FOX VALLEY LABORERS HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

As of January 1, 2019

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Dear Participant:

We are pleased to present you with this updated Summary Plan Description (SPD). This booklet explains the most important Plan features and summarizes the benefits provided through the Fox Valley Laborers Health and Welfare Fund (the "Fund"). These health and welfare benefits are available to Eligible Active, Disabled, and Retired Participants. This booklet replaces all prior SPD booklets and summaries of material modifications issued before January 1, 2019.

As these benefits are both important and valuable to you and your family, we want to make sure you fully understand how the Plan works. For this reason, this booklet is written in clear, straight-forward language and is organized to serve as an easy-to-use reference guide when you have questions about your health and welfare benefits. Certain words and phrases, however, may still seem "technical" to you. Where we could, we included definitions of these terms to help you understand them.

Please take the time to read this booklet carefully and share it with your family so that they are aware of the benefits offered. If after reading this booklet, you still have questions about your benefits, please contact the Administrative Office.

Sincerely,

Board of Trustees

This booklet describes certain provisions of the Fox Valley Laborers Health and Welfare Fund. The actual Plan provisions may be found in the Fund's legal documents. In the event of a conflict between this SPD and the legal documents, the legal documents govern. All Plans are subject to change at any time and for any reason or no reason, at the sole discretion of the Trustees.

General Information

The Fox Valley Laborers Health and Welfare Fund ("Fund") was established on October 1, 1961 between the Chicagoland Associated General Contractors, Chicago, Illinois, representing the contributing employers, and the Union, representing employees. The Union is made up of Local 582, Elgin, Illinois and Local 1035, Marengo, Illinois. The purpose of this Fund is to provide health and welfare benefits to Participants covered by collective bargaining agreements between the Union and contributing employers.

The Fund is administered exclusively by the Board of Trustees (or administrator or any committee solely authorized by the Board of Trustees) consisting of representatives appointed by the Union and representatives appointed by the employers through their collective bargaining associations.

There are many important benefits offered under the Fund. A brief description of some of these benefits is listed in the ***Your Benefits*** section.

* * * *

This booklet contains a summary of your rights and benefits under the Fox Valley Laborers Health and Welfare Fund as of January 1, 2019. If you have difficulty understanding any part of this booklet, contact the Administrative Office at 1-847-742-0900 or 1-866-828-0900, for assistance. For additional information about the Fund, visit their website at www.fvlab.com.

Although this booklet provides accurate and essential information about the Plan, you should understand that it is not a complete description. If there is ever a conflict between this booklet and the Plan's legal document, the Plan Document will govern. A copy of the Plan Document can be reviewed at the Administrative Office.

Este folleto está disponible en español. Si usted desea una copia de este folleto en español, por favor llame al 1-847-742-0900 o 1-866-828-0900.

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- PPO Providers ..... 90%; you pay 10%
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Lifetime Maximum ..... $10,000 medical per person, plus
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Years of Service:	**Calendar Year Maximum:**
Less than 10	$1,000 per family
10 – 19	$1,500 per family
20 – 29	$2,000 per family
30 or more	$2,500 per family

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Up to three (3) visits covered at 100%.

ELIGIBILITY AND PARTICIPATION

The Fox Valley Laborers Health and Welfare Fund offers you coverage for a wide range of benefits, including medical, family supplemental, prescription drug, dental, vision care, disability and death, and a member assistance program. Some of these benefits are also available for your covered Dependents.

This section tells you when you become eligible for benefits and how to stay eligible. It also tells you which Dependents can be covered for benefits and when their coverage becomes effective.

ELIGIBILITY

Active Participants

You are eligible for coverage based on your hours of work if you work for an employer(s) who makes contributions to the Fox Valley Laborers Health and Welfare Fund. You establish your eligibility for benefits during a *contribution quarter.* You earn eligibility for a benefit quarter after contributions are received by the Fund for a contribution quarter.

A *contribution quarter* is a consecutive three-month period in which contributions are made to the Fund on your behalf.

Non-Bargained Participants

If you are a Non-Bargained Participant you shall become eligible for benefits on the first day of the month following a 30-day waiting period and after the Administrative Office has received the required contributions from the Employer. Changes in coverage for your legal spouse and/or dependent children will be allowed only during the annual Open Enrollment period which is January 1 through 31, with the exception of changes due to legal separation, divorce, newborns, adoptions, or certification of loss of other insurance. Open Enrollment eligibility is effective February 1.

Dependents of Active Participants

If you are eligible for coverage, your eligible Dependents may also receive medical, family supplemental, prescription drug, dental, vision care, death benefits, and member assistance program coverage under the Fund.

Your *eligible Dependents* are your legal spouse and your children from birth until their 26th birthday.

Dependents of Active Participants (continued)

Children must be:

- your naturally born children;
- your legally adopted children or children legally placed with you for adoption in your home;
- your spouse's naturally born or legally adopted children;
- children for whom you are a legal guardian (proof of legal guardianship must be provided to the Administrative Office);
- children for whom there is a Qualified Medical Child Support Order which states that health care coverage must be maintained by you (documentation of this order must be provided to the Administrative Office); or
- children who are under your foster care (proof of foster care must be provided to the Administrative Office).

