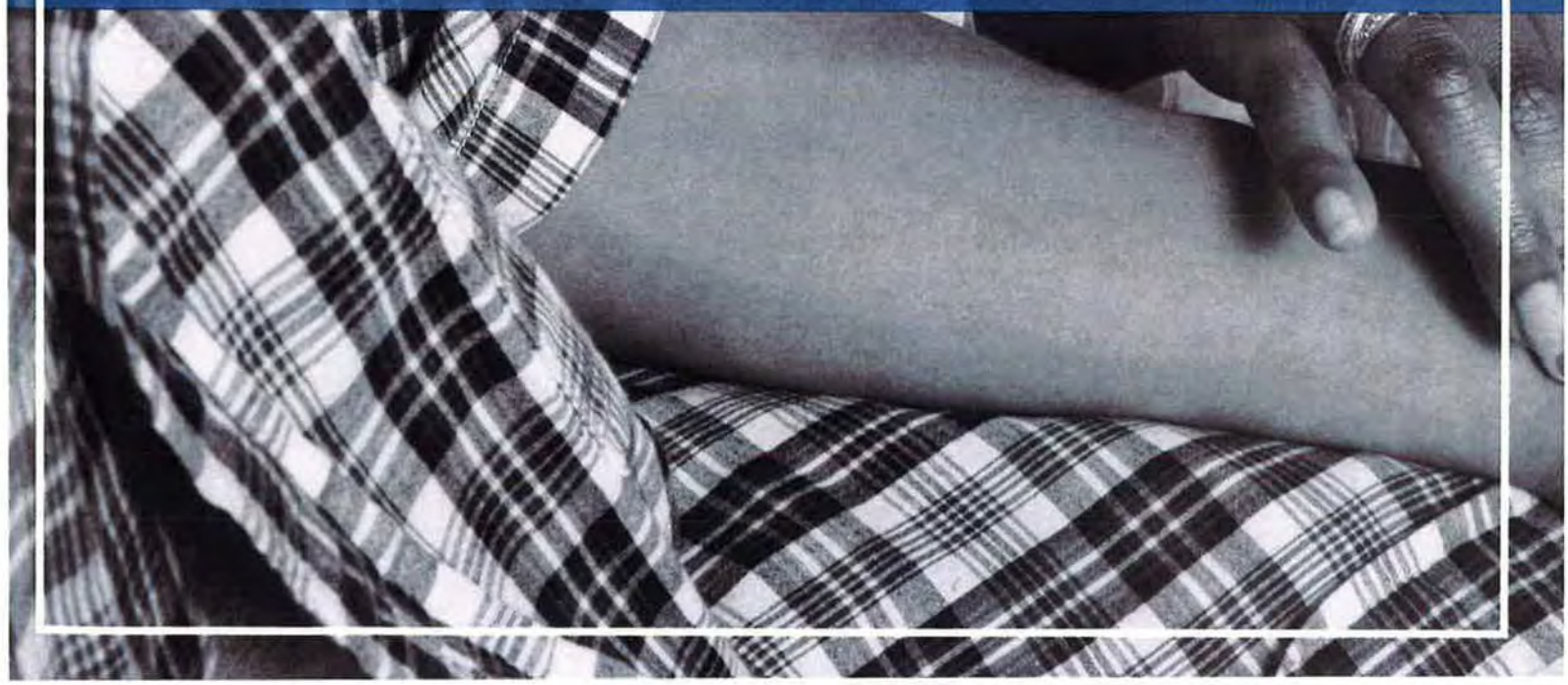
JOINT WELFARE COMMITTEE FOR THE POINTING, CLEANING AND CAULKING INDUSTRY

LOCAL 52

Summary Plan Description 2019



Dear Employee:

The Trustees are pleased to provide this updated Summary Plan Description (SPD), which describes your health and welfare benefits as of January 1, 2019. This booklet replaces and supersedes any prior benefit booklets. We urge you to read it carefully and, if you are married, to share it with your spouse.

As an eligible Employee, you participate in an excellent benefit program that helps protect you and your family from financial hardship in case of illness, injury or death.

Although this SPD provides accurate and important information about your health and welfare benefits, it is not a complete description. If there is ever a conflict between the information in this SPD and the Plan Document, the final determination will be based on the Plan Document.

If you have any questions about your benefits or other information explained in this SPD, please feel free to contact the Fund Office, Monday through Friday, 7:00 a.m. to 3:00 p.m., at 630-516-8008 or by fax at 630-516-8018.

Sincerely,

Board of Trustees

Union Trustees	Employer Trustees
Hector Arellano	Kevin Geshwender
Jim Allen	Thomas Rivkin
Mark Tetlak	Mark Snedden

This booklet is not the legal Joint Welfare Committee for the Pointing, Cleaning and Caulking Industry, Local 52 Plan Document. Only the Plan Document (the Rules and Regulations) establishes the legal rights, privileges, and obligations under the Plan. If there is a conflict or inconsistency between the provisions of the Plan Document and this booklet, the Plan Document will govern. Nothing in this Summary Plan Description (SPD) booklet is meant to interpret, extend, or change in any way the provisions expressed in the Plan Document and Trust Agreement. No employee, Union, or any representative of any employer or Union is authorized to interpret this Plan nor can any such person act as agent of the Trustees. The Trustees' intent is to continue this Plan indefinitely, subject to the provisions of the Trust Agreement. The Trustees have the authority and reserve the right to amend, modify, or discontinue all or part of this Plan whenever, in their sole discretion, conditions so warrant. Such action may take place by a majority vote at a regularly scheduled Board of Trustees meeting. The Trustees also have sole and broad discretion in interpreting the provisions of the Plan, this SPD, or any other provisions relating to the operation of the Plan.

IMPORTANT PHONE NUMBERS

The chart that follows shows the phone numbers for the various organizations that provide services under the Tuckpointers Local 52 Health and Welfare Plan.

If You Have a Question or Need Information About	Call	Phone Number	Website
Eligibility or Benefits	Fund Office	630-516-8008	
PPO Network Providers	BlueCross BlueShield of Illinois	800-810-2583	**www.bcbsil.com**
Preventative Care Program	Health Dynamics	414-443-0200	**http://healthdynamics.com/locations99/**
Prescription Drug Benefits	Express Scripts	800-818-0093	**www.express-scripts.com**
Dental Providers	Dental Network of America	866-522-6758	**www.dnoa.com** (Labor Plus)
Health Spending Account	Fund Office	630-516-8008	
Hearing Discounts	Epic Hearing Healthcare	866-956-5400	www.epichearing.com
Weekly Disability Benefits	Fund Office	630-516-8008	
Death Benefits	Fund Office	630-516-8008	

Statement of Grandfathered Status

The Board of Trustees believes that the Plan of the Joint Welfare Committee for the Pointing, Cleaning and Caulking Industry, Local 52 is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain benefits of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other requirements in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding the benefits that apply or do not apply to a grandfathered health plan and the circumstances that might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 630-516-8008. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which benefits do and do not apply to grandfathered health plans.

SCHEDULE OF BENEFITS

THE PLAN COVERS INPATIENT TREATMENT ONLY IF PROVIDED IN HOSPITALS OR FACILITIES THAT MEET THE REQUIREMENTS LISTED ON PAGE 20.

Medical Plan Feature or Benefit	Coverage Level	Page
Annual Deductible	$200 per person/$500 per family	4
Inpatient and Outpatient Hospital eligible expenses for all covered services, including medical care, Drug/Alcohol Abuse Treatment or Mental/Nervous Disorders Treatment:	Plan pays:	20
• PPO Hospital or Facility	80% of covered expenses	
• Non-PPO Hospital or Facility	70% of covered expenses	
All Other Covered Services	Plan pays 80% of covered expenses	5
Calendar Year Out-of-Pocket Maximum	$800 per person/$2,500 per family Note: only 20% of the amount you pay for non-PPO Hospitals is counted toward your Out-of-Pocket Maximum	4
Lifetime Maximum	None	5

The Plan also features some special coverages for specific medical care and services.

Special Medical Coverages		
Speech Therapy (Medically Necessary)		22
• Adult • Dependent Child diagnosed with neurological disorder	Plan pays 80% after deductible 80% up to 20 visits per Calendar Year	
Well Child Care		24
• From birth up to 6 years	Plan pays 100% of eligible routine expenses	
• From 6 years through 18 years	100% of eligible expenses, one physical exam each calendar year, including required vaccines at age 11 for tetanus and meningitis	
Routine Preventive Care Physicals (Employees and Spouses only)	Plan pays 100% of eligible charges, up to one exam per calendar year	24
Additional Preventative Screening* (Employees and Spouses only)	Plan pays 100% of covered testing, once per calendar year through Health Dynamics	24
HPV vaccinations (Eligible persons age 9 to 26 only)	Plan pays 100% of covered expenses, no deductible applies	24
Smoking Cessation (Employees and spouses only)	Plan pays 50% for prescribed drugs and nicotine patches**	24
Lifetime Maximum	$150 per person	24

**In lieu of a physical through your primary doctor, you can receive a Health Dynamics screening for no cost. Call Health Dynamics for a list of the screenings and to make an appointment at 414-443-0200.*
*** You can use your Health Spending Account to pay for the other 50%.*

Diagnostic X-Ray and Laboratory	Plan pays 100% of covered expenses, up to $150 per person per Calendar Year; then 80% after deductible is met	24
Infertility Treatment (Employees and spouses only)	Up to $10,000 per person per lifetime	24
Second or Third Surgical Opinion	Plan pays 100%, no deductible applies	25

THE PLAN COVERS INPATIENT TREATMENT ONLY IF PROVIDED IN HOSPITALS OR FACILITIES THAT MEET THE REQUIREMENTS LISTED ON PAGE 20.

Medical Plan Feature or Benefit	Coverage Level	Page
Organ Transplants:	Plan pays:	27
• Coinsurance (including organ procurement)	80% (50% if non-Center of Excellence facility)	
• Immunosuppressive (Anti-Rejection) Medications	80%, up to $10,000 per person, per lifetime (when using a Center of Excellence facility only)	
Travel and Lodging Lifetime Maximum		
Carpal Tunnel Syndrome (Bargained Employees only)	Plan pays 100% of pre-authorized work-related covered expenses, no deductible applies	29
Foot Orthotics		
• Plan Pays:	80%, after deductible	
• Calendar Year Maximum	$300 per person	
• Lifetime Maximum	$1,500 per person	
Mental/Nervous Disorders Treatment and Alcohol/Drug Abuse Treatment (Inpatient or Outpatient)	Plan does not cover non-accredited residential facilities. Plan pays:	25
• Provider or PPO Hospital or Facility	80%	
• Non-PPO Hospital or Facility	70%	
Colonoscopy Screening For Participants and Dependents age 50 up to age 75	100%, no deductible, once every 10 years	25
Prescription Drug Benefits		30
Coinsurance	Plan pays:	
Generic	80% of the cost	
Brand Name*	50% of the cost	
Specialty Drug**	80% of the cost	
Out-of-Pocket Maximum	$1,000 per person per calendar year	
Maximum Supply	Retail: 30-day supply/Mail Order: 90-day supply	
Health Spending Account	$2,500 calendar year maximum per family	38
Dental Plan Benefits		
Annual Maximum Benefit	$2,500**	36
Orthodontia Lifetime Maximum (under age 19)	$4,500	

* If a brand name medication is dispensed when a generic is available, you pay 50% of the cost of the brand name medication plus the difference in cost between the generic and brand name medication.

** You must use the Specialty Drug Pharmacy, ACCREDO.

Coinsurance Paid by Plan	In-Network	Out-of-Network
Preventive Dental Benefits	100%	80%
Basic Dental Benefits	80%	60%
Restorative Dental Benefits	80%	60%
Orthodontia Benefits	70%	50%

**Individuals under age 19 are eligible to receive preventive dental services, subject to applicable cost sharing, with no annual limits.

Weekly Disability and Death Benefits*	Coverage Level	Page
Weekly Disability Benefit*		41
Active, Bargained Employees	$600 per week for up to 26 weeks of disability; then $400 per week for up to an additional 26 weeks of disability	
Maximum Disability Period	52 weeks per disability	
However, for Disability Incurred during training under the direct supervision of the apprenticeship program (All Active Bargained Employees)		41
Weekly Benefit	$600	
Maximum Disability Period	52 weeks per disability	
Death Benefit (Bargained Employees only)*		42
Employee Death Benefit		
Less than 3 years of service	$15,000	
3 or more years of service	$30,000	
Spousal Death Benefit	$12,500	
Child Death Benefit	$12,500	

* Plan C ineligible employees, or employees on COBRA, Retirees and Dependents are not eligible for weekly disability or death benefits.

YOUR HEALTH AND WELFARE BENEFITS AT A GLANCE

Eligibility

Employees

Your eligibility is based on Employer contributions made to the Chicago Area Joint Welfare Committee for the Pointing, Cleaning and Caulking Industry, Local 52 (referred to as the Tuckpointers Local 52 Health and Welfare Trust) for your coverage under the Plan. Initially, if you are a bargained employee, your coverage begins on the first day of the month following a period of at least six consecutive months, but not exceeding nine consecutive months (excluding January, February, and March) in which you are credited with at least 600 hours of Employer Contributions. Once you become eligible, you remain eligible for at least three consecutive months.

After you meet the initial eligibility requirements, you continue to be eligible by working at least 250 hours during each three-month contribution quarter.

If you are a Plan C employee, you are initially eligible for coverage on the first day of the month following a 60-day period in which you work 30 or more hours per week and the required contributions are made to the Fund on your behalf. If you are a non-bargained employee not in Plan C or a bargained employee, you are initially eligible for coverage on the first day of the month following a 30-day period in which you work 30 or more hours per week and the required contributions are made to the Fund on your behalf.

> Note: Initial eligibility for Journeyman Assistants changed in 2018. If you are a Journeyman Assistant and you had any hours of Employer contributions in 2017, your coverage begins on the first day of the month following a three consecutive month period in which you work at least 300 hours, provided the hours are credited before July 1, 2018. Once you become eligible, you remain eligible for three consecutive months. If you did not have any hours of Employer Contribution in 2017, your initial eligibility will be the same as described above for all other bargained employees.

Dependents

Your Dependents may also have medical coverage under this Plan. Your Dependents' coverage begins when yours begins or, if later, when you first acquire a Dependent, such as a spouse or child.

MEDICAL BENEFITS

Annual Deductible

Individual. You pay the first $200 of eligible expenses per person each calendar year before the Plan begins to pay benefits for most covered expenses. This is called your annual deductible.

Family. Your family's annual deductible is met when any combination of covered family members' eligible expenses applied to their individual deductible reaches $500.

Facilities include:

- Skilled Nursing Facilities
- Alcoholism and Drug Addiction Centers
- Day Surgery Centers
- Urgent Care Centers

Coinsurance

Once the annual deductible is satisfied, the Plan pays 80% of most eligible expenses (70% of eligible expenses if you use a non-PPO Hospital or Facility).

Annual Out-of-Pocket Maximum

Individual. Once eligible out-of-pocket expenses for a covered individual exceed $800, excluding the deductible, during a calendar year, the Plan pays 100% of most eligible expenses incurred by that person for the rest of the year. However, you must always pay the full 30% when you use a non-PPO Hospital or Facility. In addition, only 20% of the non-PPO Hospital or Facility expense may be applied to the out-of-pocket maximum.

Family. The out-of-pocket maximum for all covered family members combined is $2,500 (excluding deductibles).

Lifetime Maximum

The Plan has no lifetime limit.

CARPAL TUNNEL SYNDROME

The Plan pays 100% of covered expenses relating to the treatment of carpal tunnel syndrome resulting from work-related causes. (See page 29 for additional information.) All other carpal tunnel treatments are covered like any other medical expenses, subject to the deductible and coinsurance.

Only Bargained Employees are eligible for work-related carpal tunnel syndrome benefits.

PRESCRIPTION DRUG BENEFITS

Under the prescription drug program the Plan pays:

- 80% of the cost of a generic or specialty medication; or
- 50% of the cost of a brand name medication. If a brand name is dispensed when a generic is available, you pay 50% of the cost of the brand name medication plus the difference in cost between the generic and brand name medication.

If eligible out-of-pocket prescription drug expenses for a covered individual exceed $1,000 during a calendar year, the Plan pays 100% of most eligible expenses incurred by that person for the rest of the year (see page 31).

The maximum supply per prescription is 30-days at a retail pharmacy or 90-days through the mail order program. Maintenance medicines, after initial prescription and three refills, must be filled through the mail order program to be covered.

You must use the Specialty Medication Pharmacy, Accredo to fill any specialty medication prescriptions.

DENTAL BENEFITS

Network

The Plan uses the Dental Network of America (DNoA). When you use in-network dentists, the Plan will pay a larger portion of the discounted charges. If you use out-of-network dentists, the you will pay a larger portion of the full charges. You can save money by going to network dentists.

