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth; or (b) the bridge or denture, while in the oral cavity, has been damaged beyond repair by an injury sustained while covered employee under dental plan; (c) the replacement of or addition to existing bridgework or denture or the initial bridgework or dentures is made after one year of continuous coverage for a new participant to the Fund.

Category D - Orthodontics

For those eligible dependent children age 6 who have not attained age 19.

DENTAL EXCLUSIONS AND LIMITATIONS

1. Expenses incurred solely for cosmetic reason will not be covered;
2. Covered dental expenses do not include and no benefits are provided for implants, oral hygiene instruction, broken appointments;
3. No payment will be made for procedures which are not included in the list of covered dental services of the North American Dental Association Procedures or which are not necessary; and
4. Charges for services or supplies which are not generally accepted by the dental profession and are, in the Trustees's judgment, experimental or investigational are not covered the by the Plan

HOW TO OBTAIN DENTAL BENEFITS

When filing a dental claim submit an itemized bill plus a paid receipt, if applicable. Mail to:

Southern Illinois Laborers' & Employers Health & Welfare Fund
Claims Department
2035 Washington Avenue
Cairo, IL 62914

SECTION 28

DEATH BENEFIT

SCHEDULE OF BENEFITS FOR ACTIVE EMPLOYEES ONLY

Death Benefits $12,000

THE AMOUNT OF DEATH BENEFIT WILL BE REDUCED AS SHOWN BELOW:
UPON ATTAINING AGE 65 TO 65% OF DEATH BENEFIT
UPON ATTAINING AGE 70 TO 45% OF DEATH BENEFIT
UPON ATTAINING AGE 75 TO 30% OF DEATH BENEFIT

Benefits are provided by Trustees of Southern Illinois Laborers' & Employers Health & Welfare Fund.

You may change your beneficiary any time, according to the terms of the group policy. The information on the most current enrollment card on file at the Fund Office will be used to determine your beneficiary.

If you are married, your eligible Spouse is automatically your Beneficiary. In order for your spouse to be an Eligible Spouse, you and your wife or husband must have been married continuously at the time of your death for at least 12 months.

If you wish to name someone other than your Eligible Spouse as your Beneficiary, your Eligible Spouse must consent in writing to your choice. This consent must be signed by your Spouse and witnessed by a notary public or by a representative of the Joint Board of Trustees.

If, at the time of your death, your designated Beneficiary is also deceased, your spouse becomes your Beneficiary. If your are not married or your spouse is deceased, then your dependent children become your Beneficiary, or if you have no dependent children, your estate becomes your Beneficiary,

If your Beneficiary survives you, but dies without receiving your entire Death Benefit the remaining balance is paid to the person selected by your Beneficiary, or if no one was named, to your Beneficiary's estate.

HOW TO OBTAIN DEATH BENEFITS

When filing a Death claim:

1. Secure and complete a claim form
2. Attach a certified copy (one with a raised seal) of the death certificate
3. Mail to:

Southern Illinois Laborers' & Employers Health & Welfare Fund
Claims Department
2035 Washington Ave.
Cairo, IL 62914

NOT AVAILABLE TO COBRA PARTICIPANTS

ARTICLE 3 - ELIGIBILITY/PARTICIPATION IN HEALTH CARE BENEFITS

SECTION 1

EMPLOYEE ENROLLMENT & ELIGIBILITY

Employees working for a contributing employer within the various jurisdiction of the Plan shall be eligible to receive benefits after meeting the following requirements:

1. Must be an employee or member of the Southern Illinois Laborers' or work for an employer who agrees to contribute to the Plan;
2. Required contributions for said person must have been paid by the employer for the qualifying period, and
3. Initial eligibility as set forth below must be met.

TO OBTAIN COVERAGE, YOU MUST FILL OUT THE ENROLLMENT CARD PROMPTLY AND SUBMIT MARRIAGE LICENSE, ADOPTION/ BIRTH RECORDS/CERTIFICATION OF LEGAL CUSTODY, IF APPLICABLE. AFTER COVERAGE BECOMES EFFECTIVE, IF THERE ARE ANY CHANGES SUCH AS MARITAL STATUS, NUMBER OF DEPENDENTS, BENEFICIARY OR CHANGE OF ADDRESS, YOU MUST FILL OUT A NEW ENROLLMENT CARD AND NOTIFY THE FUND OFFICE WITHIN 30 DAYS.

QUALIFYING PERIOD

Eligibility periods shall be broken up into contribution quarters (effective March 1997)

CONTRIBUTION QUARTER (WORK PERIOD)	ELIGIBILITY QUARTER (INSURANCE QUARTER)
AUGUST SEPTEMBER OCTOBER	JANUARY FEBRUARY MARCH
NOVEMBER DECEMBER JANUARY	APRIL MAY JUNE
FEBRUARY MARCH APRIL	JULY AUGUST SEPTEMBER
MAY JUNE JULY	OCTOBER NOVEMBER DECEMBER

INITIAL ELIGIBILITY

The member becomes eligible for benefits when he has worked for a contributing employer on whose behalf contributions have been received for at least;

1. 350 hours in a contribution quarter;
2. 500 hours in two contribution quarters;
3. 1,000 hours in four contribution quarters

Coverage would then become effective the following insurance quarter.

Once eligibility has been established, eligibility will continue as long as contributions meet the following requirements:

1. 350 hours for the preceding contributions quarter prior to the eligibility quarter;
2. 700 hours for the preceding two contribution quarters prior to the eligibility quarter;
3. 1,050 hours for the preceding three contribution quarter prior to the eligibility quarter;
4. 1,400 hours for the preceding four contribution quarters prior to the eligibility quarter;

ENROLLMENT DATE

First day of contribution quarter (work quarter) which qualifies a plan participant to coverage in an eligibility quarter (insurance quarter).

EFFECTIVE DATE OF COVERAGE

The effective date of coverage will be the first day of the eligibility quarter in which the Plan participant has qualified for benefits. Eligibility notices will be mailed to all qualified participants at their last known home address as shown on the Fund Office records.

SELF CONTRIBUTIONS

1. 350 hours in the current quarter
2. 700 hours in the preceding two quarters;
3. 1,050 hours in the preceding three quarters;
4. 1,400 hours in the preceding four quarters.

Which ever is the lesser amount at the current contribution rate.

Effective January 1, 2003, the self-contributions will be limited to four (4) consecutive quarters. Any participant who has made self contributions for four consecutive quarters will be allowed to continue their coverage through the Southern Illinois Laborers' & Employers Health & Welfare Fund by paying COBRA contributions. (Please refer to Article 5 in your SPD for info on COBRA rights).

If your have any questions concerning this, please do not hesitate to contact the Fund Office at 1-800-327-4532 or 1-618-734-0773.

IF A SELF CONTRIBUTION IS NOT PAID YOU MAY NOT MAKE ANOTHER CONTRIBUTION UNTIL YOU REQUALIFY FOR COVERAGE THROUGH HOURS WORKED

REINSTATEMENT OF ELIGIBILITY

If, after having once become eligible, a member loses his eligibility, his eligibility may be reestablished if he is available for work under the jurisdiction of the Fund and when contributions have been paid on his behalf with the required period as indicated below:

INELIGIBLE PERIOD	CONTRIBUTION HOURS	CONTRIBUTION QUARTER
Less than 12 months	350	3 month period
More than 1 year, but less than 2 years	350	6 month period
More than 2 years must again meet the initial eligibility	500 1,000	6 month period or 12 month period

NOTICES

As a courtesy to employees, direct contribution (self-payment) notices will be mailed to all qualified employees quarterly at the last known address shown on the Fund's records.

CREDITING OF HOURS

All non-collectible contributions may be credited for welfare purposes. Where it has not been determined by the delinquency committee that the hours are non-collectible, the following procedures would be applicable;

1. When written request from the member for crediting of hours is received by the Fund Office the Fund Office will verify that hours worked were in covered employment which is due the Fund.
2. The request, along with supporting documentation (where applicable) will be taken to the delinquency committee meeting. These requests would result from an adverse occurrence such as a loss of eligibility.
3. The Trustees will determine the likelihood of collecting and impact on participants' welfare eligibility/benefits.
4. If approved by the committee, the participant will be notified via mail that for welfare purposes he will be completely or partially eligible for benefits or that he may make a self payment. The correspondence will also indicate that further employment with the same employer will result in coverage being provided by the Fund only as a result of proper payment of the required contributions by the employers. *No unpaid annuity or vacation fund contributions will be credited.* The local union and District Council will be notified that any further employment with this employer, for any employees, may result in coverage being provided by the Fund only upon receipt of the proper contributions.

