**SOUTHERN ILLINOIS LABORERS & EMPLOYERS**
**HEALTH & WELFARE FUND**
**PLAN C - AMENDENTS**

This is an amendment to the Southern Illinois Laborers' & Employers Health & Welfare Fund's **Plan C** effective January 1, 2006.

The Trustees have entered into a contract with Healthlink to access their Open Access III product. In addition, the benefits available to retirees have been modified.

## AMENDMENT # 1

## SCHEDULE OF BENEFITS – C

| BENEFITS | TIER 1 HEALTHLINK CONTRACTED PROVIDER | TIER 2 HEALTHLINK CONTRACTED PROVIDER | TIER 3 OUT-OF-NETWORK PROVIDER |
|---|---|---|---|
| **MAJOR MEDICAL MAXIMUM**<br>SEE ARTICLE 2, SECTION 1 | Active Members - $250,000 Annual Major Medical Max with a $1,000,000 Lifetime Max<br>Retired Members - $50,000 Annual Major Medical Max with a $500,000 Lifetime Max*<br>*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 $50,000 within the calendar year of retirement. No further medical benefits are available thereafter. | | |
| **CALENDAR YEAR DEDUCTIBLE PER PERSON**<br>SEE ARTICLE 2, SECTION 3 | $500 – Active<br>$1,000 – Retired | $500 – Active<br>$1,000 – Retired | $1,000 – Active<br>$3,000 - Retired |
| **CALENDAR YEAR DEDUCTIBLE PER FAMILY**<br>SEE ARTICLE 2, SECTION 3 | $1,500 – Active<br>$3,000 – Retired | $1,500 – Active<br>$3,000 – Retired | $3,000 – Active<br>$6,000 – Retired |
| **OUT-OF-POCKET MAXIMUM**<br>PER PERSON<br>PER FAMILY UNIT<br>SEE ARTICLE 2, SECTION5 | $2,000<br>$6,000<br>DOES NOT INCLUDE DEDUCTIBLE | $2,000<br>$6,000<br>DOES NOT INCLUDE DEDUCTIBLE | $3,500<br>$10,500<br>DOES NOT INCLUDE DEDUCTIBLE |
| **HOSPITAL SERVICES** | | | |
| **INPATIENT**<br>SEE ARTICLE 2, SECTION 4 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **OUTPATIENT**<br>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 area or those full-time students attending school out of the PPO 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 percentages will be 80/20. The out-of-pocket maximum will apply. Also, subject to emergency room co-pay. | | | |
| **EMERGENCY ROOM**<br>SEE ARTICLE 2, SECTION 6 | 85% AFTER DEDUCTIBLE<br>PLUS $150 PER OCCURRENCE CO-PAY FOR NON-ACCIDENT | 80% AFTER DEDUCTIBLE<br>PLUS $150 PER OCCURRENCE CO-PAY FOR NON-ACCIDENT | 60% AFTER DEDUCTIBLE<br>PLUS $150 PER OCCURRENCE CO-PAY FOR NON-ACCIDENT |
| **PHYSICIAN SERVICES** SEE ARTICLE 2, SECTION 4 | | | |
| **OFFICE VISITS**<br>SEE ARTICLE 2, SECTION 4 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **SURGERY(INPATIENT OR OUT PATIENT)**<br>SEE ARTICLE 2, SECTION 4 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **INPATIENT VISITS**<br>SEE ARTICLE 2, SECTION 4 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **WELL CARE IN PHYSICIANS OFFICE** (ADULT OR CHILD)<br>SEE ARTICLE 2, SECTION 25 | $10 CO-PAY<br>$250 CALENDAR YEAR MAXIMUM PAID BENEFIT | $10 CO-PAY<br>$250 CALENDAR YEAR MAXIMUM PAID BENEFIT | $20 CO-PAY<br>$250 CALENDAR YEAR MAXIMUM PAID BENEFIT |
| **CHIROPRACTIC CARE**<br>(EXCLUDING X-RAYS & LAB CHARGES)<br>SEE ARTICLE 2, SECTION 7 | 85% AFTER DEDUCTIBLE<br>$600 CALENDAR YEAR MAXIMUM PAID BENEFIT | 80% AFTER DEDUCTIBLE<br>$600 CALENDAR YEAR MAXIMUM PAID BENEFIT | 60% AFTER DEDUCTIBLE<br>$600 CALENDAR YEAR MAXIMUM PAID BENEFIT |