Your Dependent children also include your children age 26 or over who are dependent upon you for financial support and maintenance and who are:

- totally and permanently disabled due to a physical handicap or mental disability and are incapable of supporting themselves. The disability must start before the child reaches age 26 and continue while the child was covered under the Fund. Proof of disability must be submitted to the Administrative Office within 60 days of the date Dependent coverage under the Fund would end. The Fund may also request on-going proof of the disability on a periodic basis.

A Dependent is totally and permanently disabled if he or she is unable to engage in his or her regular and customary activities and is not employed in any occupation for wage or profit.

Your Dependents' coverage becomes effective on the same date that your coverage starts, or if later, the date you acquire an eligible Dependent. You must notify the Administrative Office of newborn Dependents within 30 days of birth; and, provide a copy of the birth certificate and social security card within 30 days of the birth.

The Fund permits a Dependent to be added upon loss of Medicaid or a State's CHIP eligibility or to drop Dependent coverage upon gaining eligibility under Medicaid or a State's CHIP program provided you request this within 60 days of the event.

The Fund also provides coverage for a child who is considered an eligible Dependent due to a Qualified Medical Child Support Order (QMCSO).

Dependents of Non-Bargained Participants

Your Dependents' coverage becomes effective on the same date that your coverage starts, or if later, the date you acquire an *eligible Dependent*. Your *eligible Dependents* are the same as described in the section *Dependents of Active Participants* above with the following exception:

- changes in coverage for your legal spouse and/or dependent children will be allowed only during the annual Open Enrollment period which is January 1 through 31, with the exception of changes due to legal separation, divorce, newborns, adoptions, or certification of loss of other insurance. Open Enrollment eligibility is effective February 1.

WHEN COVERAGE BEGINS

Initial Eligibility for Active Participants

There are two ways you can become eligible for coverage.

1. The Fund must receive contributions from your employer for 300 or more hours of work during a Contribution Quarter before your coverage can begin. Your coverage will begin on the first day of the corresponding Benefit Quarter after the Fund receives the contributions. The following chart shows how this works.

If You Earn 300 or More Hours During These Contribution Quarters	You Will be Eligible During These Benefit Quarters
May, June, July	October, November, December
August, September, October	January, February, March
November, December, January	April, May, June
February, March, April	July, August, September

   For example, Mike started work on August 15. By October 21, Mike had earned 300 hours during the "August, September, October" contribution quarter. The Fund received the required contributions from his employer in November. As a result, Mike, will be eligible for benefits as of January 1, for the following "January, February, March" benefit quarter.

2. The Fund must receive contributions from your employer for 500 or more hours of work during a consecutive six-month period before your coverage can begin. Your coverage will begin on the first day of the month after the Fund receives the contributions.

   If your coverage starts for a month that is not the first day of a benefit quarter, you will be covered for the remainder of the benefit quarter in which you become eligible and the next benefit quarter.

Initial Eligibility for Active Participants (continued)

> **For example**, Joe started work on July 5. By November 20, he had earned 500 hours. The Fund receives contributions from his employer in December. As a result, Joe will be eligible for benefits starting January 1.

Eligibility for Non-Bargained Participants

If you are a Non-Bargained Participant, you will become eligible for benefits on the first day of the month following a 30-day waiting period and after the Administrative Office has received the required contributions from the Employer.

CONTINUING COVERAGE

Continued Coverage for Active Participants

To continue coverage, the Fund must receive either contributions from your employer for 270 or more hours of work during a Contribution Quarter or 1,000** hours or more of work in any four consecutive Contribution Quarters. The following chart shows how this works.

If You Earn 270 Hours or More During One of These Contribution Quarters	If You Earn 1,000** Hours or More During This 12-Month Period	You Will be Eligible During One of These Benefit Quarters
November, December, January	12 months ending January 31	April, May, June
February, March, April	12 months ending April 30	July, August, September
May, June, July	12 months ending July 31	October, November, December
August, September, October	12 months ending October 31	January, February, March

However, if you initially became covered because you earned 500 hours in a consecutive six-month period, and your coverage started in the middle of a benefit quarter, your coverage will continue through the end of the following Benefit Quarter.

***A modified look-back rule of 800 hours instead of 1,000 hours applies from July 1, 2018 to June 30, 2020. Therefore, to continue coverage during this period the Fund must receive either contributions from your employer for 270 or more hours of work during a Contribution Quarter or 800 hours or more of work in any four consecutive Contribution Quarters.*

Continued Coverage for Non-Bargained Participants

If you are a Non-Bargained Participant, your eligibility shall continue on a month-to-month basis while you remain employed and while the required contribution is made to the Administrative Office by your employer.

Reinstatement of Coverage

If you lose your eligibility for benefits because you did not earn sufficient contribution hours as described above, you will become eligible for benefits again once you earn 270 or more hours during a contribution quarter.

Effect of Military Service

If you are called into active military service for up to 31 days, your medical, family supplemental, prescription drug, dental, vision care, and member assistance coverage during that period will be continued at no cost to you. If you are called into active military service for more than 31 days, you can continue your coverage for up to 18 months. See Continuation of Coverage under COBRA for more information.

If your eligibility for benefits ends because you enter the military service for a period of one or more years, your contribution hours will be reinstated on the date of your discharge, but only if:

- you notify the Administrative Office, in writing, of the day you will enter military service;
- you provide a copy of your discharge papers to the Administrative Office; and
- you are employed by an employer obligated to contribute to the Fund or you make yourself available for employment, within 90 days following your discharge from military service, or such other period required by federal law.