SECTION 2

TERMINATION OF EMPLOYEE COVERAGE

The coverage of any participant with respect to himself shall automatically terminate at the earliest time indicated below:

1. The date the employee ceases active work on a full-time basis, or ceases to belong to a class eligible for coverage or both; or
2. The date of expiration of the period for which the participant last makes the required contribution, if the participant's coverage is contributory; or
3. The date the employee enters military service; or
4. The date the Plan terminates.

SECTION 3

DEPENDENT ELIGIBILITY

Eligible dependents shall include:

1. The spouse of the covered employee;
2. The covered employee's unmarried children, to age 19;
3. Unmarried children who are 19 to 23 years of age, if wholly dependent upon the employee for support and maintenance and a full-time student in an accredited school. The dependent child who is over age 19 and under the age of 23 and previously lost coverage as a full-time student under a group health plan due to no longer meeting the plan requirement of a student, the child may re-enroll as a covered dependent once the full-time student requirements are met, however, pre-existing limitations may apply.

PROOF OF ENROLLMENT AS A FULL-TIME STUDENT IN AN EDUCATIONAL INSTITUTION MUST BE FURNISHED EACH SEMESTER FOR CHILDREN 19 TO 23.

4. Legally adopted children (including those for whom adoption proceedings have been initiated and the child has been placed in the home), stepchildren, or children for whom the participant has been appointed permanent legal guardian by the courts providing such children are dependent upon the covered employee person for support and maintenance;
5. Children of a non-custodial parent employee if there is a Qualified Medical Child Support Order (QMCSO) from a domestic relations court. A QMCSO is any court judgment, decree, or other court approved settlement agreement that creates or recognizes the right of an alternate recipient (i.e., the child) to be enrolled under the group health plan. The QMCSO must include the name and address of the participant and child, a reasonable description of the type of coverage to be provided, the period of coverage, and which plan(s) it specifically affects;
6. Handicapped Children: An eligible dependent who is totally physically or mentally incapable of self-support upon attaining age 19 may be continued under the Plan while remaining incapacitated and unmarried and dependent upon the member for support, subject to the employee continuing to meet the eligibility requirements. The Trustees may request proof of incapacity from time to time.

SECTION 4

DEPENDENT EXCLUSIONS

1. A child attaining his twenty-third birthday;
2. The spouse of the covered employee, if legally separated from the covered employee; and
3. Any dependent while in military service.

SECTION 5

EFFECTIVE DATE OF DEPENDENT COVERAGE

Covered employee's coverage for eligible dependents shall become effective on the latest of the following dates:

1. The date the covered employee's coverage is effective; or
2. The date the covered employee first acquired an eligible dependent (See Article 3, Section 6).

SECTION 6

CHANGE IN FAMILY STATUS

Once you are in the Plan, it is necessary that you notify the Fund Office within 30 days of when your first dependent becomes eligible or when you no longer have any eligible dependents. When making a change , whether to add children or a new spouse, you will need to submit marriage license and/or birth certificate within 30 days.

FORMS ARE AVAILABLE FROM THE FUND OFFICE FOR REPORTING CHANGES IN FAMILY STATUS.

SECTION 7

TERMINATION OF DEPENDENT COVERAGE

The coverage of any dependent covered hereunder terminates on whichever of the following dates occur first:

1. The date such dependent ceases to be an eligible dependent;
2. The date the covered employee's coverage hereunder terminates;
3. The date the dependent enters the Armed Forces on full-time active duty;
4. The date the covered employee fails to make any required contribution; or
5. The date this Plan is terminated.

* In the event the contributing employer does not renew the Collective Bargaining Contract and/or Participation Agreement, all accumulated eligibility is forfeited.

SECTION 8

CREDITABLE COVERAGE

You and your dependents have the right to demonstrate creditable coverage to avoid application of the pre-existing limitations.

1. How Creditable Coverage is applied:
   The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date. Days of creditable coverage that occur before a significant break in coverage are not required to be counted.
2. Creditable coverage includes:
   A. Group health plans
   B. Other health insurance including individual
   C. Medicare
   D. Medicaid
   E. Military health plans
   F. Medical care programs of the Indian Health Service or of a tribal organization
   G. State risk pools
   H. Federal employee health plans
   I. Public health
   J. Health plans under §5(e) of the Peace Corps Act
3. Creditable coverage does not include any benefits specifically excluded from HIPAA portability requirements.
4. A significant break in coverage means a period of 63 days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.
5. You will automatically be provided with creditable coverage information upon termination of regular coverage; upon termination of cobra coverage and upon request not later than 24 months after termination of regular coverage or cobra coverage, whichever is later.
6. Contact the Fund office, if you need assistance in securing this Creditable Coverage Certificate from your prior plan.

SECTION 9

ELIGIBILITY/RETIRED EMPLOYEES & ELIGIBLE SPOUSE

QUALIFICATIONS

The Trustees have established a retiree plan. The plan is available for eligible retired members and their eligible dependents through the self-payment (direct contribution) provisions of the plan. In the event a retiree becomes entitled to Medicare prior to attaining age 65, Medicare becomes the primary carrier. When a retiree attains age 65, he/she is no longer covered under the retiree plan. - See Section below entitled Termination of Coverage - retirees and eligible dependents.

The direct contribution notices will be mailed to all qualified retirees/dependents on a quarterly basis at the last known address as shown on the Fund's records. It shall be the obligation of the employee/dependent to make the necessary timely payments to maintain eligibility, and the fact that such notifications were either not sent by the Fund Office or not received by the recipient shall not extend the time for making such voluntary payments.

RETIREE ELIGIBILITY

A retiree is eligible for the Plan if:

1. He qualifies for a pension under the Central Laborers' Pension Fund; and
2. Has been continuously eligible under the Southern Illinois Laborers' & Employers Health & Welfare Fund for a period of:
   (a) Five consecutive years immediately prior to the retirement date; or
   (b) Seven out of ten years immediately prior to the retirement date.

Full self-payments (direct contributions) for retiree coverage become due immediately following the Trustees approval of the members application for retiree coverage. All accumulated active hours are frozen and are not available or applied to any retiree self-payment/direct contribution.

In the event the retiree subsequently obtains employment and becomes covered under any other group plan, this retiree plan will not continue to be available.

However, in the event the retirees works for a contributing employer under the Collective Bargaining Agreement less than 39 hours a month, and the employer makes contributions to the Fund for this work on behalf of the retiree, then these hours will be accumulated and will reduce the amount of the self-payment (direct contribution) required each insurance quarter.

RETIREE ELIGIBILITY: ELIGIBLE DEPENDENTS OF RETIRED EMPLOYEES

1. The legal spouse of the employee;
2. The employee's unmarried children to age 19;
3. Unmarried children who are 19 to 23 year of age, if wholly dependent upon the employee for support and maintenance and a full-time student in an accredited school;
4. Legally adopted children (including those for who adoption proceeding have been initiated and the child has been placed in the home), stepchildren, or children for whom the participant has been appointed permanent legal guardian by the courts providing such children are dependent upon the insured employee for support and maintenance;
5. Children of a non-custodial parent employee if there is a Qualified Medical Child Support Order approved settlement agreement that creates or recognizes the right of an alternate recipient (i.e. the child) to be enrolled under the group health plan. The QMCSO must include the name and address of the participant and child, a reasonable description of the type of coverage to be provided, the period of coverage and which plan(s) it specifically affects;
6. Handicapped Children. An eligible dependent who totally physically or mentally incapable of self-support upon attaining age 19 may be continued under the Plan while remaining incapacitated and unmarried subject to the employee continuing to meet the eligibility requirements. The Plan Sponsor may request proof of incapacity from time to time, but not before the two-month period preceding the date the coverage would normally terminate. If proof is requested, but not received by the Plan Sponsor within 60 days, the child will not be considered an eligible dependent beyond the 60-day period even though still incapacitated.

EFFECTIVE DATE
The effective date of coverage will be the first day the Plan participant has qualified for benefits.