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| **MATERNITY** (FEMALE EMPLOYEE & ELIGIBLE DEPENDENT SPOUSE)<br>SEE ARTICLE 2, SECTION 13 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **BENEFITS** | **TIER 1 HEALTHLINK CONTRACTED PROVIDER** | **TIER 2 HEALTHLINK CONTRACTED PROVIDER** | **TIER 3 OUT-OF-NETWORK PROVIDER** |
| **TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)**<br>SEE ARTICLE 2, SECTION 24 | 85% AFTER DEDUCTIBLE<br>$2,000 LIFETIME MAXIMUM | 80% AFTER DEDUCTIBLE<br>$2,000 LIFETIME MAXIMUM | 60% AFTER DEDUCTIBLE<br>$2,000 LIFETIME MAXIMUM |
| **SPEECH THERAPY**<br>SEE ARTICLE 2, SECTION 22 | 85% AFTER DEDUCTIBLE<br>50 VISITS $50 PER VISIT<br>PER CALENDAR YEAR | 80% AFTER DEDUCTIBLE<br>50 VISITS $50 PER VISIT<br>PER CALENDAR YEAR | 60% AFTER DEDUCTIBLE<br>50 VISITS $50 PER VISIT<br>PER CALENDAR YEAR |
| **PHYSICAL/OCCUPATIONAL THERAPY**<br>SEE ARTICLE 2, SECTION 23 | 85% AFTER DEDUCTIBLE<br>40 VISITS PER CALENDAR YEAR COMBINED | 80% AFTER DEDUCTIBLE<br>40 VISITS PER CALENDAR YEAR COMBINED | 60% AFTER DEDUCTIBLE<br>40 VISITS PER CALENDAR YEAR COMBINED |
| **ORGAN/TISSUE TRANSPLANTS** (DONOR CHARGES NOT COVERED)<br>SEE ARTICLE 2, SECTION 17 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **DURABLE MEDICAL EQUIPMENT**<br>SEE ARTICLE 2, SECTION 9 | 85% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE | 80% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE | 60% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE |
| **WHEELCHAIRS**<br>SEE ARTICLE 2, SECTION 9 | 50% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE<br>$5,000 LIFETIME MAXIMUM | 50% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE<br>$5,000 LIFETIME MAXIMUM | 50% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE<br>$5,000 LIFETIME MAXIMUM |
| **CONVALESCENT/SKILLED NURSING FACILITY CARE**<br>SEE ARTICLE 2, SECTION 8 | 85% AFTER DEDUCTIBLE<br>30 DAYS PER CALENDAR YEAR<br>60 DAYS LIFE MAXIMUM | 80% AFTER DEDUCTIBLE<br>30 DAYS PER CALENDAR YEAR<br>60 DAYS LIFE MAXIMUM | 60% AFTER DEDUCTIBLE<br>30 DAYS PER CALENDAR YEAR<br>60 DAYS LIFE MAXIMUM |
| **HOME HEALTH CARE**<br>4 HOURS = 1 VISIT<br>SEE ARTICLE 2, SECTION 10 | 85%AFTER DEDUCTIBLE<br>100 VISITS PER CALENDAR YEAR | 80%AFTER DEDUCTIBLE<br>100 VISITS PER CALENDAR YEAR | 60%AFTER DEDUCTIBLE<br>100 VISITS PER CALENDAR YEAR |
| **HOSPICE**<br>SEE ARTICLE 2, SECTION 12 | 85% AFTER DEDUCTIBLE<br>185 DAYS LIFETIME MAXIMUM | 80% AFTER DEDUCTIBLE<br>185 DAYS LIFETIME MAXIMUM | 60% AFTER DEDUCTIBLE<br>185 DAYS LIFETIME MAXIMUM |
| **SLEEP STUDY**<br>SEE ARTICLE 2, SECTION 20 | 85% AFTER DEDUCTIBLE<br>1 PER LIFETIME | 80% AFTER DEDUCTIBLE<br>1 PER LIFETIME | 60% AFTER DEDUCTIBLE<br>1 PER LIFETIME |

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

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| **SMOKING CESSATION PROGRAM**<br>SEE ARTICLE 2, SECTION 21 | 80% NO DEDUCTIBLE – OVER THE COUNTER<br>6 MONTH LIFETIME MAXIMUM |

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| **VISION BENEFITS**<br>SEE ARTICLE 2, SECTION 26 | 100% NO DEDUCTIBLE - $200 PER CALENDAR YEAR/PER PERSON<br>INCLUDES EYE EXAM, LENSES, FRAMES, AND/OR CONTACTS<br>**WAL-MART IS NOT A COVERED VISION PROVIDER** |

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| **DENTAL BENEFITS** – SEE ARTICLE 2, SECTION 27 | |
| **DEDUCTIBLE** | $50 FOR CATEGORIES B,C.D OR ANY COMBINATION THEREOF |
| **PERCENTAGE PAYABLE** | 80% CATEGORIES A & B<br>50% CATEGORIES C & D |
| **MAXIMUMS** | $1,000 PER PERSON/PER CALENDAR YEAR CATEGORIES A, B, & C |

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| **POLICY EXCLUSIONS & LIMITATIONS**<br>SEE ARTICLE 8 |

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| **DEATH BENEFITS**<br>SEE ARTICLE 2, SECTION 28 | EMPLOYEE - $12,000<br>The amount of death benefit will be reduced as shown below:<br>1. Upon attaining age 65 to 65% of death benefit<br>2. Upon attaining age 70 to 45% of death benefit<br>3. Upon attaining age 75 to 30% of death benefit |

| PHARMACY BENEFITS | LDI<br>3 TIER FORMUALRY | ANY OTHER STORE |
|---|---|---|
| **RETAIL (LDI)**<br>30 DAY SUPPLY<br>INITIAL PRESCRIPTION & TWO REFILLS<br>SEE ARTICLE 2, SECTION 18 | $5.00 PER PRESCRIPTION GENERIC<br>$20.00 PER PRESCRIPTON FORMULARY<br>$35.00 PER PRESCRIPITON NON-FORMULARY | NONE |
| **MAIL ORDER (LDI)**<br>**MAINTENANCE MEDICATIONS**<br>90 DAY SUPPLY<br>SEE ARTICLE 2, SECTION 18 | $10.00 PER PRESCRIPTION GENERIC<br>$40.00 PER PRESCRIPTON FORMULARY<br>$70.00 PER PRESCRIPITON NON-FORMULARY | NONE |
| **SPECIALTY MEDICATIONS & BIO-INJECTABLES**<br>OBTAINED TRHU LDI PHARMACY OR MAIL ORDER<br>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**<br>SEE ARTICLE 2, SECTION 19 & ARTICLE 9, SECTION 47 | $100 CO-PAY<br>REMAINING LDI DISCOUNTED AMOUNT<br>SUBJECT TO PLAN'S REGULAR CALENDAR<br>YEAR DEDUCTIBLE AND CO-INSURANCE | NONE |

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

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

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

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

**WHENEVER THERE IS A NEED FOR A 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 NOT CERTIFIED |
|---|---|---|---|
| **INPATIENT HOSPITAL EXPENSES** – For Mental Health and/or Substance Abuse or any combination thereof are limited to 30 days per calendar year or 60 days calendar year partial hospitalization. (1 in-patient day = 2 out-patient days). All care & treatment of substance abuse is further limited to a maximum payment of $50,000 whether in-patient or our-patient or any combination of charges. | | | |
| **HOSPITAL/FACILITY IN-PATIENT OR OUT – PATIENT** SEE ARTICLE 2, SECTION 14 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | NONE |
| **PHYSICIAN OFFICE VISITS IN-PATIENT OR OUT-PATIENT** SEE ARTICLE 2, SECTION 14 | 85% 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<br>$20.00 PER PRESCRIPTION FORMULARY<br>$35.00 PER PRESCRIPITON NON-FORMULARY | $5.00 PER PRESCRIPTION GENERIC<br>$20.00 PER PRESCRIPTION FORMULARY<br>$35.00 PER PRESCRIPITON NON-FORMULARY | NONE |
| **MAILORDER (LDI) MAINTENANCE DRUGS** 90 DAY SUPPLY SEE ARTICLE 2, SECTION 14 | $10.00 PER PRESCRIPTION GENERIC<br>$40.00 PER PRESCRIPTION FORMULARY<br>$70.00 PER PRESCRIPITON NON-FORMULARY | $10.00 PER PRESCRIPTION GENERIC<br>$40.00 PER PRESCRIPTION FORMULARY<br>$70.00 PER PRESCRIPITON NON-FORMULARY | NONE |
| **MANDATORY GENERIC SUBSTITUTION – IF GENERIC IS AVAILABLE AND BRAND DISPENSED MEMBER PAYS CO-PAY PLUS COST DIFFERENTIAL WAL-MART IS NOT A COVERED PROVIDER OF PRESCRIPTION DRUGS** | | | |