Credited Hours While Temporarily Disabled

Active Participants

If you are receiving Loss of Time Benefits, Workers' Compensation Benefits or benefits under an occupational disease act because of an injury or illness, you will continue to earn hours in a contribution quarter. Welfare hours will be credited to the contribution quarter at a rate of 40 hours per week. The maximum number of hours for which you will be credited during any illness or injury is 1,040 hours. You will be credited with these hours only if you provide the Administrative Office with a written statement from your physician that you are disabled.

Non-Bargained Participants

If you are receiving Loss of Time Benefits, Workers' Compensation Benefits or benefits under an occupational disease act because of an injury or illness, your eligibility shall continue on a month-to-month basis while you remain employed and while the required contribution is made to the Administrative Office by your employer.

Reciprocal Agreements

This Fund may enter into reciprocal agreements with other welfare funds. These agreements generally provide that if you are employed outside the jurisdiction of this Fund, you may be able to continue eligibility through reciprocity, but only if you remain a Participant in this Fund.

Some of the agreements provide for an automatic transfer of your hours, and some agreements require that you request a transfer of your hours. However, from time to time, new agreements are made. As a result, we recommend that you always inform the Administrative Office if you work under the jurisdiction of another fund to ensure that all hours transferable to this Fund, in fact, have been transferred to your account in this Fund.

WHEN COVERAGE ENDS

When your coverage ends, you will be notified that your coverage has ended and why.

Active Participants

Your eligibility for coverage ends on the earliest of the date:

- you no longer meet the eligibility requirements;
- you enter military service;
- your Local Union or Employer for Non-Bargained Participants no longer participates in this Fund; or
- the Fund terminates coverage for all Participants.

Non-Bargained Participants

If you are a Non-Bargained Participant your coverage shall end on the first day of the month following thirty (30) days after termination of employment; or, when the required contribution is not received on your behalf.

Dependents

Your Dependents' coverage ends on the date the earliest of the following occurs:

- you lose eligibility;
- your Dependent no longer meets the Fund's definition of a Dependent, provided, however, that coverage will continue until the last day of the month in which the Qualifying Event occurred;
- your Dependent enters military service, provided, however, that coverage will continue until the last day of the month in which the Qualifying Event occurred;
- you die (coverage for your Dependents will continue until the last day of the benefit quarter in which your coverage would have ended or the last day of the month in which the 90th day following the date of your death occurs, whichever is later; or, for a Non-Bargained Participant shall end on the last day of the month following thirty (30) days after the date of your death; or
- the Fund terminates the Plan.

In addition, benefits will end for a Dependent spouse on the last day of the month in which the divorce occurred.

Extension of Coverage During Total Disability

If you are totally disabled on the date your coverage ends, you will be eligible for an extension of the medical coverage you had at the time you became disabled. Your coverage will only be extended to treat the condition that caused your disability. Coverage will be extended for up to nine months after your coverage ends. You are totally disabled if, as the result of an accident or illness, you are completely unable to be employed in an occupation for which you are reasonably qualified through education, training, or experience.

Continuation of Coverage During Leave Under the Family and Medical Leave Act (FMLA)

If your employer has 50 or more employees, you may be eligible for leave under the Family and Medical Leave Act (FMLA). If you take an FMLA leave, your employer will continue to contribute to the Fund on your behalf and your coverage through the Fund will continue. However, if you do not return to work after your FMLA leave ends, you may be required to repay the amount your employer paid toward your coverage during your leave. If you do not return to work after the end of your FMLA leave, you may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA, as described in the following information.

Continuation of Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), allows you to extend certain coverage for yourself and your eligible Dependents when certain circumstances, or qualifying events, would normally cause coverage to end. **This section explains COBRA continuation coverage, when it may be available to you and your family, and what you need to do to protect your right to get it**. These qualifying events and the duration of coverage are shown on the following chart:

If You Have This Qualifying Event [1]	Coverage May Continue for	For a Maximum Duration of
Your hours are reduced so that you no longer meet eligibility requirements [2]	You and your Dependents	18 months [3]
You die	Your Dependents	36 months
You become entitled to Medicare (Part A, Part B or both) [4]	Your Dependents	36 months
You are divorced or legally separated from your spouse	Your Dependents	36 months
Children no longer qualify as eligible Dependents	Your Dependent children	36 months

1. If a second qualifying event occurs within the 18 or 29-month COBRA continuation period, the period of coverage may be extended for up to 36 months from the first COBRA event. This extension may be available to your spouse and Dependent children getting COBRA continuation coverage if you die; become entitled to Medicare benefits (under Part A, Part B, or both); get divorced or legally separated; or if your Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second qualifying event would have caused your spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.
2. For reasons other than gross misconduct.
3. Twenty-nine (29) months if you or your Dependents are disabled at the time or within 60 days. You must notify the Administrative Office before the end of the 18-month period and within 60 days of the disability determination. If either you or your Dependent is no longer considered disabled by the Social Security Administration, you must notify the Administrative Office within 30 days of the determination. Extended coverage COBRA rates apply for the additional 11-month period.
4. Being eligible for Medicare at the time of your COBRA event does not prevent you from choosing COBRA for yourself.