TERMINATION OF COVERAGE - RETIREES AND ELIGIBLE DEPENDENTS
Retiree's coverage will immediately terminate at the end of the period in which:
1. The retiree attains age 65; or
2. The retiree, dies whichever comes first.

The retiree's dependent coverage will terminate:
1. If your spouse is older than you, all dependent coverage terminates when your coverage terminated.
2. If your spouse is younger than you, the spouse may continue coverage for herself/himself and the other eligible dependents until the end of the period in which she/he attains age 65.

SECTION 10

FAMILY MEDICAL LEAVE ACT

Continuation During Family and Medical Leave
This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminated during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returned to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under the Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or is or her Dependents when Plan coverage terminated.

A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the employment Waiting Period or Pre-Existing Conditions provision.

SECTION 11

EMPLOYEES ON MILITARY LEAVE
Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Re-employment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for the military service.

The maximum period of coverage of a person under such an election shall be the lessor of:
1. The 24 month period beginning on the date on which the person's absence begins; or
2. The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

A person who elects to continue coverage may be required to pay up to a 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon re-employment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

ARTICLE 4 - PRE-EXISTING CONDITION

The term "Pre-Existing Condition" means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to the enrollment date. Pregnancy shall not be considered a pre-existing condition hereunder. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to the genetic information within a 6 month period prior to the enrollment date.

A newborn or newly adopted child (under age 18) who begins Dependent Coverage hereunder within 30 days of birth or placement for adoption (or who has Creditable Coverage from birth, adoption, or placement for adoption without a Significant Break in Coverage) does not have any pre-existing conditions.

If the covered person does not receive medical care or services, including prescription drugs or other medical supplies either recommended or actually received and is not under a Physician's care with respect to the pre-existing (or related) conditions for a period of six (6) consecutive months beginning on or after the date participation in the Plan began, the pre-existing conditions exclusion will no longer apply and any eligible charges incurred after the treatment-free period will be considered.

If a covered person is subject to the Pre-existing Condition Limitation; the limitation will no longer apply:
1. When the Participant presents documentation of 12 months of Creditable Coverage; or
2. After 12 consecutive months minus any period of partial Creditable Coverage credit.

SECTION 1

SIGNIFICANT BREAK IN COVERAGE
A significant break in coverage means a period of 63 days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

SECTION 2

SPECIAL ENROLLEE
The term "Special Enrollee" means an employee or dependent who is entitled to and who requests special enrollment:
1. Within 30 days of losing other health coverage; or
2. For a newly acquired dependent, within 30 days of the marriage, birth, adoption, or placement for adoption, whichever event applies.
3. The employee or the dependent who initially declined coverage stating, in writing, that coverage is available under another group health plan or other health insurance coverage was the reason for declining enrollment. This applies only if:
   A. The plan required such a statement when the employee declined enrollment: and
   B. The employee is provided with notice of the requirement to provide the statement(and the consequences of the employee's failure to provide the statement) at the time the employee declined enrollment; or
4. The employee who declined enrollment of the employee or dependent under the plan, had COBRA continuation coverage under another plan and COBRA continuation coverage under that other plan has since been exhausted; or
5. The other coverage that applied to the employee or dependent when enrollment was declined was not under a COBRA continuation provision and either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated. For the purpose, loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing; or
6. Individuals who lose other coverage to nonpayment of premium or for cause (e.g., filing fraudulent claims) shall not be special enrollees; or
7. Individuals who lose their coverage for: divorce or legal separation, death, termination of employment or reduction in hours of employment.

SECTION 3

WAITING PERIOD

The term "Waiting Period" means the length of time that must pass under this Plan (or for purposes of determining creditable coverage, any other health plan) before an employee or dependent is eligible to enroll in the Plan (or other health plan as the case may be). Notwithstanding the foregoing, the time between the date a late enrollee or special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage shall not be treated as a waiting period.

ARTICLE 5 - CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

SECTION 1

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because you may have become covered under Southern Illinois Laborers' & Employer Health & Welfare Fund (The Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

COBRA continuation coverage for the Plan is administrated by Southern Illinois Laborers' & Employer Health & Welfare Fund , 2035 Washington Ave, Cairo, Illinois 62914 , phone 800-327-4532 or 618-734-0773.

COBRA CONTINUATION COVERAGE

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

Note: Special COBRA rights apply to employees who have terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment under a federal law called the Trade Act of 1974. These employees must have made petitions for certification to apply for TAA on or after November 4, 2002.

The employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Under the new tax provisions, eligible individuals can either take a tax credit or get advanced payment of 65% of premiums paid for qualified health insurance, including continuation coverage.

If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free 1-866-626-4282. More information about the Trade Act is also available at http://www.ows.doleta.gov/dmstree/tegl/tegl12k2/tegl_11-02.htm.

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

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

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

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

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

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "dependent child".

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event (1) within 30 days of any of these events or (2) within 30 days following the date coverage ends.

For the other qualifying events (divorce or legal separation of employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the COBRA Administrator.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or dependent child losing eligibility as a dependent child, COBRA continuation lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Sponsor.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE
If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Sponsor.

IF YOU HAVE QUESTIONS
If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor or you may contact the nearest Regional or District Office of U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SECTION 2

WHEN MUST NOTICES BE GIVEN?

Qualifying Event	**Qualified Beneficiaries**	**Continuation Coverage**	**Notice of Qualifying Event**	**Notice of COBRA Rights**
Termination or reduction of hours of employment	Covered employee, spouse, and dependent child	18 months extended to 29 months if disabled	Employer to Trustees within 30 days of qualifying event	Trustees to qualified beneficiary within 14 days of notice
Death of covered employee	Spouse, Dependent child	36 months	Employer to Trustees within 30 days of qualifying event	Trustees to qualified beneficiary within 14 days of notice
Divorce or legal separation	Spouse, dependent child	36 months	Covered employee or qualified beneficiary to Trustees within 60 days of qualifying event	Trustees to qualified beneficiary within 14 days of notice
Dependent child's loss of dependency status	Dependent child	36 months	Covered employee or qualified beneficiary to Trustees within 60 days of qualifying event	Trustees to qualified beneficiary within 14 days of notice
Entitlement to Medicare	Spouse, dependent child	36 months	Employer to Trustees within 30 days of qualifying event	Trustees to qualified beneficiary within 14 days of notice
Bankruptcy of employer	Retired covered employee, widows	Until death	Employer to Trustees within 30 days of qualifying event	Trustees to qualified beneficiary within 14 days of notice

ARTICLE 6 - UTILIZATION REVIEW

The Trustees have entered into a contract with a Utilization Review Organization for the purpose of reviewing the appropriateness and quality of care. The current Utilization Review Organization is HealthLink.

HEALTHLINK, INC.
P.O. BOX 419104
ST. LOUIS, MISSOURI 63141-9104
1-800-624-2356

SECTION 1

UTILIZATION AND QUALITY REVIEW
A utilization and quality review program is a part of the Plan. The program includes pre-admission review, pre-procedure review, continued stay review, discharge planning and obstetrical review.

BENEFITS WILL BE REDUCED BY $500 FOR FAILURE TO PRE-CERTIFY ANY INPATIENT HOSPITAL ADMISSIONS, EXCEPT AS NOTED BELOW

HOSPITAL ADMISSIONS MUST BE PRE-CERTIFIED WHETHER YOU USE IN-NETWORK OR OUT-OF-NETWORK PROVIDERS.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996
HEALTH PLANS AND INSURANCE ISSUERS MAY NOT RESTRICT A MOTHERS' OR NEWBORNS' BENEFITS OR A HOSPITAL LENGTH OF STAY THAT IS IN CONNECTION WITH CHILDBIRTH TO LESS THAN 48 HOURS FOR A NORMAL VAGINAL DELIVERY OR 96 HOURS FOLLOWING A DELIVERY BY CAESAREAN SECTION

SECTION 2

PRECERTIFICATION - NON-EMERGENCY
Precertification is a process in which the patient, the doctor and HealthLink review and discuss the medical necessity and appropriateness of certain aspects of recommended treatment. Not only does Precertification help determine the medical appropriateness of the care, but it will also help save money by assuring that unnecessary treatment is eliminated.

WHEN A DOCTOR RECOMMENDS ELECTIVE HOSPITALIZATION, HEALTHLINK MUST BE CONTACTED AT 1-800-624-2356, AT LEAST 7 DAYS PRIOR TO ADMISSIONS, BUT NOT MORE THAN 10 DAYS IN ADVANCE.

