SOUTHERN ILLINOIS LABORERS' & EMPLOYERS' HEALTH & WELFARE FUND

PLAN C

December 2021 Edition

5100 ED SMITH WAY, SUITE A
MARION, IL 62959
618-998-1300
www.silehw.org

UNION TRUSTEES

Matt Smith, Chairman
LIUNA Midwest Region
1 North Old State Capitol Plaza, Suite 525
Springfield, Illinois 62701

Eric Oller
Laborers' Local 459
100 N 17th Street
Belleville, Illinois 62226

Rodney Masterson
SCILDC
5100 Ed Smith Way, Suite B
Marion, Illinois 62959

Flint Taylor
Laborers Local 1197
P.O. Box 56
McLeansboro, Illinois 62859

Jerry Womick
Laborers Local 773
5100 Ed Smith Way
Marion, Illinois 62959

EMPLOYER TRUSTEES

James McPhail, Secretary
Southern Illinois Asphalt Co. Inc.
1208 S. Kingshighway
P.O. Box 637
Cape Girardeau, MO 63702

Robert Balint
Howell Paving, Inc.
P.O. Box 1115
Salem, IL 62881

Brian Rehbein
Egyptian Contractor Association
1500 N Oakland
P.O. Box 2107
Carbondale, Illinois 62902

Laura Wilson
ET Simonds Construction
P.O. Box 2107
Carbondale, Illinois 62902

Jerry Ross
Ross Construction, Inc.
504 West Jackson, P.O. Box 249
Marion, Illinois 62959

CONSULTANT TO THE TRUSTEES
Megan Hughey, United Actuarial Services
11590 N. Meridian Street, Suite 610
Carmel, IN 46032

FUND ATTORNEY
Britt W. Sowle, Cavanagh & O'Hara, LLP
101 West Vandalia Street, Suite 245
Edwardsville, IL 62025

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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.

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

PPO/UR provider through Blue Cross Blue Shield of Illinois, Inc.

Mail order, retail and specialty drug program sponsored by SAV-RX.

The following pages explain your benefits under the Southern Illinois Laborers' & Employers' Health & Welfare Fund (the "Plan" or "Fund"). The Plan is a non-grandfathered welfare Plan under the Patient Protection and Affordable Care Act. The Plan provides valuable health care coverage for you and your family, however in order to receive the maximum benefits available under the Plan you must comply with the Plan's eligibility and enrollment requirements, use Blue Cross Blue Shield of Illinois's In-Network Providers whenever possible and promptly file claims, enrollment forms and any other information requested by the Fund's Administrative Office.

PLAN SPONSOR
The Plan Sponsor is the Joint Board of Trustees of the Southern Illinois Laborers' & Employers' Health & Welfare Fund. All Plan Participants and Beneficiaries possess the right to submit a written request, or examine at the Fund Office during regular business hours (1) a complete list of Contributing Employers and Unions that participate in the Plan, (2) a copy of any collective bargaining agreement entered into between a Contributing Employer and the Union requiring contributions to the Plan.

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.

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 the Fund Office of the **Southern Illinois Laborers' and Employers' Health & Welfare Fund** located at 5100 Ed Smith Way, Suite A, Marion, Illinois 62959.

PLAN WEBSITE
All Plan Participants and Dependents are provided access to important Plan information and documents on the Plan's website, which is located at www.silehw.org. The website offers digitalized, printable information to allow efficient access to the following:

1. Summary Plan Descriptions and associated amendments;
2. Summary of Material Modification mailings;
3. Summary of Benefits and Coverages;
4. Life insurance policies;
5. Check stub crediting procedures for eligibility purposes;
6. Service provider contact information and website links;
7. Retiree coverage information;
8. Claim, enrollment, change of address forms, copies of applicable collective bargaining agreements and wage addendums.

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.

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.

PLAN INTERPRETATION
The Trustees maintain the right to modify, amend, or terminate this Plan. A reviewing court shall not substitute its judgment for that of the Board of Trustees except to evaluate the Trustees' decision pursuant to the standards set forth in the *Firestone Tire and Rubber et al., v. Richard Bruch*, 489 U.S. 101 (1989), decision.

ARTICLE 1 SCHEDULE OF BENEFITS – PLAN C

BENEFITS	IN-NETWORK (You will pay the least)	OUT-OF-NETWORK PROVIDER (You will pay the most)
CALENDAR YEAR DEDUCTIBLE PER PERSON	$850 – ACTIVE $1,250 - RETIRED	$4,000 – ACTIVE $3,500 - RETIRED
CALENDAR YEAR DEDUCTIBLE PER FAMILY	$2,550 – ACTIVE $3,750 – RETIRED	$12,000 – ACTIVE $10,500 – RETIRED
MEDICAL OUT-OF-POCKET PER PERSON PER FAMILY UNIT	 $5,250 – ACTIVE $4,500 – RETIRED $10,500 – ACTIVE $9,000 – RETIRED DOES INCLUDE DEDUCTIBLE	 UNLIMITED - ACTIVE UNLIMITED - RETIRED UNLIMTED - ACTIVE UNLIMITED - RETIRED UNLIMITED DOES INCLUDE DEDUCTIBLE
PHARMACY OUT-OF-POCKET PER PERSON PER FAMILY UNIT	 $1,900 – ACTIVE $2,350 – RETIRED $3,800 – ACTIVE $4,700 – RETIRED DOES INCLUDE DEDUCTIBLE	 UNLIMITED - ACTIVE UNLIMITED – RETIRED UNLIMITED - ACTIVE UNLIMITED - RETIRED DOES INCLUDE DEDUCTIBLE
NOTE: THE ABOVE LISTED PHARMACY AND MEDICAL OUT-OF-POCKET MAXIMUMS ARE SEPARATE. IF YOU REACH THE OUT-OF-POCKET MAXIMUM FOR MEDICAL AT ANY POINT DURING A CALENDAR YEAR, THE PLAN WILL PAY 100% OF ALL COVERED MEDICAL EXPENSES THROUGH THE REMAINDER OF THAT CALENDAR YEAR. LIKEWISE, IF YOU REACH THE OUT-OF-POCKET MAXIMUM FOR PHARMACY AT ANY POINT DURING A CALENDAR YEAR, THE PLAN WILL PAY 100% OF ALL COVERED PHARMACY EXPENSES THROUGH THE REMAINDER OF THAT CALENDAR YEAR.		
HOSPITAL SERVICES		
INPATIENT	80% AFTER DEDUCTIBLE	45% AFTER DEDUCTIBLE
OUTPATIENT	80% AFTER DEDUCTIBLE	45% AFTER DEDUCTIBLE
WRAP AROUND – IF A MEMBER UTILIZED A PPO PROVIDER/FACILITY WHO SUBCONTRACTED TO A NON-PPO PROVIDER, THE SUBCONTRACTED NON-PPO PROVIDER'S CHARGES WILL ALSO BE TREATED AND PAID AT THE PPO LEVEL. IN ADDITION, ALL EMERGENCY AMBULANCE SERVICES WILL BE PAID AT THE PPO LEVEL.		
EMERGENCY ROOM	80% AFTER DEDUCTIBLE PLUS $175 PER OCCURRENCE CO-PAY FOR NON-ACCIDENT, WAIVED IF ADMITTED	80% AFTER DEDUCTIBLE PLUS $175 PER OCCURRENCE CO-PAY FOR NON-ACCIDENT, WAIVED IF ADMITTED
PHYSICIAN SERVICES		
OFFICE VISITS (INCLUDES TELEMEDICINE) SEE SECTION 2.02	80% AFTER DEDUCTIBLE	45% AFTER DEDUCTIBLE
SURGERY (INPATIENT OR OUTPATIENT)	80% AFTER DEDUCTIBLE	45% AFTER DEDUCTIBLE