## Change Article 3 – ELIGIBILITY/PARTICIPATION IN HEALTH CARE BENEFITS, Section Self-Contributions page 20, to now read:

1. 350 hours in the current quarter;
2. 700 hours in the preceding two quarters;
3. 1050 hours in the preceding three quarters;
4. 1400 hours in the preceding four quarters.

**Whichever is the lesser amount at the current contribution rate**

Effective January 1, 2006, the self-contributions will be limited to six (6) consecutive quarters. Any participant who has made self contributions for six 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 the SPD for information on COBRA rights).

If you 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.***

**Add to ARTICLE 11 – COORDINATION OF BENEFITS – BENEFIT COMBINING PROVISIONS page 47**

5. No coverage of any kind under this plan shall be afforded to a participant's dependent who has medical coverage of any kind under his or her employer's plan unless the employer's plan provides the same maximum benefits to all its employees irrespective of the coverage the employee (or the person of whom he or she is a dependent) may have in another plan. Any dependent of a participant adversely affected by this provision shall be entitled to appeal to the Board of Trustees for determination of hardship exceptions based upon circumstances beyond the control of said dependent and the assignment, by the dependent to the Board of Trustees, of available remedies against the dependent's employer and/or the employer's Plan or Insurer.

# AMENDMENT # 2

These changes are to be made effective January 1, 2006 as the Trustees have restated the Coordination of Benefits section.

**Change and restate Article 11 (page 47) to read as follows:**

**ARTICLE 11 - COORDINATION OF BENEFITS (COB) - BENEFIT COMBINING PROVISIONS**

## APPLICABILITY

Coordination of benefits (COB) applies when a Plan Participant has health coverage under one or more **Benefit Plan(s)**, which will pay part or all of the expense incurred for an **Allowable Expense.** This is done to ensure that the amount of benefits payable for an **Allowable Expense** under **This Plan** and any other **Benefit Plan(s)** 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 that would have been paid if there were no other **Benefit Plan(s)** involved. The terms **Benefit Plan(s)** and **This Plan** are defined below.

If COB applies, the order of benefit determination rules should be looked at first. Those rules determine when the benefits of **This Plan** are determined either before or after those of another **Benefit Plan(s)** are determined. The benefits of **This Plan**:

1. Shall not be reduced when under the order of benefit determination rules, **This Plan** determines it' benefits before another **Benefit Plan(s)**; but

2. May be reduced when under the order of benefit determination rules, another **Benefit Plan(s)** determines its benefit first.

This reduction is further described in EFFECT ON BENEFITS section set forth below.

***DEFINITIONS***

"**Allowable Expense(s)**" means any reasonable, necessary, and customary expenses incurred while covered under **This Plan**, part or all of which would be covered under **This Plan. Allowable Expense(s)** do not include expenses contained in the "Exclusions" sections of **This Plan.**

When **This Plan** is secondary, "**Allowable Expense**" will include any deductible or coinsurance amounts not paid by the other **Benefit Plan(s).**

When **This Plan** is secondary, "**Allowable Expense**" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the plan participant or covered person for the difference between the provider's contracted amount and the provider's regular billed charge.

**Claim Determination Period -** means a Plan Year. However, it does not include any part of a year during which a person had no coverage under **This Plan**.

**Benefit Plan(s) -** means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such **Benefit Plan(s)** shall include, without limitation:

- Group, blanket or franchise insurance coverage;
- Blue Cross, Blue Shield, group practice, individual practice and other pre-payment coverage;
- Any coverage under a jointly trusteed labor-management plan, union welfare plans, employer organization plans or employee benefit organization plans;
- A licensed Health Maintenance Organization (HMO);
- Any federal, state or local governmental program, including Medicare or coverage required or provided by any statute. This does not, however, include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.) Note: for purposes of **This Plan**, any person who is covered under Medicare Part "A" is also deemed covered under Medicare Part "B";
- Any plan or policies funded in whole or in party by an employer, or deductions made by an employer from an employee's compensation or retirement benefits;
- Any coverage for students, other than accident coverage, for which the parent payment pays the entire premium, which is sponsored by, or provided through a school or other educational institution; and
- Group, group-type and individual automobile "no-fault" contracts, including individual auto insurance coverage on automobiles leased or owned by the employer. **This Plan** is always a secondary plan to benefits provided under any mandatory "no-fault" auto insurance act in the state in which the Plan Participant resides.

Each contract or other arrangement for coverage stated above means a separate **Benefit Plan(s)**.
Also, if an arrangement has two parts and COB rules apply to one of the two, each of the parts is construed to mean a separate **Benefit Plan(s).**

**Benefit Plan(s)** does not mean non-group hospital or surgical indemnity plans or individual or family insurance or subscriber contracts.

**This Plan** means the Southern Illinois Laborers' and Employers Health & Welfare Fund.

***ORDER OF BENEFIT DETERMINATION***

**A. GENERAL** - When there is a basis for a claim under **This Plan** and one or more **Benefit Plan(s)**, **This Plan** is a Secondary Plan unless:

1. The other **Benefit Plan(s)** has rules which coordinate it's benefits with those of **This Plan** and
2. The rules of both of the other **Benefit Plan(s)** and **This Plan** require that **This Plan** be the primary plan.