If a proceeding in bankruptcy under title 11 of the United States Code is filed with respect to the plan sponsor, and that bankruptcy results in the loss of coverage for you as a retired employee covered under the Plan, you will be offered COBRA continuation coverage. Your spouse, surviving spouse, and Dependent children will also be offered COBRA continuation coverage if bankruptcy results in the loss of their coverage under the Plan. COBRA continuation coverage will be offered for up to 36 months for this qualifying event.

Continuation of Coverage Under COBRA (continued)

COBRA continuation coverage is identical to the group medical, family supplemental, prescription drug, dental, vision care, and member assistance coverage you and your family have through the Fox Valley Laborers Health and Welfare Fund. Loss of Time, Death, and Accidental Dismemberment Benefits are **not** continued. You do not have to provide evidence of good health to continue coverage. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

It is your responsibility to inform the Administrative Office, in writing, of a divorce, legal separation, or a child losing Dependent status. However, you should notify the Administrative Office of any qualifying event within 60 days of the event or you may lose your right to continue coverage. Once the Administrative Office is notified of an event that affects your coverage or your Dependents' coverage, you will be notified within 14 days whether or not you have the right to choose continuation coverage. You must let the Administrative Office know that you want continuation coverage within 60 days of the date you or your Dependent would lose coverage or 60 days from the date you receive notice of your right to elect continuation coverage, if later. You may elect COBRA continuation coverage on behalf of your spouse and your children. Your spouse and/or Dependent children will also be given the opportunity to continue coverage independently from you.

If you choose to continue coverage, you or your Dependents will be required to pay the COBRA rates as set by the Board of Trustees. Your COBRA cost is 102% of the cost of coverage. If you become eligible for Social Security disability benefits your COBRA cost is 150% of the cost of coverage starting with the 19th month. These rates may change from time to time. You will be notified of the rate when you are notified that you are eligible. In addition, you will be notified if the rates change. If you do not elect to continue coverage, your health care coverage under the Fund will end. Your initial payment for coverage retroactive to the date your coverage began must be made within 45 days following the initial 60-day election period. Ongoing payments are due on the fifteenth of the month prior to that coverage period. You have a 30-day grace period to make each payment. If you do not pay your required COBRA payment before or within the 30-day grace period, your COBRA coverage ends.

Coverage is not generally available to anyone who was not participating in the Fund before the loss of coverage. However, if a child is born to you, adopted by you, or placed for adoption with you while you are on COBRA, that child can be added to your coverage. Once you elect COBRA continuation coverage, you may not change your coverage for any reason other than those specifically listed in this section.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for

Continuation of Coverage Under COBRA (continued)

lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Credit

Active Participants are eligible for COBRA continuation coverage if the Fund does not receive contributions from your employer for 270 or more hours of work during a contribution quarter. However, if the Fund receives some contributions from your employer during a contribution quarter, you will receive COBRA credit, for up to two eligibility quarters. COBRA credit is the appropriate Welfare rate times the number of hours reported. This COBRA credit can be applied toward your COBRA premium payments for the corresponding eligibility quarter.

COBRA credit is limited to two consecutive eligibility quarters. COBRA credit earned during the first contribution quarter does not carry over to the second contribution quarter. COBRA credits for the second eligibility quarter are based on hours reported in the corresponding contribution quarter. After the second eligibility quarter on COBRA, no more COBRA credit will be granted.

Non-Bargained Participants are not eligible for COBRA credit.

Other Coverage Options Besides COBRA Continuation Coverage

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 can learn more about many of these options at www.HealthCare.gov.

When COBRA Continuation Coverage Ends

Coverage extended through COBRA will end for you and your eligible Dependents when any of the following events occur:

- at the end of the 18, 29, or 36-month period;
- you do not pay your premiums on time;
- you or a Dependent becomes covered under any other group health care plan after your COBRA continuation coverage under this Plan started;
- you or a Dependent becomes entitled to Medicare after choosing COBRA;
- you are no longer determined to be disabled during your extended period of coverage for up to 29 months (loss of your Social Security benefit); or
- if this Fund stops providing coverage for all its Participants.

When COBRA Continuation Coverage Ends (continued)

If you have any questions about continuation of coverage through COBRA, please contact the Administrative Office below.

Administrative Office:

Fox Valley Laborers Health and Welfare Fund
2371 Bowes Road, Suite 500
Elgin, IL 60123-5523
1-847-742-0900 or Toll Free 1-866-828-0900

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.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Administrative Office (see above for contact information) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrative Office.

MEDICAL BENEFITS

The Fund provides benefits to help you pay for health care expenses. However, before the Medical Plan (the "Plan") pays any benefits, each covered health care expense must satisfy the conditions described below:

MEDICALLY NECESSARY SERVICES

Medical expenses that are reasonably necessary are covered if the services and treatment are considered medically necessary.

Medically necessary services include:

- a medical service or supply that is reasonably necessary for the care or treatment of injury or illness (pregnancy is treated as any other illness under the Plan);
- a dental service or supply that is reasonably necessary for dental care; and
- a psychiatric service or supply that is reasonably necessary to provide for mental disorder or substance abuse treatment.

MEDICALLY NECESSARY SERVICES (continued)

Please note that even though a *physician* may prescribe, order, recommend, or approve a service or supply, that service or supply may still not be considered medically necessary. The final determination of the medical necessity of a service or supply will be made by the Board of Trustees or its appointed delegate.