The nurse reviewer will obtain the pertinent information about the case from the doctor or his representative. The nurse reviewer evaluates the necessity of the proposed hospitalization using physician-developed criteria. In most cases, the nurse reviewer will be able to approve admission. In certain situations, the nurse reviewer will discuss the case with a reviewing physician, who will review the case and any further information provided to determine whether hospitalization is necessary. If the reviewing physician agrees the hospitalization is necessary, then the admission is approved. If it is determined the admission is not medically necessary, the patient, the physician, or the hospital has the right to appeal the decision. (See Article 12, Section 7 - Appeal Procedure)

SECTION 3

PRECERTIFICATION - EMERGENCY
Should the employee or covered dependent be admitted to the hospital in an emergency situation, HealthLink must be contacted within 48 hours after the admission. HealthLink is available 24 hours a day, seven days a week, 365 days a year.

SECTION 4

WEEKEND HOSPITAL ADMISSIONS
When an insured person is admitted as a resident patient in a hospital on a Friday or Saturday, benefits will be payable for expenses incurred on that Friday, Saturday and/or Sunday only if the admission is for medical emergency or for surgery which is performed within 24 hours of the admission.

SECTION 5

CONTINUED STAY REVIEW
Continued stay review begins after a patient is hospitalized. The doctor and HealthLink review and discuss the medical necessity and appropriateness of treatment as long as the patient remains hospitalized. If it is determined the admission is not medically necessary, the patient, the physician or the hospital has the right to appeal the decision. (See Article 12, Section 7 - Appeal Procedure)

SECTION 6

DISCHARGE PLANNING
Discharge planning is a process in which the patient, the doctor and HealthLink identify the appropriate level of care after discharge from an inpatient setting and discuss alternatives such as skilled nursing facilities, home health care services, hospice programs, etc.

SECTION 7

UTILIZATION REVIEW
The patient, the doctor, or the hospital has a right to appeal a decision regarding an admission or a procedure. When HealthLink does not approve treatment as appropriate or medically necessary, the patient may call HealthLink with a follow-up in writing requesting a reconsideration.

IT IS THE PATIENT'S RESPONSIBILITY TO VERIFY THE CURRENT PPO STATUS OF THE PROVIDER OF SERVICE. CALL THE PPO NETWORK DIRECT OF VISIT THEIR THEIR WEB-SITE AT www.healthlink.com .

ARTICLE 7 - COVERED CHARGES

The covered charges referred to in this provision are charges incurred for the following services and supplies which are necessary for treatment of an accidental injury or sickness and which are reasonable and customary as determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned:

1. Hospital charges for room and board (excluding charges in excess of the Room Limitation), operating, delivery, recovery rooms;
2. Hospital charges for drugs, medicines and other hospital services and supplies, if used while confined in the hospital as a resident patient;
3. Hospital charges for outpatient services;
4. Charges made by a physician or surgeon for the performance of an operation (including circumcision) or the repair of a dislocation or fracture (see Article 2, Section 16);
5. Charges for the services of a professional anesthetist; provided such anesthetist is not employed by a hospital which submits a charge for the services;
6. Charges made by a physician for medical services, including his/her active services as an assistant surgeon;
7. Allergy tests and allergy immunizations;
8. Charges for local professional ambulance service (ground or air) to, but not back from, the nearest hospital, which can provide treatment unique to the illness/sickness. Local is defined as service rendered in the metropolitan area. In the case of a rural service, local is defined as transportation to the nearest metropolitan area. Air ambulance is defined as aircraft specifically designed and operated for medical use only. In no event will ambulance service include scheduled flights of a commercial aircraft, railroad, bus or ship; nor any service rendered for the convenience of the patient;
9. Cardiac rehabilitation not to exceed one 12-week program per calendar year, outpatient only;
10. Charges for the following additional services and supplies:
    A. Diagnostic x-ray and laboratory service for diagnosing disease;
    B. Oxygen and the rental of equipment (up to purchase price) for its administration;
    C. Blood or blood plasma and its administration;
    D. Radium, radioactive isotopes and x-ray therapy;
    E. Casts, splints, braces, trusses, crutches, cervical collars, head halter and other traction apparatus;
    F. Colostomy bag, ileostomy supplies and catheters;
    G. Drugs and medicines which are only legally obtainable with a written prescription; and
    H. Diabetic Supplies unless covered by Rx program.
11. Artificial limbs and eyes;
12. Dental services rendered by a physician, dentist or oral surgeon for treatment within 6 months of an injury to the jaw or natural teeth, including the initial replacement of these teeth and any necessary dental x-rays;
13. Services of a physical therapist and/or occupational therapist, limited to 40 visits per year, combined;
14. Reconstructive surgery because of a congenital disease or birth defect of an eligible dependent child:
    A. Which manifests itself within the first five years of the child's life;
    B. Which impairs a function of the body.
15. Pulmonary rehabilitation following surgery and upon written prescription by primary physician;
16. Elective sterilization, but not the reversal of elective sterilization;
17. Breast reconstruction in connection with mastectomy is covered (subject to all Plan provisions) as follows:
    A. Reconstruction of the breast on which the mastectomy has been performed;
    B. Surgery and reconstruction of the other breast to produce symmetrical appearance; and
    C. Coverage for prosthesis and physical complications of all stages of mastectomy, including lymphadema: in a manner determined in consultation with the attending physician and the patient.
18. Surgical stockings - one pair per lifetime;
19. Orthotics, but not shoes;
20. Any care/treatment recommended and approved by a large case management organization;
21. Implantable contacts, but only following cataract surgery;
22. Care/treatment recommended and approved by a Member Assistance Program;
23. Dietary counseling session following initial diagnosis of diabetes.

ARTICLE 8 - EXCLUSIONS AND LIMITATIONS

No medical benefits will be payable under the Plan for charges incurred for:

1. Loss caused by accidental bodily injury or sickness for which you are entitled to benefits under any Workers' Compensation or occupational disease law whether or not a claim is made for those benefits;
2. Loss caused by war or any act of war (declared or undeclared) or military or naval service of any country;
3. Any loss, expense or charge resulting from any illegal activity. This exclusion does not apply if the injury or sickness resulted from an act of domestic violence or a medical condition (including both physical and mental health);
4. Hospital confinements which are basically to control or alter the patient's surrounding or environment, or maintenance care of alcoholism or drug dependency;
5. Experimental care, research procedure, service or supply (See definitions);
6. Charges in excess of covered expenses;
7. Care provided by a family member or any type of care not ordered by a licensed physician;
8. Charges for which you would not otherwise have legal obligation to pay;
9. Eye refractions or the fitting or cost of visual aids except as specified in Article 2, Section 26;
10. The fitting or cost of hearing aids except as specified in Article 2 , Section 10;
11. Radial keratotomies and a similar type corrective surgery;
12. Acupuncture, acupressure, hypnosis, massage therapy;
13. Treatment of complications resulting from non-covered care, except complications resulting from elective abortions;
14. Non-prescription drugs or supplies, comfort or convenience service or supplies;
15. Charges made by medical personnel or "stand by" services when no care was actually rendered;
16. Charges the patient would not otherwise have any legal obligation to pay;
17. Hospital confinements primarily for observation and/or diagnostic studies which could have been performed on an out-patient basis;
18. Care not considered medically necessary for the diagnosis/treatment or inpatient care inconsistent with the condition requiring hospitalization, or in excess of usual and customary charges;
19. The portion of an inpatient hospital admission that began prior to the person's effective date;
20. Rest cures, domiciliary care, convalescent care or custodial care, which is care provided primarily for convenience, or to assist the patient in the activities of daily living, or custodial in nature when the constant attention of trained medical personnel is not required;
21. Inpatient hospital care for environmental change or care in institutions providing education in special environments;
22. Charges made by an inpatient facility/hospital for services while patient is out on "pass";
23. Charges for telephone consultations, missed appointments or fees sometimes added for filling out a claim form;
24. Travel or personal services or supplies;
25. Personal convenience items such as special air conditioners, humidifiers, physical fitness equipment and other such devices, whether or not ordered by a physician;
26. Surgery for psychological or emotional reasons or to improve appearance (cosmetic);
27. Any loss, expense or charge which results from appetite control, diet programs, diet supplements/pills, nutritional supplements/vitamins, nutritional counseling except following initial diagnosis of diabetes;
28. Smoking cessation supplies and/or products except as provided for in Article 2, Section 21;
29. Transsexual surgery;
30. Penile implants and care for and/or related to sexual dysfunction; and
31. Obesity - care and treatment of obesity, weight loss or dietary control, whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery including but not limited to, gastric bypass, stapling and intestinal bypass and lap band surgery, or the excision of excess skin and subcutaneous tissue; including reversals of these procedures.