B. **RULES -** The rules establishing the order of benefit determination are as follows:

1. **Employee/dependent** - The **Benefit Plan(s)** that covers the person as an employee or non-dependent, rather than as a dependent, is primary. The **Benefit Plan(s)** that covers the person as a dependent is secondary.

2. **Dependent child/parent not legally separated or divorced -** except as stated in item B.3 below, when **This Plan** and another **Benefit Plan(s)** cover the same child as a dependent of his or her parents:

    a. The benefits of the **Benefit Plan(s)** of the parent whose birthday falls earlier in the year are primary and are determined before those of the **Benefit Plan(s)** of the parent whose birthday falls later in that year; but

    b. If both parents have the same birthday, the benefits of the **Benefit Plan(s)** which covered one parent longer, are primary and are determined before those the **Benefit Plan(s)** which covered the other parent the shorter period of time.

3. **Dependent child/parents legally separated or divorced -** If two or more **Benefit Plan(s)** cover a dependent child of divorced or legally separated parents, benefits for the child are determined in the following order:

    i. First, the **Benefit Plan(s)** of the parent with custody shall be primary;
    ii. Then, the **Benefit Plan(s)** of the spouse of the parent with custody of the child
    iii. Finally, the **Benefit Plan(s)** of the parent not having custody of the child.

    Notwithstanding (a) through (c), 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 primary and shall be determined before the benefits of any other **Benefit(s) Plan** which covers the child as a dependent child. The **Benefit Plan(s)** of the other parent shall be the secondary **Benefit Plan(s)**.

b. **Active/inactive employee -** The **Benefit Plan(s)** which covers a person as an employee who is neither laid off nor retired (or as that employee=s dependent) will be primary over the **Benefit Plan(s)** that covers the person as a laid off or retired employee (or as that employee's dependent).

c. **Continuation coverage -** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another **Benefit Plan(s)**, the benefits of the **Benefit Plan(s)** that covers the person as an active employee shall be primary and shall be determined before the benefits of the continuation coverage.

d. **Longer/shorter length of coverage -** If none of the above rules determines the order of benefits, the **Benefit Plan(s)** that covered the employee the longest is primary.

No coverage of any kind under **This Plan** shall be afforded to a participant's dependent who has medical coverage of any kind under his or her employer's plan unless the employer's plan provides the same maximum benefit to all it's employees irrespective of the coverage the employee (or the person of whom he or she is a dependent) may have in another plan. Any dependent of a participant adversely affected by this provision shall be entitled to appeal to the Board of Trustees for determination of hardship exceptions based upon circumstances beyond the control of said dependent and the assignment, by the dependent to the Board of Trustees, of available remedies against the dependent's employer and/or the employer's Plan or Insurer.

***EFFECT ON BENEFITS***

If **This Plan** is a secondary plan in accordance with the order of benefit determination rules, the benefits of **This Plan** will be reduced when the sum of 1 and 2 below, exceed the Allowable Expenses in a plan year.

1. The benefits payable for the Allowable Expenses under **This Plan** in the absence of this COB provision; and

2. The benefits payable for the Allowable Expenses under the other **Benefit Plan(s)**, in the absence of a similar COB provision, whether or not claim is made.

In such event, the benefits of **This Plan** will be reduced so that they, plus the benefits payable under the other **Benefit Plan(s),** do not total more than those Allowable Expenses. When the benefits of **This Plan** are reduced as described above, each benefit is reduced in proportion. It is then charged against any benefit limit of **This Plan** that applies.

***RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION***

Certain facts are needed to apply these COB rules. The Plan Sponsor has the right to decide which facts it requires. **This Plan** may, without the consent of or notice to any person or insurance company, release to or obtain from any other insurance company or other organization or person any information, which **This Plan** deems necessary for the purposes of this provision. Any person claiming benefits under **This Plan** must furnish the Plan Sponsor any facts it needs to pay the claim.

***RIGHT OF RECOVERY***

If the amount of payment made under **This Plan** is more that it should have paid under this COB provision, the Plan Sponsor may recover the excess from one or more of:

1. The person(s) it has paid or for whom it has paid
2. Insurance companies
3. Other organizations or entities

## AMENDMENT # 3

This change is to be made effective May 11, 2006 and restates the Home Health Benefits as follows:

**Change and restate Article 2, Section 11 (page 7-8) to read as follows:**

**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 attending physician must establish 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;
2. 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
3. The amount payable for all such services and supplies will not exceed the amount that is own 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;
5. Allowable drugs and medications prescribed by a physician if not provided under the Plan's Prescription Drug and/or Specialty Drug Program; and
6. 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.

## AMENDMENT # 4

Effective this 11th day of May 2006, Article 3, entitled "Eligibility/Participation in Health Care Benefits, Section 3 entitled Dependent Eligibility of the Summary Plan Description and Plan Document is hereby deleted and replaced with the following language:

**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 age 23 and previously lost coverage as a full-time student under a group health plan due to o longer meeting the plan requirement of a student, 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. Adopted children, stepchildren or children for whom the participant has been appointed permanent legal guardian by a court of competent jurisdiction, provided that, such children are dependent upon the covered employee/participant for support and maintenance. Adopted children are children that are legally adopted or placed with the covered employee/participant for adoption.
5. Children or 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 (ie the child) to be enrolled under the group health plan. The QMSCO 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, subject to the employee continuing to meet the eligibility requirements. The Trustees may request proof of incapacity from time to time.