A *physician* is an individual licensed by a governmental authority having jurisdiction over his or her license and who operates within the scope of his or her license. A physician includes a doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry.

ANNUAL DEDUCTIBLE

Before the Plan pays benefits, you are required to pay a certain amount in covered expenses – this is called the deductible. The deductible is payable only once each calendar year for each individual and is limited to a maximum family amount.

The annual deductible is $150 per person, up to a maximum of $400 per family. This means that after your family has paid a total of $400 in covered expenses, your family will have satisfied the family deductible for the year.

A new deductible must be satisfied by you and your eligible Dependents each calendar year (January 1 through December 31) before benefits are paid in that year. The deductible is made up of eligible expenses incurred during that calendar year.

Carryover Deductible

Expenses incurred during October, November, and/or December of a calendar year that apply toward your deductible will apply toward your deductible for that current year, as well as for the following calendar year. For example, if you do not incur any expenses in 2018 until November 2018, the expenses you incurred in November 2018 will be applied toward meeting your 2018 annual deductible and toward meeting your 2019 annual deductible.

Common Accident Deductible

If two or more family members are injured in the same accident or contract the same contagious disease within a 30-day period, only one individual deductible is required before medical benefits are payable for treatment of injuries or illness resulting from that same accident or contagious disease for the rest of that calendar year.

HOW THE PLAN PAYS BENEFITS

After you pay the annual deductible, the Plan will reimburse you for most covered expenses at 90% of the *allowable charge* for PPO provider services or 80% of the *allowable charge* for non-PPO provider services, up to any Plan maximums. You pay the remaining percentage of covered expenses – this is called your copayment. You also pay the full amount of any expenses that exceed allowable charges for non-PPO provider services, any amount that is not covered under the Plan, and any amount over the Plan maximums. For PPO provider covered services, the allowable charge is the network negotiated charge and the Plan pays 90% of those charges.

For non-PPO provider services, an *allowable charge* is the reasonable and customary charge made by a health care provider for the diagnosis, service, or treatment of an illness or injury that is given at the appropriate level of care. Generally, a service is considered reasonable if it is within the customary practices of providers in the community where the service is provided. For non-PPO provider covered services, the allowable charge is determined at the 90th percentile by Fair Health or such other firm chosen by the Trustees and the Plan pays 80% of those charges.

Out-of-Pocket Limit

After a covered person incurs $1,500 in covered expenses, plus the deductible, during a calendar year, the Plan will reimburse most of that person's covered expenses at 100% of allowable charges for the remainder of that calendar year.

Expenses that do not count toward the out-of-pocket limit are:

- charges that exceed the allowable charges;
- charges that apply to the deductible; and
- any other charges that are not covered by the Plan.

The out-of-pocket maximum applies separately to each covered family member.

Maximum Benefits

The Plan pays certain benefits up to specified maximums. These maximums apply individually to you and each of your eligible Dependents, as indicated below.

Lifetime Maximums

Some benefits are limited to an overall lifetime maximum per person.

- Infertility Treatment: Charges for all infertility services and treatment are limited to a lifetime maximum of $10,000 per person and prescription drug maximum of $10,000.

Calendar Year Maximums

Some benefits are limited to a calendar year maximum, as follows:

- *Accidental Injury:* The first $750 of Hospital charges incurred within 48 hours of and for treatment of an accidental injury per person per year is paid at 100%. The balance is paid at the Plan percentage of allowable charges. The deductible does not apply.

Specific Benefit Maximums

Some benefits are limited to specific maximums over specific benefit periods, as follows:

- *Hearing Expense Benefits:* Benefits are limited to $3,000 per ear in every two-year period.
- *Bariatric Surgery:* Benefits for bariatric surgery are limited to one surgery per lifetime.

PREFERRED PROVIDER ORGANIZATION (PPO)

To help control the high costs often associated with quality health care, the Plan has entered into an agreement with a Preferred Provider Organization (PPO). The PPO is a network of hospitals and physicians who have a special arrangement with the Plan to provide you with high quality health care benefits at reduced, pre-negotiated rates. This means that when you visit a physician or hospital that participates in the PPO network, you will pay lower out-of-pocket costs for most services and treatment, plus the Plan will pay a higher percentage of those costs.

Of course you may go to any hospital or physician you wish. However, if you use a provider that does not participate in the network, you may pay more than you would if you went to a PPO provider. For more information about the Plan's PPO provider or for a listing of PPO providers, contact the Administrative Office.

Blue Cross/Blue Shield is currently the Plan's PPO network. To locate a network provider call Blue Cross/Blue Shield at 1-800-810-2583 or visit their website at www.bcbsil.com.

COVERED EXPENSES

Inpatient Hospital Services and Supplies

Room and board for a registered bed patient is provided at the hospital's semi-private room rate for inpatient hospitalization for each period of hospital confinement. Private rooms are only covered if it is determined to be medically necessary. Federal law requires that benefits for any hospital confinement for a mother and/or newborn child be paid for at least 48 hours following a normal vaginal delivery or at least 96 hours following a caesarean section. However, federal law generally does not prohibit the

Inpatient Hospital Services and Supplies (continued)

mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In addition, hospital charges may not be allowed if you are admitted over a weekend (Friday or Saturday). The only time you are covered for a weekend admission is if treatment or surgery is provided within 24 hours of hospital admission. Hospital benefits may be allowed if weekend admission is medically necessary.