THIS LIST IS NOT MEANT TO BE ALL INCLUSIVE. ANY EXCLUSION/LIMITATION STATED DOES NOT NECESSARILY INCLUDE ALL CHARGES WHICH ARE EXCLUDED OR LIMITED. ONLY THOSE CHARGES LISTED AS COVERED CAN BE ASSUMED PAYABLE.

ROOM LIMITATIONS

Private Room:	Charges will be reduced to the semi-private room charge made in the hospital where the eligible person is confined.
Semi-Private Room:	The semi-private room charge made in the hospital where the eligible person is confined.
Ward Accommodation:	The ward accommodation charge made in the hospital where the eligible person is confined.
Intensive Care:	The reasonable and customary charge made in the hospital where the eligible person is confined.
Post Intensive Care:	The reasonable and customary charge made in the hospital where the eligible person is confined.

ANY REPRESENTATION OF THE BENEFITS BY FUND EMPLOYEES IS NOT A GUARANTEE OF BENEFITS. NO ONE HAS THE AUTHORITY TO SPEAK FOR THE TRUSTEES IN EXPLAINING THE ELIGIBILITY RULES OR BENEFITS OF THE FUND EXCEPT THE FULL BOARD OF TRUSTEES.

ARTICLE 9 - DEFINITIONS

SECTION 1

AMBULATORY SURGICAL CENTER
A center approved and licensed as such by the state. If the state does not have license requirements, it must meet all of the following tests:
1. Have out-patient facilities for diagnosis or treatment of an injury or surgery;
2. Supervised by a staff of physicians;
3. Provide nursing services by registered graduate nurses;
4. Maintain medical records on all patients;
5. Have emergency equipment and supplies with medical personnel trained in use of same; and
6. Have a contract with a hospital for admission in the case of emergency.

SECTION 2

BIRTHING CENTER
Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

SECTION 3

CALENDAR YEAR
A Calendar Year is January 1 through December 31 of the same year.

SECTION 4

COBRA
Cobra means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

SECTION 5

CONTRIBUTING EMPLOYER
The term Contributing Employer means:
1. An employer who is a member of, or is represented in collective bargaining by, the Association and who is bound by the Collective Bargaining Agreement with the Union to make payments to the Trust Fund with respect to employees represented by the Union;
2. An employer who is not a member of, nor represented in collective bargaining by the Association, but who is bound by a Collective Bargaining Agreement with the Union to make payments to the Trust Fund with respect to employees represented by the Union;
3. The Union, for the purpose of making the required contributions into the Trust Fund for employees of the Union;
4. An employer who is required to make payments of contributions to the Trust Fund by any law or ordinance applicable to the State of Illinois or to any political subdivision or municipal or corporation thereof, or because of any written agreement entered into by an employer with such State or political subdivision or municipal corporation thereof; or
5. An employer who is required to make payments or contributions to the Trust Fund by execution of a Participation Agreement.

SECTION 6

COVERED EXPENSES
Covered expenses are reasonable, customary and necessary expenses incurred including hospital, surgical and medical care expenses required for diagnosis and treatment of injury and illness.

SECTION 7

COVERED PROVIDER
A legally qualified and licensed practitioner of the healing arts, acting within the scope of his practice, provided that such provider is neither the claimant or a relative of the claimant to the following degree: parent, spouse of parent, spouse, child, spouse of child, or parent or child of spouse. The medical board may require, in its sole discretion, that any physician have training as a specialist or be a practicing specialist in a field of medicine. The term "covered provider" shall include Doctor of Medicine (M.D.), Doctor of Osteopathy(D.O.), Doctor of Podiatry, Doctor of Dental Medicine, Doctor of Dental Surgery, certified Nurse Anesthetist, Advance Practice Nurse, Doctor of Chiropractic, Audiologist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W), Midwife, Occupational Therapist, Optometrist (O.D.), Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist . Clinical Psychologist, and social worker are also covered when referral is made by a M.D. or D.O. providing service under the MAP. Service of a qualified physiotherapist or a registered graduate nurse (RN) or licensed practical nurse (LPN/LVN) are covered if referral is made by M.D. or D.O. providers.

SECTION 8

CUSTODIAL CARE
Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding, or supervision over medication which could normally be self-administered.

SECTION 9

DENTIST
A duly licensed dentist acting within the scope of his license, including a physician furnishing covered dental services which he is licensed to perform. Such dentist shall not be the claimant or a relative of the claimant to the following degree: parent, spouse of parent, spouse, child, spouse of child, or parent or child of spouse. The dental board may require, in its sole discretion that any dentist has training as a specialist or be a practicing specialist in a field of dentistry.

SECTION 10

DURABLE MEDICAL EQUIPMENT
Equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

SECTION 11

EMPLOYEE/PARTICIPANT
An active full-time employee of a contributing employer. Unless otherwise stated in a Collective Bargaining Agreement, an employee is considered to be full-time if he/she works at least 20 hours per week and is on the regular payroll for the employer for that work. Any work performed by full-time employees requires a full monthly contribution by the contributing employer.

SECTION 12

ERISA
ERISA is the Employee Retirement Income Security Act of 1974, as amended.

SECTION 13

EXPERIMENTAL/INVESTIGATIVE PROCEDURES
Services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decisions of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If the drug, device, medical treatment or procedure -- or if the patient informed consent document utilized with the drug, device, treatment or procedure -- was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
3. If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, or is in the research, experimental, study or investigational arm of on-going phase II clinical trials, or is in the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy is compared with a standard means of treatment or diagnosis;
4. If reliable evidence shows that the prevailing opinion among experts regarding the drug device, medical treatment or procedure is that further studies or clinical trials are necessary 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 shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) 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.

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

SECTION 14

FAMILY UNIT
A family unit is the covered Employee and the family members who are covered as Dependents under the Plan.

SECTION 15

FORMULARY
Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

SECTION 16

FULL-TIME EMPLOYEE
Unless otherwise stated in a Collective Bargaining Agreement, an employee is considered to be full-time if he/she works at least 20 hours per week and is on the regular payroll for the employer for that work. Any work performed by full-time employees requires a full monthly contribution by the contributing employer.

SECTION 17

GENDER AND NUMBER
The masculine gender shall be deemed to include the feminine and the singular shall include the plural unless otherwise clearly required by the context.

SECTION 18

GENERIC DRUG
A Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

SECTION 19

GENETIC INFORMATION
Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

SECTION 20

HOME HEALTH CARE AGENCY
An organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

SECTION 21

HOME HEALTH CARE PLAN
A Home Health Care Plan must meet these tests; it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

SECTION 22

HOME HEALTH CARE SERVICES & SUPPLIES
Home Health Care Services & Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

SECTION 23

HOSPICE AGENCY
An organization where its main function is to provide Hospice Care Services & Supplies and it is licensed by the state in which it is located, if licensing is required.

SECTION 24

HOSPICE CARE PLAN
A plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

SECTION 25

HOSPICE CARE SERVICES & SUPPLIES
Hospice Care Services & Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

SECTION 26

HOSPICE UNIT
A facility or separate Hospital Unit, that provides treatment under a hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

SECTION 27

HOSPITAL
The term "hospital" means an institution which meets all of the following requirements:

1. It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations; it is legally operated; it has service by registered graduate nurses; and it complies with A or B:
   A. It mainly provides general inpatient medical care and treatment of sick and injured persons by the use of medical, diagnostic, and major surgical facilities are in or under its control;
   B. It mainly provides specialized inpatient medical care and treatment of sick and injured persons by the use of medical and diagnostic facilities (including x-ray and laboratory). All such facilities are in it, under its control, or available to it under a written agreement with a hospital or with a specialized provider of these facilities; or
2. It is an institution that provides care and treatment of mental, psychoneurotic, and personality disorders; alcoholism, or drug abuse through one or more specialized programs and meets all of theses tests:
   A. It is staffed by registered graduate nurses and other mental health professionals;
   B. It provides for the clinical supervision of such specialized programs by Physicians who are licensed in the state in which it is located; and
   C. Each specialized program provided by it must:
      (i) Provide treatment for no less than three hours nor more than 12 hours per day; and
      (ii) Furnish a written, individual treatment plan which states specific goals and objectives; and
      (iii) Maintain, at a minimum, ongoing weekly progress notes which demonstrate periodic review and direct patient evaluation by the attending Physician; and
      (iv) Meet either of these two tests;
         (a) It is accredited by the Joint Committee on Accreditation of Healthcare Organizations to provide the type of specialized programs as described above; or
         (b) It is licensed, accredited, or approved by the appropriate agency in the state in which it is located to provide the specialized type program described above.