BENEFITS	IN-NETWORK (You will pay the least)	OUT-OF-NETWORK PROVIDER (You will pay the most)
PREVENTIVE SERVICES SEE SECTION 2.13	100%	45% AFTER DEDUCTIBLE
CHIROPRACTIC CARE (EXCLUDING X-RAYS & LAB CHARGES)	80% AFTER DEDUCTIBLE 20 VISITS CALENDAR YEAR MAXIMUM PAID BENEFIT	45% AFTER DEDUCTIBLE 20 VISITS CALENDAR YEAR MAXIMUM PAID BENEFIT
MATERNITY (FEMALE EMPLOYEE & ELIGIBLE DEPENDENT SPOUSE) SEE SECTION 2.08 NOTE: ELIGIBLE FEMALE DEPENDENTS OTHER THAN AN ELIGIBLE SPOUSE WILL RECEIVE MATERNITY BENEFITS UP TO DELIVERY ONLY	80% AFTER DEDUCTIBLE	45% AFTER DEDUCTIBLE
TEMPOROMANDIBULAR JOINT SYNDROME (TMJ) SEE SECTION 2.18	80% AFTER DEDUCTIBLE $2,000 MAXIMUM	45% AFTER DEDUCTIBLE $2,000 MAXIMUM
PHYSICAL /OCCUPATIONAL/SPEECH THERAPY SEE SECTION 2.17	80% AFTER DEDUCTIBLE 50 VISITS PER CALENDAR YEAR COMBINED	45% AFTER DEDUCTIBLE 50 VISITS PER CALENDAR YEAR COMBINED
ORGAN/TISSUE TRANSPLANTS (DONOR CHARGES NOT COVERED) SEE SECTION 2.11	80% AFTER DEDUCTIBLE	45% AFTER DEDUCTIBLE
DURABLE MEDICAL EQUIPMENT SEE SECTION 2.04	80% AFTER DEDUCTIBLE RENTAL UP TO PURCHASE PRICE	45% AFTER DEDUCTIBLE RENTAL UP TO PURCHASE PRICE
WHEEL CHAIRS SEE SECTION 2.04	50% AFTER DEDUCTIBLE RENTAL UP TO PURCHASE PRICE $1000 PER WHEELCHAIR MAXIMUM BENEFIT	50% AFTER DEDUCTIBLE RENTAL UP TO PURCHASE PRICE $1000 PER WHEELCHAIR MAXIMUM BENEFIT
CONVALESCENT/SKILLED NURSING FACILITY CARE SEE SECTION 2.03	80% AFTER DEDUCTIBLE 30 DAYS CALENDAR YEAR	45% AFTER DEDUCTIBLE 30 DAYS CALENDAR YEAR
HOME HEALTH CARE 4 HOURS = 1 VISIT SEE SECTION 2.06	80% AFTER DEDUCTIBLE 100 VISITS PER CALENDAR YEAR	45% AFTER DEDUCTIBLE 100 VISITS PER CALENDAR YEAR
HOSPICE SEE SECTION 2.07	80% AFTER DEDUCTIBLE 185 DAYS ANNUAL MAXIMUM	45% AFTER DEDUCTIBLE 185 DAYS ANNUAL MAXIMUM
SLEEP STUDY SEE SECTION 2.15	80% AFTER DEDUCTIBLE $4,000 MAXIMUM	45% AFTER DEDUCTIBLE $4,000 MAXIMUM
SUBSTANCE ABUSE INPATIENT AND OUTPATIENT (INCLUDES TELEMEDICINE)	80% AFTER DEDUCTIBLE	45% AFTER DEDUCTIBLE

MENTAL ILLNESS INPATIENT AND OUTPATIENT (INCLUDES TELEMEDICINE)	80% AFTER DEDUCTIBLE	45% AFTER DEDUCTIBLE
HEARING PROGRAM SEE SECTION 2.05		NO DEDUCTIBLE MUST BE AMPLIFON PROVIDER HEARING BENEFITS AVAILABLE ONCE EVERY FIVE YEARS EVALUATION $60 RESTOCKING $100 HEARING BENEFITS AVAILABLE $500 PER DEVICE/YEAR
TELEMEDICINE PROGRAM SEE SECTION 2.22		TELEMEDICINE VISITS SECURED THROUGH MD LIVE WILL BE COVERED AT 100% UP TO THE PER VISIT COVERAGE MAXIMUM DESCRIBED BELOW. 80% IF VISIT IS WITH IN-NETWORK PROVIDER BUT NOT SECURED THROUGH MD LIVE 45% IF TELEMEDICINE VISIT IS NOT SECURED THROUGH MDLIVE AND PROVIDER IS OUT-OF-NETWORK. MEDICAL, MENTAL HEALTH AND SUBSTANCE ABUSE TELEMEDICINE VISITS WILL BE SUBJECT TO THE FOLLOWING PER VISIT MAXIMUMS: $44.00 PER TELEMEDICINE VISIT UP TO 30 MINUTES FOR MEDICAL TREATMENT AND VIDEO CONSULTATIONS $175.00 PER TELEMEDICINE VISIT FOR MEDICAL DOCTOR MENTAL HEALTH AND SUBSTANCE ABUSE DIAGOSTIC EVALUATIONS WITH MEDICAL SERVICES $80.00 PER TELEMEDICINE VISIT UP TO 40 MINUTES FOR OFFICE/OUTPATIENT MEDICAL DOCTOR MENTAL HEALTH AND SUBSTANCE ABUSE MEDICATION MANAGEMENT $80.00 PER TELEMEDICINE VISIT FOR PHD/MASTER LEVEL MENTAL HEALTH AND SUBSTANCE ABUSE PSYCHIATRIC DIAGOSTIC EVALUATIONS $80.00 PER TELEMEDICINE VISIT UP TO 45 MINUTES FOR PHD/MASTER LEVEL MENTAL HEALTH AND SUBSTANCE ABUSE PSYCHOTHERAPY WITH PATIENT AND/OR FAMILY MEMBER OR FAMILY PSYCHOTHERAPY WITH PATIENT PRESENT
SMOKING CESSATION PROGRAM SEE SECTION 2.16		100% NO DEDUCTIBLE –OVER THE COUNTER OR PRESCRIBED
VISION BENEFITS – NOT AVAILABLE TO RETIREES SEE SECTION 2.19		INCLUDES EYE EXAM, LENSES, FRAMES, AND/OR CONTACTS 100% NO DEDUCTIBLE - $200 PER CALENDAR YEAR/PER PERSON NOTE: PEDIATRIC VISION CARE THROUGH AGE 18 INCLUDES ONE ROUTINE EYE EXAM EACH YEAR UP TO A MAXIMUM BENEFIT OF $100 PER EXAM. 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 SECTION 2.20		
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 ADULT 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 THROUGH AGE 18. PEDIATRIC ORAL CARE IS NOT SUBJECT TO THE ANNUAL BENEFIT MAXIMUM.
PLAN EXCLUSIONS & LIMITATIONS SEE ARTICLE 7	
DEATH BENEFITS (NOT AVAILABLE TO COBRA PARTICIPANTS) SEE SECTION 2.21	EMPLOYEE - $12,000 THE AMOUNT OF DEATH BENEFIT WILL BE REDUCED AS SHOWN BELOW: 1. UPON ATTAINING AGE 65 TO 65% IF DEATH BENEFIT 2. UPON ATTAINING AGE 70 TO 45% IF DEATH BENEFIT 3. UPON ATTAINING AGE 75 TO 30% IF DEATH BENEFIT

PHARMACY BENEFITS	SAV-RX 3 TIER FORMULARY
RETAIL (SAV-RX) 30 DAY SUPPLY	GREATER OF $10 OR 25% WITH MAXIMUM OF $20 PER GENERIC PRESCRIPTION GREATER OF $35 OR 30% WITH MAXIMUM OF $40PER FORMULARY PRESCRIPTION GREATER OF $45 OR 35% WITH A MAXIMUM OF $70 PER NON-FORMULARY PRESCRIPTION
90 DAY SUPPLY (AT SAV-RX OTHER RETAIL PHARMACIES) MAINTENANCE MEDICATIONS	GREATER OF $20 OR 25% WITH A MAXIMUM OF $50 PER GENERIC PRESCRIPTION GREATER OF $70 OR 30% WITH A MAXIMUM OF $75 PRESCRIPTION PER BRAND PREFERRED PRESCRIPTION GREATER OF $90 OR 35% WITH A MAXIMUM OF $75 PRESCRIPTION PER BRAND NON-PREFERRED PRESCRIPTION

SPECIALTY MEDICATIONS & BIO-INJECTABLES PROVIDED BY AND/OR ADMINISTERED BY PHYSICIANS OR AT A MEDICAL FACILITY SEE SECTION 2.14	30% COINSURANCE WITH A MAXIMUM OF $225 PER PRESCRIPTION SUBJECT TO PLAN'S PHARMACY OUT-OF-POCKET MAXIMUM
SPECIALTY MEDICATIONS AND BIO-INJECTIBLES OBTAINED THRU SAV-RX PHARMACY OR MAIL ORDER SEE SECTION 2.14	30% COINSURANCE WITH A MAXIMUM OF $225 PER PRESCRIPTION SUBJECT TO PLAN'S PHARMACY OUT-OF-POCKET MAXIMUM

WAL-MART IS NOT A COVERED PROVIDER OF PRESCRIPTION BENEFITS

SEE SECTION 2.12 FOR A LIST OF NON-COVERED DRUGS

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 SAV-RX AT 1-877-728-7910 OR FUND OFFICE AT 1-618-998-1300

ARTICLE 2 SUMMARY OF BENEFITS

Section 2.01 Medical Benefits

Major Medical Lifetime Maximum - **No Lifetime Maximum – Active and Retired Members**
Major Medical Annual Maximum - **No Annual Maximum – Active and Retired Members**

Section 2.02 Preferred Provider Organization

The Trustees have entered into a contract with Blue Cross Blue Shield of Illinois to provide comprehensive medical services at discounted rates. An eligible person can choose any Covered/In-Network Provider. However, if a Covered/In-Network Provider is used the Plan will pay 80% of covered charges. If a Non-Covered/Out-of-Network Provider is used the Plan will pay 45%. See Article 6 for important information about the Open Access III Organizations and Utilization Review.

It is the patient's responsibility to verify the current status of the provider of service. Call the Open Access III network direct at 1-800-624-2356 or visit their website at www.Blue Cross Blue Shield of Illinois.com.

BENEFITS WILL BE REDUCED BY $500 FOR FAILURE TO PRE-CERTIFY ANY INPATIENT HOSPITAL ADMISSION, EXCEPT AS NOTED BELOW (SEE SECTION 6.1).

BLUE CROSS BLUE SHIELD OF ILLINOIS REQUIRES THAT YOU PRE-CERTIFY FOR CERTAIN INPATIENT AND OUTPATIENT MEDICAL, SURGICAL, BEHAVIORAL, AMBULATORY AND ANCILLARY SERVICES, IN ADDITIONAL TO CERTAIN DURABLE MEDICAL EQUIPMENT, DIAGNOSTIC IMAGING, AND SPECIALTY INFUSION DRUGS. PLEASE SEE APPENDIX "A" TO THIS SUMMARY PLAN DESCRIPTION FOR A LISTING OF ALL SERVICES THAT REQUIRE PRECERTIFICATION. FAILURE TO PRE-CERTIFY FOR THE SERVICES LISTED IN APPENDIX "A" WILL RESULT IN NO BENEFIT COVERAGE FOR THOSE SERVICES.