You are covered for other services and supplies provided, including, but not limited to, radiology, lab work, pathology, etc.

Pre-Notification of Services

Pre-notification of services is required for all inpatient hospital services, including treatment for mental health and substance abuse. The provider should contact Hines & Associates, Inc. as indicated on the participant's ID card prior to admitting the patient. Prior authorization is required for all transplant surgeries and bariatric surgeries which must be approved by the Administrative Office.

A *hospital* is a legally operated institution that is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations and has 24 hour-a-day supervision by a staff of physicians and registered graduate nurses. A hospital mainly provides:

- general inpatient medical care and treatment of sick and injured persons by the use of medical, diagnostic, and major surgical facilities. All of these facilities must be in the hospital or under its control; or
- specialized inpatient care and treatment of sick and injured persons by the use of medical and diagnostic facilities (including X-ray and laboratory). All of these facilities must be in the hospital, under its control, or available under a written agreement with a hospital or with a specialized provider of these facilities.

In addition, a hospital that treats mental and nervous disorders or substance abuse must be an institution that provides care and treatment of mental, psychoneurotic, and personality disorders, alcoholism, or drug abuse through one or more specialized programs and meets all of the following requirements:

- has 24 hour-a-day supervision by a staff of physicians, registered graduate nurses and other mental health professionals;
- it provides for the clinical supervision of such specialized programs by physicians who are licensed in the state in which it is located;
- each specialized program:
    - provides treatment for a minimum of three hours and a maximum of 12 hours per day;
    - provides a written, individual treatment plan that states specific goals and objectives;

Pre-Notification of Services (continued)

- maintains, at a minimum, ongoing weekly progress notes that demonstrate periodic review and direct patient evaluation by the attending physician; and
- meets either of these two requirements:
    1. it is accredited by the Joint Commission on Accreditation of Healthcare Organizations to provide the type of specialized program described above; or
    2. it is licensed, accredited, or approved by the appropriate agency in the state in which it is located to provide the type of specialized program described above.

A hospital is ***not*** a nursing home, an institution that is used mainly as a place for convalescence, rest, nursing care for the aged, homelike or custodial care, or training in the routines of daily living, or mainly a school.

Accidental Injury Benefit

In the event of an accidental injury, the Plan pays 100% of covered expenses for office visits, physician services, and hospital charges incurred within 48 hours of the accidental injury, up to $750 per person each calendar year. The deductible does not apply.

Intensive Care Unit

You are covered for services and supplies provided in the intensive care unit of a hospital.

Emergency Care

You are covered for allowable charges you may have as a result of a medical *emergency* due to injury or illness, in a hospital, physician's office, clinic, ambulatory surgical center, emergency care facility, or outpatient surgical center.

A medical emergency is defined by this Plan as medical care or treatment that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which is severe enough that the lack of immediate attention could reasonably be expected to result in any of the following:

- the patient's health would be placed in serious jeopardy;
- bodily function would be seriously impaired; or
- there would be serious dysfunction of a bodily organ or part.

Emergency care includes mental disorder treatment when the lack of treatment could reasonably be expected to result in the patient harming themselves and/or other persons.

Skilled Nursing Care

The Plan provides benefits for skilled nursing care provided by a licensed registered or practical nurse when care is prescribed by a treating physician.

Anesthesia Services

Anesthesia services are covered if the care is provided by a physician, licensed anesthesiologist, or RN anesthetist for the administration of anesthetics.

Physical and Occupational Therapy

The Plan provides for treatment of a physical disability for which there is a reasonable expectation of significant improvement in the status of that disability as determined by the Plan. The Plan covers services provided by a registered physical therapist, or a registered or state licensed occupational therapist for short-term therapy. Services must be ordered by a physician under an individual treatment plan and must be certified by the physician as necessary for the improvement of the patient's condition through "short-term" care. The physician must provide a written prescription which includes frequency, duration, and prognosis. The term "short-term" for purposes of Physical/Occupational Therapy benefits is defined as a continuous course of treatment of "up to 26 weeks" for a specific condition/diagnosis. The "up to 26 weeks" period begins on the first day of therapy. Treatment is considered continuous if there is no gap in the course of treatment from the first day of therapy. A gap of greater than four weeks in duration is considered to be a break in treatment and ends the coverage of therapy for that specific condition/diagnosis.

In the event of an accidental injury resulting in hospitalization, a Participant may request an extension of "short-term" therapy benefits. Requests for an extension of the maximum 26-week period must be recommended by a physician and reviewed by the Administrative Office and Medical Management. An extension of benefits will be considered only after a medical review to determine medical necessity, reasonable expectation of significant improvement, and non-experimental treatment status according to accepted standards of medical practices through established medical review mechanism. Extension of benefits will be approved in four week increments with an overall maximum benefit of no more than 52 weeks.

In addition, occupational and physical therapy services will be covered for treatment of a Dependent with a congenital disability without regard to the reasonable expectation of significant improvement of the disability or the "short-term" care of up to 26 weeks limitation.

Durable Medical Equipment

The Plan covers the rental of crutches, a wheelchair, hospital bed, or other durable medical equipment not to exceed a reasonable purchase price. Equipment that is considered to be durable medical equipment includes equipment that:

- can withstand repeated use and is not a consumable or disposable item;
- is exclusively and customarily used to service a medical purpose;
- is not useful to a person in the absence of injury or illness; and
- is appropriate for use in the home.