A hospital does not include a nursing home; neither does it include an institution, or part of one which:
1. Is used mainly as a place for convalescence, rest, nursing care or for the aged;
2. Furnished mainly homelike or custodial care, or training in the routines of daily living; or
3. Is mainly a school.

Except, in the case where the Member Assistance Program (MAP), in connection with an approved course of treatment, utilizes these types of facility.

SECTION 28

ILLNESS
A bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage, or complications of Pregnancy.

SECTION 29

INJURY
An accidental physical Injury to the body caused by unexpected external means.

SECTION 30

INTENSIVE CARE UNIT
A separate, clearly designated service area which is maintained within a Hospital solely for the care and treatments who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit.". It has: facilities for special nursing care not available in regular rooms and ward of the Hospital; special life saving equipment which is immediately available at all times; at lease two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

SECTION 31

LEGAL GUARDIAN
A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

SECTION 32

LIFETIME
A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does lifetime mean during the lifetime of the Covered Person.

***SECTION* 33**

MEDICAL CARE FACILITY
A Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

SECTION 34

MEDICAL EMERGENCY
A sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respirations, convulsions or other such acute medical conditions. In certain circumstances, a person may receive the benefit for HealthLink services (80%) for care outside the HealthLink Network when there is a medical emergency. The higher benefit level will be paid only until the patient has stabilized and can safely obtain medical care at a HealthLink facility. This applies to facility charges only.

SECTION 35

MEDICALLY NECESSARY
Care and treatment recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary

SECTION 36

MEDICARE
The Health Insurance For the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

SECTION 37

MENTAL DISORDER
Any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health & Human Services or is listed in the current edition of Diagnostic & Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

SECTION 38

OUT-OF-AREA
Out-of-Area is defined as outside the HealthLink jurisdiction and one or more of the following applies:
the member is a full time student and an eligible dependent child under the plan, or the member is traveling outside the HealthLink area for business or pleasure and encounters a medical emergency.

SECTION 39

OUTPATIENT CARE AND/OR SERVICES
Treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical, or the patient's home.

SECTION 40

PHARMACY
A licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

SECTION 41

PLAN PARTICIPANT
Any Employee or Dependent who is covered under this Plan by meeting the eligibility rules established by the Trustees.

SECTION 42

PLAN YEAR
The 12 month period beginning on either the effective date of the Plan or on the day following the first Plan Year which is a short Plan Year.

SECTION 43

PRESCRIPTION DRUG
Any of the following: A Food and Drug Administration approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of sickness or injury.

SECTION 44

REASONABLE AND CUSTOMARY CHARGE
A charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will consider the actual charge billed if it is less than the Usual & Reasonable Charge.

The Trustees have the discretionary authority to decide whether a charge is Usual & Reasonable.

SECTION 45

SICKNESS
Sickness is: For a covered Employee and covered Spouse; Illness, disease or Pregnancy.
For a covered Dependent other than Spouse; Illness or disease, not including Pregnancy or its complications.

SECTION 46

SKILLED NURSING FACILITY
A facility that fully meets all of these tests:
1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) Under the direction or a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
7. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

SECTION 47

SPECIALTY MEDICATIONS & BIO-INJECTABLES
Specialty medications and bio-injectables are medications that provide highly sophisticated treatment for patients with rare or chronic conditions. They are mainly given by injection although some are given orally. Bio-injectable and specialty medications are for complex health conditions, including but not limited to: HIV/AIDS, cystic fibrosis, deep vein thrombosis, growth hormone disorders, hepatitis, psoriasis, rheumatoid arthritis, solid organ transplant, multiple sclerosis, etc.

Medications such as insulin and injectable migraine therapy are excluded from this program and can be purchased at your local retail pharmacy or the LDI mail service.

SECTION 48

SPINAL MANIPULATION/CHIROPRACTIC CARE
Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

SECTION 49

SUBSTANCE ABUSE
Regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine containing drinks.

SECTION 50

TEMPOROMANDIBULAR JOINT (TMJ)
Treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

SECTION 51

TOTAL DISABILITY (TOTALLY DISABLED)
In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

ARTICLE 10 - SUBROGATION AND RIGHT OF REIMBURSEMENT

No benefits will be paid under any coverage of the plan with respect to any injury or sickness for which a Third Party may be liable or legally responsible. Third Party means a person or organization other than the Covered Person who suffers loss. This exclusion will apply whether or not the injury or injuries occurred while the Coverage Person was eligible under the Plan. The Plan will, however, pay benefits according to the terms of the Plan as follows:

1. As a condition to receiving medical, dental, vision, prescription benefits, or any combination of benefits under this Plan for any injury or illness that occurs because of or as a result of an act or omission of another person, the Covered Person(s), including all Dependents, agree to transfer to the Plan their rights to recover damages in full.
2. If a Covered Person or Dependent receives any recovery by way of judgment, settlement or otherwise, from a Third Party, the Covered Person or Dependent agrees to reimburse the Plan in full for any medical, dental, vision, prescription benefits, or any combination of expenses paid by the Plan (i.e., the Plan shall be first reimbursed fully to the extent of any and all benefits paid by the Plan from any monies received by the Covered Person, with the balance, if any, to be retained by the Covered Person.
3. If a Covered Person or Dependant receives any recovery, by way of judgment, settlement, compromise, or otherwise, from any other person or business entity, the Covered Person or Dependent agrees to reimburse the Plan in full, regardless of whether the settlement or judgment specifically designates the recovery or any portion thereof as payment for medical benefits, dental benefits, vision benefits, prescription benefits, disability benefits, or any combination of benefits paid by the Plan.. (The Plan shall be first fully reimbursed to the extent of any and all benefits paid by it from any monies recovered, with the balance, if any, to be retained by the Covered Person or Dependent.)
4. If a repayment or subrogation agreement is required to be signed, this clause remains in effect regardless of whether it is actually signed. Acceptance of benefits under this Plan signifies and constitutes an acceptance of these terms and conditions.
5. The Plan's right of full recovery, either by way of subrogation or right of reimbursement, shall be from the monies the Covered Person or Dependent or guardian of a Covered Person or Dependent receives or is entitled to receive from the Third Party, any liability or other insurance covering the Third Party, the Covered Person's own uninsured motorist coverage, underinsured motorist insurance, any medical pay insurance under any applicable insurance policy, or any no-fault or school insurance coverage which are paid or which are payable.
6. If a Covered Person, Dependent or guardian of a Covered Person or Dependent receives any recovery by way of judgment, settlement or otherwise, from a Third Party, the Covered Person, Dependent, guardian of the Covered Person or Dependent, or attorney (if the attorney is holding the monetary recovery) must hold the monetary recovery in constructive trust and promptly reimburse the Plan for the benefits provided, up to the amount of the monetary recovery. The Covered Person, Dependent, guardian of the Covered Person or Dependent, or attorney shall be fiduciaries with respect to the monetary recovery.
7. The Plan shall have an equitable lien upon and will have first priority in any recovery regardless of whether the settlement or judgment specifically designates or characterizes the recovery as including the benefits paid by the Plan, and regardless of whether the Covered Person or Dependent is "made whole" by the monetary recovery.
8. The Covered Person has a legal obligation to avoid doing anything that would prejudice the Plan's right of subrogation or reimbursement.
9. In the event a Covered Person's or Dependent's repayment is not promptly made or in the event a Covered Person or Dependent prejudices the Plan's right of recovery, the Plan may withhold or offset the payment of future benefits on behalf of the Covered Person or Dependent until such time as the full amount owed to the Plan, plus ten percent (10%) interest per annum, is fully repaid.
10. In the event a Covered Person's or Dependent's repayment is not promptly made or in the event that a Covered Person or Dependent prejudices the Plan's right of subrogation or reimbursement, the Plan may pursue any and all legal remedies to collect the amount due. If the Plan prevails in a lawsuit to enforce the provision and/or the provisions of a subrogation agreement executed by the Covered Person or Dependent, or guardian of the Covered Person or Dependent, then the Plan shall be entitled to recover the amount due to the Plan, plus interest in the amount of ten percent (10%) per annum, and the costs incurred in the collection of the amount, including reasonable attorney's fees.
11. The Plan will not pay attorney's fees or costs associated with the Covered Person's or Dependent's claim/lawsuit without express written authorization.
12. The Plan's rights as set forth herein shall survive the death of the Covered Person or Dependent and shall bind the deceased Covered Person's or Dependent's successors, assigns, estate, and executor.