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 2.03 Convalescent/Skilled Nursing Facility Care

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 include;
1. Room/board;

2. General nursing care; and
3. Medical services and supplies.

Section 2.04 Durable Medical Equipment

Benefits will be payable for the rental (up to the purchase price) of Hospital-type bed, kidney dialysis equipment, or other Durable Medical Equipment which meets all of the following tests:
1. Can withstand repeated use;
2. Is 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. $1,000 per wheelchair, paid at 50%.

Section 2.05 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 is as set forth in the Schedule of Benefits. Hearing benefits are only available through Amplifon providers.

IN ORDER TO RECEIVE THIS BENEFIT, THE PARTICIPANT MUST RECEIVE SERVICES FROM A PARTICIPATING PROVIDER IN THE HEARING CARE NETWORK.

Section 2.06 Home Health Care

A Home Health Care Agency is an institution which is licensed as a home health agency and which fully meets the following requirements:
1. Is operated 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 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;
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 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 a 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 the number of visits per person/per Calendar Year set forth in the Schedule of Benefits.

Section 2.07 Hospice Care

The Hospice Care Plan must be submitted in writing by the attending physician of a Hospice Agency 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 the annual maximum number of days set forth in the Schedule of Benefits.

Section 2.08 Maternity Benefits

Employee & 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 Blue Cross Blue Shield of Illinois. In which case the Plan will allow two post-discharge visits; at least one of the visits must be provided at home.

Please note that Maternity Benefits for **Eligible Non-Spouse Female Dependents** are provided up to childbirth only.

Developmental Genetic Testing
1. The Plan will cover Reasonable any Customary expenses for chromosome microarray genetic testing of toddlers (defined as Eligible Dependent children ages 0-3), including post-testing temporary rehabilitation charges, subject to a determination of Medical Necessity by the Utilization Review Organization. Any ongoing or lifetime custodial or maintenance rehabilitation charges associated with a toddler's developmental disability, whether identified through the chromosome microarray genetic testing or otherwise, will not be a Covered Expense under the Plan.

Maternity Limitations
1. The female Employee, Eligible Spouse or Dependent 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 the 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, with a second ultrasound also covered if determined as Medically Necessary; 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 benefits will be payable for any complication which is the result of an elective abortion. Elective abortion means any abortion procedure other than one where the mother's life would be endangered if the fetus were carried to term, or abortion procedures offered by a provider to a patient subsequent to a finding of fetal acrania, exencephaly or anencephaly;
2. Any expense or charge for the promotion of fertility, including (but not limited to) fertility test, hormone therapy, artificial insemination, in vitro fertilization and embryo transfer; and
3. Genetic counseling (including genetic amniocentesis and chronic villus sampling).

Section 2.09 Mouth Conditions

Please refer to the Schedule of Benefits for details regarding dental exclusions, limitations and maximums. 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

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);
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.

Section 2.10 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 2.11 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. Transplant procedures for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants are covered medical expenses under this Plan. Allowable procedures are limited to the transplant procedures referenced above or as allowed by Medicare. Covered medical expenses for an organ transplant are the charges incurred for lifetime recipient care, follow-up care and donor expense.

2. **When a transplant is NOT performed at a Center of Excellence, the Plan does not cover any services related to the transplant.**

3. Recipient care includes charges for:

   A. The use of temporary mechanical equipment, pending the acquisition of matched human organs;

   B. Hospital and related facilities, Physician professional fees and ancillary charges;

   C. Direct, non-medical costs for one member of the recipient's immediate family (two members if the recipient is under the age of eighteen) for;

      (i) Transportation to and from the approved facility where the transplant is performed, and

      (ii) Temporary lodging and meals at a prearranged location during the recipient's confinement in an approved transplant facility not to exceed $200 per day. Direct non-medical costs are only payable if the recipient lives more than 50 miles from the approved transplant facility. Benefits for transportation, lodging and meals are limited to a combined Plan maximum of $10,000 per transplant.

4. Follow-up care includes charges for:

   A. Professional fees;

   B. Hospital;

   C. Prescription Drugs; and

   D. Related facility charges and ancillary charges which result directly from the transplant procedure incurred after discharge from the Hospital stay during which the transplant occurred.

5. Donor expense includes charges for the following:

   A. Testing to identify a suitable donor;

   B. The expense for the acquisition of organs from a donor;

   C. Transportation of an organ or a donor on life support; and

   D. The expense of life support of a donor pending the removal of usable organs.

6. The transplant must be performed to replace an organ or tissue.

7. There is no coverage under the Plan for charges incurred by a Participant/Employee or Dependent who is seeking to act as a donor of organs or tissue.

Section 2.12 Prescription Drug Card Program

Retail – SAV-RX; Mail Order – SAV-RX
Web-site www.SAVRX.com

Retail
30 Day Supply – See of the Schedule of Benefits

90 Day Supply – See of the Schedule of Benefits

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

WALMART IS NOT A COVERED PROVIDER OF PRESCRIPTION DRUGS.

MANDATORY GENERIC SUBSTITUTION

IF A GENERIC PRESCRIPTION DRUG IS AVAILABLE TO YOU BUT A BRAND NAME PRESCRIPTION DRUG IS DISPENSED, YOU WILL BE REQUIRED TO PAY THE BRAND PRESCRIPTION DRUG CO-PAY PLUS THE DIFFERENCE IN COST BETWEEN THE GENERIC PRESCRIPTION DRUG AND THE BRAND PRESCRIPTION DRUG

NON-COVERED PRESCRIPTION ITEMS:
Items lawfully obtained without a prescription
Allergy serums
Injectables – See Prior Authorization
Federal legend vitamins
Ostomy Supplies & 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 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 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 scheduled amount.

PRIOR AUTHORIZATION FOR COVERED PRESCRIPTION ITEMS

For a comprehensive list of covered prescription items, excluding the non-covered prescription items listed above, please refer to the Fund Pharmacy Benefit Manager SAV-RX's website, **www.SAVRX.com**. You can click on the formulary link or the generic link. Your group number is **83061** and will be needed.

Section 2.13 Preventive Care

The Plan provides coverage for one hundred percent (100%) of all expenses incurred for routine preventative/wellness care that are received through In-Network Providers and forty-five percent (45%) of such expenses that are received through Out-of-Network Providers , including but not limited to physical examinations, immunizations, and related diagnostic testing when performed by an eligible provider. The Plan will cover *routine* colonoscopy, mammogram, PAP test, PSA, blood profiles and HPV vaccine (administered according to established medical guidelines) and cost sharing (Deductibles, co-insurance, or Co-Payments) will not apply. Routine vision exams and routine dental services are not considered eligible Expenses Incurred for the purpose of this Section. A complete list of covered wellness/preventive services required under the Patient Protection and Affordable Care Act can be located on the website for the United States Preventive Services Task Force at:

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations
or a copy can be provided to you by the Fund Administrator upon request.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

Preventive Services Benefit Overview

Physical Examination covered after Deductible with the standard Coinsurance: The Plan will cover the expense related to a routine physical examination (including routine OB/GYN exams) by a Physician at 100% with no deductible or Coinsurance. This benefit is limited to one examination per year for each Participant.

Preventive Services Covered with No Cost-Sharing: The following list illustrates the benefits are available under the Fund's Preventive Services Benefit with no cost-sharing. In certain circumstances, as determined by the Fund, the preventive benefit is only payable with an appropriate diagnosis. For a comprehensive list of Preventive Services Benefits, you may visit the United States Preventive Service Task Force website listed above or a copy can be provided to you by the Fund Administrator upon request.

Covered Preventive Services for Adults

1. Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.
2. Alcohol Misuse screening and counseling: Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
3. Aspirin use for men and women of certain ages is covered.
4. Blood Pressure screening for all adults.
5. Cholesterol screening (Lipid Disorders Screening) for men aged 35 and older; men aged 20-35 if they are at increased risk for coronary heart disease; and women who have heart disease or risk factors for heart disease.
6. Colorectal Cancer screening for adults beginning at age 50.
7. Depression screening for adults.
8. Type 2 Diabetes screening for adults with high blood pressure.

9. Diet counseling for adults at higher risk for chronic disease.
10. HIV screening for all adults at higher risk.
11. Routine adult immunizations are covered for Participants who meet the age and gender requirements and who meet the CDC medical criteria for recommendation. Immunization vaccines for adults--doses, recommended ages, and recommended populations must be satisfied:

    a. Diphtheria/tetanus/pertussis (DTP)
    b. Measles/mumps/rubella (MMR)
    c. Poliomyelitis
    d. Influenza (Flu Shot)
    e. Human papillomavirus (HPV)
    f. Pneumococcal (polysaccharide)
    g. Hepatitis A
    h. Hepatitis B
    i. Meningococcal
    j. Herpes Zoster
    k. Varicella

12. Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting.
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
14. Tobacco Use screening for all adults and cessation interventions for tobacco users.
15. Syphilis screening for all adults at higher risk.