Purchase of durable medical equipment and the cost of maintenance agreements are covered only when the Plan determines that it is cost effective for the Plan. The amount of Plan benefits payable for the purchase of durable medical equipment will be reduced by any benefits paid by the Plan for the rental of such equipment.

Speech Therapy

Benefits are available for speech therapy performed by a licensed speech therapist and prescribed by a physician if it's to:

- restore speech that was completely or severely impaired as a result of an accidental injury or illness; or
- develop speech in individuals who are unable to speak as the result of a hearing disorder.

Physical Exam Benefits

Benefits are payable for an annual routine physical exam performed by a Medical Doctor (M.D. or D.O.) for you and your spouse. Benefits include expenses incurred for X-ray and laboratory tests.

Your eligible expenses for a physical exam are fully covered immediately at 100% of the allowable charges. You do not need to satisfy the individual annual deductible before receiving benefits. The following expenses are not covered:

- charges for services or supplies that are covered in whole or in part under any other provisions of the Plan;
- any expense for a physical exam that is not performed by a physician;
- charges that exceed allowable charges; or
- any expense incurred in connection with an illness or injury.

Hearing Expense Benefits

Benefits are payable for hearing expenses. This benefit provides a maximum benefit of $3,000 per ear, for the following hearing expenses every two consecutive calendar years:

- an otologic examination performed by a physician or a surgeon;
- an audiologic examination and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation within 30 days following the delivery of the hearing aid;
- the hearing aid (monaural or binaural) prescribed as a result of an examination. This generally includes ear mold(s), the hearing aid instrument, the initial batteries, cords, and other necessary ancillary equipment;
- replacement batteries; and
- hearing aid repairs.

The following expenses are not covered:

- medical examinations not provided for hearing aids not prescribed by a licensed otologist or otolaryngologist;
- any service or materials provided as a result of Workers' Compensation or occupational disease law, or for which no charge is made, or provided by or payable under the plan or law of any government, federal or state, or any political subdivision;
- hearing examinations required by an employer as a condition of employment, or that the employer is required to provide because of a labor agreement;
- examinations by an audiologist when not referred by an otologist or an otolaryngologist or when the exam is not preceded by a medical exam;
- charges by a speech pathologist or any charges for speech therapy, speech reading, lessons in lip reading; or
- charges for rental or purchase of amplifiers.

Substance Abuse Benefits

The Plan covers substance abuse treatment as any other medical illness.

Mental Disorder Benefits

Benefits are payable for *mental disorder treatment as any other illness.* Mental disorder care must be provided by a licensed psychiatrist, Doctor of Medicine, Doctor of Osteopathy, clinical psychologist, licensed clinical professional counselor, or a licensed social worker. A mental disorder treatment is any illness:

- identified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. For purpose of this benefit, it excludes psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause (treatment for these may be covered under the substance abuse benefit); and

Mental Disorder Benefits (continued)

- where the psychotherapy or other psychotherapeutic methods are the primary sources of treatment.

All inpatient services given by a mental health facility or area of a hospital that provides mental health or substance abuse treatment for an illness identified in the DSM are covered by the Plan. Pre-notification of services is required for all inpatient hospital services. The provider should contact Hines & Associates, Inc. as indicated on the participant's ID card prior to admitting the patient.

Detoxification services, adjustment reactions, developmental delays, and marriage and family counseling are not considered under this Plan to be mental disorder treatment.

Inpatient Care for Newborns

The Plan pays benefits for hospital charges and physician's fees for a well newborn child during the period of hospital confinement for which the female Participant or wife of a Participant is confined for giving birth to the child. The deductible does not apply.

Newborn Care

The Plan pays newborn care benefits for a Dependent child who has congenital defects, birth abnormalities, prematurity, or any other cause present at birth up to age two.

Well Baby Care

Benefits are payable for pediatric office visits and related laboratory services incurred by a Dependent child during the first 24 months following birth. You do not need to satisfy the individual annual deductible before receiving benefits.

Immunizations

The Plan provides benefits for charges for vaccinations, immunizations and laboratory tests required by the school for children in the school system and mandated by the Board of Education for eligible Dependent children. In addition, the Plan covers immunization charges for you and your spouse. These eligible expenses are covered immediately at 100% of the allowable charges. You do not need to satisfy the individual annual deductible before receiving benefits.

The Plan also pays 100% of allowable charges for Hepatitis B inoculations. The deductible does not apply.

School Physicals

Benefits are payable for a school physical for athletic participation and school physical required by the school for children in the school system and mandated by the Board of Education for Dependent children. These eligible expenses are immediately covered at 100% of allowable charges. You do not need to satisfy the individual annual deductible before receiving benefits.

Certified Nurse/Midwife Services

The Plan covers expenses for the services of a certified nurse/midwife in connection with pregnancy, if it is within the scope of the certified nurse/midwife's license. The amount of the benefit is based upon the allowable charges for a normal delivery.

Reconstructive Surgery

The Plan complies with the Women's Health and Cancer Rights Act of 1998 and provides medical and surgical benefits in connection with a mastectomy. Reconstructive breast surgery following a mastectomy will be provided on the same basis as other surgical procedures covered by the Plan and include:

- reconstruction of the breast on which a mastectomy is performed, including coverage for nipple and areola reconstruction and/or re-pigmentation;
- reconstructive surgery on the other breast to produce a symmetrical appearance;
- prostheses and surgical bras following a mastectomy; and
- physical complications of any stage of mastectomy, including lymphedemas.