**YOUR EMPLOYER MUST MAKE THE REQUIRED CONTRIBUTION IN ORDER TO BE ELIGIBLE FOR DEPENDENT COVERAGE**

## AMENDMENT # 5

Effective this 1st day of January 2007, Article 2, entitled "Summary of Benefits", Section 27 entitled "Dental Benefits", Category B – Dental Services of the Summary Plan Description and Plan Document is hereby deleted and replaced with the following language:

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

| Covered Procedure | Limitations |
|---|---|
| 1. Fillings | Amalgam, silicate, acrylic, synthetic porcelain or Composite fillings |
| 2. Extractions and Oral Surgery | |
| 3. General Anesthetics | |
| 4. Periodontal treatment of gums | |
| 5. Endodontic treatment of dental pulp, Including root canal therapy | |
| 6. Drugs for treatment of dental disease/injury When administered by the attending dentist | |

## AMENDMENT # 6

Effective this 1st day of January 2007, Article 1, entitled "Schedule of Benefits - A"; and Article 2, entitled "Summary of Benefits", Section 25 of the Summary Plan Description and Plan Document is hereby deleted and replaced with the following language:

**SCHEDULE OF BENEFITS – A**

| Benefit | Tier 1 Healthlink | Tier 2 Healthlink | Tier 3 Out-of-Network |
|---|---|---|---|
| Well Care in Physician Office (Adult) | $10 co-pay $350 calendar yr Maximum Paid | $10 co-pay $350 calendar yr Maximum Paid | $20 co-pay $350 calendar yr Maximum Paid |
| Well Care in Physician Office (Child – birth to age 19) | $10 co-pay $250 calendar yr Maximum Paid | $10 co-pay $250 calendar yr Maximum Paid | $20 co-pay $250 calendar yr Maximum Paid |

**SUMMARY OF BENEFITS, SECTION 25**

**WELLNESS BENEFIT – ANNUAL PREVENTION CARE**

Maximum payment of $350 per eligible adult, per calendar year. Charges in excess of the $350 maximum payment are not covered by the Plan.

Maximum payment of $250 per eligible child (birth to age 19) 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

## AMENDMENT #7
AS OF 2/15/07

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers' Health & Welfare Fund may amend the Summary Plan Description pursuant to Article 13 of the Plan; and

NOW THEREFORE, the Trustees hereby adopt the following amendment and amend Article 8, Paragraph 1 of the Summary Plan Description to read as follows:

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. The Plan shall withhold benefits for any injury, which may be compensable under Workers' Compensation or Occupational Disease Law until you have made a reasonable effort to exhaust your claim to benefits under Workers' Compensation or Occupational Disease Law. A "reasonable effort" to exhaust your claim for benefits includes (1) securing a final determination of your claim from the Illinois Workers Compensation Commission, or similar state entity designed to adjudicate workers' compensation or occupational disease claims, or (2) demonstrati1ng, by appeal, to the Board of Trustees by clear and convincing evidence that filing a claim for Workers Compensation or occupational disease benefits is futile and would not result in the award of benefits.

# AMENDMENT # 8

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers' Health & Welfare Fun may amend the Summary Plan Description; and

NOW THEREFORE, the Trustees hereby adopt the following amendment adding to Article 14- PAYMENT OF BENEFITS, Section 4 – REFUNDS to read as follows:

**SECTION 4 – REFUNDS**

Any benefit payment made in error due to misinformation or lack of information provided by the member, the member's dependents, and/or provider(s) or due to an error in calculation and regardless of the date of the payment, may require the Fund Office to request a refund.

If the outstanding amount owed has resulted from any act or omission, misinformation or a lack of information provided by the member or the member's dependents, and not otherwise recovered from a provider, the member or the member's dependents, the Fund Office may reduce or offset benefit payments from future claims submitted by the member or dependents until the plan has recovered the benefit overpayment.

# AMENDMENT # 9

WHEREAS, the board of Trustees of the Southern Illinois Laborers' & Employers' Health & Welfare Fund may amend the Summary Plan Description pursuant to Article 13 of the Plan; and

WHEREAS, the Trustees, upon review of Article 7, Paragraph 23 of the Summary Plan Description have determined that Paragraph 23 shall be amended to include language to better serve the interests of the Plan; and

NOW THEREFORE, the Trustees amend Article 7, Paragraph 23 of the Summary Plan Description to read as follows:

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 are concerned:

**23. One dietary counseling session within six months of initial diagnosis of diabetes. Thereafter, one dietary counseling session shall be covered during each twelve-month period after the initial session. Each dietary counseling session must be prescribed, in writing, by a treating physician.**

# AMENDMENT # 10

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers Health & Welfare Fund may amend the Summary Plan Description pursuant to Article 13 of the Plan; and

WHEREAS, the Trustees, have agreed to make a plan improvement to the Well Care Benefit, effective January 1, 2009.

NOW THEREFORE, the Trustees amend Article 2, Section 25 of the Summary Plan Description to read as follows:

SCHEDULE OF BENEFITS

| Benefit | Tier 1 Healthlink | Tier 2 Healthlink | Tier 3 Out-of-Network |
|---|---|---|---|
| Well Care in Physician Office (Adult) | $10 co-pay<br>$500 calendar year Maximum Paid | $10 co-pay<br>$500 calendar year Maximum Paid | $20 co-pay<br>$500 calendar year Maximum Paid |
| Well Care in Physician Office (Child – birth to age 19) | $10 co-pay<br>$300 calendar year Maximum Paid | $10 co-pay<br>$300 calendar year Maximum Paid | $20 co-pay<br>$300 calendar year Maximum Paid |

ARTICLE 2 – WELLNESS BENEFIT – ANNUAL PREVENTION CARE

Maximum payment of $500 per eligible adult, per calendar year. Charges in excess of the $500 maximum payment are not covered by the Plan.

Maximum payment of $300 per eligible child (birth to age 19), per calendar year. Charges in excess of the $300 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 a $20 co-pay for a non-PPO provider. Ancillary services rendered in connection with a well-care visit are paid 100% up to the maximum payment.

# AMENDMENT #11

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers Health & Welfare Fund may amend the Summary Plan Description pursuant to Article 13 of the Plan; and

WHEREAS, the Trustees, have agreed to make plan improvements, effective January 1, 2009 (for continued eligibility rules – effective with work performed beginning February 1, 2009),

NOW THEREFORE, the Trustees amend Article 2, Section 1 of the Summary Plan Description to read as follows:

Schedule of Benefits

| Benefit | Tier 1 Healthlink | Tier 2 Healthlink | Tier 3 Out-of-Network |
|---|---|---|---|
| **Major Medical Maximum**<br>Active Members - $1,000,000 Lifetime Maximum Benefit<br>Retired Members - $250,000 Annually with a $500,000 Lifetime Maximum Benefit | | | |

- Change the dental plan, Category C to now read:

**Category C – Major Restorative/Prosthodontics**

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

iii. The replacement of/or addition to existing bridgework or denture or the initial bridgework or dentures is made for a participant of the Fund after continuous coverage during any consecutive twelve (12) month period.