Coinsurance

The coinsurance the Plan pays is based on the type of service provided, as follows:

- Preventive Dental Benefits: 100% in-network, 80% out-of-network
- Basic Dental Benefits: 80% in-network, 60% out-of-network
- Restorative Dental Benefits: 80% in-network, 60% out-of-network
- Orthodontia Benefits: 70% in-network, 50% out-of-network

Annual Maximum

The Plan will pay for covered services, at the coinsurance rate above, up to $2,500 per person per year. Orthodontia is limited to Dependents less than 19 years old and up to a $4,500 lifetime maximum

HEALTH SPENDING ACCOUNT (HSA)

The Plan pays up to $2,500 per family each calendar year for eligible out-of-pocket health care expenses, including medical, prescription drug, dental, vision and hearing expenses. Dental expenses will be paid after you have reached the annual dental maximum. The Plan will pay 100% of these expenses. You cannot use the Health Spending Account to pay for expense that are part of your Plan deductibles.

WEEKLY DISABILITY BENEFITS

Retirees, Dependents are not eligible.

The Plan pays $600 a week for up to 26 weeks and $400 a week for up to the next 26 weeks for each **non-work-related** disability. If the disability is due to an:

- Injury, benefits begin on the first day of the disability; or
- Illness, benefits begin on the eighth day of continuous disability.

DEATH BENEFITS

If you die while covered under this Plan, your beneficiary receives a death benefit. The benefit amount is:

- $15,000 if you have less than three years of service; or

> If you marry, divorce, or have or adopt a child, be sure to contact the Fund Office right away so that your records can be updated for proper coverage. You will be required to submit supporting documentation, such as a marriage certificate, divorce decree, birth certificate, adoption papers or other documentation as necessary. You should also contact the Fund Office if a member of your immediate family dies.

- $30,000 if you have three or more years of service.

If your spouse dies while you are covered under this Plan, you will receive a death benefit of $12,500, as long as you had been married for at least one year prior to your spouse's death.

If your child (under age 22) dies while you are covered under this Plan, you will receive a death benefit of $12,500.

WHEN COVERAGE ENDS

In general, coverage ends, on the first to occur as follows:

- When you have used up your eligibility based on your Employers' contributions to the Plan;
- When you stop making self-payments for coverage; or
- On the date the Plan is discontinued.

Coverage for a Dependent ends when you are no longer eligible, or when he or she is no longer considered a Dependent under the Plan.

CONTINUING COVERAGE

If coverage ends, you and/or your Dependents may be eligible to continue coverage for a limited time under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

ELIGIBILITY AND PARTICIPATION

When You First Become Eligible

BARGAINED EMPLOYEES

You are first eligible for coverage under the Tuckpointers Local 52 Health and Welfare Trust if:

- You are working in Covered Employment;
- You are an active Employee of a participating Employer;
- You work at least 600 hours during any period of at least six months up to nine months (excluding January, February, and March); and
- Your Employer makes the required contributions to the Tuckpointers Local 52 Health and Welfare Trust based on your job classification and your hours worked (defined as covered employment).

Your coverage begins on the first day of the month following the date you meet the eligibility requirement.

If I work 600 hours in four months, do I still have to wait until the end of the consecutive six-month period for coverage to begin?

Yes, the six-month period is part of the eligibility requirement. Therefore, to become eligible initially, you must wait until the end of a consecutive **six-month period**, (excluding January, February, and March) during which you worked at least 600 hours.

If I do not work at least 600 hours in a consecutive six-month period but work at least 600 hours in a consecutive **eight-month period**, when does my coverage begin?

You will be eligible at the end of the consecutive eight-month period (excluding January, February, and March) during which you worked at least 600 hours.

NON-BARGAINED EMPLOYEES

As a non-bargained employee, you are initially eligible for coverage on the first day of the month following a 30-day period (60-day period for Plan C employees) in which you work 30 or more hours per week and the required contributions are made to the Fund on your behalf. You must:

- Be working for a contributing employer that has signed a participation agreement with the Fund to make contributions on your behalf; and
- Complete and submit an enrollment form.
- For new non-bargained employee groups, Plan coverage begins on the date the participation agreement between a contributing employer and the Fund is effective.

YOUR DEPENDENTS

In general, your Dependents' coverage begins when yours does or, if later, when you acquire an eligible Dependent (i.e., through marriage, birth, adoption, placement, etc.).

Special Enrollment

When you experience a life event and lose or acquire a Dependent—such as getting married, having a child through birth or adoption, the death of a Dependent or a Dependent child aging out of eligibility—you may request special enrollment for yourself and your Dependents. However, you must request special enrollment and provide the required documents within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office.

Under federal law, an individual has the special right to enroll in any other group health plan for which he or she may be eligible (such as a plan sponsored by a spouse's employer) within 30 days after his or her regular coverage under this Plan terminates due to a qualifying event. The individual will not have to wait until that other plan's next open enrollment period. If that individual elects COBRA Continuation Coverage under this Plan, he or she will have that same special right to enroll in another group health plan at the end of the COBRA coverage if he or she keeps the COBRA coverage for the maximum period it is available.

Required Documents to Enroll a Dependent

For all dependents:

- Copy of a Birth Certificate
- Copy of the dependent's social security card

Based on reason for life event:

- Copy of a Marriage Certificate
- Copy of a Divorce Decree
- Copy of Adoption or Placement papers
- Copy of tax forms for step-children

If you marry, divorce, or have or adopt a child, be sure to contact the Fund Office right away so that your records can be updated for proper coverage. You will be required to submit supporting documentation, such as a marriage certificate, divorce decree, birth certificate, adoption papers or other documentation as necessary. You should also contact the Fund Office if a member of your immediate family dies.

Continuing Your Eligibility

BARGAINED EMPLOYEES

For your coverage to continue after you are initially eligible:

- Your Employer must continue to make the required contributions to the Tuckpointers Local 52 Health and Welfare Trust on your behalf; and
- You must work at least 250 hours within each three-month contribution quarter to have coverage during the corresponding three-month benefit quarter.

Let's say you work at least 250 hours during the July, August, and September contribution quarter and your Employer makes the required contributions to the Tuckpointers Local 52 Health and Welfare Trust for you during this period. You would be covered during the November, December, and January benefit quarter.

A **contribution quarter** is a three-month period during which your Employer makes required contributions to the Tuckpointers Local 52 Health and Welfare Trust based on your hours worked. A **benefit quarter** is the three-month period during which you have coverage based on your Employer's required contributions to the Tuckpointers Local 52 Health and Welfare Trust during the corresponding contribution quarter.

The following chart shows contribution quarters and their corresponding benefit quarters.

Contribution Quarter	Corresponding Benefit Quarter
January, February, March	May, June, July
April, May, June	August, September, October
July, August, September	November, December, January
October, November, December	February, March, April

IF YOU DO NOT WORK 250 HOURS DURING A CONTRIBUTION QUARTER

If you do not work at least 250 hours during a contribution quarter, meaning you are "short hours," the Tuckpointers Local 52 Health and Welfare Trust will look at your work hours for which required Employer contributions were made during the current and previous contribution quarters. You will be eligible during the corresponding benefit quarter if you work at least:

- 500 hours in the current and prior contribution quarters combined;
- 750 hours in the current and prior two contribution quarters combined; or
- 1,000 hours in the current and prior three contribution quarters combined.

Let's say you did not work at least 250 hours during the January, February, and March contribution quarter. Normally, you would not be covered during the May, June, and July benefit quarter. In this case, however, the Tuckpointers Local 52 Health and Welfare Trust looks back at your work record as far as the previous three contribution quarters. They find that you did work at least 500 hours during the current and prior contribution quarters combined (January, February, and March plus October, November, and December). Therefore, your coverage would continue during May, June, and July—the corresponding benefit quarter.

IF YOU DO NOT HAVE THE HOURS TO CONTINUE ELIGIBILITY

If you do not work enough hours in covered employment to meet any of the work hour requirements during any contribution quarter after your initial eligibility, you may make self-payments to continue coverage during the next two consecutive benefit quarters as long as you were covered by the Plan within one year before the date of your first self-payment, or you initially became eligible within the past year. The amount of your self-payment would be based on how many hours you are short of the 250 work hours required during a contribution quarter times the current hourly Employer contribution rate. If you work in the construction industry for a non-union employer or are a non-bargained employee, you cannot self-pay for coverage.

WORK-RELATED INJURIES

The Tuckpointers Local 52 Health and Welfare Trust does not cover work-related Injuries or illnesses, except for carpal tunnel syndrome as described on page 33. In addition, medical benefits under this Plan are not payable for Injuries or illnesses arising out of any type of employment for wage or profit. Contact your Employer's workers' compensation provider.

IF YOU DO NOT WORK BECAUSE OF DISABILITY

Once eligible for coverage under the Plan, you are entitled to six months of "credit hours" to apply toward continuing your coverage if you become disabled. These hours are issued at a rate of three credit hours for each day you are disabled, seven days a week. To receive credit hours, you must call the Fund Office and request a disability claim form. You fill out the form and have your attending Physician fill out the Physician section of the form. On the form, your Physician will state when your disability began and will give an estimate of when it will end. These are the dates used by the Fund Office to issue disability credit hours. Please note that when you are released by your Physician to return to work, you must notify the Fund Office immediately and submit a written release from your Physician to return to work. If you are on workers' compensation disability benefits, you can receive credit hours only with a medical document; contact the Fund Office for further information.

Family Medical Leave Act (FMLA): If your employer is required to comply with FMLA and you are eligible and receive the proper leave from your employer, then your employer will continue to pay for your coverage during your leave. The Fund Office will only continue your eligibility if your employer continues to make the required contributions. **Contact your employer to see if FMLA applies to you.**

If you are unable to work at least 250 hours during a contribution quarter due to a disability from an Injury or sickness, you may re-establish eligibility if you work at least 250 hours during any consecutive three-month period within one year following loss of coverage for which your Employer was required to make contributions to the Tuckpointers Local 52 Health and Welfare Trust.

IF YOU DO NOT WORK FOR REASONS OTHER THAN DISABILITY

If you are unable to work at least 250 hours during a contribution quarter for any reason other than a disability and you were covered under the Tuckpointers Local 52 Health and Welfare Trust in either of the preceding two consecutive benefit quarters, you may re-establish eligibility. You re-establish eligibility by working at least 250 hours during any consecutive three-month period following loss of coverage for which your Employer is required to make contributions to the Tuckpointers Local 52 Health and Welfare Trust. If you were not covered under the Tuckpointers Local 52 Health and Welfare Trust in either of the preceding two consecutive benefit quarters, you may re-establish eligibility if you work at least 600 hours within six consecutive months.

Your re-established coverage begins on the first day of the month in which you meet the eligibility requirements and continues for three months.

NON-BARGAINED EMPLOYEES

For your coverage to continue after you are initially eligible:

- Your employer must continue to make the required monthly contributions to the Tuckpointers Local 52 Health and Welfare Trust on your behalf; and
- You must work at least 30 hours per week each month.

When Coverage Ends

If you are a bargained employee, your coverage under the Tuckpointers Local 52 Health and Welfare Trust will end on the last day of the benefit quarter in which the earliest of the following occurs:

- You are no longer eligible for Plan coverage;
- 31 days after you enter the armed forces of any country (see Military Service on page 12);
- The Plan ends; or
- You stop making any required self-payments.

If you are a non-bargained employee, your coverage under the Tuckpointers Local 52 Health and Welfare Trust will end on the earliest of the:

- Last day of the calendar month in which you no longer met the Plan's continuing eligibility requirements;
- First day of the month for which the required employer contribution is not received on your behalf;
- Date your contributing employer is no longer signatory to a current collective bargaining agreement with Bricklayers and Allied Craftsmen, Administrative District Council 1;
- Date your employer's participation agreement ends; or
- Date non-bargained employee coverage is terminated.

Your Dependent's coverage ends on the earliest of the:

- Date your coverage ends (as described above);
- Date he or she no longer meets the Plan's definition of Dependent;
- First day of the month for which the required employer or self-payment contribution is not received on behalf of your Dependents;
- The date your Dependent enters the military; or
- Date the Plan no longer provides coverage for Dependents of non-bargained employees.

In the event of your death, your Dependent's coverage will continue until the last day of the month in which you die.

If you are Totally Disabled due to a sickness or Injury and are under a Physician's care on the date your coverage ends, your coverage will be extended for that disability only as long as you remain disabled for that particular sickness or Injury. The extension will be for a maximum of 12 months following the date your coverage ended. Since the coverage extension is only for the particular disability you had at the time your coverage ended, you will need to make self-payments to continue full coverage or to be covered under COBRA continuation coverage as this extension does not apply to any eligible expenses not directly attributable to that particular disability.

When you lose eligibility and have to make self-payments, you will receive a COBRA Notice that explains your rights under COBRA to continue coverage. See page 15 for more information on COBRA Continuation Coverage.

In considering whether to elect continuation coverage, you should take into account that not continuing your group health coverage will affect your future rights under federal law.

You have special enrollment rights under federal law. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You have the right to request special enrollment within 30 days after your group health coverage ends because of a Qualifying Event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

You may also use Blue DirectionsSM, a service provided to the Tuckpointers by Blue Cross Blue Shield, to find and purchase individual coverage. Blue Directions lets you review individual policies for yourself and your family. To access Blue Directions, visit www.bluedirections.com/tuckpointerslocal52 or call 877-252-3948.

RESCINDING COVERAGE

The Plan may rescind your or your Dependent's coverage for fraud or intentional misrepresentation of a material fact after the Plan provides you with notice, as required by law. 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 or your Dependent should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage:

- The Plan terminates your or your Dependent's coverage back to the date of loss of eligibility when there is a delay in administrative recordkeeping between the participant's loss of eligibility and notice to the Plan of the participant's loss of eligibility.
- The Plan retroactively terminates coverage because of your failure to make timely self-payments for coverage.

For any other unintentional mistakes or errors under which you were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively once the mistake is identified. Such cancellation will not be considered a rescission of coverage.

WHO DETERMINES ELIGIBILITY

The Trustees have the authority to determine any and all questions about the administration, interpretation, and application of the Trust Agreement, including questions about the eligibility of Employees, their Dependents, and any other person.

Reciprocity

The Fund may enter into reciprocal agreements with other welfare funds, in which case you may be entitled to eligibility under this Plan because of such agreements. However, your eligibility will not begin until contributions are transferred from the reciprocal fund(s) to this Fund. For more information, contact the Fund Office.

Military Service And Eligibility

If you serve in the Uniformed Services for up to 31 days, your health coverage will continue as long as you make the required self-payment if any is required. If you serve in the Uniformed Services for more than 31 days, you may continue your coverage by paying the required self-payments for up to 24 consecutive months or, if sooner, the end of the period during which you are eligible to apply for reemployment in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Uniformed Services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Coverage under USERRA will run concurrently with COBRA Continuation Coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA Continuation Coverage. The procedures for electing coverage under USERRA will be the same procedures described in the *COBRA Continuation Coverage* section beginning on page 00 except that only the Employee has the right to elect USERRA coverage for himself or herself and his/her Dependents, and that coverage will extend to a maximum of 24 months.

Your coverage will continue to the earliest of the following:

- The date you or your Dependents do not make the required self-payments;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- The date you lose your rights under USERRA (for instance, for a dishonorable discharge);
- The last day of the month after 24 consecutive months; or
- The date the Fund no longer provides any group health benefits.

You need to notify the Fund Office in writing when you enter the Uniformed Services. For more information about self-payments under USERRA, contact the Fund Office.

If You Do Not Continue Coverage Under USERRA

If you do not continue coverage under USERRA, your coverage will end immediately when you enter the Uniformed Services. Your Dependents will have the opportunity to elect COBRA Continuation Coverage.

Reinstating Your Coverage

When you are discharged or released from the Uniformed Services, you may apply for reemployment with your former Employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your Employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of service in the Uniformed Services. When you are discharged or released from service in the Uniformed Services that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a participating Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a participating Employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for participating Employer.

When you are discharged, if you are hospitalized or recovering from an Sickness or Injury that was incurred during your service in the Uniformed Services, you have until the end of the period that is necessary for you to recover to return to, or make yourself available for, work for a participating Employer. Your prior eligibility status will be frozen when you enter the Uniformed Services until the end of the leave, provided your Employer properly grants the leave under federal law and makes the required notification and payment to the Fund.

If You Retire

If you are a bargained employee who retires or otherwise leaves covered employment and you do not have any more credited hours, you may make self-payments to continue coverage for two self-payment quarters (six months). After this time, you may elect COBRA continuation coverage and make the self-payments for COBRA continuation coverage. This coverage may continue for up to 36 months, or until age 65 if sooner. If you elect to continue coverage under this provision, your coverage will end when you become eligible for Medicare or any other group health plan. Contact the Fund Office for more information about continuing your coverage when you retire or otherwise leave covered employment.