Covered Preventive Services for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women.
2. Bacteriuria urinary tract or other infection screening for pregnant women.
3. BRCA counseling about genetic testing for women with positive screening results. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for BRCA counseling and, if indicated after BRCA counseling. BRCA 1 or 2 genetic tests will also be a covered Preventive Service benefit through the Plan.
4. Breast cancer mammography screening every 1 to 2 years for women aged 40 and older.
5. Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by Physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention.
6. Breast feeding comprehensive support and counseling from trained providers, as well as access to breast feeding supplies for pregnant and nursing women, including manual breast pumps.
7. Cervical Cancer screening for sexually active women.
8. Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
9. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health Plans sponsored by certain exempt “religious employers”.
10. Domestic and interpersonal violence screening and counseling for all women.
11. Folic Acid supplements for women who may become pregnant.
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.

13. Gonorrhea screening for all women at higher risk.
14. Hepatitis B screening for pregnant women at their first prenatal visit.
15. HIV Screening and Counseling for sexually active women.
16. Human Papillomavirus (HPV) DNA tests every 3 years for women with normal cytology results who are 30 years old or older.
17. Osteoporosis screening for women over age 60 depending on risk factor.
18. Rh Incompatibility screening for all pregnant women or other women at increased risk.
19. Sexually Transmitted Infections Counseling for sexually active women.
20. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
21. Syphilis screening for all pregnant women or other women at increased risk.
22. Well-woman visits to obtain recommended preventive services.

Covered Preventive Services for Dependent Children

1. Alcohol and Drug Use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children of all ages
4. Blood Pressure screening for children
5. Cervical Dysplasia screening for sexually active females
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents at higher risk
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorders
10. Fluoride Chemoprevention for by the application of fluoride varnish to the primary teeth of all infants and children through age 18.
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children
14. Hematocrit or Hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. Hepatitis B screening for persons at high risk
17. HIV screening for adolescents at higher risk
18. Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary:
19. Diphtheria, Tetanus, Pertussis
20. Haemophilus influenzae type b
21. Hepatitis A
22. Hepatitis B
23. Human Papillomavirus
24. Inactivated Poliovirus
25. Influenza
26. Measles, Mumps, Rubella
27. Meningococcal
28. Pneumococcal
29. Rotavirus
30. Varicella
31. Iron supplements for children ages 6 to 12 months at risk for anemia
32. Lead screening for children at risk of exposure
33. Medical History for all children throughout development
34. Obesity screening and counseling
35. Oral Health risk assessment for young children
36. Phenylketonuria (PKU) screening for this genetic disorder in newborns

37. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
38. Skin Cancer behavioral counseling for young adults age 10 to 24 who have fair skin about minimizing their exposure to UV radiation.
39. Tobacco use interventions to prevent initiation of tobacco use in school-aged children and adolescents.
40. Tuberculin testing for children at higher risk of tuberculosis
41. Vision screening for all children

Office Visit Coverage

Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for in-network office visits under the Preventive Services benefit. Non-network office visits are not covered under the Preventive Services benefit under any condition.

1. If a preventive item or service is billed separately from an office visit, then the Plan will impose cost sharing with respect to the office visit.
2. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.
3. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

Section 2.14 Specialty Medications & Bio-Injectables

The specialty medication and bio-injectable program is for those Participants with specific chronic or rare disease requiring bio-injectable or specialty drugs.

The bio-injectable and specialty drug program utilizes SAV-RX'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, this benefit incorporates the delivery of these medications. Your Specialty coordinator and assigned case manager will help guide you through the process to fill your medication.

1. Covered bio-injectable and specialty drug charges will be paid according to the Schedule of Benefits. In addition: Cancer related drugs are excluded from the 30% co-insurance.
2. The first dialysis treatment each month, that includes bio-injectable or specialty medications, will be subject to a $225 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 SAV-RX 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 SAV-RX MAIL SERVICE.

Section 2.15 Sleep Study

$4,000 maximum once every five years subject to a finding of Medical Necessity.

Section 2.16 Smoking Cessation Coverage

For information on smoking programs and initiatives, contact the Fund Office at 1-618-998-1300.

Smoking cessation coverage is provided at 100% with no Deductible or cost sharing. Please see the Schedule of Benefits for further information.

Section 2.17 Physical Therapy/Occupational Therapy/Speech Therapy

Covered Expenses for Physical/Occupational/Speech Therapy are limited to 50 visits combined per Calendar Year and will be payable as shown in the Schedule of Benefits.

LIMITS FOR SPEECH THERAPY
The Plan provides benefits for speech therapy when rendered by a licensed speech therapist or qualified physician 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.

Speech therapy expenses that **will not** be covered are as follows:
1. Self-care/self-help training, or supplies used in connection with such self-care/self-help training; 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 of child of spouse.

Section 2.18 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 and/or associated structures including nerves and chewing muscles; and treatment for the purpose of diagnosis or prevention for the conditions above including orofacial muscle disorders and/or facial-cranial pain syndromes.

Please refer to the Schedule of Benefits for Plan coverage maximums.

Section 2.19 Vision Benefits

The eligible Participant and/or Dependent, will be reimbursed 100% of the amount incurred up to a maximum payment benefit as described in the Schedule of Benefits. This includes eye examinations, lenses, frames, and/or contacts.

Pediatric Vision Care benefits through age 18 will be provided as set forth in the Schedule of Benefits and include the following:

1. One routine eye exam per Calendar Year ; and
2. One pair of standard frames, lenses or non-disposable contacts per Calendar Year (including fittings)

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.

3. Broken or lost frames, lenses, or non-disposable contacts.

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
5100 Ed Smith Way, Suite A
Marion, IL 62959

WALMART IS NOT A COVERED VISION PROVIDER

Section 2.20 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 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
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 is any period of thirty-six (36) consecutive months
7. Supplementary bitewing	Twice in any period of six (6) consecutive months

Pediatric Dental Care Benefits through age 18 will be provided according to the Schedule of Benefits and include the following:

1. A total of one oral cleaning and oral exam every six (6) consecutive months.

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

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 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 six (6) months after the installation
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 restoration fillings described above.
4. Prosthodontics	Includes attachments and adjustments during the six (6) months following the 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 (5) 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 for a Participant of the Fund after continuous coverage during any consecutive twelve (12) month period.

Category D – Orthodontics

For those eligible Dependent children age six (6) through age eighteen (18), coverage for non-medically necessary orthodontics will be provided up to the Lifetime Maximum listed in the Schedule of Benefits.

DENTAL EXCLUSIONS AND LIMITATIONS

1. Expenses incurred solely for cosmetic reason will not be covered;
2. Dental care which is included as a covered expense under the Medical Benefit;
3. Covered dental expenses do not include and no benefits are provided for implants, oral hygiene instructions, broken appointments;
4. Charges for failure to keep a scheduled appointment with a Dentist.
5. Charges for the completion of insurance forms;
6. Duplicate charges that are due to the negligence of the patient;
7. Telephone charges;
8. 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
9. 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.
10. Treatment by other than a licensed Dentist, except charges by a licensed dental hygienist, under the supervision and direction of a Dentist.

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
5100 Ed Smith Way, Suite A
Marion, IL 62959

Section 2.21 Death Benefits

SCHEDULE OF BENEFITS FOR ACTIVE EMPLOYEES AND RETIREES ONLY

Death Benefit ……$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.

You may name more than one beneficiary. If you name multiple beneficiaries, each surviving beneficiary will share equally in the benefit unless otherwise indicated on your enrollment card on file at the Fund Office.

If, at the time of your death, your designated Beneficiary is also deceased, or you have no named, surviving beneficiary on file at the Fund Office, benefits will be payable as follows:

1. To your surviving spouse, if any;
2. To your surviving children in equal shares, if any;
3. To your surviving brothers and sisters in equal shares, if any; or
4. To the executor(s) or administrator(s) of your estate.

In order to determine which class of individuals is entitled to the benefit, the Fund Office may rely on an affidavit made by any individual listed above. If payment is made based on such affidavit, the Fund Office and Board of Trustees will be discharged of its liability for the amount so paid, unless written notice of claim is received by another individual listed above at the Fund Office before the benefit is paid.

If the designated Beneficiary is a minor or someone not able to give a valid release for payment, the Fund Office will pay the benefit to his or her legal guardian.

In the event of a divorce, your ex-spouse, who was otherwise designated as the Beneficiary, will be cancelled as your Beneficiary as of the date of the divorce, unless such ex-spouse is specifically designated the beneficiary of the benefit through a Qualified Domestic Relations Order entered by a court of law.

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
5100 Ed Smith Way, Suite A
Marion, IL 62959

DEATH BENEFITS ARE NOT AVAILABLE TO COBRA PARTICIPANTS

Section 2.22 Telemedicine Program

Telemedicine services consist of the delivery of clinical medicine, mental health, and substance abuse treatment via real-time telecommunications such as telephone, the internet, or other communication networks or devices that do not involve direct patient contact.

The Fund provides telemedicine services through MD Live, a telemedicine provider contracted through Blue Cross Blue Shield of Illinois. Telemedicine services you receive through MDLive are covered by the Fund at 100%, subject to the per telemedicine visit maximum set forth in the Schedule of Benefits.

MDLive Website: www.MDLIVE.com/BCBSIL
MDLive Telephone: 1-888-676-4204

Telemedicine services will still be covered by the Fund if not secured through MD Live, but not at 100%. Telemedicine services provided by In-Network Providers and Out-of-Network providers will be covered up to the maximum allowable amount set forth in the Schedule of Benefits.

ARTICLE 3 ELIGIBILITY/PARTICIPATION IN HEALTHCARE BENEFITS

Section 3.01 Employee Enrollment and Eligibility

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

1. Must be an employee working for an employer who agrees to contribute to the Plan pursuant to a collective bargaining agreement or participation agreement approved by the Board of Trustees;
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.