FAILURE TO COMPLY WITH THIS PROVISION WILL RESULT IN THE DENIAL OF THE CLAIM.

ARTICLE 11 - COORDINATION OF BENEFITS - BENEFIT COMBINING PROVISIONS

If a participant or a covered dependent is entitled to benefits under any other plan (as defined below) which will pay part or all of the expense incurred for necessary, reasonable and customary charges for treatment of an illness or injury, the amount of benefits payable under this Plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred. In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if there were no other plan involved.

The term "Plan" includes any plan providing benefits or services for or by reason of hospital, medical, dental or vision care or treatment, or healing under:

1. Group insurance;
2. Group practice, group Blue Cross, group Blue Shield, individual practice offered on a group basis or other group prepayment coverage;
3. Labor-management trustees plans, union welfare plans, employer organization plans or employee benefits organization plans;
4. Any coverage under governmental programs including Medicare, Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Deficit Reduction Act of 1984 (DEFRA), and any coverage required or provided by statute;
5. Motor vehicle insurance; or
6. Group insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution.

The rules establishing the order of benefit determination are:

1. The benefits of a plan which covers the person on whose expense claims are based other than as a dependent will be determined before the benefits of a plan which covers the person as a dependent;
2. In the case where the claimant is a dependent child and both parents carry dependent coverage, then the plan of the parent with the earliest date of birth, excluding year of birth, shall be determined before the plan of the parent with the date of birth that occurs later in a calendar year (birthday rule), except that:
   A. When the parent with custody of the child has not remarried, the benefit determination order is:
      (i) Primary - the parent with custody
      (ii) Secondary - the parent without custody.
   B. When the parent with custody of the child has remarried-
      (i) Primary - the parent with custody
      (ii) Secondary - the step-parent
      (iii) Tertiary - the parent without custody.

   Notwithstanding A and B above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.
3. When rules 1 and 2 above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expense claims are based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.
4. Benefits of a plan which do not contain a coordination of benefits provision will be determined before the benefits of this plan.

The Plan may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information which the Plan deems necessary for the purposes of this provision.

Any person claiming benefits under this Plan must as a condition furnish to the Plan such information as may be necessary to administer this provision.

ARTICLE 12 - HOW TO OBTAIN MEDICAL BENEFITS

SECTION 1

WHEN CLAIMS SHOULD BE FILED

Claims should be filed within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

1. It's not reasonably possible to submit the claim in that time; and
2. The claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Department will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A claim form signed by the member is required with each family member's first claim of the calendar year. Failure to submit a claim form will delay the processing of your claim. If the claim form *or other requested information* is not received timely, you will be notified that your claim is closed and will be reopened only if you submit the necessary information within one (1) year of the date the claim was incurred.

SECTION 2

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of claims and each has a specific timetable for either approval, payment, request for further information, or denial of the claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of claims are:

SECTION 3

URGENT CARE CLAIM

A claim involving urgent care is any claim for medical care or treatment where the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

A Physician with knowledge of the claimant's medical condition may determine if a claim is one involving urgent care. If there is not such Physician, an individual acting on behalf of the Plan applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In a case of a claim involving urgent care, the following timetable applies:

Notification to claimant of benefit determination	72 hours

Insufficient information on the claim, or failure to follow the Plan's procedure for filing a claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours

Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a claim involving urgent care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

SECTION 4

PRE-SERVICE CLAIM

A pre-service claim means any claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, approval in advance of obtaining medical care. These are, for example, claims subject to pre-certification. Please see the utilization review section of the booklet (Article 6, Section 1) for further information about information about pre-service claims.

In the case of a pre-service claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

SECTION 5

POST-SERVICE CLAIM

A post-service claim means any claim for a Plan benefit that is not a claim involving urgent care or a pre-service claim; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a post-service claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the claim:	
Notification of	15 days
Response by claimant	45 days
Review of adverse benefit determination of an appeal	30 days per benefit

SECTION 6

NOTICE TO CLAIMANT OF ADVERSE BENEFIT DETERMINATIONS

Except with urgent care claims, when the notification may be orally followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific Plan provisions on which the determination was based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures and time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination of review.
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. If the adverse determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
7. If the adverse benefit determination is based on the medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

SECTION 7

APPEAL PROCEDURE

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgement, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgement. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the determination will be identified.

ARTICLE 13 - STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT 1974

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.
4. Review this summary plan description and the documents governing the Plan or rules governing COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a Certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Condition exclusion for 12 (18 months for late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such case, the court may require the Plan Administrator to provide materials and to pay the Plan Participant up to $110 a day until he or she receives materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state of federal court.

In addition, if a Plan Participant disagrees with the Plan's decisions or lack thereof concerning the qualified state of medical child support , he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Employee Benefits Security Administrator, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance Inquiries, Employee Benefits Security Administration at 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever, in their judgment, conditions so warrant. Notwithstanding any language contained in this Summary Plan Description, this booklet and SPD is automatically amended to the extent or exclusion illegal or against the Public Policy of the people of the United States. Participants will be notified of any Plan changes.

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

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

ARTICLE 14 - PAYMENT OF BENEFITS

SECTION 1

PAYMENT OF CLAIMS
Benefits under the Plan will be paid directly to the hospital, doctor or other provider. Only with a receipt of written documentation that the covered employee has paid all or a portion of the service to a non-HealthLink provider, will payment be made to the covered employee. This Plan will not assign benefits to pharmacies.

SECTION 2

PAYMENT OF MEDICAL AND DEATH BENEFITS
All benefits due hereunder shall be paid in accordance with the Payment of Claims provisions, except that subject to any valid assignment of benefits.

DEATH In the event of the death of the covered employee under this Plan, any remaining unassigned unpaid benefits may be paid to any one or more of the following:
1. To a doctor, hospital or other party who provided the service giving rise to the benefit;
2. To the claimant's spouse or children;
3. To the person or entity responsible for the funeral bill of the claimant; or
4. To the claimant's estate.

MINOR OR INCOMPETENT If any unassigned benefit under this Plan becomes due to a minor or incompetent, the Trustees, in their discretion, may make such payment to a person or institution providing care for the minor or incompetent, even though such person is not a court-appointed guardian. The Trustees may use their judgment in determining minority, incompetency, and which of one or more parties contending that they are entitled to payment should be paid.

Any payment made in accordance with the above provisions shall be a complete discharge of the Trustees' liability to the extent of such payment, and the Trustees shall not be obligated to see to the application of the money so paid.

SECTION 3

IMPROPER OR FALSE CLAIMS - LOSS OF BENEFITS
If false information on any material subject is furnished to the Trustees, they may deny all or part of the claim and may charge the claimant for expenses incurred relating to the falsehood. If benefits have already been paid, based on false information on a material subject, the Trustees may recover the benefits plus expenses incurred in such recovery, including attorney's fees and investigation expense.

ARTICLE 15 - PRIVACY AMENDMENT

SECTION 1

DEFINITIONS
For purposes of the Privacy Amendment, the following definitions shall apply. Terms used, but not otherwise defined, in this Privacy Amendment shall have the same meaning as those terms in 45 CFR §160.103 and 45 CFR §164.501.

CFR - Code of Federal Regulations.