If you are a bargained employee who retires on or after age 60 with 25 or more years of service, when COBRA ends, you may make self-payments to continue medical, prescription drug, and health spending account benefits; extended self-pay retiree coverage does not include weekly disability or death benefits.

Coverage continues for:

- You, until you are age 65, or if earlier, until you are eligible for Medicare.
- Your eligible spouse, if any, until your spouse is age 65, or if earlier, until your spouse is eligible for Medicare.
- Your eligible Dependent children, if any, until the earlier of when they no longer meet the Plan's definition of Dependent or you and your spouse are both age 65 or otherwise eligible for Medicare.

Extended self-pay retiree coverage is available *after* you have continued active coverage using your credited hours and *after* you have made self-payments to continue coverage for two self-payment quarters (six months) and after COBRA. If you discontinue self-payments or COBRA payments, you cannot reapply for extended self-pay retiree coverage

If You Leave Covered Employment

If you leave employment covered under the Plan, your coverage ends at the end of the benefit quarter for which you met the eligibility requirements. Then, in most cases, you may make self-payments to continue coverage for the next two consecutive benefits quarters after which you can elect up to 18 months of COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

Under certain circumstances, coverage for you or your eligible Dependents can be temporarily continued, at your expense, after it would normally end. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides you with the right to this COBRA Continuation Coverage.

COBRA Coverage and Qualified Beneficiaries

COBRA Continuation Coverage is almost identical to the coverage you had under the Health Plan. You may continue Medical Benefits only or Medical Benefits and other health care benefits. Weekly Accident and Sickness, Death, and Accidental Death and Dismemberment Benefits are not included in COBRA Continuation Coverage. COBRA coverage is available to "qualified beneficiaries" who are defined as you and your Dependents who were covered under the Plan on the day before your coverage ended.

If you have a newborn child, adopt a child, or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add this child to your coverage. You must notify the Fund Office, in writing, of the birth or placement to have this child added to your coverage.

Children born, adopted, or placed for adoption as described above, have the same COBRA Continuation Coverage rights as a spouse or Dependent who was covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, their continued coverage depends on timely and uninterrupted payment of premiums on their behalf.

Paying for COBRA Coverage

You pay the full cost of the COBRA Continuation Coverage plus an administrative charge. The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost of COBRA Continuation Coverage will be determined by the Trustees on a yearly basis, and will not exceed 102% of the cost to provide this coverage, unless you are receiving 29-month COBRA Continuation Coverage, as described below, in which case the cost will not exceed 150% of the cost to provide this coverage for the 11-month disability extension.

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your and/or your Dependents' coverage under the Plan ended. This payment is due no later than 45 days after the date you or your Dependents signed the election form and returned it to the Fund Office. Subsequent payments are due on the first day of the month for which you are continuing coverage. However, you are allowed a 30-day grace period from the first day of the month. If payment is not received by the due date (or within the grace period), your COBRA Continuation Coverage will end as of the end of the month for which payment was last received. Once your COBRA Continuation Coverage ends, it cannot be reinstated.

Notices You Must Provide to the Fund

You or your Dependents must inform the Fund Office of a divorce, legal separation, or a child no longer meeting the Plan's definition of a Dependent within 60 days of such a qualifying event.

If you do not notify the Fund Office within 60 days of such an event, you will lose your right to elect COBRA Continuation Coverage.

The Fund Office will rely on its records for determining when eligibility is lost under certain circumstances. To help ensure that you do not suffer a gap in coverage, the Fund urges you or your family to notify the Fund Office of any qualifying event as soon as it occurs.

COBRA Election Notice

When the Fund Office is notified that one of these events has occurred, you and your Dependents will be notified of your right to elect COBRA Continuation Coverage. Once you receive a COBRA Continuation Coverage notice, you have 60 days to respond if you wish to elect COBRA Continuation Coverage. Each of your Dependents has the right to elect coverage independently from you.

If the Fund Office determines that you are not eligible for COBRA Continuation Coverage, it will notify you in writing of your ineligibility.

The length of COBRA Continuation Coverage available to you and the qualifying events that trigger the right to COBRA Continuation Coverage are outlined in the following subsections.

18-Month COBRA Continuation Coverage

You may elect to purchase COBRA Continuation Coverage for yourself and your eligible Dependents for up to 18 months if your coverage ends because of one of the following qualifying events:

- Your employment ends due to retirement or other termination of employment, not including termination due to gross misconduct;
- You do not work the required number of hours in a contribution quarter to continue coverage.

29-Month COBRA Continuation Coverage

If your coverage ends due to your employment ending or not working enough hours, and at the time of the event, or within the first 60 days of COBRA Continuation Coverage, you or one of your eligible Dependents is totally disabled (as determined by the Social Security Administration), COBRA Continuation Coverage for the family members who are covered under COBRA Continuation Coverage is offered for an additional 11 months, for a total of 29 months. This option offers the disabled individual and family members coverage until Medicare coverage becomes effective. Coverage for the additional 11 months will be at a higher cost. The cost for the additional 11 months is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

You must notify the Fund Office of the Social Security Administration's determination of disability within 60 days of the disability determination and before the end of the first 18 months of COBRA Continuation Coverage. Otherwise, you will not be eligible for the additional 11 months of coverage. In addition, you must notify the Fund Office within 30 days of receiving notice from the Social Security Administration that you or your disabled Dependent is no longer considered disabled by the Social Security Administration because you or your disabled Dependent have recovered.

36-Month COBRA Continuation Coverage

Your eligible Dependents may elect to purchase COBRA Continuation Coverage for up to 36 months if their Health Plan coverage ends due to of one of the following qualifying events:

- Your death;
- Your divorce or legal separation; or
- Your child no longer meeting the Plan's definition of a Dependent.

36-Month COBRA Continuation Coverage for Second Qualifying Event

If your eligible Dependents have a second qualifying event during the initial 18-month COBRA period (for a termination of coverage or reduction in hours), they may continue COBRA Continuation Coverage for up to a total of 36 months, provided they are otherwise eligible and they notify the Fund Office of the second qualifying event in writing within 60 days of the second qualifying event. Second qualifying events include:

- Your death;
- Your divorce or legal separation; or
- Your child no longer meeting the Plan's definition of a Dependent.

When COBRA Continuation Coverage Ends

COBRA Continuation Coverage may end for any of the following reasons:

- You or your Dependent first becomes covered under another group health plan after the date on which you elected COBRA Continuation Coverage. However, coverage will continue if you or an eligible Dependent has an existing health problem for which coverage is excluded under the other group plan;
- The required contribution is not paid;
- The Fund terminates the Plan;
- You or your Dependent reaches the end of the 18-month, 29-month, or 36-month COBRA Continuation Coverage period;
- You first become entitled to Medicare after the date on which COBRA Continuation Coverage is elected; or
- Your Dependent first becomes entitled to Medicare after the date on which COBRA Continuation Coverage is elected.

MEDICAL BENEFITS

How The Plan Works

The Plan pays a large part of your bills for the treatment of a non-occupational illness or accidental injury and helps protect you against expensive medical care related to severe illness or accidental injury.

Here's how the Plan works:

You have eligible expenses. Your medical benefits take effect when a claim is filed by you or a health care provider for reimbursement of eligible expenses. These are generally defined as medically necessary services or supplies related to the treatment of an illness, Injury, pregnancy, or childbirth that are within Allowable Charge limits and are covered by the Plan.

Allowable Charge means the amount of the expenses that falls within a range of what most health care providers in your area charge for the same medical treatment or service. For PPO providers it means the pre-negotiated charge.

You pay an annual deductible. Each calendar year (January 1–December 31), before the Plan pays anything for most eligible expenses, you pay so many dollars for your eligible expenses. This is called the annual deductible. The annual deductible is $200 per person. Your family deductible is $500. The family deductible is in place to help limit how many deductibles you may have to pay if you have several family members in the Plan.

Common Accident Provision. If two or more covered family members are Injured in the same accident, their eligible expenses related to these Injuries will be combined and applied to one $200 individual deductible. Once the $200 individual deductible is met, based on accident related expenses for all family members Injured in the accident, benefits would be payable for all of their eligible expenses related to the accident. This is called a common accident provision.

Carryover Provision. Another feature of the Plan is called the carryover provision. If you incur eligible expenses that you apply to your deductible in October, November, or December of one year, you may apply the same expenses to your annual deductible for the next year.

After the deductible is met, you and the Plan share most expenses. After the annual deductible is met, you pay a portion of any eligible expenses and the Plan pays the rest. The cost-sharing arrangement is called coinsurance. In most cases, you pay 20% and the Plan pays 80%, as long as you follow the cost-effective Plan features discussed under *What Is Covered* (on page 20) and Special Coverages (on page 24). The Plan pays 70% of non-PPO Hospital or Facility eligible expenses.

HOW THE FAMILY DEDUCTIBLE WORKS

Let's say you, your spouse, and your two children are covered by the Plan. So far, your eligible medical expenses for the year look like this:

Family Member	Eligible Expense
You	$150
Your Spouse	$200
Child 1	$100
Child 2	$50
Total Family Deductible	$500

In this case, your spouse met his or her deductible, so the Plan would begin to pay benefits for your spouse's eligible expenses. Even though no else in your family reached his or her $200 individual deductible, as a family, your eligible expenses applied to your annual deductibles reached the $500 family deductible. At this point, the Plan would begin to pay benefits for additional eligible expenses incurred by all of you during this calendar year. You don't have to wait for one to satisfy the individual deductible for the family deductible to be met, either. The family deductible is met when any combination of covered family members' expenses used to meet their individual deductibles combined reaches $500.

Your share of eligible expenses is limited. If you have high medical expenses, the Plan protects you by limiting the amount of eligible expenses you have to pay out of your own pocket. This is called your annual out-of-pocket maximum. When a covered individual's out-of-pocket payments towards eligible expenses exceed $800, not including the annual deductible, in any calendar year, the Plan pays 100% of most additional eligible expenses incurred by that individual during the rest of the year. If you have family coverage, the Plan limits how much you would pay out of your pocket, excluding deductibles, for most family members' eligible expenses combined. The family out-of-pocket maximum is $2,500 per calendar year and works the same way as the family deductible previously discussed.

However, it is important to note that certain expenses are not used to meet your out-of-pocket maximum, and are not paid at 100% once you meet the out-of-pocket maximum. These expenses include:

- Amounts paid toward the annual deductible;
- Additional amounts paid for using a non-PPO Hospital or Facility;
- Expenses paid for transplants received outside the transplant network; and
- Non-covered expenses.

You must always pay the full 30% coinsurance amount for non-PPO Hospital or Facility covered expenses. In addition, only 20% of the amount you pay for non-PPO Hospital or Facility covered expenses is applied to your out-of-pocket maximum.

Using the Preferred Provider Organization (PPO) can save you money. The Plan offers benefits and care from a network of Physicians, Hospitals and Facilities working through the BlueCross BlueShield of Illinois (BCBSIL) PPO.

When you use a PPO provider, you save money for yourself and the Plan because the PPO provider has agreed to charge a pre-negotiated dollar amount for their services. Contact BCBSIL at 1-800-571-1043 or www.bcbsil.com to determine whether your Physician or Hospital or Facility participates in the PPO. You may also contact the Fund Office and they will furnish you, at no charge, a separate document listing the Hospitals and Facilities that belong to the PPO network. In addition, treatment received from a PPO Hospital or Facility is reimbursed at a higher percentage than treatment received from non-PPO Hospitals and Facilities.

If you use a PPO Hospital or Facility, eligible expenses are paid at 80%, after the annual deductible. If you use a non-PPO Hospital or Facility, eligible expenses are paid at 70%, after the annual deductible. Even though you pay 30% of the expenses for non-PPO Hospitals and Facilities, only 20% of the eligible expenses, or two-thirds of what you pay, may be applied to your out-of-pocket maximum.

Here's what you could pay when using a PPO Hospital versus a non-PPO Hospital assuming you are eligible for benefit coverage and have already satisfied your $200 deductible.

John goes into the hospital and is there for two days, the costs associated with a PPO and Non-PPO hospital are shown below. Notice that the cost for the PPO hospital is considerably less than that of the non-PPO hospital because the PPO hospital charges negotiated rates that are discounted. In addition, the Plan pays a higher percentage of the costs if you use a PPO hospital and providers.

	PPO Hospital*	Non-PPO Hospital
Expense charged for a 2-day Hospital stay	$1,920	$3,200
Plan pays	$1,536 (80%)	$2,240 (70%)
You pay	$384 (20%)	$960 (30%)
Amount applied to your out-of-pocket maximum	$384 (20%)	$640 (20%)

You save $576 by using a PPO Hospital ($960 minus $384 = $576).

* This example assumes a PPO savings rate of approximately 40%. Your savings may vary depending on the actual Hospital confinement.

What is Covered

Covered medical expenses are eligible expenses for which the Plan will pay benefits if you are under the care of a Physician and the eligible services and supplies are ordered or provided by a Physician and Medically Necessary.

The Plan pays 80% (70% for non-PPO Hospitals and Facilities) of Allowable Charges for the following eligible medical expenses, after the deductible:

A. **Room and board and normal daily services and supplies** furnished by a Hospital, Skilled Nursing Facility, or Treatment Facility for Alcohol and/or Drug Dependency, including charges for a private room for contagious or communicable diseases, intensive care units, and nursery charges for newborns, whether sick or well. Payment is based on the facility's semi-private room rate. If a facility does not have semi-private rooms, benefits are paid based on 90% of the facility's private room rate.

B. **Pregnancy and pregnancy-related services and supplies**, including but not limited to Hospital/Facility charges, Physician delivery fees, prenatal laboratory and x-ray examinations, home birth delivery by an MD, sonograms and ultrasound testing, prenatal office visits, anesthesia and its administration, and tubal ligations. Pregnancy is treated as any other illness or medical condition.

   Benefits are not restricted for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean section. However, a provider is not required to obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable). The mother's or newborn's attending provider may, after consulting with the mother, discharge the mother or newborn earlier than 48 hours (or 96 hours as applicable). Services and supplies provided for care of well newborns while the mother is Hospital confined, including Hospital charges, circumcision, and Physician visits, are not included on the mother's bill, but are expenses incurred by the newborn child as a separate individual. However, the newborn's deductible will be considered met if the mother has met her deductible.

C. **Anesthetics and their administration.**

D. **Emergency care** in an emergency treatment center or Hospital emergency room if provided within 24 hours of an accident or Injury.

E. **Ambulance/transportation** services as follows:

(1) Emergency local transportation by a professional ambulance service, limited to the first trip to and/or from a Hospital/Facility for any one sickness or for all Injuries sustained in any one accident; or

(2) If a Physician certifies that an individual's disability requires specialized or unique treatment that is not available in a local Hospital or Facility, charges incurred for transportation for such treatment are covered if the transportation is:

a. By regularly scheduled commercial airlines or railroad or by professional air ambulance;

b. From the city or town where the Injury or sickness occurred to the nearest Hospital or Facility qualified to render the special treatment; and

c. Within the continental limits of the United States, Mexico, or Canada, including the geographical boundaries of Puerto Rico and Hawaii.

F. **Registered nurse services**, provided the nurse does not reside in your home and is not a member of your immediate family. Private duty professional nursing is covered if it begins within seven days of patient discharge, when the patient is not confined in a Hospital or health care facility that provides nursing care.

G. **Physician's services** for medical and surgical care.

H. **Surgery and related charges** (subject to the Plan's Second Surgical Opinion program, see page 25), including pre-admission tests (X-ray examinations and/or laboratory tests) made before the admission. Pre-admission tests, not including tests for research, case findings, or surveys, are covered if:

(1) The tests are ordered by the attending Physician or surgeon;

(2) The tests are performed in the outpatient department of the Hospital or Facility to which the individual is being admitted;

(3) Any Hospital or Facility confinement begins within 48 hours after the tests are performed; and

(4) The tests are medically valid at the time of the Hospital or Facility admission.

This also covers Medically Necessary services and supplies provided in an outpatient surgical facility, a Hospital outpatient department, a Physician's office, a clinic, or elsewhere, as a result of a surgical procedure performed other than in a Hospital within the following time limits:

(1) The day of surgery for surgeon, consultations, and anesthesia;

(2) Within seven days either before or following the date of surgery for out-patient services and supplies, X-rays and tests, laboratory procedures, and services and supplies provided by a facility; or

(3) Within 30 days following the date of surgery for prescriptions (limited to a 30-day supply, and Medically Necessary equipment and supplies).