AFTER MEETING THE INITIAL ELIGIBILITY REQUIREMENTS AND RECEIVING THE ENROLLMENT MATERIALS FROM THE FUND OFFICE, TO OBTAIN COVERAGE YOU MUST FULLY COMPLETE AND RETURN THE ENROLLMENT MATERIALS PROMPTLY TO THE FUND OFFICE. UPON RECEIPT OF YOUR COMPLETED ENROLLMENT MATERIALS, INCLUDING BUT NOT LIMITED TO MARRIAGE LICENSE AND ADOPTION/BIRTH RECORDS/CERTIFICATION OF LEGAL CUSTODY, IF APPLICABLE, YOUR COVERAGE WILL BE MADE EFFECTIVE RETROACTIVELY TO YOUR INITIAL ELIGIBILITY DATE. AFTER COVERAGE BECOMES EFFECTIVE, IF THERE ARE ANY QUALIFYING EVENT CHANGES SUCH AS MARITAL STATUS, NUMBER OF DEPENDENTS, BENEFICIARY, OR CHANGE OF ADDRESS, YOU MUST CONTACT THE FUND OFFICE, FILL OUT A NEW ENROLLMENT CARD AND RETURN THE ENROLLMENT CARD, WITH ANY REQUESTED DOCUMENTATION, WITHIN 30 DAYS OF THE QUALIFYING EVENT.

QUALIFYING PERIOD

Eligibility periods shall be broken up into contribution quarters, as follows:

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

INITIAL ELIGIBILITY
The Employee becomes eligible for benefits when he or she 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; or
3. 1,000 hours in four contributions quarters.

Coverage would then become effective the following eligibility/insurance quarter.

Once eligibility has been established, eligibility will continue as long as contributions meet the following requirements:
1. 300 hours for the preceding contribution quarter prior to the eligibility quarter;
2. 600 hours for the preceding two contribution quarters prior to the eligibility quarter;
3. 900 hours for the preceding three contribution quarters prior to the eligibility quarter; or
4. 1,200 hours for the preceding four contribution quarters prior to the eligibility quarter.

ENROLLMENT DATE
First day of contributions 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
After becoming eligible for benefits, an Employee may remit self-contributions to the Fund in order to maintain eligibility. The amount of the self-contribution that must be paid by an employee is the hourly contribution rate approved by the Board of Trustees. The number of self-contribution hours to be paid by an Employee is the difference between the contribution hours reported by the Employer and received by the Fund, and the remaining number of contribution hours required to maintain eligibility, as follows:

1. 300 hours for the preceding contribution quarter prior to the eligibility quarter;
2. 600 hours for the preceding two contribution quarters prior to the eligibility quarter;
3. 900 hours for the preceding three contribution quarters prior to the eligibility quarter; or
4. 1,200 hours for the preceding four contribution quarters prior to the eligibility quarter.

SELF-CONTRIBUTION PAYMENT DEADLINE AND LIMITS
Self-contribution notices are mailed by the Fund Office to eligible Employees in advance of the start date of the applicable eligibility quarter. The self-contribution notice will instruct you to return the self-contribution to the Fund Office within twenty (20) days, which will be measured from the postmarked date on the envelope containing your self-contribution. Any self-contributions received by the Fund Office after the start date of the application eligibility quarter will be denied, therefore it is extremely important that you ensure the self-contribution is received in a timely manner. If your self-contribution is denied, you may appeal this denial in writing to the Board of Trustees within thirty (30) days after the denial notice is mailed to you. The written appeal must be mailed to the Fund Office and include any supporting documentation as to why the self-contribution payment deadline was not met.

SINGLE QUARTER SELF CONTRIBUTION OPTION FOR FAMILY OF DECEASED EMPLOYEE
In the event an eligible Employee dies while actively working, the Spouse of the deceased Employee will be provided the opportunity to make a self-contribution payment and continue coverage for one (1) eligibility quarter immediately following the Employee's death. The Spouse must notify the Fund in writing of the Employee's death and provide all requested documentation prior to the start of the eligibility

quarter following the Employee's death in order for the self-contribution to be accepted by the Fund for coverage purposes. In addition, no coverage will be provided until the self-contribution payment is received by the Fund. This single quarter self-contribution payment will continue coverage for both the Spouse and the enrolled, eligible Dependents of the deceased Employee until the end of the one (1) eligibility quarter following the death of the eligible Employee. The Spouse may then continue coverage only be electing COBRA and paying the required COBRA contributions as set forth in Article 5 of this SPD.

The opportunity to remit 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 your SPD for info on COBRA rights).

If you have any questions concerning this, please do not hesitate to contact the Fund Office at 1-618-998-1300.

IF A SELF CONTRIBUTION IS NOT PAID YOU MAY NOT MAKE ANOTHER SELF CONTRIBUTION AND YOUR COVERAGE WILL IMMEDIATELY TERMINATE UNTIL YOU REQUALIFY FOR COVERAGE THROUGH HOURS WORKED

REINSTATEMENT OF ELIGIBILITY

If, after having once attained eligibility with the Fund, an employee loses his or her eligibility, eligibility may be reestablished if contributions have been paid on his or her behalf with the required period as indicated below:

INELIGIBLE PERIOD	CONTRIBUTION HOURS	CONTRIBUTION PERIOD
Less than 12 months	300	3-month period
More than 1 year, but less than 2 years	350	6-month period
If more than 2 years must again meet the initial eligibility requirements	350 500 1,000	3-month period 6-month period 12-month period

NOTICES

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

CREDITING OF HOURS

Uncollected Employer contributions may be credited for welfare purposes according to the following procedures:

1. When written request from the Participant 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 Board of Trustees for review.
3. The Trustees will determine the likelihood of collecting and impact on participants' welfare eligibility/benefits.
4. If approved by the Board of Trustees, the Participant will be notified via mail that for welfare purposes he or she will be completely or partially eligible for benefits or that a self-payment opportunity is available. 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 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 from the Participant's Employer.

Section 3.02 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
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 the military service; or
4. The date the Plan terminates.

Section 3.03 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:
   A. Biological Child;
   B. Stepchild;
   C. Child for whom you are the Legal Guardian;
   D. Child placed with you for adoption.
3. An unmarried child age 26 or older who is permanently and totally disabled, as long as:
   A. The handicap began before age 26 and he or she remains handicapped;
   B. The child depends on you for more than one-half of his or her support and maintenance during the Calendar Year;
   C. 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:
      i. 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;
      ii. The child's parents provide over one-half of the child's support during Calendar Year; and
      iii. The child is in custody of one or both of his or her parents for more than one-half of the Calendar Year.
   D. 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 3.04 Dependent Exclusions

1. A child after the end of the month in which the child attains his or her twenty-sixth birthday unless covered under Section 3.03;
2. The spouse of a covered Employee, if legally separated from the covered Employee; and
3. Any Dependent while in military service.

Section 3.05 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 acquires an eligible Dependent, provided the covered Employee notifies the Fund Administrator and returns all required enrollment forms and supporting documentation within the time limits explained in Section 3.06 of this Summary Plan Description.

Section 3.06 Change in Family Status

At some point in your life, you may experience a change in family status that affects your health benefits. The information below is designed to explain what you need to do when you experience a change in family status.

Notifying the Fund Office – What You Need to Do

By notifying the Fund Office of Qualifying Events or Changes in Family Status, such as gaining new Dependents, you help avoid delays or denials in payment of benefits. It is also important to notify the Fund Office when a Dependent loses eligibility. This helps ensure your Dependent is offered COBRA continuation coverage if applicable.

You must notify the Fund Office within 60 days of the date you experience a Qualifying Event or any change in your family status because various paperwork will be needed from you. For example:

- **When your Dependent acquires other health and/or dental plan coverage;**
- **When your Dependent loses his/her other health plan coverage;**
- **When you have a child (birth certificate will be needed);**
- **When you adopt a child, or a child is placed with you for adoption or guardianship (court paperwork will be needed);**
- **When you get married (marriage certificate will be needed);**
- **When you get divorced (court paperwork will be needed);**
- **When your child is no longer eligible for coverage.**

Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order that requires a Participant to provide medical coverage for his or her child(ren) (called alternate recipient(s) in situations involving divorce, legal separation or a paternity dispute). If the Plan receives a valid QMCSO and a Participant does not enroll the child(ren), the custodial parent or state agency may enroll the affected child(ren). A QMCSO is either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing the Plan to cover a child(ren) as Dependent(s) of the Participant. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid.

The Plan shall comply with the terms of a Qualified Medical Child Support Order ("QMCSO"), directing the Plan to provide benefits to one or more alternate recipients, pursuant to the procedure set forth below:

- An order which purports to be a QMCSO must be served on the Fund Office.

- The Fund Office shall, within twenty (20) days of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:

    - a clause which creates or recognizes the existence of a Dependent's right to receive benefits under the Plan;

    - the name and last known mailing address of the Covered Person with respect to whom the order is issued and each Dependent covered by the order;

    - a reasonable description of the type of coverage to be provided by the Plan to each Dependent;

    - a clause which specifies that the order applies to the Plan, as well as the time period to which the order applies; and

    - a clause which states that the order does not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.

An order which, in the judgment of the Fund's legal counsel, does not meet the requirements of a QMCSO shall be returned, for revision, to legal counsel who prepared the order. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section. The Fund Office shall notify all parties involved, including a designated representative of the Covered Dependent, of the Fund Counsel's decision and of the respective parties' entitlement to benefits.