Disclosure - The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Individually Identifiable Health Information - Information that:
1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
3. That identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Privacy Rule - The Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

Protected Health Information (PHI) - Individually identifiable health information that is:
1. Transmitted by electronic media;
2. Maintained in electronic media; or
3. Transmitted or maintained in any other form or medium. This definition does not include education records covered by the Family Educational Right and Privacy Act.

Required by Law - A mandate contained in law that compels the Plan to make a use or disclosure of PHI and this is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court or grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

Secretary - The Secretary of the Department of Health and Human Services or his/her designee.

U.S.C. - United States Code.

Use - With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

SECTION 2

ROLE OF THE PLAN SPONSOR
The Plan Sponsor performs certain Plan Administration functions on behalf of the Plan and requires access to Protected Health Information (PHI) for the purpose of performing such Plan Administration functions. The Plan will only disclose PHI to Plan Sponsor upon receipt of a Certification of Compliance with the Standards for Privacy of Individually Identifiable Health Information. Plan Sponsor will not use or disclose PHI in any manner that is inconsistent with this Privacy Amendment.

SECTION 3

PERMITTED USES AND DISCLOSURES

The Plan Sponsor may use your PHI for any of the following purposes:

1. Obtaining premiums
2. Coverage determinations
3. Obtaining or providing reimbursement for health care
4. Eligibility determinations
5. Coordination of Benefits determinations
6. Claim adjudication
7. Subrogation
8. Billing
9. Claims management
10. Filing stop loss claims
11. Medical necessity reviews
12. Utilization review
13. Review for justification of charges
14. Pre-certification
15. Pre authorization
16. Concurrent review
17. Retrospective review
18. Case management and/or coordination
19. Providing treatment alternatives
20. Credentialing
21. Licensing
22. Certification
23. Accreditation
24. Training
25. Evaluating health plan performance
26. Underwriting
27. Premium rating
28. Ceding, securing or placing stop loss contracts
29. Other activities related to renewal or replacement of health insurance contracts
30. Medical review
31. Legal services
32. Auditing
33. Fraud abuse and detection
34. Compliance
35. Cost-management and planning analyses
36. Administration
37. Quality Assessment
38. Customer service
39. Grievance resolution
40. Due diligence
41. Fund-raising for the covered entity
42. De-identifying PHI
43. As Required by Law

SECTION 4

PROTECTING YOUR PRIVACY

In order to protect your privacy, the Plan Sponsor will limit the Use and Disclosure of your PHI by:

1. Restricting Use or Disclosure of PHI other than as permitted or required by the plan documents, or as required by law.
2. Ensuring that any agents, including subcontractors, to whom it provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
3. Prohibiting Use or Disclosure of PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor.
4. Reporting to the Plan any Use or Disclosure of PHI that is inconsistent with the Uses or Disclosures provided for by this Privacy Amendment of which it becomes aware.
5. Making its internal practices, books, and records relating to the Use and Disclosure of PHI received from the Plan available to the Secretary for purposes of determining compliance by the Plan with the Privacy Rule.
6. If feasible, returning or destroying all PHI received from the Plan that Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limiting further Uses and Disclosures to those purposes that make the return or destruction infeasible.

To ensure adequate separation between the Plan and Plan Sponsor, the Plan Sponsor will restrict access to PHI to those employees or other persons under the control of the Plan Sponsor who perform Plan Administration function for the Plan. Such employees or classes of employees or other persons under the control of the Plan Sponsor include:

1. Third-Party Administrator
2. Privacy Officer
3. Claims Dept. Employees

Such employees or classes of employees or any other persons under the control of the Plan Sponsor will limit their use of PHI to the performance of Plan Administration functions for the Plan and adhere to the policies and practices described in the Plan's Privacy Policy.

SECTION 5

YOUR RIGHTS

Federal privacy law applies to group health plans with fifty or more participants. This law gives you the following rights with respect to the Use and Disclosure of your PHI.

1. You may request restrictions on the Use and Disclosure of your PHI. However, any such request is subject to approval by the Plan.
2. You may request to receive communications from the Plan containing PHI by alternative means, or at an alternative location. Your request must be made in writing and must clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. In addition, the request must specify the alternative address or method of contact.
3. You have the right to inspect, copy, receive copies or a summary of your PHI that is maintained by the Plan, subject to the limitations described in 45 CFR § 164.524. A cost-based fee will apply to any request for copies or summaries of PHI. In the event the Plan cannot comply with a request made under this paragraph, the Plan will provide a written statement explaining the basis for the denial of access; your right to a review and how to exercise that right, if applicable; and how to file a complaint.
4. You may request amendment of your PHI that is maintained by the Plan. Within sixty days of receiving a request under this paragraph, the Plan will notify you of its intent to accept or deny the amendment. In the case of a denial, the notification will describe the basis for the denial; your right to file a statement of disagreement; your rights if you do not file a statement of disagreement; how to file a complaint with the Plan; and your right to complain to the Secretary of the United States Department of Health & Human Services.
5. You have a right to an accounting of certain disclosures of your PHI made by the Plan in the six years prior to the date on which you request the accounting, subject to the limitations described in 45 CFR §164.528. The Plan will provide an accounting requested under this paragraph in writing within sixty days after the receipt of such request.

SECTION 6

COMPLAINTS

Suspected violations of the Privacy Amendment by an employee or class of employees or other person under the control of the Plan or the Plan Sponsor, should be reported to Ken Kapper, Privacy Officer; 2035 Washington Ave., Cairo, IL 62914; Phone # 618-734-0773 or Fax # 618-734-2773. The Plan and/or Plan Sponsor will investigate any reported violations of the Privacy Amendment and take the appropriate actions to correct or cease the violation.

ARTICLE 16 -HIPPA STANDARD SECURITY REQUIREMENTS

This provision is intended to bring the Southern Illinois Laborers' & Employer Health & Welfare Fund (hereinafter the "Plan") into compliance with requirements of 45 CFR §164.314 (b) (1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 (the regulations are referred to herein as the "HIPAA SECURITY STANDARDS") and by establishing Plan sponsor's obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective on April 21, 2005.

SECTION 1

DEFINITIONS

Electronic Protected Health Information - The term "Electronic Protected Health Information" has the meaning set forth in 45 CFR §160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Plan - The term Plan means "Southern Illinois Laborers' & Employer Health & Welfare Fund".

Plan Documents - The term "Plan Documents" means the group health plan's governing documents and instruments (i.e., the documents under which the group health Plan was established and is maintained, including, but not limited to the Southern Illinois Laborers' & Employer Health & Welfare Fund).

Plan Sponsor - The term "Plan Sponsor" means the entity as defined in section 3 (16) (b) of ERISA, 29 U.S.C. § 1002 (10) (B). The Plan Sponsor is the Southern Illinois Laborers' & Employer Health & Welfare Fund .

Security Incidents- The term "Security Incidents" has a meaning set forth in 45 CFR § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

SECTION 2

PLAN SPONSOR OBLIGATIONS

Where Electronic Protected Health Information will be created, received or maintained or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan;
2. The Plan Sponsor shall ensure that the adequate separation that is required by 45 CFR § 164.504 (f) (2) (iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. The Plan Sponsor shall insure that any agent, including a subcontractor, to whom is provided Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and

The Plan Sponsor shall report to the Plan and Security Incidents of which it becomes aware as described below:

1. The Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification or destruction of the Plan's Electronic Protected Health Information; and
2. The Plan Sponsor shall report to the Plan any other security incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

SECTION 3

RESPONSIBILITIES FOR PLAN ADMINISTRATOR

The Southern Illinois Laborers' & Employer Health & Welfare Fund is to be administered by the Plan Administrator, also called the Plan Sponsor in accordance with the provisions of ERISA. An individual may be appointed to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies, or is otherwise removed from the position, Southern Illinois Laborers' & Employer Health & Welfare Fund shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

SECTION 4

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistences or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
9. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate.

SECTION 5

FIDUCIARY A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

SECTION 6

FIDUCIARY DUTIES A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3. In accordance with the Plan documents to the extent that they agree with ERISA.

SECTION 7

THE NAMED FIDUCIARY A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a Trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the name fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedure to appoint the fiduciary or continuing either the appointment or the procedures; or
2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with Plan's rules as established by the Trustees.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for employment.

SECTION 8

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping with pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, any overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of the overpayment will be deducted from future benefits payable.