- Change INITIAL ELIGIBILITY to now read as follows:

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 (2) contribution quarters;
3. 1,000 hours in four (4) 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:*

*300 hours for the preceding contribution quarter prior to the eligibility quarter*
*600 hours for the preceding two (2) contribution quarters prior to the eligibility quarter*
*900 hours for the preceding three (3) contribution quarters prior to the eligibility quarter*
*1,200 hours for the preceding four (4) contribution quarters prior to the eligibility quarter*

# AMENDMENT # 12

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers Health & Welfare Fund may amend the Summary Plan Description pursuant to Article 13 of the Plan; and

WHEREAS, the Trustees, have agreed to clarify certain sections of the plan effective April 1, 2009.

NOW THEREFORE, the Trustees amend Article 2, Section 15 of the Summary Plan Description to read as follows:

**MOUTH CONDITIONS**

Subject to the exclusions set forth in the Dental Exclusions and Limitations and other Exclusions and Limitations set forth in this Summary Plan Description, the Plan will pay for the following:

1. The dentist's fee for removing fully or partially bony impacted bony 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 with 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 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 surrounding and supplemental tissue of the teeth);
2. Deformities of the bone/jaw surrounding the teeth;
3. Malocclusion (abnormal positional and/or relationship to teeth);
4. Ailments or defects of the teeth and supporting tissues and bone/jaw (excluding appliances used to close an acquitted or congenital opening); or
5. Tooth, extractions or other dental care or surgery, except as outlined under Mouth Conditions;

6. Dental implants;
7. 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
8. Charges for services or supplies which are not generally accepted by the dental profession and are, in the Trustee's judgment, experimental or investigational are not covered by the Plan.

**NOW THEREFORE**, the Trustees amend Article 4, Section 2 of the Summary Plan Description to comply with the HIPPA Portability, Privacy and Security regulations and will now read as follows:

**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, or;

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 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 dependant 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 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; or

Effective April 1, 2009-
Individuals who lose their coverage under Medicaid or under a state children's health insurance program (SCHIP) have 60 days after the termination of coverage to request a special enrollment.

Individuals who were eligible for a state premium assistance subsidy through Medicaid or SHCIP and lose coverage under Medicaid or SCHIP have 60 days after the termination of coverage to request a special enrollment.

# AMENDMENT #13

WHEREAS, the Trust Document and Summary Plan Description ("Plan") grants to the Trustees to amend provisions of the plan from time to time; and

WHEREAS, it is the desire of the Trustees to amend the Plan to comply with the new federal law commonly referred to as "Michelle's Law" to become effective January 1, 2010.

***NOW THEREFORE***, the Plan shall be amended as follows:

Article 3, add Section 7a

**Michelle's Law**

A dependent enrolled in the Plan on the basis of being a student at a postsecondary educational institution immediately before the first day of a medically necessary leave of absence from school, shall be treated as a full-time student for one (1) year after the first day of the medically necessary leave of absence or until the date on which such coverage would otherwise terminate under the terms of the Plan (such as attaining a maximum age for full-time student coverage).

A medically necessary leave of absence occurs when a dependent, whose coverage is contingent upon maintaining a full-time student status, starts a leave of absence from schools that (i) commences while the student is suffering from a serious illness or injury; (ii) is medically necessary; and (iii) would ordinarily cause the dependent to lose full-time student status for purposes of coverage under the terms of the Plan. Such leave of absence applies only when the Plan is provided with a certification by the treating physician that verifies that (i) the dependent is suffering from a serious illness or injury, and the leave of absence is medically necessary.

# AMENDMENT #14

WHEREAS, the Trust Document and Summary Plan Description ("Plan") grants to the Trustees to amend provisions of the Plan from time to time; and

WHEREAS, it is the desire of the Trustees to amend the Plan to comply with the new federal law relative to mental health to become effective January 1, 2010.

***NOW THEREFORE***, the Plan shall be amended as follows:

Article 2, **remove** from Section 14 the paragraph that reads:

Limits: 30 days in-patient care per calendar year or 60 days out-patient 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.

# Amendment #15

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers Health & Welfare Fund may amend the Summary Plan Description pursuant to Article 13 of the Restated Agreement and Declaration of Trust; and

NOW THEREFORE, the Trustees hereby adopt the following amendment effective August 1, 2011 revising and replacing Article 1 of the Summary Plan Description entitled "Schedule of Benefits" in its entirety to now read as follows:

## SCHEDULE OF BENEFITS – PLAN C

| BENEFITS | TIER 1<br>HEALTHLINK<br>CONTRACTED PROVIDER | TIER 2<br>HEALTHLINK<br>CONTRACTED PROVIDER | TIER 3<br>OUT-OF-NETWORK<br>PROVIDER |
|---|---|---|---|
| **MAJOR MEDICAL LIFETIME MAXIMUM**<br>SEE ARTICLE 2, SECTION 1 | UNLIMITED | | |
| **MAJOR MEDICAL ANNUAL MAXIMUM – ACTIVE MEMBERS** | Plan Year Beginning August 1, 2011 - $1,000,000 Annual Maximum<br>Plan Year Beginning August 1, 2012 - $1,250,000 Annual Maximum<br>Plan Year Beginning August 1, 2013 - $2,000,000 Annual Maximum<br>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<br>Plan Year Beginning August 1, 2012 - $1,250,000 Annual Maximum<br>Plan Year Beginning August 1, 2013 - $2,000,000 Annual Maximum<br>Plan Year Beginning August 1, 2014 and Subsequent Years – No Annual Maximum | | |
| **CALENDAR YEAR DEDUCTIBLE PER PERSON**<br>SEE ARTICLE 2, SECTION 3 | $500 – Active<br>$1,000 - Retired | $500 – Active<br>$1,000 - Retired | $1,000 – Active<br>$3,000 - Retired |
| **CALENDAR YEAR DEDUCTIBLE PER FAMILY**<br>SEE ARTICLE 2, SECTION 3 | $1,500 – Active<br>$3,000 - Retired | $1,500 – Active<br>$3,000 - Retired | $3,000 - Active<br>$6,000 - Retired |
| **OUT-OF-POCKET**<br>PER PERSON<br>PER FAMILY UNIT<br>SEE ARTICLE 2, SECTION 5 | <br>$2,000<br>$6,000<br>DOES NOT INCLUDE DEDUCTIBLE | <br>$2,000<br>$6,000<br>DOES NOT INCLUDE DEDUCTIBLE | <br>$3,500<br>$10,500<br>DOES NOT INCLUDE DEDUCTIBLE |
| **HOSPITAL SERVICES** | | | |
| **INPATIENT**<br>SEE ARTICLE 2, SECTION 4 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **OUTPATIENT**<br>SEE ARTICLE 2, SECTION 4 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **WRAP AROUND** – If a member utilized 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 utilized 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**<br>SEE ARTICLE 2, SECTION 6 | 85% AFTTER DEDUCTIBLE<br>PLUS $150 PER OCCURRENCE CO-PAY FOR NON-ACCIDENT | 80% AFTER DEDUCTIBLE<br>PLUS $150 PER OCCURRENCE CO-PAY FOR NON-ACCIDENT | 60% AFTER DEDUCTIBLE<br>PLUS $150 PER OCCURRENCE CO-PAY FOR NON-ACCIDENT |
| **PHYSICIAL SERVICES** SEE ARTICLE 2, SECTION 4 | | | |
| **OFFICE VISITS**<br>SEE ARTICLE 2, SECTION 4 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **SURGERY (INPATIENT OR OUTPATIENT)**<br>SEE ARTICLE 2, SECTION 4 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |

| BENEFITS | TIER 1<br>HEALTHLINK<br>CONTRACTED PROVIDER | TIER 2<br>HEALTHLINK<br>CONTRACTED PROVIDER | TIER 3<br>OUT-OF-NETWORK<br>PROVIDER |
|---|---|---|---|
| **WELL-CARE IN PHYSICIANS OFFICE**<br>SEE ARTICLE 2, SECTION 25 | $10 CO-PAY | $10 CO-PAY | $20 CO-PAY |
| **CHIROPRACTIC CARE**<br>(EXCLUDING X-RAYS & LAB CHARGES)<br>SEE ARTICLE 2, SECTION 7 | 85% AFTER DEDUCTIBLE<br>$600 CALENDAR YEAR MAXIMUM PAID BENEFIT | 80% AFTER DEDUCTIBLE<br>$600 CALENDAR YEAR MAXIMUM PAID BENEFIT | 60% AFTER DEDUCTIBLE<br>$600 CALENDAR YEAR MAXIMUM PAID BENEFIT |
| **MATERNITY** (FEMALE EMPLOYEE & ELIGIBLE DEPENDENT SPOUSE)<br>SEE ARTICLE 2, SECTION 13 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)**<br>SEE ARTICLE 2, SECTION 24 | 85% AFTER DEDUCTIBLE<br>$2,000 LIFETIME MAXIMUM | 80% AFTER DEDUCTIBLE<br>$2,000 LIFETIME MAXIMUM | 60% AFTER DEDUCTIBLE<br>$2,000 LIFETIME MAXIMUM |
| **PHYSICAL/OCCUPATIONAL/ SPEECH THERAPY**<br>SEE ARTICLE 2, SECTIONS 22 & 23 | 85% AFTER DEDUCTIBLE<br>50 VISITS PER CALENDAR YEAR COMBINED | 80% AFTER DEDUCTIBLE<br>50 VISITS PER CALENDAR YEAR COMBINED | 60% AFTER DEDUCTIBLE<br>50 VISITS PER CALENDAR YEAR COMBINED |
| **ORGAN/TISSUE TRANSPLANTS** (DONOR CHARGES NOT COVERED)<br>SEE ARTICLE 2, SECTION 17 | 85% AFTER DEDUCTIBLE | 80% AFTER DEDUCTIBLE | 60% AFTER DEDUCTIBLE |
| **DURABLE MEDICAL EQUIPMENT**<br>SEE ARTICLE 2, SECTION 9 | 85% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE | 80% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE | 60% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE |
| **WHELLCHAIRS**<br>SEE ARTICLE 2, SECTION 23 | 50% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE<br>$1,000 PER WHEELCHAIR MAXIMUM BENEFIT | 50% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE<br>$1,000 PER WHEELCHAIR MAXIMUM BENEFIT | 50% AFTER DEDUCTIBLE<br>RENTAL UP TO PURCHASE PRICE<br>$1,000 PER WHEELCHAIR MAXIMUM BENEFIT |
| **CONVALESCENT/SKILLED NURSING FACILITY CARE**<br>SEE ARTICLE 2, SECTION 8 | 85% AFTER DEDUCTIBLE<br>30 DAYS PER CALENDAR YEAR | 80% AFTER DEDUCTIBLE<br>30 DAYS PER CALENDAR YEAR | 60% AFTER DEDUCTIBLE<br>30 DAYS PER CALENDAR YEAR |
| **HOME HEALTH CARE**<br>4 HOURS = 1 VISIT<br>SEE ARTICLE 2, SECTION 12 | 85% AFTER DEDUCTIBLE<br>100 VISITS PER CALENDAR YEAR | 80% AFTER DEDUCTIBLE<br>100 VISITS PER CALENDAR YEAR | 60% AFTER DEDUCTIBLE<br>100 VISITS PER CALENDAR YEAR |
| **HOSPICE**<br>SEE ARTICLE 2, SECTION 12 | 85% AFTER DEDUCTIBLE<br>185 DAYS ANNUAL MAXIMUM | 80% AFTER DEDUCTIBLE<br>185 DAYS ANNUAL MAXIMUM | 60% AFTER DEDUCTIBLE<br>185 DAYS ANNUAL MAXIMUM |
| **SLEEP STUDY**<br>SEE ARTICLE 2, SECTION 20 | 85% AFTER DEDUCTIBLE<br>1 PER LIFETIME | 80% AFTER DEDUCTIBLE<br>1 PER LIFETIME | 60% AFTER DEDUCTIBLE<br>1 PER LIFETIME |