Reimbursement of benefit payments under the Plan pursuant to a QMCSO may be made to the Covered Dependent or the Covered Dependent's custodial parent.

Adding Dependents

If you are eligible for benefits and you acquire a Dependent through a qualifying event such as marriage, the birth of a child, adoption, or placement for adoption of a child or obtaining Legal Guardianship of a child, eligibility for that Dependent begins on the date of the qualifying event as long as you notify the Fund Office within 30 days of one of these events **AND** return a completed enrollment form with supporting documentation within the required timeframe.

In certain instances, coverage for your additional Dependents will be effective from the date of the event if you apply for a change within 60 days of any of the following events:

- Loss of eligibility for your Dependent when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- Your Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

Your completed enrollment form and supporting documentation MUST be post-marked or received by the Fund Office within 60 days of the date the Fund Office mailed the form to you. Your completed form and supporting documentation may be returned via mail, scan/email, fax or hand-delivery (during office hours) to the Fund Office. YOUR NEWLY ACQUIRED DEPENDENT(S) WILL NOT BE COVERED BY THE

HEALTH PLAN IF YOU DO NOT RETURN THE COMPLETED ENROLLMENT FORM AND SUPPORTING DOCUMENTATION WITHIN THE REQUIRED TIMEFRAME.

Late Enrollment of Dependents after Qualifying Event

If you are eligible for benefits and you acquire a Dependent through a qualifying event, but fail to notify the Fund Office and return a completed enrollment form within the required timeframes discussed in the "Adding Dependents" section above, you may still seek to enroll the Dependent with the Fund Office. Under these circumstances, you would need to request an enrollment form and return the completed enrollment form and supporting documentation to the Fund Office. Thereafter, the Dependent will be provided coverage from the date the completed enrollment form and supporting documentation are post-marked or received by the Fund Office. Please note that coverage for the Dependent will not be provided retroactively to the date of the qualifying event, and you must be eligible for benefits with the Fund to enroll the Dependent.

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

Section 3.07 Termination of Dependent Coverage

The coverage of any Dependent covered hereunder terminates on whichever of the following dates occurs 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 United States military service on full-time active duty;
4. The date the covered Employee fails to make any required contribution; or
5. The date the Plan is terminated.

Section 3.08 Timely Enrollment of Special Enrollee

The enrollment of an Employee or Dependent that qualifies as a Special Enrollee will be "timely" if an enrollment form and any supporting documentation is completed and submitted to the Fund Administrator no later than 31 days after the person becomes eligible for the coverage. In the event an Employee or Dependent does not enroll timely, then he/she can only enroll in the events he/she meets the requirements under the Special Enrollment Period provision.

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.
2. 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 consequences of the Employee's failure to provide the statement) at the time the Employee declined enrollment; or
3. 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
4. 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 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

5. Individuals who lose other coverage to nonpayment of premium or for cause (e.g., filing fraudulent claims) shall not be special enrollees; or
6. Individuals who lose their coverage for: divorce or legal separation, death, termination of employment or reduction of hours in employment.

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 special enrollment.

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

SPECIAL ENROLLMENT PERIODS

The enrollment date of anyone who enrolls under a Special Enrollment Period is the first day of the calendar month following the date that the Employees satisfies all of the following:

1. **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:
   A. The Employee or Dependent was covered under a group health Plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
   B. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
   C. The coverage of the Employee or Dependent who had lost coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment or reduction of hours of employment) or employer contributions toward the coverage were terminated.
   D. The Employee or Dependent requests enrollment in the Plan not later than 31 days after date of exhaustions of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making fraudulent claims), that individual does not have a Special Enrollment.

Section 3.09 Eligibility/Retired Employees & Eligible Spouse

QUALIFICATIONS/RETIREE ELIGIBILITY – UNDER 65

1. Must have been covered by an active Plan at the time of retirement;
2. Must be receiving a full pension from a qualified pension plan;
3. Must be between the age of 53 and 65 and ineligible for Medicare; and
4. Must elect coverage when first eligible and coverage must be continuous and uninterrupted.

THE ELECTION OF RETIREE COVERAGE ONCE MADE IS PERMANENT AND CANNOT BE CHANGED

RETIREE EFFECTIVE DATE
The effective date of coverage will be the first day the Plan Participant has qualified for benefits and appropriate premiums have been received by the Fund.

TERMINATION OF COVERAGE – RETIREE AND/OR ELIGIBLE SPOUSE (IF APPLICABLE)

Coverage will immediately terminate at the end of the earliest period in which:

1. The retiree attains age 65;
2. The retiree qualifies for Medicare coverage;
3. The retiree fails to pay the appropriate premium; or
4. The retiree dies, whichever comes first;
5. The date the Plan terminates.

See Article 1 – Schedule of Benefits

UPON DEATH OF THE RETIREE, ELIGIBLE SPOUSE MAY ELECT COBRA COVERAGE OR COTINUE RETIREE COVERAGE

Section 3.10 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, a Waiting Period will not be imposed unless they were in effect for the Employee and/or his 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.

Section 3.11 Employees on Military Leave

Employees going into or returning from Unites States military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment & 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 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 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 CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

Section 4.01 Continuation Coverage Rights Under COBRA

INTRODUCTION
COBRA continuation coverage for the Plan is administered by Southern Illinois Laborers' & Employers' Health & Welfare Fund, 5100 Ed Smith Way, Suite A, Marion, Illinois 62959, phone 618-998-1300. A detailed description of COBRA continuation coverage is as follows.

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

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

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 lose your coverage under the Plan because of any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's hours of 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 their 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 employments 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 an 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 the coverage ends.

For 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 have otherwise 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 Employee's hours or 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 Fund's Administrative Manager.

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 Fund's Administrative Manager.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Fund's Administrative Manager or you may contact the nearest Regional or District Office of Department of U.S. 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 Fund's Administrative Manager informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Administrator.

Section 4.02 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	Covered Employee to Fund Office within 30 days of qualifying event	Fund Office to qualified Beneficiary within 14 days of notice
Death of covered Employee	Spouse, Dependent child	36 months	Covered Employee to Trustees within 30 days of qualifying event	Fund Office 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	Fund Office 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 Fund office within 60 days of qualifying event	Fund office to qualified beneficiary within 14 days of notice
Entitlement to Medicare	Spouse, Dependent child	36 months	Covered employee to Fund office within 30 days of qualifying event	Fund office to qualified beneficiary within 14 days of notice
Bankruptcy of employer	Retired covered employee, widows	Until death	Covered employee to fund office within 30 days of qualifying event	Fund office to qualified beneficiary within 14 days of notice

ARTICLE 5 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 Blue Cross Blue Shield of Illinois.

BLUE CROSS BLUE SHIELD OF ILLINOIS
A Division of Health Care Services Corporation
300 E. Randolph Street
Chicago, IL 60601

Section 5.01 Utilization and Quality Review

A utilization and quality review program is part of the Plan. The program includes pre-admission review, pre-procedure review, continued stay review, discharge Planning and obstetrical review.

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

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

ANY FAILURE TO PRECERTIFY FOR OUTPATIENT HOSPITAL ADMISSIONS WILL RESULT IN NO COVERAGE FOR THE CHARGES ASSOCIATED WITH THE OUTPATIENT HOSPITAL ADMISSION

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 5.02 Pre-Certification – Non-Emergency

Pre-certification is a process in which the patient, the doctor and Blue Cross Blue Shield of Illinois review and discuss the Medical Necessity and appropriateness of certain aspects of recommended treatment. Not only does Pre-certification 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, BLUE CROSS BLUE SHIELD OF ILLINOIS MUST BE CONTACTED AT 1-877-284-0102, 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 Section 11.07 – Appeal Procedure)

Section 5.03 Pre-Certification - Emergency

Should the Employee or covered Dependent be admitted to the Hospital in an emergency situation, Blue Cross Blue Shield of Illinois must be contacted within 48 hours after the admission. Blue Cross Blue Shield of Illinois is available 24 hours a day, seven days a week, 365 days a year. See Section 5.02 for additional Pre-Certification requirements.

Section 5.04 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 5.05 Continued Stay Review

Continued stay review begins after a patient is hospitalized. The doctor and Blue Cross Blue Shield of Illinois will 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 Section 11.07 – Appeal Procedure)

Section 5.06 Discharge Planning

Discharge Planning is a process in which the patient, the doctor, and Blue Cross Blue Shield of Illinois 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 5.07 Utilization Review

The patient, the doctor, or the Hospital has a right to appeal a decision regarding an admission or a procedure. When Blue Cross Blue Shield of Illinois does not approve treatment as appropriate or medically necessary, the patient may call Blue Cross Blue Shield of Illinois 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 OR VISIT THEIR WEBSITE AT www.Blue Cross Blue Shield of Illinois.com.

ARTICLE 6 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 for services of a professional anesthetist; provided such anesthetist in not employed by a Hospital which submits a charge for the services;

5. Charges made by a physician for medical services, including his/her active services as an assistant surgeon;

6. Allergy tests and allergy immunizations;

7. 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 a 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;

8. Cardiac rehabilitation not to exceed one 12-week program per Calendar Year, outpatient only;

9. 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.

10. Telemedicine charges for services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the internet, or other communication networks or devices that do not involve direct patient contact;

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 initial replacement of these teeth and any necessary dental x-rays;

13. Services of a physical therapist, speech therapist and/or occupational therapist, limited to 50 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 a 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 for the reversal of elective sterilization;

17. Breast reconstruction in connection with mastectomy is covered (subject to 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 lymphedema: 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. 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.