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. If you or a Dependent is receiving benefits under the Plan in connection with a mastectomy and elect breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending Physician and the patient for:

(1) Reconstruction of the breast on which the mastectomy was performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and treatment of physical complication at all stages of the mastectomy, including lymphedemas.

I. **Speech therapy** when provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagic or swallowing defects and disorders due to an illness, Injury, or surgical procedure. Speech therapy given to develop or improve speech after surgery is performed to correct a birth defect that impaired the ability to speak is also covered. The Plan provides speech therapy benefits to a Dependent Child who has been diagnosed with a neurological disorder, when determined to be Medically Necessary, subject to the limitations shown in the Schedule of Benefits on page 1.

J. **Occupational therapy**, not including supplies, performed by a registered occupational therapist for occupational therapy recommended by a Physician due to a non-occupational Injury or sickness.

K. **Skilled nursing care** services and supplies provided during an approved confinement in a Skilled Nursing Facility. To be an approved confinement, the confinement must:

(1) Be preceded by at least three-consecutive days of a Hospital confinement for which Plan benefits are payable;

(2) Begin within three days after a Hospital confinement or within three days after a Skilled Nursing Facility confinement for which Plan benefits are payable;

(3) Be due to the Injury or sickness that required the previous Hospital confinement; and

(4) Be certified by the attending Physician as essential for recuperation from an Injury or sickness and that it is not, other than incidentally, for custodial care. The attending Physician must continue treatment of the individual and personally see the individual at least once each 14 days and must certify that continuation of such confinement is necessary for continued treatment of the Injury or sickness requiring the confinement.

L. **Medical supplies**, including:

(1) Whole blood or blood plasma (if not replaced or donated) and its administration;

(2) Surgical supplies including appliances to replace or aid any impaired physical organs or parts of organs, including such items as artificial limbs, eyes, and larynxes. Only the initial charge for any such appliance is covered;

(3) Oxygen and the rental of the equipment for its administration;

(4) Rental or purchase (if determined to be more cost effective) of durable medical equipment, including a wheelchair, Hospital bed, or other similar therapeutic equipment; and

(5) Casts, splints, braces, crutches, and trusses.

M. **Treatment for an injury to the jaw or to sound natural teeth**, including the initial replacement of such teeth and any necessary dental X-rays, provided the services and/or supplies are received within 12 months of the date of the incident causing the Injury. In the event treatment occurs more than 12 months after the Injury, coverage for such treatment may be extended for an additional six months if satisfactory medical evidence is furnished showing that the delay in treatment was due to:

(1) Damage to nerves in the oral cavity suffered at the time of the Injury that required time to heal or regenerate;

(2) Care of a fractured jaw or jaws that required immobilization of the bone structure that prevented other treatment;

(3) Additional time required for stabilization of the Injury;

(4) In the case of a child, allowance for the normal growth process; or

(5) A delay in the healing process.

N. **Home Health** Care rendered in an individual's home provided:

(1) The Home Health Agency meets the Plan's definition of such a provider;

(2) The plan of home nursing care is established and approved, in writing, by the patient's Physician within seven days following a Hospital confinement; and

(3) The Physician certifies that the care is for the same or related condition for which the patient was Hospitalized and that proper treatment of the patient's condition would require Hospital confinement in the absence of the services and supplies provided as part of the home health care plan.

(4) Covered expenses include:

a. Part-time or intermittent skilled nursing care provided by or under the supervision of a registered professional nurse (services of an RN or LPN are covered if the patient's condition requires the professional services of a trained nurse). The nurse cannot reside with or be a member of the family. Private duty professional nursing is covered only if Medically Necessary when the patient is not confined in a Hospital or health care facility that provides nursing care;

b. Medical services provided under the direction of a Physician;

c. Part-time or intermittent home health aide services;

d. Medical supplies (other than drugs and biologicals) and the use of medical appliances;

e. Medical services of interns and residents in training under an approved teaching program of a Hospital with which the Home Health Agency is affiliated; and

f. Any of the above that are provided on an outpatient basis at a Hospital or Skilled Nursing Facility under arrangements made by the Home Health Agency and that involve the use of equipment of such a nature that cannot readily be made available to the individual at home or that are furnished at such facility to which the individual has gone to receive any item or service involved in the use of such equipment (excluding transportation of the individual).

O. **Physiotherapy** provided in or out of a Hospital, by an MD or a registered physical therapist under the direction of a licensed Physician provided:

(1) There is an active written treatment regimen designed by the MD or registered physical therapist;

(2) The services are of such a level of complexity that the judgment, knowledge, and skills of a qualified physical therapist are required on the premises when services are rendered;

(3) There is an expectation, based on the Physician's assessment, that the patient will improve significantly in a reasonable, generally predictable, period of time; and

(4) The services are reasonable and necessary to the treatment of the condition and considered to be within the accepted standards of medical practice as specific and effective treatment for the patient's diagnosed condition.

P. **Back, neck, spine, and vertebra treatment supplies** and services rendered by a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic Medicine, or Registered Physical Therapist (under the direction of a Physician) for conditions due to subluxation, strains, sprains, and nerve root problems.

Q. **Impotence** treatment, services, and supplies (not including medications), when due to organic causes.

SPECIAL COVERAGES

R. **Physical exams (for Employees and eligible Spouses).** Taking care of yourself and having regular routine checkups to detect any medical problems before they become serious medical conditions is extremely important. In recognition of this, the Plan pays 100% for one physical exam each year. As an alternative to a physical from your physician, you can have a Health Dynamics screening, which has more screenings included, at no cost to you, once a year. Call Health Dynamics at 414-443-0200 to make an appointment or for more information.

S. **Well child care.**

(1) The Plan pays 100% of the cost for covered services (including routine office visits) with no deductible required from birth up to age six. For eligible children ages six through 18, the Plan will pay 100% of eligible expenses (including one physical exam each year and any accompanying required vaccines for tetanus and meningitis) with no deductible required.

(2) The Plan covers 100% of covered expenses for HPV vaccinations and their administration for eligible individuals age nine to 26.

T. **Smoking cessation.** The Plan pays 50% of the cost for prescribed drugs and nicotine patches for you and your covered spouse (not covered children), up to a lifetime maximum of $150. You must file a claim directly with the Fund Office within one year after you pay for the prescribed drugs or nicotine patches. You may claim the remainder of the costs through reimbursement under the HSA. Claims received after that will not be considered for reimbursement.

U. **Diagnostic X-ray and laboratory exams.** The Plan pays 100% of the first $150 in eligible expenses per person during each calendar year. Once expenses reach $150, the deductible and the 80% coinsurance rate (70% for non-PPO Hospitals of Facilities) apply to additional eligible diagnostic X-ray and laboratory expenses during that year. This benefit includes eligible mammography expenses once per calendar year for women age 35 and over and a pap smear test once per calendar year.

V. **Infertility treatment (for Employees and spouses).** Benefits are payable at 80% (70% for non-PPO Hospitals or Facilities), after the annual deductible, for diagnosis and treatment of infertility. Infertility, under the Plan, is defined as the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a pregnancy. The lifetime maximum is $10,000 per person.

Treatments covered under the Plan include:

(1) In-vitro fertilization;

(2) Uterine embryo lavage;

(3) Embryo transfer;

(4) Artificial insemination;

(5) Gamete intrafallopian tube transfer;

(6) Zygote intrafallopian tube transfer; and

(7) Low tubal ovum transfer.

Benefits for these procedures are payable as long as:

(1) The covered individual has not been able to complete a successful pregnancy through reasonable, less costly appropriate treatment covered under the Plan;

(2) The covered individual has not undergone four completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, two more completed oocyte retrievals will be covered; and

(3) The procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization.

Note: Benefits are payable for eligible expenses incurred by a covered person and/or surrogate donor or recipient for actual and/or attempted impregnation and/or fertilization.

W. **Alcoholism and substance abuse treatment.** Benefits for eligible expenses related to the inpatient and outpatient treatment of alcoholism and/or substance abuse are payable at 80% (70% for non-PPO Hospitals or Facilities), after the deductible is met.

X. **Mental, psychoneurotic, and personality disorder treatment.** Benefits for eligible expenses related to the inpatient treatment of mental, psychoneurotic, and/or personality disorders are payable at 80% (70% for non-PPO Hospitals or Facilities), after the annual deductible is met.

Outpatient mental or nervous disorder treatment must be provided by a psychiatrist or by a psychologist providing treatment at the request of and under the supervision of an MD specializing in psychiatry. Outpatient psychiatric treatment must be provided by a physician, licensed clinical psychologist, or licensed social worker upon the referral of a physician. Covered expenses include:

(1) Individual, family, and group psychotherapy;

(2) Diagnostic psychological testing, but only when administered by a person who is licensed or certified to do so; and

Y. **Colonoscopy screening.** Costs are covered at 100% and are not subject to the deductible, as long as:

(1) The patient is at least age 50, but less than age 75 and

(2) The screening is only done once every 10 years.

SECOND SURGICAL OPINION

If your Physician recommends elective surgery that requires a second opinion, the Plan pays 100% of eligible second surgical opinion expenses, with no deductible required. Elective surgery means that the medical condition for which surgery is recommended is not immediately life threatening and, therefore, is not an emergency and can be scheduled at your convenience. In addition, if the second opinion disagrees with your Physician's recommendation, you may obtain a third opinion, if you want, and those eligible expenses are also covered at 100%.

Second opinions can save money—and unnecessary discomfort—if it is found there is an alternative, less painful, procedure for treating the condition or that surgery really is not necessary at all. The Plan covers 100% of all eligible second and third opinion expenses related to recommended procedures that require a second opinion for full benefits to be payable.

WHEN YOU NEED A SECOND OPINION

A second surgical opinion is needed only for certain non-cosmetic, Medically Necessary elective surgeries listed below, effective July 1, 2017. This list is subject to change as new surgeries and procedures become available:

- Adenoidectomy;
- Breast operations (except incision and drainage for abscess);
- Bladder repair;
- Bunionectomy;
- Carpal Tunnel Syndrome;
- Cataract extraction;
- Cholecystectomy (except acute obstruction, infection or jaundice);
- Coronary artery bypass (except impending myocardial infarction or MI, also known as a heart attack);
- Deviated septum (submucous resection);

- Dilation and curettage (except pregnancy related);
- Hammertoe repair;
- Hemorrhoidectomy (except acutely thrombosed or infected);
- Hernia repair (inguinal, femoral, ventral, incisional and hiatal);
- Hysterectomy (vaginal and abdominal);
- Knee surgery (arthroscopy, arthrotomy and knee replacement, except hemarthrosis);
- Laminectomy;
- Prostatectomy (transurethral, supra and retro-pubic);
- Release for entrapment of medial nerve (Carpal Tunnel Syndrome);
- Tonsillectomy; and
- Varicose vein stripping and ligation.

If a second opinion is not obtained when required: If you do not obtain a second opinion when required under the Plan, your benefits for the elective surgery will be reduced by 20%, and your benefits for the fees charged by the Physician performing the procedure will be reduced to 50%. The additional amounts you would have to pay out-of-pocket do not count towards meeting your annual deductible or out-of-pocket maximum.

Here's a comparison of what you would pay when you get a second surgical opinion versus not getting a second surgical opinion for your elective surgery. This assumes you are eligible for benefit coverage, you have already satisfied the $200 annual deductible, and you use a PPO Hospital.

	Second Surgical Opinion		No Second Surgical Opinion	
ELIGIBLE EXPENSES	PLAN PAYS	YOU PAY	PLAN PAYS	YOU PAY
Second surgical opinion: $100	$100 (100%)	$0 (0%)	Not obtained	
PPO Hospital outpatient: $2,200	$1,760 (80%)	$440 (20%)	$1,320 (60%)	$880 (40%)
Surgeon: $800	$640 (80%)	$160 (20%)	$400 (50%)	$400 (50%)
Total you pay		$600		$1,280
Amount applied to your out-of-pocket maximum		$600		$600

You save $680 ($1,280 minus $600) by getting a second surgical opinion, and the entire amount you do pay when you get a second surgical opinion is applied toward meeting your out-of-pocket maximum.

A few things to keep in mind: The second opinion provision is in place to encourage more active involvement in your medical and health care cost control. Keep in mind, however, that you always have the final say as to whether or not to go ahead with surgery. No benefit reduction would occur for having the surgery, only for not obtaining a second surgical opinion when required.

In addition, when scheduling a second surgical opinion, it's important to note that the Physician providing the second surgical opinion must be a Board Certified Specialist who is not:

- Associated with the Physician first recommending the procedure;
- Assisting on or performing the surgery; or
- Treating the patient for the specific condition that required the second (or third) surgical opinion.

ORGAN TRANSPLANT BENEFITS

The Plan provides coverage for non-Experimental organ and bone marrow transplant surgeries including a live donor's expenses. Types of transplant surgeries covered include:

- Heart;
- Lung;
- Heart/lung;
- Liver;
- Kidney;
- Pancreas;
- Kidney/pancreas;
- Autologous bone marrow;
- Allogeneic bone marrow; and
- Stem cell.

The Plan has contracted with LifeTrac, a centers of excellence network, which includes leading organ and bone marrow transplant facilities. With LifeTrac, you have access to experienced medical institutions and surgical teams throughout the country. Transplant facilities are subject to change. To obtain the most up-to-date list of facilities, contact the Fund Office. A list of transplant facilities will be provided to you at no cost.

If you would like to know whether a specific type of transplant is covered by the Plan, contact the Fund Office. The Fund Office will help you manage care received through the LifeTrac Network and assist you in gathering information and selecting an appropriate course of action. If you or a Dependent becomes a candidate for an organ or bone marrow transplant, contact the Fund Office to help maximize your benefits and the level of care you receive. **If you do not contact the Fund Office before treatment, the benefits payable by the Plan may be reduced.**

The following chart shows the Plan's organ transplant coverage. You should be aware that the Plan will pay a lower percentage (50%) of covered expenses for transplant procedures provided outside the LifeTrac Centers of Excellence Network.

SCHEDULE OF BENEFITS FOR ORGAN TRANSPLANTS

Before scheduling transplant surgery, you should call the Fund Office.

Annual Deductible	Transplant benefits are subject to the Plan's medical deductible of $200 per person; $500 family maximum
Copayment (including organ procurement) Centers of Excellence Network	After you satisfy your medical annual deductible, the Plan pays: 80% of covered charges
Outside Centers of Excellence Network	50% of covered charges
Annual Out-of-Pocket Maximum Centers of Excellence Network	Your out-of-pocket expenses are limited to the Plan's medical annual out-of-pocket maximum of $800 per person, $2,500 family maximum (excluding deductible). The Plan pays 100% of most covered expenses once your portion of covered expenses reaches the out-of-pocket maximum
Outside Centers of Excellence Network	No out-of-pocket maximum
Immunosuppressive (Anti-Rejection) Medications	The Plan pays 80% of covered medications
Travel and Lodging Benefit Centers of Excellence Network	If you or one of your Dependents must travel more than 100 miles from your home to a LifeTrac facility, the Plan will pay 80% (up to $10,000 per person per lifetime) of all transportation, lodging, and meal costs for one adult to accompany the recipient. If the recipient is under age 18, the Plan will provide transportation, temporary lodging, and meals for two adults
Outside Centers of Excellence Network	Not covered

Expenses not covered by the organ transplant benefit. *Any expenses over any maximums stated are not covered. Expenses you incur, as a result of not using a centers of excellence facility, are your responsibility as well and do not apply to your out-of-pocket maximum or deductible. Before receiving any treatment, you should contact the Fund Office to verify treatment at the appropriate facility.*

WHAT IS NOT COVERED

In addition to the exclusions in What Is Not Covered Under The Plan, the following expenses are not covered under the Plan's Medical Benefits, but are covered under the HSA (see page 38):

- Vision care.
- Eye surgery, such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring).
- Hearing exams and hearing aids (A discount program is available; contact Epic Hearing for details).

CARPAL TUNNEL SYNDROME BENEFITS

For Journeymen And Journeyman Assistants Only

Generally, the Plan does not cover work related Injuries. However, the Plan provides coverage for Employees only for the treatment of Carpal Tunnel Syndrome (CTS). To be eligible for this benefit:

- Your Carpal Tunnel Syndrome must have been caused by industry employment (related to your work);
- You must have two continuous years of industry service (1,000 or more hours in covered employment in a calendar year);
- You must be eligible for benefits as an active Employee; and
- Your surgery must be pre-certified and you must obtain a second opinion.

Non-work related carpal tunnel treatment is covered as any other medical expense.

If you suffer from Carpal Tunnel Syndrome, you may be eligible for weekly disability benefits while you are receiving treatment for this condition (see page 41).