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

| | |
|---|---|
| **SMOKING CESSATION PROGRAM**<br>SEE ARTICLE 2, SECTION 21 | 80 % NO DEDUCTIBLE – OVER THE COUNTER<br>6 MONTH LIFETIME |
| **VISION BENEFITS – NOT AVAILABLE TO RETIREES**<br>SEE ARTICLE 2, SECTION 26 | 100% NO DEDUCTIBLE - $200 PER CALENDAR YEAR/PER PERSON<br>INCLUDES EYE EXAM, LENSES, FRAMES, AND/OR CONTACTS<br><br>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.<br><br>**WAL-MART IS NOT A COVERED VISION PROVIDER** |

| **DENTAL BENEFITS** – NOT AVAILABLE TO RETIREES<br>SEE ARTICLE 2, SECTION 27 | |
|---|---|
| **DEDUCTIBLE** | $50 FOR CATEGORIES B,C,D OR ANY COMBINATION THEREOF |
| **PERCENTAGE PAYABLE** | 80% CATEGORIES A & B<br>50% CATEGORIES C & D |
| **MAXIMUMS** | $1,000 PER PERSON/PER CALENDAR YEAR CATEGORIES A, B & C (combined)<br>$1,000 LIFETIME MAXIMUM CATEGORY D (Eligible dependents age 6-18)<br><br>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 LIMIATIONS. |

| **POLICY EXLUSIONS & LIMITATIONS**<br>SEE ARTICLE 8 |
|---|

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

| **PHARMACY BENEFITS** | **LDI**<br>**3 TIER FORMULARY** | **ANY OTHER STORE** |
|---|---|---|
| **RETAIL (LDI)**<br>30 DAY SUPPLY<br>INITIAL PRESCRIPTION & TWO REFILLS<br>SEE ARTICLE 2, SECTION 8 | $5.00 PER PRESCRIPTION GENERIC<br>$20.00 PER PRESCRIPTION FORMULARY<br>$35.00 PER PRESCRIPTION NON-FORMULARY | NONE |
| **MAIL ORDER (LDI)**<br>**MAINTENANCE MEDICATIONS**<br>90 DAY SUPPLY<br>SEE ARTICLE 2, SECTION 18 | $10.00 PER PRESCRIPTION GENERIC<br>$40.00 PER PRESCRIPTION FORMULARY<br>$70.00 PER PRESCRIPTION NON-FORMULARY | NONE |
| **SPECIALTY MEDICATIONS & BIO-INJECTABLES**<br>OBTAINED THRU LDI PHARMACY OR MAIL ORDER<br>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**<br>SEE ARTICLE 2, SECTION 19 & ARTICLE 9, SECTION 47 | $100 CO-PAY<br>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 $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 1-618-998-1300**

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

**CANCER RELATED DRUGS ARE EXLUDED 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 | | | |
| **RETAIN (LDI)** 30 DAY SUPPLY SEE ARTICLE 2, SECTION 14 | $5.00 PER PRESCRIPTION GENERIC<br>$20.00 PER PRESCRIPTION FORMULARY<br>$35.00 PER PRESCRIPTION NON-FORMULARY | $5.00 PER PRESCRIPTION GENERIC<br>$20.00 PER PRESCRIPTION FORMULARY<br>$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<br>$40.00 PER PRESCRIPTION FORMULARY<br>$70.00 PER PRESCRIPTION NON-FORMULARY | $10.00 PER PRESCRIPTION GENERIC<br>$40.00 PER PRESCRIPTION FORMULARY<br>$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**<br><br>**WAL-MART IS NOT A COVERED PROVIDER OF PRESCRIPTION DRUGS** | | | |

# AMENDMENT #16

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers Health & Welfare Fund may amend the Summary Plan Description pursuant to Article 13 of the Restated Agreement and Declaration of Trust; and

NOW THEREFORE, the Trustees hereby adopt the following amendment effective August 1, 2011 revising and replacing Article 3, Section 3 and Section 4 in their entirety to now read as follows:

*SECTION 3 – DEPENDENT ELIGIBILITY*

Eligible dependents shall include:

1. The spouse of the covered employee;
2. The child (married or unmarried) of a covered employee up to age 26 who is a:
    - Biological Child;
    - Stepchild;
    - Child for whom you are the legal guardian;
    - Legally adopted child; or
    - Child placed with you for adoption.
3. An unmarried child age 26 or older who is permanently and totally disabled, as long as:
    - The handicap began before age 26 and he or she remains handicapped;
    - The child depends on you for more than one-half of his or her support and maintenance during the calendar year;
    - The child permanently lives with you for more than one-half of the calendar year; however, if the child does not live with you, he or she is an Eligible Dependent if:
        - The child's parents are divorced, legally separated, separated under a written separation agreement, or completely live apart at all times during the last six months of the calendar year;
        - The child's parents provide over one-half of the child's support during calendar year; and
        - The child is in the custody of one or both of his or her parents for more than one-half of the calendar year.
    - You submit proof of the child's handicap to the Fund Office no later than 60 days after the child turns age 26 and periodically thereafter as requested by the Trustees (but not more than once every two years).
4. A child named as an alternative recipient in a Qualified Medical Child Support Order (QMCSO).

*SECTION 4 – DEPENDENT EXCLUSIONS*

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

THE PLAN WILL NOT COVER ADULT DEPENDENT CHILDREN BETWEEN THE AGE OF 19 to 26 IF THE ADULT DEPENDENT CHILD IS ELIGIBLE FOR HEALTH INSURANCE COVERAGE THROUGH HIS/HER EMPLOYER OR SPOUSE.

YOUR EMPLOYER MUST MAKE THE REQUIRED CONTRIBUTION IN ORDER TO BE ELIGIBLE FOR DEPENDENT COVERAGE.

# AMENDMENT #17

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers' Health & Welfare Fund may amend the Summary Plan Description pursuant to Article 13 of the Restated Agreement and Declaration of Trust; and

NOW THEREFORE, the Trustees hereby adopt the following amendment effective September 23, 2013 revising and replacing Article 9 by the addition of a new § 49 to now read as follows:

***SECTION 49***

SPOUSE
The person recognized as the covered Employee's husband or wife under the laws of the state or foreign jurisdiction where the marriage was celebrated. The Plan Administrator may require documentation proving a legal marital relationship.

(The three sections following the new definition of "Spouse" shall be renumbered accordingly, but are otherwise unchanged).

This amendment to the Summary Plan Description is hereby adopted this 20th day of February, 2014 effective retroactively to September 23, 2013.