ARTICLE 7 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. 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' Compensations 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 occupation disease claims, or (2) demonstrating, 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. In order for you to seek reconsideration of any medical claims denied under this exclusion, you must also be currently eligible for benefit coverage with the Plan on the date your reconsideration request is received.
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 any 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 Section 2.10;
10. The fitting or cost of hearing aids except as specified in Section 2.10;
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 while the patient is out on "pass";
23. Charges for telephone consultations (other than telephone consultations provided under the Fund's Telemed program), 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. Transsexual surgery;
29. Penile implants and care for and/or related to sexual dysfunction; and

30. Obesity – care and treatment of obesity, weight loss or dietary control (other than preventive body mass index screening and counseling, see Section 2.18) whether or not it is, in any case, a part of the treatment 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.
31. Gene Therapies: Expenses related to gene therapies will not be considered eligible.
32. Treatment or services rendered by a medical provider in conjunction with a visit or inpatient stay during which the patient is aware that he/she is not permitted to leave but does so with intent or leaves against medical advice.

THIS LIST IN 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 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 8 DEFINITIONS

Section 8.01 Administrative Manager

The individual, corporation or partnership appointed by the Board of Trustees to perform the administrative functions of the Plan.

Section 8.02 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 an emergency.

Section 8.03 Association

The Associated General Contractors of Illinois and any other employer organization which may become a party to the Agreement and Declaration of Trust.

Section 8.04 Beneficiary

The individual who will receive the death benefit because of the death of a Participant or Retiree.

Section 8.05 Birthing Center

Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where birth occurs 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 the 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 8.06 Calendar Year

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

Section 8.07 COBRA

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

Section 8.08 Coinsurance

The percentage of expenses which must be paid by a Participant after payment of the Deductible, as determined in accordance with the Schedule of Benefits, and subject to the maximum out-of-pocket limitation as specified in the Schedule of Benefits. Coinsurance amounts do apply towards the satisfaction of the out-of-pocket maximum.

Section 8.09 Collective Bargaining Agreement

The Collective Bargaining Agreement or other written agreement between the Association, or an Employer and the Union, requiring contributions to the Plan.

Section 8.10 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 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 of contributions to the Trust Fund by execution of a Participation Agreement.

Section 8.11 Co-Pay or Copayment

The fixed dollar amount that a Participant must pay each time for certain services. Co-Pay amounts do apply towards the satisfaction of the Out-of-Pocket maximum.

Section 8.12 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 8.13 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 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 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 8.14 Custodial Care

Custodial Care is care (including room and board needed to provide that care) this 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 8.15 Deductible

The total expenses a Participant or Dependent must incur during a Calendar Year before the Plan pays benefits. Deductible expense shall apply towards satisfaction of the Out-of-Pocket Maximum.

Section 8.16 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 practicing specialist in a field of Dentistry.

Section 8.17 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 8.18 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 8.19 ERISA

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

Section 8.20 Experimental/Investigative Procedures

Drugs, medical supplies, medical devices, medical equipment, medical or surgical procedures, treatments or services which do not meet accepted standards of medical practice. A drug, device, treatment or procedure is considered to be Experiment and/or investigational:

1. if the device, drug, treatment or procedure has not received the approval or endorsement of the American Medical Association (AMA), U.S. Food and Drug Administration (FDA) or the National Institute of Health (NIH) at the time the device, drug or procedure was furnished; or
2. if reliable evidence demonstrated that the device, drug, treatment or procedure is the subject of ongoing Phase I, II, or III Clinical Trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with standard means of treatment or diagnosis: or
3. if reliable evidence demonstrates that a consensus of opinion among medical experts regarding the device, drug, treatment or procedures 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 the standard means of treatment or diagnosis.

This Experimental or Investigative definition and its application by the Plan does not include participation in or the "Routine Patient Costs" for "Approved Clinical Trials" for which coverage is required by the Patient Protection and Affordable Care Act. An Approved Clinical Trial is a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application. The routine patient costs for Approved Clinical Trials include all items and services typically covered by the Plan for individuals not enrolled in an Approved Clinical Trial.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature, the written protocol(s) used by the treating facility, the protocol(s) of another facility studying substantially the same device, drug, treatment or procedure, or the written informed consent used by the treating facility or another facility studying substantially the same device, drug, treatment or procedure.

Section 8.21 Family Unit

A Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Section 8.22 Formulary

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

Section 8.23 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 8.24 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 as being generic.

Section 8.25 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 an direct analysis of genes or chromosomes.

Section 8.26 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 8.27 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 a Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Section 8.28 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 the behalf of the Hospital.

Section 8.29 Hospice Agency

An organization where its main function is to provide Hospice Care Services & Supplies for persons suffering from a condition that has a terminal prognosis, and which is licensed by the state or locality in which it is located, if licensing is required. A Hospice Agency must have an interdisciplinary group of personnel which includes at least one physician and one registered nurse, and it must maintain central clinical records on all patients. A Hospice Agency must meet the standards of the National Hospice Organization (NHO).

Section 8.30 Hospice Care Plan

A written Plan of terminal patient care that is established and conducted by a Hospice Agency and is supervised by a Physician. 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.

Section 8.31 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 8.32 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 8.33 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 the facilities; or available to it under a written agreement with a Hospital or with specialized provider of the 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 these 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. Furnishes mainly homelike or Custodial Care, or training in the routines of daily living; or
3. Is mainly a school.

Section 8.34 Illness

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

Section 8.35 Injury

A non-occupational accidental physical Injury to the body caused by unexpected external means.

Section 8.36 Intensive Care Unit

A separate, clearly designated service area which is maintained within a Hospital solely for the care and treatments of those 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 lifesaving equipment which is immediately available at all times; at least 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 8.37 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 8.38 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 8.39 Medical Care Facility

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

Section 8.40 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, convulsion or other such acute medical conditions. In the event a Participant and/or Dependents require Medical Emergency treatment outside of the PPO network area, benefits will be provided at the In-Network benefit level for medical emergency services described in the Schedule of Benefits. The In-Network benefit level will be paid only until the patient has stabilized and can safely obtain medical care at a Blue Cross Blue Shield of Illinois PPO network facility or provider. This applies to facility charges only.

Section 8.41 Medically Necessary

The services and supplies listed in the Plan that meet all of the following criteria, (1) through (6):

1. The service or supply must be provided by a Physician, Hospital or other Covered Provider under the Plan, and consistent with the diagnosis or treatment of the Sickness or Injury. Certain routine and preventative health care services and supplies will be considered needed and appropriately provided for medical care only if they are included in the list of covered health services under the Plan.

2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.

3. It is furnished by a provider with appropriate training, experience, staff and facilities for the administering of the particular service or supply.

4. It must be the appropriate supply or level of service which can be safely provided to a patient; and with regard to a person who is an inpatient, it must mean the patient's Sickness or Injury requires that the service or supply cannot be safely provided to that person on an outpatient basis.

5. It must not be primarily for the convenience of the patient, Physician, Hospital or other Covered Provider under the Plan.

6. It must not be scholastic, vocational training, educational or developmental in nature, or experimental or investigational.

The Plan Administrator has delegated the initial discretionary authority to determine Medical Necessity under the Plan to the UTILIZATION REVIEW ORGANIZATION. Covered Persons may appeal a denial based on Medically Necessary to the Plan Administrator by following the Plan appeal provisions as described in Section 11 of this Summary Plan Description.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury, Sickness, Mental Illness or pregnancy does not mean that it is a Medically Necessary service or supply as defined above. The definition of Medically Necessary used in this booklet relates only to coverage under this Plan and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

Section 8.42 Medicare

The Health Insurance for the Aged and Disabled program under title XVIII of the Social Security Act, as amended.

Section 8.43 Mental Disorder/Mental Illness

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 8.44 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 8.45 Pediatric

Dependent infants, children and adolescents from birth through age 18.

Section 8.46 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 8.47 Plan

The Southern Illinois Laborers' & Employers' Health & Welfare Fund.

Section 8.48 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 8.49 Prescription Drug

Any of the following: A Food and Drug Administration approved drug or medicine which, under federal law, is required to the 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 8.50 Reasonable and Customary

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.

Section 8.51 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 8.52 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 of 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, mentally handicapped, 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 8.53 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 SAV-RX mail service.

Section 8.54 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 from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Section 8.55 Spouse

Effective September 23, 2013, 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.

Section 8.56 Substance Abuse/Alcoholism Abuse

Uncontrollable or excessive abuse of any addictive substance and the resultant physiological or psychological dependence which develops with continued use, requiring medical treatment as determined by a Physician.

Section 8.57 Substance/Alcoholism Abuse Treatment Facility

A facility whose primary function is the treatment of Substance/Alcoholism Abuse and which is duly licensed by the appropriate state and local authority to provide such services. Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment. Detoxification is care aimed primarily at overcoming after-effects of a specific episode of drinking or substance abuse. Maintenance care consists of providing an environment without access to alcohol or drugs.