COVERED CTS EXPENSES

The Plan pays 100% of the following eligible CTS expenses, with no deductible required:

- Comprehensive examination;
- X-rays;
- Pre-op evaluation;
- Non-Experimental carpal tunnel surgery (open release, mini-open release, endoscopy, percutaneous balloon tunnel-plasty), including:
  - Surgeon's fee;
  - Outpatient facility fees;
  - X-ray and lab fees;
  - Anesthesia fees; and
  - Surgical supplies and devices;
- Follow-up office visits, and
- Physical therapy.

PRESCRIPTION DRUG BENEFITS

How The Plan Works

The prescription drug program is administered by Express Scripts. Under the prescription drug program, the Plan will pay:

- 80% of the cost of generic and specialty medication; or
- 50% of the cost of brand name medication.

If a generic equivalent is available for your brand name medication, you will be responsible for paying the difference in cost between the generic and brand name medication, in addition to paying 50% of the cost of the brand name medication. The additional amount you pay does not apply toward meeting your prescription drug out-of-pocket maximum.

Benefits for prescription drugs are not subject to the Plan's annual medical deductible.

PRE-APPROVAL/AUTHORIZATION

Certain medications require pre-approval/authorization from the Fund Office before they will be covered under the Plan's Prescription Drug Benefits. The Fund Office will only provide pre-approval/authorization of a medication if it is determined to be Medically Necessary. The Fund Office's medical consultant will assist the Fund in determining the Medical Necessity of the medication. To help make this determination, you are required to provide the Fund Office with a letter from the prescribing Physician stating that the medication is Medically Necessary. Once the Fund Office pre-approves/authorizes the medication, the medication is pre-approved/authorized for a one-year period. If the medication is required for a longer period, you must re-submit proof of Medical Necessity after each successive one-year period, as applicable.

Medications prescribed to treat obesity require pre-approval. Attention Deficit Disorder Hyperactivity Disorder (ADHD) medications require prior authorization, based on the age of the patient and the type of medication, as follows:

- Stimulant medications for patients 18 years of age or older; authorizations last one year
- Non-stimulant medications for patients less than age 6 or age 18 and over; authorizations last three years.

Prior authorization will be handled by Express Scripts, the pharmacist, and your physician.

GENERIC VS. BRAND NAME MEDICATIONS

By law, a generic equivalent of a brand name drug must have the same active ingredients, potency and effectiveness as the brand name—and almost always costs less. For this reason, if you or one of your Dependents elect to receive a brand name drug when a generic equivalent is available, you'll pay the difference in the cost in addition to 50% of the cost of the brand name prescription. Your pharmacist can assist you in substituting generic medications when it is appropriate.

If you request a brand name medication when a generic is available and appropriate, the additional amount you pay (the difference in cost between the brand name and generic) does not apply to your Prescription Drug out-of-pocket maximum. In addition, you are still required to pay this additional amount once you reach your out-of-pocket maximum.

SPECIALTY MEDICATIONS

Specialty medications are used to treat complex medical conditions, such as cancer. These medications may be administered by injection or infusion and require special handling or refrigeration. Because specialty medications require additional care and handling, we use a specialty pharmacy called Accredo. For a complete list of conditions that use specialty medications or for more information about Accredo, go to www.accredo.com.

ANNUAL OUT-OF-POCKET MAXIMUM

If you have high prescription expenses, the Plan protects you by limiting the amount of eligible expenses you have to pay out of your own pocket. This is called your annual out-of-pocket maximum. When a covered individual's out-of-pocket payments towards covered prescription drugs exceed $1,000 in any calendar year, the Plan pays 100% of most additional covered prescription drugs incurred by that individual during the rest of the year.

Retail Pharmacy Program

The retail pharmacy program, provided through a retail pharmacy network, is for your short-term prescription needs (up to a 30-day supply). The network includes most major chain stores. Network pharmacies recognize you as a member of the Plan when you present your prescription drug card.

If you do not have your prescription filled at a pharmacy in the network, your prescription is not covered under the Plan.

Here's how the retail pharmacy program works:

- Find a network pharmacy in your area. Most major drug store chains participate in the network. Call your pharmacy to see if they participate in the network. You may also call the Fund Office to ask about participating pharmacies.
- Show your prescription drug identification card when you fill your prescription.
- Pay your copayment for your prescription.

Mail Order Program

If you take a medication on an ongoing (maintenance) basis (for example, for arthritis, high blood pressure, heart conditions, and/or diabetes), you need to fill your prescription through the mail order program (or it will not be covered by the Plan).

The mail order program provides a safe, convenient way for you to have up to a 90-day supply of your maintenance medications delivered right to your home.

Step-by-step instructions on how to use the mail order program for new and refill orders are provided on the mail order form. If you have any questions regarding the mail order program or need a mail order program form, call customer service at 800-818-0093 or visit their website at www.express-scripts.com for call the Fund Office Written inquiries and mail order prescriptions should be addressed to:

Express Scripts
P.O. Box 747000
Cincinnati, OH 45274-7000

Covered Expenses

Benefits for prescription drugs are not subject to the Plan's annual medical deductible. When your prescriptions are filled at a network pharmacy, you do not need to file a claim form to be reimbursed for prescription drug expenses. You simply pay your share of the cost for the prescription at the time it is filled; benefits are automatic.

This list is just a partial list of eligible health care expenses.

The Plan covers Allowable Charge prescription drug expenses for the following, provided they are Medically Necessary for treatment of an Injury or sickness:

- Medications that, by federal law, can only be dispensed by prescription and that are required to bear the legend, "Caution, Federal Law Prohibits Dispensing Without Prescription;"
- Compounded medications of which at least one ingredient is a prescription legend drug;
- Insulin;
- Insulin syringes/needles;
- Attention Deficit Disorder (ADD) medications, based on the age of the patient and the type of medication;
- Medications prescribed to treat obesity, provided:
  - The medication is Medically Necessary, as stated in a letter from the prescribing Physician;
  - You contact the Fund Office for pre-approval/authorization before purchasing the prescription medication; and

If a weight loss medication is not covered under the Plan's Prescription Drug Benefits, it may be eligible for reimbursement under the Plan's Health Spending Account Benefit, if eligible. Generally, weight loss programs, undertaken at a Physician's direction to treat an existing disease, are eligible for reimbursement under the Health Spending Account Benefit.

What Is Not Covered

The following expenses are not covered.

- Medicines that do not require a prescription (over-the-counter), except insulin.
- Appliances, devices, or prosthetics (other than insulin or insulin needles or syringes).
- Drugs that are considered Experimental or not approved by the U.S. Food and Drug Administration (FDA) for the condition, dose, rate, and frequency for which they are prescribed.
- Drugs to promote hair growth.
- Drugs used for weight control, unless prescribed to treat obesity when determined to be Medically Necessary and pre-approved by the Plan.
- Non-prescription drug items including nutritional supplements, regardless of intended use.
- Drugs used for cosmetic purposes.
- Lifestyle drugs (including Viagra and similar medications for the treatment of impotence).
- Vitamins, except for prescription pre-natal vitamins and certain prescribed iron supplements.
- Anabolic steroids.
- Administration of prescription legend drugs or injectable insulin.
- Smoking cessation medications (may be covered under the Plan's medical benefits).
- Lancets.
- Prescription drugs that can be obtained at no charge through local, state, or federal programs, including Workers' Compensation.
- Prescriptions dispensed or administered while an inpatient (covered under the Medical benefit).

DENTAL PLAN BENEFITS

You and your eligible Dependents are eligible for the dental benefits described in this section. See page 2 in the Schedule of Benefits for any maximums and coinsurance amounts.

HOW THE DENTAL PROGRAM WORKS

There is nothing for you to do.

- You do not need to enroll in the program if you are eligible for medical coverage. You are automatically eligible.
- You can go to any dentist.
- **After** you reach the Dental Annual Maximum Benefit Limit, you may receive reimbursement for eligible dental expenses through your Health Spending Account.

You and your Dependents have access to the national DNoA Preferred Network, which consists of general dentists, specialty dentists, and orthodontists from whom you can receive discounted, quality dental care.

You and your Dependents will be free to use any dentists, whether in the DNoA network or not. It will be entirely up to you. Just know that you and the Fund will save money when you receive your care in-network. The dentists in the DNoA Preferred Network have agreed to charge discounted rates for the dental care they provide. Non-network dentists have not. Because a network dentist's billed charges will be less, you and the Fund will pay your share of a smaller amount. In addition, as the table on page 6 shows, when you and your Dependents receive your dental services from a DNoA Preferred Network dentist, the Fund will pay a higher percentage of the expenses than it will if you receive your care from a non-network dentist, which means even more savings for you. DNoA Preferred Network dentists will not balance bill you for charges in excess of the discounted amount. You will not need a referral to see a specialty network dentist and network dentists will file claims for you.

FINDING A NETWORK DENTIST

To find a DNoA Preferred Network dentist, visit the DNoA website at www.dnoa.com., enter your zip code and select "Labor Plus" or call **866-522-6758** between 8 a.m. and 6 p.m. CDT. If your current dentist is not in the network, you can nominate him/her for inclusion by logging on to www.dnoa.com and requesting a recruitment package. The recruitment package will be sent directly to your dentist.

DENTAL ID CARDS

Your Dental and your BCBSIL ID cards are combined into one ID card. Be sure to show the ID card to any dentist from whom you receive care, **before** the care is provided.

REIMBURSEMENT OF DENTAL EXPENSES THROUGH YOUR HEALTH SPENDING ACCOUNT

If your benefit payments reach the Calendar Year Maximum Benefit or $2,500, any additional eligible dental expenses you have during that same calendar year may be reimbursable under the Health Spending Account.

Remember, the maximum benefit amount reimbursable each year under your Health Spending Account is $2,500 per family. No deductible applies.

Dental Care Expense Benefits

When you or your Dependents receive dental treatment by a licensed dentist, the Plan will cover an amount equal to the applicable coinsurance percentage shown below for any covered dental charges incurred during a calendar year. However, in no event will the Plan cover more than the maximum calendar year benefit amount per covered person under this dental benefit.

Certain eligible dental expenses may be reimbursable under the Health Spending Account if your dental expenses exceed the annual or lifetime maximums payable under this dental benefit.

Any **dental** expenses paid by you will not be applied to the medical plan calendar year out-of-pocket maximum.

Annual Maximum Benefit per Calendar Year (per person) $2,500.00

Individuals **under the age of 19** are eligible to receive preventive dental services subject to applicable cost sharing, with no annual limits applied (subject to applicable service limits).

Orthodontia **Lifetime** Maximum (under age 19 only) $4,500.00

(For initial installation while covered under the Plan only. Does not apply to previous placed appliances.)

Coinsurance Percentage Paid by Plan

• Part 1 – Preventive Dental Benefits	100% (in-network); 80% (out-of-network)
• Part 2 – Basic Dental Benefits	80% (in-network); 60% (out-of-network
• Part 3 – Restorative Dental Benefits	80% (in-network); 60% (out-of-network)
• Orthodontia Benefits	70% (in-network); 50% (out-of-network)

PART 1 – PREVENTIVE DENTAL BENEFITS

These benefits are limited to the following:

A. Oral examination performed by a dentist, limited to **two times (2)** in a calendar year.

B. Prophylaxis (cleaning of teeth), scaling, cleaning and polishing, performed by dentist or dental hygienist, limited to **two times (2)** in a calendar year.

C. Bite-wing x-rays, limited to **once** in a period of **12** consecutive months.

D. Full mouth x-rays, limited to **once** in a period of **36** months.

E. Topical application of sodium or stannous fluoride. Fluoride limited to covered persons under age 19 and limited to not more than once per calendar year.

F. Periodontal prophylaxis limited to once every **3** months, not to exceed **4** times per calendar year.

G. Examination in connection with emergency palliative treatment (for example toothache, injury, etc.).

H. Examination for consultation purposes (for example braces, etc.).

PART 2 – BASIC DENTAL BENEFITS

These benefits are limited to the following:

A. Dental x-rays as required for diagnosis of a specific dental condition.

B. Application of sealants on bicuspid and posterior teeth (molars), limited to permanent bicuspids and molars, once in a period of 36 consecutive months, for children under age 19.

C. Injection of necessary antibiotic drugs by the attending dentist.

D. Tooth extractions.

E. Space maintainers for the premature loss of posterior primary teeth, limited to children under age 14.

F. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed or broken teeth.

G. Treatment of periodontal and other diseases of the gums and supporting structures of the mouth (gingiva and/or alveolar bone).

H. Occlusal adjustment, only in connection with periosurgery.

I. Oral surgery, including extractions and surgical procedures, limited to removal of impacted teeth or as necessary for:

1. Wisdom teeth;
2. Teeth covered partially or totally by bone;
3. Root canal treatment; or
4. Gingivectomy.

J. Administration of local anesthesia in connection with covered dental services.

K. Administration of general anesthesia and/or intravenous sedation (only in connection with covered oral surgery).

L. Endodontic treatment, including root canal therapy.

M. Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition.

PART 3 - RESTORATIVE DENTAL BENEFITS

These benefits are limited to the following:

A. Inlays, onlays and crowns (including porcelain for the front teeth). When porcelain is used for onlays or crowns on posterior teeth, Plan benefits are limited to the amount payable for metal onlays or crowns.

B. Repair or recementing of crowns, inlays or onlays.

C. Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth that were extracted. Expenses on account of adjustments to fixed bridgework are covered only for the 6-month period following initial installation.

D. Installation of fixed bridgework, implants and dentures. Installation of fixed bridgework must be completed within 12 months of the extraction.

E. Replacement of an existing partial or full removable denture or fixed bridgework; addition of teeth to an existing partial or removable denture; bridgework to replace teeth that were extracted if evidence, satisfactory to the Plan Administrator or its designee, is presented that one of the following conditions have been satisfied:

1. The replacement or addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed and the addition of teeth is completed within 12 months of the extraction.
2. The existing denture or bridgework cannot be made serviceable and was installed at least 5 years prior to the replacement date.
3. The existing denture is an immediate temporary denture replacing one or more natural teeth extracted. Replacement by a permanent denture is required. The replacement must take place within 12 months from the placement of the temporary denture.
4. The replacement is due to injury requiring oral surgery and the replacement takes place within 15 months of the injury.

F. Precision or semi-precision attachments for prosthetic devices.

ORTHODONTIA BENEFITS

These benefits are limited to the following:

A. Covered persons under age 19 only.

B. A separate **lifetime** maximum of $4,500.

C. Charges for orthodontia care do not become payable under the Plan until the services relating to such charges are actually provided.

D. Initial and subsequent installation of orthodontic appliances. The treatment must be within **90 days** of the date the treatment plan is submitted; otherwise, a new treatment plan must be submitted to the Fund Office.

E. The patient must be covered under the Plan at the time the services are rendered and payment will only be made for services that were rendered while the patient was covered under the Plan, regardless of the agreed upon payment schedule.

If eligibility terminates while a covered person is receiving dental or orthodontia benefits, coverage will be provided only for expenses for treatment performed and completed prior to the date the covered person lost eligibility.

Dental Benefit Exclusions

Charges incurred for the following expenses are not covered.

A. Dental care that is included as a covered expense under any medical expense benefit.

B. Dental services or supplies furnished without charge or paid for by a government unit, employer, benefit association, union or similar group, or for which no charge would be made in the absence of dental expense benefits.

C. Illness or injury that arises out of any occupation or employment for wage or profit, or which is compensable under any Workers' Compensation Law or similar legislation.

D. Services or supplies furnished before the effective date of benefit eligibility of any covered person who receives such services or supplies.

E. Treatment of any condition caused by war, or by any act of war, declared or undeclared, or by participating in a riot or committing a criminal offense.

F. Charges for failure to keep a scheduled appointment for dental treatment of any kind.

G. Charges for services with respect to congenital or developmental malformations, or dentistry for purely cosmetic reasons, except orthodontia, including but not limited to: cleft palate, maxillary and mandibular malformation, enamel hypoplasia, fluorosis and anodontia.

H. Charges for completion of claim forms.

I. Expenses not eligible because of the application of coordination of benefits.

J. Charges for services to replace teeth or appliances to replace teeth that were extracted **more than 12 months** prior to the replacement.

The Plan does not coordinate benefits with a dental HMO Plan.

Definitions

Calendar Year begins at 12:01A.M. on January 1st and continues until 12:01 A.M. on the next following January 1st.

Course of Treatment refers to a planned program of one or more services or supplies, whether rendered by one or more dentists, for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed condition.

Covered Dental Charges refers to the Allowable Charge, or fee for services or supplies furnished on the recommendation and approval of a dentist.

Dentist refers to a person licensed to practice dentistry by the governmental authority having jurisdiction over the license and practice of dentistry and who is acting within the scope of that license.

Dental Hygienist refers to a person licensed to practice dental hygiene by the governmental authority having jurisdiction over the practice of dentistry and who works under the supervision of a dentist.

Date of Expense: a charge shall be deemed to have been incurred on the date the service is rendered.

HEALTH SPENDING ACCOUNT (HSA)

A Health Spending Account is available for you and your covered Dependents. This benefit helps pay for health care expenses that are not covered by the Plan. The maximum benefit is $2,500 per family each calendar year. The Plan pays 100% of these expenses and no deductible applies. You must use the amount available for eligible expenses incurred for that year. Any amount left in your Health Spending Account will revert to the Fund. A new benefit will apply in the next calendar year.

To be reimbursed for eligible expenses, you must file a claim with the Fund. You must include receipts for each eligible expense. You have until April 1 of the following year to submit your claim for the previous calendar year. For example, if you incur an eligible expense on December 15, 2017, you have until April 1, 2018 to submit the claim to the Fund Office.

Contact the Fund Office to receive a Health Spending Account claim form. Claim forms require your signature and cannot be faxed to the Fund Office.

You are strongly encouraged to submit these claims throughout the year, as the costs are incurred, instead of sending an entire year's worth of expenses at the deadline. There is less chance that you will misplace documents, receipts, EOB's and it takes longer to process the claims due to the large number of claims coming in.

The Fund is not responsible for providing the necessary claim documentation, such as EOB's. Requests for "copies of all EOB's for the year" will be honored on a monthly basis only. It may take 30 to 45 days to get copies in the mail. Claims submitted after April 1 of a given year will not be accepted.

For more information on submitting claims, see page 52.

WHAT IS COVERED

In general, eligible health care expenses include expenses that this Plan does not cover or that are in excess of the amounts the Plan pays. In addition, eligible health care expenses include medical, prescription drug, dental, and vision expenses as well as any non-reimbursed medical expenses that can be deducted from your individual tax return if you itemize deductions (itemized deductions are listed in Section 213(d) of the Internal Revenue Code, see examples below). However, if you submit an expense for reimbursement under the Plan's Health Spending Account benefit, you cannot deduct that expense on your individual tax return

Hearing Aid Discount and Reimbursement

The Plan has entered into an agreement with **Epic Hearing Healthcare** to provide a discount program for hearing aids. You receive a discount when purchasing an eligible hearing aid from Epic Hearing Healthcare. You will be reimbursed with available funds from your Health Spending Account up to the annual maximum limit.

Eligible Expenses

To be eligible under the program, expenses must be:

- Incurred while you are covered under the Plan;
- Incurred for you or your Dependent; and
- For Medically Necessary services and supplies that this Plan does not cover.

The following are examples of some types of services that may be eligible health care expenses:

- Acupuncture;
- Artificial limbs;
- Braille books and magazines;
- Car controls for the handicapped;
- Chiropractic care;
- Dental care;
- Duplicate prosthetic devices;
- Prescription medication copayments;
- Guide dogs;
- Hearing aids and exams;
- Hearing treatment;
- Injections;
- Learning disability tuition;
- Naprapath services;
- Organ transplants;
- Orthodontic treatment (for covered adults over age 19);
- Orthopedic shoes;
- Oxygen;
- Radial keratotomy and corrective laser surgery;
- Special schools for the handicapped;
- Telephone for the deaf;
- Vision care; and
- Wheelchairs.

This list is just a partial list of eligible health care expenses.

WHAT IS NOT COVERED

This list of what is not covered is a sampling of items not eligible for reimbursement. If you are not sure if an expense is eligible for reimbursement, contact the Fund Office.

Certain expenses that do not meet the definition of eligible expenses are not covered under the Plan. Some expenses that are not eligible for reimbursement include:

- Over the counter medications.
- Expenses used to satisfy the deductible.
- Expenses applied to the out-of-pocket maximum.
- Group medical insurance premiums you pay.
- Any expense not deductible under Section 213(d) of the Internal Revenue Code, such as, but not limited to:
  - Nursing services for a healthy baby.
  - Dancing/swimming lessons.
  - Diaper service.
  - Funeral service.
  - Expenses for a trip taken for a non-medical reason (even if on Physician's advice).
  - School expenses for problem children.
  - Meals and lodging when away from home for medical treatment not received at a medical facility.
  - Maternity clothes.
  - Any expense you deduct on your individual tax return.

WEEKLY DISABILITY BENEFITS

Your Plan includes disability protection for you by providing income when you become disabled and cannot work because of a **non-work-related** disability.

COBRA and Plan C Participants and Dependents are not eligible for weekly disability benefits.

You are eligible for weekly disability benefits if:

- You are a bargaining unit employee covered by this Plan;
- The disability begins while you are covered under this Plan;
- You are continuously disabled due to a non-work related Injury or illness;
- You are unable to perform any job for wage or profit; and
- You are under the care of a Physician.

However, please note that Weekly Disability Benefits are only paid if:

- You are under the direct and continuing care of a Physician;
- Your Total Disability is not due to any occupation or employment for remuneration, wage, or profit or for which you are or may be entitled to benefits under **any Workers' Compensation, occupational disease, employer's liability, or similar law; and**
- You are not receiving any unemployment compensation.

WHEN BENEFITS BEGIN

The date benefits begin depends on the cause of the disability:

- If the disability is due to an Injury, benefits begin on the first day of disability.
- If the disability is due to an illness, benefits begin on the eighth consecutive day of continuous disability.

AMOUNT

The amount of the weekly disability benefit is:

- $600 a week for up to the first 26 weeks of a disability; and
- $400 a week for up to the next 26 weeks of disability.

The maximum weekly disability payment period is 52 weeks per disability or until you recover, if sooner.

Separate periods of disability are considered one period of disability unless the second disability is caused by an illness or Injury totally unrelated to the first disability and you have met the active work requirements.

> I seriously Injured my arm in a car accident and am receiving weekly disability benefits. If I return to work and find my arm has not healed enough for me to do my job, would my weekly disability benefits begin again?
>
> If your Injured arm prevents you from doing your job when you return to work, you would be considered to be in the same disability period and would be eligible for weekly disability payments based on the number of weeks not already paid. For instance, if you had already received 20 weeks of disability payments, you would be eligible for up to another 32 weeks.

WHEN BENEFITS END

Your weekly disability benefits will end on the earliest of the date:

- You are no longer under the care of a physician for the disability;
- You recover from your disability;
- You retire;
- You die; or
- You receive all disability payments available for that period of disability.

DEATH BENEFIT

Your death benefit helps protect your family against the effects of a sudden loss of your income if you die.

COBRA and **Plan C** employees and their dependents are **not** eligible for death benefits.

AMOUNT

Employee Death Benefit

The amount of benefits payable upon your death while covered is based on your years of service under this Plan at the time of your death, as follows:

Years Of Service	Benefit Amount
Less than 3 years	$15,000
3 or more years	$30,000

Spouse's Death Benefit

If your spouse dies, you would receive $12,500 to help with your spouse's funeral and final expenses. This benefit will be paid to the employee or, if both the employee and spouse die at the same time, to the employee's estate. The IRS treats this benefit as taxable income.

To be eligible for this benefit, you must be eligible for Plan benefits at the time of your spouse's death and not on COBRA or in Plan C, and you must have been married to your spouse for at least one year.

Child's Death Benefit

If your child, under age 22, dies, you would receive $12,500 to help with your child's funeral and final expenses. This benefit will be paid to the employee or, if both the employee and child die at the same time, to the employee's estate. The IRS treats this benefit as taxable income.

To be eligible for this benefit, you must be eligible for Plan benefits at the time of your child's death, and not on COBRA or in Plan C.

YOUR BENEFICIARY

In the event of your death, the benefit amount is paid to your beneficiary. When you join the Plan, you complete a beneficiary designation form to name a beneficiary, who can be anyone you choose. You can change your beneficiary at any time by completing and signing a new beneficiary designation form and submitting it to the Fund Office.

You may name more than one beneficiary. If any of your designated beneficiaries dies before you do, your death benefit would be paid in equal shares to any remaining beneficiaries who survive you, unless you indicated otherwise on the form.

If you don't name a beneficiary, or no named beneficiary survives you, your benefit is paid to:

- Your spouse; or if none, then
- Your child(ren) in equal shares; or if none, then
- Your parents in equal shares; or if none, then
- Your siblings in equal shares; or if none, then
- Your estate.

You are the beneficiary for the spouse's death and child's death benefit.

COVERAGE DURING DISABILITY

If you become Totally Disabled as a covered participant before age 60, death benefits will be extended to you at no cost, provided that annually you give the Fund Office written proof that you are still Totally Disabled. Upon your death, your beneficiary would receive your full death benefit amount, based on your years of service at the time you became Totally Disabled. Total Disability means that you are unable to work at any job for which you are reasonably suited by education, training, or experience as a result of an illness or Injury.

To qualify for this continued coverage, you must contact the Fund Office after you have been continuously Totally Disabled for nine months, but in no case later than one year from the date of your disability. You will have to complete the appropriate forms and provide the Plan with satisfactory written proof of your Total Disability. This proof may be required more than once a year for the first two years of your continuous Total Disability and once a year after two years of disability. If this proof of continued Total Disability is not furnished when required, this extension will end.

WHAT IS NOT COVERED UNDER THE PLAN

Your coverage is designed to cover a broad range of Medically Necessary services and supplies. However, no plan can cover every type of service and supply. It is important to be aware of this. Following is a list of some services, supplies, and expenses not covered by the Plan. These are in addition to any other exclusions otherwise listed.

A. Charges over the Allowable Charge.

B. Speech therapy for functional purposes including, but not limited to, stuttering, stammering, and conditions of psychoneurotic origin.

C. Private duty nursing care, except when Medically Necessary.

D. Educational, job training, and/or vocational rehabilitation.

E. Rehabilitation therapy services provided to an individual who is unconscious, comatose, or otherwise incapable of participating in a purposeful manner with the therapy services, including, but not limited to, coma stimulation programs and services.

F. Foot care, including but not limited to, trimming of toenails, removal of corns, calluses, or bunions, and preventive care.

G. Physician services for a weak, sprained, flat, unstable, or imbalanced foot. However, open cutting operations are covered.

H. Accidental bodily Injury, illness, or disease sustained while performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit, or for which benefits are or may be payable under any Workers' Compensation, employer liability, occupational disease, or similar law, except for Carpal Tunnel Syndrome Benefits for Employees.

I. Illnesses or Injuries due to any act of war, either declared or undeclared, except as required by law.

J. Services and/or supplies furnished by any government or for which payment is not required or provided while confined in a Hospital operated by the U.S. Government or an agency of the U.S. Government.

K. Any incurred by or on account of a Dependent for any medical expense incurred prior to the date the Dependent becomes covered under the Plan.

L. Any care, treatment, service, surgical procedure, supply, or Hospital or Facility confinement that is not Medically Necessary.

M. Services and/or supplies Experimental in nature or that do not meet accepted standards of medical practice.

N. Any treatment, service, supply, Hospital or Facility confinement, or surgical procedure that is of an elective nature, which includes any nonemergency plastic or cosmetic surgery on the body (including but not limited to such areas as the eyelids, nose, face, breasts, or abdominal tissue). However, this does not apply to:

   (1) Cosmetic surgery performed for the correction of defects incurred through traumatic Injuries;

   (2) Correction of congenital defects;

   (3) Corrective surgical procedures on organs of the body that perform or function improperly;

   (4) Voluntary vasectomies and other sterilization procedures performed on Employees and Dependent spouses; and

   (5) Reconstructive breast surgery following a mastectomy. This includes reconstruction of the breast on which a mastectomy is performed, reconstructive surgery on the other breast to produce a symmetrical appearance, any necessary prostheses required as a result of a mastectomy, and physical complications of any stage of mastectomy, including lymphedemas.

O. Any Injury or sickness for which the individual is not under the regular care of a Physician.

P. Any care, treatment, service, surgical procedure, supply, or Hospital or Facility confinement provided by or received from or on the recommendation of a medical provider or facility that does not meet one of the Plan's definition of an approved provider or facility.

Q. Any care, treatment, service, surgical procedure, supply, or Hospital or Facility confinement not recommended or approved by the attending Physician.

R. Any care, treatment, service, surgical procedure, supply, or Hospital or Facility confinement not provided for the treatment or correction (or in connection with) of a specific non-occupational accidental bodily Injury, sickness, or congenital defect unless specifically identified as covered under the Plan. However, this does not apply to charges incurred for routine medical care of a well newborn child during the mother's confinement if such child is the Dependent of an Employee and is born while the Employee is eligible for benefits.

S. Care or treatment of an Employee or Dependent where the person providing the care or treatment is related by blood or marriage to the Employee or Dependent or who ordinarily lives in the Employee's or Dependent's home.

T. Any type of custodial care (care that is designed primarily to assist an individual in meeting the activities of daily living), regardless of what the care is called.

U. Any special education rendered to any individual, regardless of the type of education, the purpose of the education, the recommendation of the attending Physician, or the qualifications of the individual(s) providing the special education. However, this does not apply to outpatient psychiatric treatment.

V. Education, training, or room and board while the individual is confined in an institution that is primarily a school or institution of learning or training.

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

X. Charges incurred while confined in an institution that is primarily a place of rest, a place for the aged, or a nursing home (other than a Skilled Nursing Facility).

Y. Any type of physical examination, employment physical examination, premarital examination, school physical examination, or any other medical examination or test for checkup purposes not necessary for treatment of a sickness. This applies to cancer prevention examinations and cancer detection center examinations, tuberculosis examinations, sickle cell anemia examinations, or any other type of physical examination or test that is given primarily to determine whether an individual has a specific sickness or disease where there have been no symptoms. However, this does not apply to well child care or an annual physical exam for Employees and Spouses.

Z. Any services, supplies, or treatments that are preventive in nature, except as required by law and except for HPV vaccinations as described under What is Covered in the Medical Benefits section.

AA. Travel, whether or not recommended by a Physician, except as otherwise specified by the Plan.

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

CC. Any treatment of alcoholism and/or substance abuse that is provided in a treatment facility that does not meet this Plan's definition of an approved facility.

DD. Any care, treatment, service, surgical procedure, supply, or Hospital or Facility confinement provided for or in connection with an overweight condition or condition of obesity, except when Medically Necessary.

EE. Reversal of, or attempts to reverse, a previous elective sterilization.

FF. Vasectomies or other sterilization procedures for Dependent children.

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

HH. Charges incurred as a result of treatment or consultation with a social worker, a marriage counselor, a *naprapath (*or you can use your HSA to pay for NAPROPATH service), or a naturopath.

II. Acupuncture.

JJ. Confinement in a facility providing nursing services unless the facility meets the Plan's definition of a Skilled Nursing Facility and the confinement meets the criteria for an approved confinement.

KK. Home nursing care program unless the nursing care is provided through a provider that meets the Plan's definition of a Home Health Agency.

LL. Radial keratotomy, corrective laser eye surgery or similar procedures.

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

NN. Injuries resulting from or sustained as a result of your commission, or attempted commission, of an illegal act that involves violence or the threat of violence to another person or in which a firearm, explosive, or other weapon likely to cause physical harm or death is used except that injuries resulting from acts of domestic violence will be covered. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution (including, with limitation, acquittal or failure to prosecute) in connection with the acts involved.

OO. Non-emergency care when traveling outside the U. S.

PP. Any service, treatment or device not specifically covered under this Plan.

Please note, some of the services not covered under the Plan may be eligible for reimbursement through the Health Spending Account. For more information about this benefit, see *Health Spending Account* on page 38.

RR. Services that are payable by a third party, such as a school district.

COORDINATION OF BENEFITS

The Plan has been designed to help you meet the cost of health care expenses (including medical and prescription drug care). It is not intended, however, that you receive greater benefits than your actual health care expenses. The amount of benefits payable under this Plan will take into account any coverage you or a Dependent has under other health plans. Benefits under this Plan will be coordinated with the benefits payable to you or your Dependents under other plans.

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

If you or your Dependents are covered under another plan, you must report such other coverage when making a claim for benefits.

Other plan means any plan, other than this Plan, that provides benefits or services for medical or prescription drugs that are provided by:

- Group, blanket, or franchise insurance coverage;
- Service plan contracts, group practice, individual practice, or other prepayment coverage;
- Any coverage under labor-management trustee plans, union welfare plans, or employer or employee benefit organization plans; and
- Any coverage under federal, state, or other governmental plans or programs that are largely tax-supported or provided through act of government, including Medicare, but excluding Medicaid.

Allowable expenses are any necessary, Allowable Charges or expenses, at least part of which are covered under one of the plans covering you, your spouse, or Dependents for which benefit payments are made. If a plan provides benefits in the form of services or supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an allowable expense) will be considered both an allowable expense and a benefit paid.

ORDER OF PAYMENT

If you, or your Dependent, is covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits do not exceed 100% of the allowable expense incurred.