Section 8.58 Temporomandibular Joint (TMJ)

Treatment of jaw joint disorders including conditions of structure linking the jaw bone and skull and the complex 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 8.59 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 9 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 Covered Person was eligible under the Plan. The Plan will, however, pay benefits according to 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 right 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 Dependent 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 completed and signed, the Plan reserves the right to deny coverage if such repayment or subrogation agreement is not fully signed and returned. The terms and conditions of this Subrogation and Right of Reimbursement provision remains in effect and binding regardless of whether any required repayment or subrogation agreement is actually fully signed and returned. 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 them 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 of 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, 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 of the Board of Trustees. The Plan expresses disclaims and does not recognize any "common fund" doctrine of any State.
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 THE ABOVE PROVISIONS WILL RESULT IN THE DENIAL OF THE CLAIM(S).

ARTICLE 10 COORDINATION OF BENEFITS – BENEFIT COMBINING PROVISIONS

APPLICABILITY
Coordination of benefits (COB) applies when a Plan Participant has health coverage under one or more Benefit Plan, 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 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 involved. The terms benefit Plan 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 are determine. The benefits of this Plan:

1. Shall not be reduced when under the order of benefit determination rules, this Plan determines its benefits before another benefit Plan; but
2. May be reduced when under the benefit determination rules, another benefit Plan determines its benefits 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 expenses(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.

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 - means any Plan, policy or coverage providing benefits or services for, or by reason of medical, dental, or vision care. Such benefit Plan shall include, without limitation:

1. Group, blanket or franchise insurance coverage;
2. Blue Cross, Blue Shield, group practice, individual practice and other pre-payment coverage;
3. Any coverage under a jointly trusted labor-management Plan, union welfare Plans, employer organization Plans or Employee benefit organization Plans;
4. A licensed Health Maintenance Organization (HMO);
5. 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 the purposes of this Plan, any person who is covered under Medicare par "A" is also deemed covered under Medicare part "B";

6. Any Plan or policies funded in whole or in part by an employer, or deductions made by an employer from an Employee's compensation or retirement benefits;
7. 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
8. 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. 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.

Benefit Plan 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, this Plan is a Secondary Plan unless:
    1. The other benefit Plans(s) has rules which coordinate it's benefits with those of this Plan and
    2. The rules of both of the other benefit Plan 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 that covers the person as an Employee or non-Dependent, rather than as a Dependent, is primary. The benefit Plan that covers the person as a Dependent is secondary.
    2. **Dependent child/parent not legally separated or divorced** – except as stated in item 2i below, when this Plan and another benefit Plan cover the same child as a Dependent of his or her parents:
        i. The benefits of the benefit Plan of the parent whose birthday falls earlier in the year are primary and determined before those of the benefit Plan of the parent whose birthday falls later in that year; but
        ii. If both parents have the same birthday, the benefits of the benefit Plan which covered one parent longer, are primary and are determine before those the benefit Plan which covered the other parent the shorter period of time.
    3. **Dependent child/parents legally separated or divorced** – If two or more benefit Plan 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 of the parent with custody shall be primary;
        ii. Then, the benefit Plan of the spouse of the parent with custody of the child;
        iii. Finally, the benefit Plan of the parent not having custody of the child.

        Notwithstanding (i) through (iii), if there is 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 Plan which covers the child as a Dependent child. The benefit Plan of the other parent shall be the secondary benefit Plan.
    4. **Active/inactive Employee** – The benefit Plan 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 that covers the person as a laid off or retired Employee (or as that Employee's Dependent).

5. **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, the benefits of the benefit Plan that covers the person as an active Employee shall be primary and shall be determined before the benefits of the continuation coverage.
6. **Longer/shorter length of coverage** – If none of the above rules determines the order of benefits, the benefit Plan 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 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, 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, 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 the 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 to obtain from any other insurance company or organization or person any information, which this Plan deems necessary for the purpose of this provision. Any person claiming benefits under this Plan must furnish the Plan Sponsor any facts it needs to pay the claim.

RIGHT TO RECOVERY

If the amount of payment 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 who it has paid;
2. Insurance companies; and
3. Other organizations or entities

ARTICLE 11 HOW TO OBTAIN MEDICAL BENEFITS

Section 11.01 When Claim Should Be Filed

Claims should be filed within 90 days of the date charges for the services 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 Participant seek a 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 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 11.02 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 11.03 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 judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In 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 of 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 review, may be transmitted between the Plan and claimant by telephone, facsimile, or other similarly expeditious method.

Section 11.04 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 (Section 5.1) 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 11.05 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 11.06 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 is based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material 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 benefit 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 included that such a rule, guideline, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to 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 judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge, upon request.

Section 11.07 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. Any claimant wishing to appeal an adverse benefit determination must place the appeal in writing and deliver it to the Fund Office via U.S. Mail at the following address:

Southern Illinois Laborers' and Employers' Health & Welfare Fund
5100 Ed Smith Way, Suite A
Marion, Illinois 62959
(618) 997-9063 [Facsimile]

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 begins 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 benefit determination nor a subordinate of the individual.

If the determination was based on medical judgment, including determination 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 judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the determination will be identified.

Section 11.08 Exhaustion of Plan Remedies

You must exhaust all of the claims and appeals procedures of the Plan before you bring any action in court or administrative action for benefits. If the Plan fails to comply with its claim and appeal procedures, you will be deemed to have exhausted the procedures. After you have exhausted all of the procedures in this section and if you are dissatisfied with the written decision of the Board of Trustees on appeal, you may request an external review of your claim or institute legal action, including actions or proceedings before administrative agencies.

Section 11.09 External Review of Claims

This External Review process is intended to comply with the Affordable Care Act of 2010 external review requirements.

If your appeal of a claim is denied, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

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

Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of the denial of your claim appeal or adverse benefit

determination on appeal of your claim. For convenience, these determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for an Adverse Determination.

Section 11.10 Preliminary Review

1. Within five (5) business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:
   A. You were covered under the Plan at the time the health care item or service was provided;
   B. The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;
   C. You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances); and
   D. You have provided all of the information and forms required to process an external review.
2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:
   A. If your request is complete and eligible for external review; or
   B. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
   C. If your request is not complete, the notice will describe the information or materials needed to make the request complete and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Section 11.11 Review by Independent Review Organization (IRO)

If the request is complete and eligible, the Plan will assign the request to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.
Once the claim is assigned to an IRO, the following procedure will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).
2. Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.
3. If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination; it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
4. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan,

unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

5. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.
6. The assigned IRO's decision notice will contain:
   A. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
   B. The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
   C. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
   D. A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
   E. A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
   F. A statement that judicial review may be available to you; and
   G. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act of 2010 to assist with external review processes.

Section 11.12 Expedited External Review of Claims

You may request an expedited external review if:

1. You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
2. You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or,
3. You receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, described above. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

Section 11.13 After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.
If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a) within three years of receiving the final review notice under these procedures.

ARTICLE 12 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 1074 (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.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the Participant has the 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 request 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 a suit in a federal court. In such case, the court may require the Plan Administrator to provide materials and to the pay the Plan Participant up to a maximum of $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 the 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, 489 U.S. 21 (Feb. 21, 1989).

ARTICLE 13 PAYMENT OF BENEFITS

Section 13.01 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-Blue Cross Blue Shield of Illinois provider, will payment be made to the covered Employee. This Plan will not assign benefits to pharmacies.

Section 13.02 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, incompetence, and which 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 13.03 Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been a fraud, an intentional misrepresentation of material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

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

If benefits have already been paid based on fraud, intentional misrepresentation of a material fact, or material omission, the Trustees may recover the benefits plus expenses incurred in such recovery, including attorney's fees and investigation expense.

Section 13.04 Refunds

Any benefit payment made in error due to the misinformation or lack of information provided by the member, the member's Dependents, and/or provider(s) or due to an error in calculations 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 lack of information provided by the member or the member's Dependents, and not otherwise recovered from a provider, the 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.

ARTICLE 14 PRIVACY AMENDMENT

Section 14.01 Definitions

For the 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 not limited to, court orders and court ordered warrants; subpoenas or summons issued by a court of 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 14.02 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 up 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 14.03 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 determination
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
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 14.04 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 the Privacy Amendment of which it becomes aware.
5. Making its internal practices, books, and records relating to 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 PHI when no longer needed for the purpose of which the disclosure was made, except when return or destruction is not feasible, limiting further Uses and Disclosures to the 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 or 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 14.05 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 even 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 of 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 14.06 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 the Plan's Administrative Manager; 5100 Ed Smith Way, Suite A; Phone # 618-998-1300 or Fax # 618-997-9063. 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 15 HIPAA STANDARD SECURITY REQUIREMENTS

This provision is intended to bring the Southern Illinois Laborers' & Employers' Health & Welfare Fund(hereinafter the "Plan") into compliance with requirement of 45 CFR § 164.314 (b) (1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and it implementing regulations, 45 CFR 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 15.01 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' & Employers' Health & Welfare Fund".

Plan Documents – The term "Plan Document" 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' & Employers' Health & Welfare Fund).

Plan Sponsor – the term "Plan Sponsor" means the entity as defined in section 3(16)(b) of ERISA, 20 U.S.C. § 1002 (10)(B). The Plan Sponsor is the Southern Illinois Laborers' & Employers' Health & Welfare Fund.

Security Incidents - The term "Security Incidents" has a meaning set forth in 45 CFR §163.304, 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 15.02 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 of 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 15.03 Responsibilities for Plan Administration

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

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

Section 15.04 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, inconsistencies 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 is qualified under ERISA Sec. 609.
9. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate.

Section 15.05 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 15.06 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 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 comply with ERISA.

Section 15.07 The Named Fiduciary

A "named fiduciary" is a person or entity named in the Plan with fiduciary authority and control over 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 the 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 of 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 under 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 15.08 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 in 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 overpayment will be deducted from future benefits payable.