The following rules determine the order of payment:

- A plan that does not have a coordination of benefits rule is primary.
- A plan that covers an individual as an Employee is primary.
- If a Dependent child is covered under more than one plan, the following rules determine the order of payment:
- If the parents are *not divorced* or separated:
  - The plan of the parent whose birthday (excluding the year of birth) occurs earlier in the calendar year is primary.
  - If a plan does not use the "birthday rule" to determine which plan is primary, then that plan will be primary.
  - If neither of the preceding situations is applicable, the plan covering the parent the longest will be primary.
- If the parents are divorced or separated:
  - Where there *is a court decree* that establishes financial responsibility for medical expenses, the plan covering the Dependent child(ren) of the parent who has financial responsibility is primary.
  - Where there *is no court decree*, the plan of the custodial parent is primary, the plan of the stepparent having custody is secondary, and the plan of the parent not having custody of the child pays third.

In the case of a Dependent child who is employed, this Plan is primary if the child's employer does not provide group benefit coverage or the child is not yet eligible for such group coverage. This Plan is secondary to the plan of the child's employer on the date that the child becomes eligible for coverage under his or her employer's plan, up to age 26.

If a person is a dependent under this Plan and dependent under his or her spouse's plan, then the plan that has covered the dependent for the longest time will be primary. If both plans began covering the dependent at the same time, then the birthday rule will apply substituting the dependent's spouse for the Employee's spouse.

If a husband and wife are both covered under this Plan as Employees, claims will be paid as the claims of Employees and will not be coordinated as the claim of a Dependent of the other spouse.

If none of the above rules applies, the plan covering the patient the longest will be primary. If both plans began covering the Dependent at the same time, then the birthday rule will apply substituting the Dependent's spouse for the Employee's spouse.

However, if you are a laid-off employee, retiree, or Dependent of such a person, benefits will be determined after the benefits of any other plan covering you as an employee or a Dependent of an employee.

If you or your Dependents receive benefits from the Plan while you are not eligible to receive them, the Plan may recover and collect those payments from you, your Dependents, or other organizations that may be liable to the Plan for such repayments.

COORDINATION WITH MANAGED CARE PLANS

If you or your Dependents are covered by a Managed Care Plan, such as a Health Maintenance Organization (HMO), your Plan will presume that you and your Dependents have complied with that Plan's rules necessary for your expenses to be covered by that Plan. If you or your Dependents have not followed that Plan's rules, then this Plan will not cover your expenses.

COORDINATION OF BENEFITS WITH MEDICARE

Medicare is a four-part program. The first part is officially called "Hospital Insurance Benefits for the Aged and Disabled," and is commonly referred to as Part A of Medicare. The second part is officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled," and is commonly referred to as Part B of Medicare. Part A of Medicare primarily covers Hospital benefits, although it also provides other benefits. Part B of Medicare primarily covers Physician's services, although it, too, covers a number of other items and services. Part C of Medicare, called Medicare Advantage, covers Medicare managed care plans. As noted above, if you are covered by a managed care plan, the Plan will presume that you have complied with that Plan's rules necessary for your expenses to be covered by that Plan, Medicare Part D provides prescription drug coverage.

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, Dependent widow, or have chronic End-Stage Renal Disease (ESRD). You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare or you are eligible to join a Medicare Advantage Plan. You are also eligible to join Medicare Part D. Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You will be required to pay a monthly premium for Part B and Part D of Medicare.

Any benefits payable to you or your Dependents under any portion of this Plan will be reduced by the amount of any benefits or other compensation to which you are entitled under any federal law, rules, or regulations constituting a governmental health plan, such as Medicare. Benefits will similarly be reduced if you or your Dependents are above age 65 and have elected Medicare as the primary plan over this Plan for the same Injury or sickness. This is true regardless of whether or not you have received or submitted a claim for these benefits from Medicare.

For all purposes of this provision, if you or your Dependents are entitled to benefits or other compensation under Medicare, the Plan will reduce your benefits by the amount Medicare would have paid, even if you are not enrolled or participating.

This Plan will pay first, before Medicare, if you:

- Are actively employed and eligible for Medicare due to age;
- Have "current employment status" with an Employer, as defined by federal law, but are eligible for Medicare; or
- Are eligible for Medicare due to End-Stage Renal Disease (ESRD); however, this Plan is primary only for a maximum period of 30 months, after which time, Medicare is primary.

Please note: retiree coverage ends when you become eligible for Medicare, whether you are a Dependent or a retiree under the Plan.

COORDINATION WITH MEDICAID

The Plan is primary over Medicaid for active employees and their Dependents.

INFORMATION GATHERING

For purposes of implementing the Plan's coordination of benefits provisions only, the Trustees or Plan Administrator may in accordance with the privacy rules, without the consent of, or notice to, any person, release to or obtain from any insurance company or other organization or person any information, about any person that the Plan deems to be necessary for these purposes. The Plan will comply with any federal regulation or law relating to an individual's right to privacy, as it may relate to this provision. Any person claiming benefits under this Plan must provide to the Trustees or Plan Administrator such information as may be necessary to implement the provisions of this section or to determine their applicability.

PRIVACY POLICY

The Plan is required to protect the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. Protected Health Information (PHI) is all individually identifiable health information transmitted or maintained by the Plan that relates to your past, present, or future health, treatment, or payment for health care services.

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

Your rights under HIPAA include the right to:

- Receive confidential communications of your PHI, as applicable;
- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

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

REIMBURSEMENT AND SUBROGATION

In the event that you and/or your Dependent recover any amount as a result of the act, conduct, or legal liability of any person, party, or insurance company, whether by suit, settlement, or otherwise, the Fund is entitled to immediate and full reimbursement to the extent of all benefits provided. You are required to sign and submit a Subrogation Agreement, or any other required forms, to the Fund Office **before** any payment will be made. If payment has already been made, the Fund reserves the right to reduce future payments. The Fund will be first and fully reimbursed before you and/or your Dependent are entitled to retain any amounts. If you and/or your Dependent refuse or fail to repay such amount, the Fund will deduct such amounts from future claims submitted on your behalf or on behalf of your Dependent until the full amount is recovered. The Trustees may, at their discretion, pursue a claim against any third party, including pursuing a claim in court.

The Trustees believe that the Plan's right of subrogation will result in savings for the Fund, which will benefit all eligible individuals because the cost of treatment for accidental Injuries or sickness will be the responsibility of the third party who caused or contributed to the Injury or sickness.

Generally, your claims and benefit payments will continue to be paid in the same way as they were previously. However, you or your Dependent will have certain responsibilities to the Fund. An eligible person who receives benefits from the Fund under these circumstances must sign and deliver all related papers and forms to the Fund and must do whatever else is necessary to help the Fund administer this subrogation clause. An eligible person must not do anything or sign any document that may impede the Fund's right to recover the benefits paid relative to the loss.

If you or your Dependent accept a settlement or receive an award for an Injury or illness caused by a third party, future medical expenses for such Injury or illness caused by the responsible third party are not eligible expenses under this Plan.

CLAIM REVIEW AND APPEAL PROCEDURES

Filing Claims

Many health care providers will submit claims for you. Be sure to show your ID card so your provider knows where to submit your claim. If your provider does not submit your claim for you, it is then your responsibility to do so. Contact the Fund Office for the appropriate claim form and be sure to provide all requested information, as outlined below. All claims must be filed within 12 months of the date of service for benefits to be paid under the Plan. All claims must be submitted in writing (or electronic format) on a form provided by the Plan or one of the Plan's providers. However, urgent care claims may be submitted orally. If a claim is denied or reduced, there is a process you can follow to have your claim reviewed.

If you need to submit a claim, contact the Fund Office for the appropriate form. Forward your claim and all related bills to the Fund Office. See below for more information on medical claims and page 42 for more information on submitting Health Spending Account claims.

HOW TO FILE A MEDICAL OR WEEKLY DISABILITY CLAIM

If you use the services of a Physician or Hospital or Facility in the BlueCross BlueShield of Illinois Preferred Provider Organization (PPO), the PPO Physician or Hospital or Facility will file your claims for you. The address is shown on your medical ID card:

BlueCross BlueShield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

You should give the Plan notice of your Injury or sickness for which you will be making a claim for benefits within 60 days of the date you begin incurring expenses for the Injury or sickness. If you have a claim or expect to have a claim for yourself or one of your Dependents, contact the Fund Office for a claim form at the address or numbers listed below:

Tuckpointers Local 52 Health and Welfare Fund Office
660 Industrial Drive, Suite 201
Elmhurst, Illinois 60126
Telephone: 630-516-8008
Fax: 630-516-8018

When you receive the claim form, fill it in completely and sign it as the Employee. Attach your Physician's own itemized insurance form/bill to your claim form.

Check to see that all parts of the form are completed and that all questions have been answered. Attach all Hospital or Facility and other itemized bills relating to the claim. Each bill must show the name of the patient, the date and the charge for each service rendered, and the sickness or Injury for which each item of expense was incurred. Be sure to include your ID number on all of your Documents.

You can assign certain benefits. This means that you sign a form that allows Hospitals, Facilities, Physicians, etc. to send their bills directly to the Claims Administrator. The Claims Administrator then makes payments directly to them. You must pay any amounts not paid by the Fund. You cannot assign benefits paid under the Health Spending Account benefit. You must pay first and the Plan will reimburse you.

When you sign the form that allows the Plan to pay your Hospital and Physician bills directly, you are only assigning to your providers your right to payment from the Plan. You may not assign your right to bring an action against the Fund, such as a contract action, an action for personal damages, or a claim under ERISA. Any state or federal court action relating to benefits under the Fund must be in your name or your beneficiary's name, unless federal law provides otherwise.

Be sure to send the claim form, with all attachments, within 60 days from the beginning of the first loss from your illness or Injury. All claims must be filed (in writing or electronic format) within 12 months of the date of service for benefits to be paid under the Plan.

HOW TO FILE A HEALTH SPENDING ACCOUNT CLAIM

To be reimbursed for an eligible health care expense, you must submit to the Fund Office:

- A completed claim form;
- A copy of a statement from a health care provider showing the patient's name, date of service, and type and amount of expense incurred; and
- Either a:
  - Receipt showing payment; or
  - Copy of an insurance statement (Explanation of Benefits) denying payment or showing non-covered charges.

The Fund Office must receive all requests for reimbursement **no later than April 1st** following the calendar year in which the expense was incurred. The Fund Office provides claim forms. It's a good idea to make a copy of all materials you submit for your records. Those you submit will not be returned to you.

Claim Determinations

When you submit a claim for benefits, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. All claims are processed promptly and will be paid as soon as administratively possible, when complete claim information is received.

You will be notified of an initial determination within certain time frames. If circumstances require an extension of time for making a determination on your claim, you will be notified, in writing, that an extension is necessary. The notice will state the special circumstances and the date a determination is expected.

The deadlines differ for the different types of claims as shown in the following information.

Health Care Claims, which include medical and prescription drug claims:

- Urgent Care Claims—An urgent care claim is a claim for medical care or treatment without which would seriously jeopardize your life, health, or ability to regain maximum function if normal pre-service standards were applied or would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition. An initial determination will be made within 72 hours from receipt of your claim, unless additional information is needed. Notice of a determination on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. You will then have up to 48 hours to provide the additional information. The initial 72-hour deadline is suspended for up to 48 hours or, if sooner, until the information is received. Notice of the determination will be provided no later than 48 hours after the Claims Administrator receives the additional information or, if sooner, the end of the period given for you to provide this information.
- Pre-Service Claims—A pre-service claim is a claim for Plan benefits where precertification is required before you obtain care. Carpal Tunnel Syndrome, Prescription drugs to treat obesity and Organ Transplant benefits are included under pre-service claims. An initial determination will be made within 15 days from receipt of your claim. If it is determined that additional time is necessary to make a determination, due to matters beyond the control of the Plan, you will be notified within the initial 15-day deadline that up to 15 additional days may be needed. If additional information is needed to process your claim, the initial period will be suspended, and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made before the end of the initial period, which was suspended.

- **Concurrent Care Claims**—A concurrent care claim is a claim that is reconsidered after it is initially approved (such as recertification of an ongoing course of treatment) and the reconsideration results in reduced benefits or a termination of benefits. While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment (i.e., longer than the prescribed period of time or number of treatments), the Plan will act on your request as soon as possible and you will be notified within 24 hours after receipt of your request, provided your claim is received at least 24 hours before the expiration of the approved treatment.
- **Post-Service Claims**—A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim. An initial determination will be made within 30 days from receipt of your claim. If it is determined that additional time is necessary to make a determination, due to matters beyond the control of the Plan, you will be notified within the initial 30-day deadline that up to 15 additional days may be needed. If additional information is needed to process your claim, the initial period will be suspended, and you will be notified of what information is needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made before the end of the initial period, which was suspended.

Weekly Disability Benefit Claims. An initial determination will be made within 45 days from receipt of your claim. If it is determined that additional time is necessary to make a determination, due to matters beyond the control of the Plan, you will be notified within the initial 45-day period that up to 30 additional days may be needed. If still additional time is needed, you will be notified that an additional up to 30 days is required.

If additional information is needed to process your claim, the Benefit Office will request the information from you or your physician in writing. Once the request for information is sent out, the period is suspended until you return the requested information, which must be within 45 days of the request. If you fail to return the requested information, the claim will be denied. If you acquire the information after the claim has been denied, you can follow the appeal procedures to appeal the denial.

Death Benefit Claims. Generally, you will receive written notice on a decision on your claim within 90 days after the Plan receives your claim. If it is determined that additional time is necessary to make a determination, due to matters beyond the control of the Plan, you will be notified within the initial 90-day deadline that up to 90 additional days may be needed.

If additional information is needed to process your claim, the Benefit Office will request the information from you or your physician in writing. Once the request for information is sent out, the period is suspended until you return the requested information, which must be within 45 days of the request. If you fail to return the requested information, the claim will be denied. If you acquire the information after the claim has been denied, you can follow the appeal procedures to appeal the denial.

PAYMENT OF BENEFITS

Benefits are only paid for covered expenses incurred by individuals who are covered under the Plan at the time the expenses are incurred, provided a claim(s) is made for the benefits within 12 months after the expense is incurred.

Generally, payment is made directly to the provider. However, if you submit the claim along with a paid receipt, payment will be made directly to you. If payment is made to you, you are responsible for payment to the provider. Once the Fund makes payment on a claim, no further payment will be made. You will receive an Explanation of Benefits (EOB) form showing what the Plan has paid. You are responsible for paying any amounts not paid by the Plan.

If an individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed, the Trustees may, at their option, make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of such individual.

If an individual dies before all amounts due have been paid, the Trustees may, at their option, make such payment to the executor, administrator, or personal representative of the individual's estate or to his or her surviving spouse, parent, child(ren), or to any other person(s) entitled to such payments.

Any payments made by the Fund fully discharges the liability of the Trustees to the extent of such payment. However, benefits payable under the Plan are limited to the Fund assets available for payment of such benefits.

IF A CLAIM IS DENIED

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered. If your claim is denied (in whole or in part), you will be provided with certain information about your claim within the time frames previously described. When you are notified of an initial denial on your claim, the notice will include:

- The specific reason(s) for the determination;
- Reference to the Plan provision(s) on which the determination was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A copy of the Plan's claims review procedures and time periods to appeal your claim;
- A statement of your right to bring a lawsuit under ERISA §502(a) following the denial of a claim; and
- If your claim is denied based on:
  - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the rule, guideline, protocol, or similar criteria is available to you, at no cost, upon request; or
  - Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment or exclusion or limit is available to you, at no cost, upon request.

If your denied claim is an urgent care claim, a description of the expedited review process will also be included.

Denial of Disability Claims after December 31, 2017

For a denial of a disability claim filed on or after January 1, 2018, the denial notice will be provided in a culturally and linguistically appropriate manner and will include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the Plan of the health care professional treating the claimant and vocational professionals who evaluated the claimant; and
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- A statement that the claimant in entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Appealing A Denied Claim

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

In general, you should send your written request for an appeal to the Fund Office as soon as possible. For urgent care claims, your appeal may be made orally. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within 180 days after you receive the notice of denial (60 days for a Death Benefit claim).
Your written appeal must explain the reasons you disagree with the determination on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

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

APPEAL DETERMINATIONS

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

A determination on your appeal will be made within certain time frames. You will be notified, in writing, of the determination on your appeal no later than five days after the determination is made, as set forth in the time frames below; however, oral notice of a determination on your urgent care claim may be provided to you sooner:

- Urgent Care Claims—A determination will be made within 72 hours from receipt of your appeal.
- Pre-Service Claims—A determination will be made within 30 days from receipt of your appeal.
- Concurrent Care Claims—A determination will be made before reduction or termination of your benefit. However, in the case of an appeal concerning a request to extend a course of treatment, a determination will be made in accordance with the deadlines described in this section based on the type of claim (urgent care, pre-service, or post-service, as appropriate).
- Post-Service Health Care, Weekly Disability Benefit, and Death Benefit Claims—A determination will be made at the next regularly scheduled quarterly meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second meeting following receipt of your appeal. If special circumstances require a further extension, a determination will be made at the third meeting following receipt of your appeal. You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a determination. You will receive written notice of the decision of the meeting at which the Trustees decided your appeal.

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

- A statement that you have a right to bring a civil action under ERISA §502(a) following the denial of your claim;
- The specific reason(s) for the determination;
- Reference to the Plan provision(s) on which the determination was based;
- If your claim is denied based on:
  - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or
  - Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.

You may not begin any legal action until you have followed and exhausted the Plan's claims and appeals procedures.

Disability Claims on or after January 1, 2018

Prior to issuing a denial of an appeal, the Fund Administrator will provide the claimant, free of charge:

- Any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the discretion of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date; and
- The rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

In the case of a denial of an appeal of a disability benefit claim, the notice will be provided in a culturally and linguistically appropriate manner and will include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the Plan of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; and
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination , applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- Either specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

Authorized Representatives

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

Authorized representatives may include a:

- Health care provider that has knowledge of the condition;
- Legal spouse;
- Dependent child age 18 or over;
- Parent or adult sibling;
- Grandparent;
- Court-ordered representative, such as an individual with power of attorney for health care purposes, legal guardian, or conservator; or
- Other adult.

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

The Plan Administrator, or its designated representative, has the discretion to determine whether an authorized representative has been properly designated in accordance with the Plan's terms. The Plan Administrator reserves the right to withhold information from a person who claims to be an authorized representative if there is suspicion about the qualifications of that individual.

Medical Judgments

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

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

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

You may not begin any legal action until you have followed and exhausted the Plan's claims and appeals procedures.

ADMINISTRATIVE INFORMATION

This section provides you with information about how the Tuckpointers Local 52 Health and Welfare Trust is administered.

Plan Name

Chicago Area Joint Welfare Committee for the Pointing, Cleaning and Caulking Industry, Local 52 Plan. Referred to as: The Tuckpointers 52 Health and Welfare Plan.

Fund Office

Tuckpointers 52 Health and Welfare Plan
660 Industrial Drive, Suite 201
Elmhurst, Illinois 60126
Telephone: 630-516-8008
Fax: 630-516-8018

Plan Administrator And Sponsor

The group program (the Plan) is administered and sponsored by the Board of Trustees, consisting of an equal number of Union and Employer Trustees. The current Trustees are:

Union Trustees	Employer Trustees
Hector Arellano	Kevin Geshwender
Jim Allen	Thomas Rivkin
Mark Tetlak	Mark Snedden

You may contact all or any of the Trustees through the Fund Office.

Employer Identification Number

36-2344463

Plan Number

501

Plan Year

May 1 through April 30

Type of Plan

The Plan is a welfare plan that includes health care (medical and prescription drug), weekly disability, and death benefits. For complete details of Plan benefits, please contact the Benefits Office for a copy of the Plan document. The Plan document, not this Summary Plan Description, is the legally governing document for the Plan.

Plan Funding

Employer contributions and self-payments finance the benefits described in this booklet. All Employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements.
The Plan's benefits are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Fund assets is allocated for reserves to carry out the objectives of the Plan.

The Board of Trustees holds all assets in trust. Benefits and administrative expenses are paid from the Trust.

Type of Administration

The Joint Welfare Committee for the Pointing, Cleaning and Caulking Industry, Local 52 is responsible for all benefits under the Plan.

Collective Bargaining Agreements

This Plan is maintained under a collective bargaining agreement. A copy of the agreement may be obtained by Plan participants upon written request to the Plan Administrator and is available for examination by Plan participants. You may also obtain, upon written request a list of contributing employers or information about whether a particular employer or employee organization is contributing to the Plan and their address.

Agent For Service of Legal Process

If legal disputes involving the Plan arise, any legal documents should be served upon:

Stephen J. Rosenblat, Esq.
Baum, Sigman, Auerbach & Neuman, Ltd.
200 West Adams Street, Suite 2200
Chicago, Illinois 60606

However, such documents may also be served upon any individual Trustee at the address of the Fund Office.

Eligibility Requirements

A summary of the Plan's requirements for eligibility for benefits is shown in this booklet. Circumstances that may cause you to lose eligibility are also explained. Your coverage by this Plan does not constitute a guarantee of your continued employment and you are not vested in the benefits described in this booklet.

Workers' Compensation and The Plan

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

Plan Amendment and Termination

The Board of Trustees expects that the Plan will be permanent. However, the Trustees have the authority to increase, decrease, or change benefits, eligibility rules, or other provisions of the Plan as they may determine to be in the best interests of Plan participants and beneficiaries. Any such amendment, which will be communicated in writing, will be made in accordance with the Plan Document and ERISA, and will not affect valid claims that originated before the date of the amendment.

This Plan may be discontinued or terminated under certain circumstances, for example, if future collective bargaining agreements or participation agreements do not require Employer contributions to the Fund. In such event, all coverage for participants will end immediately. Any such discontinuation will not affect valid claims that originate before the termination date of the Plan as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the assets available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

Board of Trustees' Discretion and Authority

All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement. However, the Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of participants and beneficiaries.

Under the Plan document and the Trust Agreement creating the Fund, the Trustees or persons acting for them have sole authority and broad discretion to make final determinations regarding any application for benefits and the interpretation of the Plan, the Trust Agreement, and any other regulations, procedures, or administrative rules adopted by the Trustees. Decisions of the Trustees (or where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner and the Trustees decisions will be accorded judicial deference. Benefits under this Plan will be paid only when the Board of Trustees (or persons delegated by the Trustees) decide, in their discretion, that the participant or beneficiary is entitled to benefits in accordance with the Plan's terms.

If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefits provided to different classes of participants may vary. In addition, any required Contributions may vary depending on the benefits provided and other factors.

YOUR RIGHTS AS A PLAN PARTICIPANT

As a participant in the Plan established by the Chicago Area Joint Welfare Committee for the Pointing, Cleaning and Caulking Industry, Local 52, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants be entitled to the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Employee Benefits Security Administration (EBSA) (listed in your telephone directory) at:

Nearest Regional Office:	National Office:
Employee Benefits Security Administration U.S. Department of Labor Chicago Regional Office 230 S. Dearborn Street, Suite 2160 Chicago, Illinois 60604 Telephone: 312-353-0900	Division of Technical Assistance and Inquiries Employee Benefits Security Administration U.S. Department of Labor 200 Constitution Avenue NW Washington, D.C. 20210

For more information about your rights and responsibilities, or for a list of EBSA offices, contact the EBSA by:

- Calling 866-444-3272; or
- Visiting their website at www.dol.gov/ebsa.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration (ESBA) at 888-444-EBSA (3272).

DEFINITIONS

The following are definitions of specific words and terms used in this booklet or that would be helpful in understanding covered or excluded services.

Allowable Charge

- With respect to a *PPO network provider*, the Allowable Charge is the negotiated fee/rate set forth in the agreement with the participating network health and/or dental provider, facility, or organization and the Plan.
- With respect to a *Non-PPO provider*, the Allowable Charge means the amount as determined by the Board of Trustees that the Plan will pay for a particular service or supply. Under no circumstances shall the Plan pay an Allowable Charge for out-of-network services or supplies that are determined by any provider, facility, or other person or organization other than the Board of Trustees. The Board of Trustees has determined Allowable Charge to mean the amount most consistently charged by a licensed Physician or other professional provider for a given service. An Allowable Charge refers to a charge that is within the range of usual charges for a given service billed by most Physicians or other professional providers with similar training and experience in a given geographic area. When considering the range of usual charges, the Plan may consider discounted rates allowed by network providers as a basis for Allowable Charges.
- With regard to Medicare, the Medicare Act limits the amount that Physicians can bill Medicare patients above the Medicare allowance for a particular procedure or service. Neither the Medicare patient covered by the Plan nor the Plan will be responsible for paying any charges that exceed such legal limits or the limiting charge under the law.

Claims Administrator

The Fund administers the claims of the Plan.

Dentist

A person:

- Holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD);
- Who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered;
- Who acts within the scope of his or her license; and
- Who is not the patient or the spouse, parent, sibling (by birth or marriage), or child of the patient.

Dependent

"Dependent" means the following categories of individuals:

- Eligible Participant's spouse (if not legally separated or divorced);
- Eligible Participant's Children who are younger than 26 years of age;
- Children shall mean:
  - Natural children; or
  - Children who are legally adopted by the Eligible Participant or placed for adoption in the Eligible Participant's home; or
  - Step children; or
  - Foster children, which are children who are placed with the Eligible Participant by an authorized placement agency or by judgment, decree, or other order of court of competent jurisdiction.

- Eligible Participant's unmarried Children who are 26 years of age or older and who are permanently and totally disabled due to physical handicap or mental disability provided such children maintain a principal place of residence with the Eligible Participant for more than one-half of the calendar year and further provided that the Eligible Participant provides more than one-half the children's support. The child must have become disabled before reaching 26 years of age and remain disabled. Proof of disability must be submitted within 60 days of the date dependency coverage under Plan would terminate and periodically as requested by the Fund Office.
- If the child does not live with the Eligible Participant, the child will be a Dependent child provided that the child's parents:
  - are divorced or legally separated under a decree of divorce or separate maintenance;
  - are separated under a written separation agreement; or
  - live apart at all times during the last six months of the calendar year;
  - The child's parents provide over one-half of the child's support; and
  - The child is in the custody of one or both of his or her parents for more than one-half of the calendar year.
- This Plan also considers children who are named as alternative recipients in a Qualified Medical Child Support Order (QMCSO) as Dependents under this Plan.

Durable Medical Equipment

Equipment that:

- Can withstand repeated use;
- Is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and
- Is not disposable or non-durable.

Employee

An individual who works for a participating Employer that pays contributions to the Fund for the Employee's work in accordance with a written agreement providing for such contributions.

This includes people on whose behalf Employer contributions are made in accordance with a written participation agreement and are employed by and under the direction of the:

- Union;
- Trustees of the Tuckpointers Local 52 Health and Welfare Trust Fund;
- Trustees of the Tuckpointers Local 52 Pension Fund;
- Trustees of the Tuckpointers Local 52 Defined Contribution Annuity Trust Fund; or
- Trustees of the District Council Training Center Fund.

A Sole Proprietor or a partner in a partnership or similar business entity required to make Employer Contributions to the Plan is also considered an Employee under the Plan.

Employer

An employer that is required, by the terms of a collective bargaining agreement with the Union, to make contributions to the Fund on behalf of their Employees. This includes the following Employers that make contributions on behalf of their employees in accordance with a written participation agreement:

- Union;
- Trustees of the Tuckpointers Local 52 Health and Welfare Trust Fund;
- Trustees of the Tuckpointers Local 52 Pension Fund;
- Trustees of the Tuckpointers Local 52 Defined Contribution Annuity Trust Fund; or
- Trustees of the District Council Training Center Fund.

This also includes an employer who is obligated to make contributions to the Trust Fund for its non-bargained employees under the terms of its written participation agreement with the Fund.

Experimental or Investigative

The use of any treatment, procedure, facility, equipment, drug, device, or supply that is not yet generally recognized as accepted medical practice, including the use of any of such items requiring federal or other governmental agency approval for which such approval has not been granted at the time such service or supply was rendered or provided.

Home Health Agency

An agency that is:

- Licensed by the state;
- Primarily engaged in providing skilled nursing care in patients' homes;
- Operated under professionally developed policies and under the supervision of a Physician or Registered Nurse (RN); and
- Eligible under Medicare.

Hospital or Facility

An institution that:

- Is licensed and operating according to law;
- Is engaged primarily in providing medical care and treatment to sick and Injured individuals on an inpatient basis at the patient's expense; and
- Is a hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH); or
- Is a hospital, psychiatric hospital, or tuberculosis hospital, as those terms are defined by Medicare, that is qualified to participate in and eligible to receive payments in accordance with the provisions of Medicare; or

Meets all of the following:

- In return for payment from its patients, it provides on an in-patient basis, diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment, and care of Injured and sick individuals under the supervision of a staff of Physicians licensed to practice medicine;
- It provides, on the premises, 24-hour-a-day nursing services by or under the supervision of registered graduate nurses;
- It is operated continuously with organized facilities for operative surgery on the premises; and
- It is not a place for rest, for the aged, for drug addicts, for alcoholics, or nursing or convalescent home.

Infertility

The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy, as certified by a Physician.

Injury

Bodily Injury caused solely by an accident that results directly and independently of all other causes in a loss covered by the Plan.

Intensive Care Unit

An accommodation or part of a Hospital, other than a postoperative recovery room, that:

- Provides room and board;
- Is established by the Hospital for a formal intensive care program;
- Is exclusively reserved for critically ill patients requiring constant audiovisual observation prescribed by a Physician and performed by a Physician or by a specially trained registered graduate nurse; and
- Provides all necessary life-saving equipment, drugs, and supplies in the immediate vicinity on a stand-by basis.

Medically Necessary or Medical Necessity

Those services, treatments, or supplies provided by a Hospital or Facility, Physician, or other qualified provider of medical services and supplies that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an individual's Injury or sickness. To be considered Medically Necessary, the service, treatment, or supply must:

- Be consistent with the symptoms or diagnosis and treatment of the Eligible Individual's condition, sickness, Injury, disease, or ailment;
- Be appropriate according to standards of good medical practice;
- Not be solely for the convenience of the individual, Physician, Hospital or Facility; and
- Be the most appropriate that can safely be provided to the individual.

Physician

You have free choice of a Physician.

A legally qualified physician or surgeon that is licensed to practice medicine or surgery and/or is acting within the scope of their license at the time and place the services are performed, which includes a:

- Doctor of Medicine (MD);
- Doctor of Osteopathy (DO);
- Doctor of Podiatric Medicine (DPM);
- Doctor of Dental Science (DDS);
- Doctor of Optometry (OD), for covered vision expenses only; or
- Doctor of Chiropractic Medicine (DC).
- Social workers, marriage counselors, acupuncturists, naprapaths, and naturopaths are examples of titles **not included** in the definition of Physician.

Skilled Nursing Facility

A nursing facility, by whatever name called, that:

- Is an institution, or a distinct part of an institution, that has in effect a transfer agreement with one or more Hospitals;
- Is primarily engaged in providing inpatient skilled nursing care and related services for individuals who require medical or nursing care;
- Is duly licensed by the appropriate governmental authorities;
- Has one or more Physicians and one or more registered professional nurses responsible for the care of inpatients;
- Requires that every patient must be under the supervision of a Physician;
- Maintains clinical records on all patients;
- Provides 24-hour-a-day nursing services;
- Provides appropriate methods and procedures for the dispensing and administering of medications and biologicals;
- Has in effect a utilization review plan;
- Is eligible to participate under Medicare; and
- Is not an institution that is primarily for the care and treatment of mental diseases or tuberculosis.

Total Disability or Totally Disabled

Total Disability means being prevented by a non-occupational accidental Injury or disease from engaging in:

- For you, your regular job and doing no other work for pay or profit; or
- For your Dependent, in substantially all the normal activities of a person in good health.

Treatment Facility for Alcohol and/or Drug Dependency

A rehabilitation facility for the treatment of individuals suffering from alcohol and/or drug dependency. The facility may be a freestanding facility or may be a designated portion of a Hospital or other facility provided such designated portion is solely for the purpose of providing rehabilitative treatment for individuals suffering from alcohol and/or drug dependency. To be considered an approved treatment facility under the Plan, the facility must be:

- Licensed and operating according to law and
- Accredited by the Joint Commission on Accreditation of Hospitals (JCAH).

Trust Fund or Fund

All cash and other property held by the Trustees under the terms of the Trust agreement.

Union

When reference is made to the Union, it means the Administrative District Council 1 of the Bricklayers and Allied Craft Workers, AFL-CIO or its predecessor, Tuckpointers Local 52 of the Bricklayers and Allied Craft Workers, ALF-CIO.

Nothing in this statement is meant to interpret, extend, or change in any way the provisions expressed in the Plan document. The Trustees reserve the right to amend, modify, or discontinue all or part of this Plan at any time. The Plan may be terminated under circumstances allowable under ERISA and the terms of the governing Trust Agreement. In the event of Plan termination, you will be notified in writing and the Trustees will apply the Plan assets to pay or provide for the payment of any and all obligations of the Plan. Any remaining surplus will be used for the exclusive benefit of participants and beneficiaries and payment of the administrative expenses of the Plan. The Board of Trustees has full discretion and authority to interpret the terms of all documents establishing the plan of benefits, including but not limited to the rules of eligibility, and to decide any factual question related to eligibility for and the type and amount of benefits. The decision of the Trustees will be final and binding.