Reconstructive surgery, other than as outlined above, is only covered if due to an underlying illness. In this instance, the surgery may be approved by the Plan on a case by case basis.

Bariatric Surgery

The Plan pays benefits for charges incurred for bariatric surgery recommended by a physician; if the Participant or Dependent has a Body Mass Index (BMI) [weight (kilograms)/height (meters)^2] of 40 or higher, or has a BMI of 35 or higher with one or more related co-morbid conditions; as determined in the sole and absolute discretion of the Board of Trustees or its Delegate; limited to one surgery per lifetime. Covered Services must be incurred at an in-network bariatric surgery Center of Excellence. There is no coverage for bariatric surgery performed out of the applicable network. Prior authorization is required for all bariatric surgery services.

Second Surgical Opinions

The Plan pays benefits for second surgical opinions including necessary X-ray and laboratory examinations. The second surgical opinion must be provided by a *qualified physician*.

A *qualified physician* is a physician who is board-certified in the field of medical specialization concerned with the condition involved.

Physician's Surgical Services

The Plan pays benefits for physician's or surgeon's fees for medical treatment, including inpatient or outpatient surgical procedures. The usual and customary charge for an assistant surgeon is also an allowable expense when medically necessary.

Podiatry Services

The Plan covers medically necessary treatment by a licensed doctor of podiatry. Coverage is the same as any other medical illness.

Ambulance

The Plan covers professional ambulance transportation when medically necessary.

Ground transportation by professional ambulance to the nearest appropriate facility is covered if needed due to a medical emergency, acute illness, or for inter-health facility transfer.

Air transportation by professional ambulance is covered only if due to inaccessibility by ground transport or if the use of ground transport would be detrimental to the patient's health status.

Hospice Care

The Plan provides hospice care benefits for any covered individual who is diagnosed as terminally ill, with six months or less to live, by a certified physician.

In addition, bereavement counseling by clergy or any volunteer group are covered until the eligible Participant or Dependent has died. The charges for these services must be authorized by the treating physician and billed through the hospice program.

Skilled Nursing Facility

The Plan covers charges related to a skilled nursing facility confinement if you are admitted within 14 days after a hospital stay that lasted at least three days. The admission must be for the same condition that required hospitalization.

Nurse Practitioner

Expenses for the services of a licensed or certified nurse practitioner acting within the scope of that license are covered by the Plan.

Chiropractic Care and Acupuncture

The Plan provides benefits for chiropractic care and acupuncture for you or your Dependent **over age five** for treatment of the back, neck, spine, and vertebra, for conditions due to subluxation, strains, sprains, and nerve root problems. The care must be provided by a licensed physician.

Note: The Plan will not cover chiropractic care if it is received at the same time as physical therapy.

Transplant Procedures

The Plan covers allowable charges for the following human-to-human organ or tissue transplant procedures under the medical benefit:

- bone marrow (self and other donated);
- heart transplants;
- heart and lung transplants;
- lung transplants;
- liver transplants;
- cornea transplants;
- kidney transplants;
- stem cell (after review);
- pancreas transplants (after review);
- kidney/pancreas transplants (after review); and
- kidney/liver transplants (after review).

"After review" means a medical review to determine medical necessity and non-experimental treatment status according to accepted standards of medical practices through established medical review mechanisms.

The maximum benefit payable is the total of all medical benefits otherwise payable under the Plan that are incurred as the result of you or your Dependent undergoing one of the above transplants. Charges for services and supplies provided to a donor who does not have medical coverage for these expenses are also included in this limit. Donor expenses are limited to $25,000 (Participant or Dependent donating to another Participant or Dependent, or to a donor without medical coverage). All covered expenses must be incurred at an in-network transplant Center of Excellence for all covered transplants except cornea and kidney. Cornea and kidney transplant services must be incurred at a provider in the Preferred Provider Network. ***There is no coverage for transplants performed out of the applicable preferred provider network.*** Prior authorization is required for all covered transplant services.

Transplant Procedures (continued)

Covered services must be for a human-to-human organ or tissue transplant and include:

- organ and tissue procurement;
- transportation, lodging, and meal costs up to $10,000 for the recipient and a companion, or two companions if the recipient is a minor;
- hospital, room and board, and medical supplies;
- diagnosis, treatment, and surgical procedures performed by a Medical Doctor (M.D.);
- private nursing care by an RN or LPN;
- rental of wheelchair, hospital-type beds, and respiratory therapy equipment or other durable medical equipment;
- local ambulance services;
- medications;
- X-rays and other diagnostic services, laboratory tests, and oxygen; and
- surgical dressings and supplies.

A transplant benefit period begins five days before the date of the organ or tissue transplant (30 days before for bone marrow transplants) and ends 18 months after the transplant procedure. Multiple transplant procedures may be covered under the same or separate benefit periods. If the transplants are due to:

- related causes, they will be covered in the same benefit period;
- unrelated causes, they will be covered under separate benefit periods; or
- related causes, they are covered under separate benefit periods if the eligible Participant returns to active work before the second transplant, or for a Dependent, if the Dependent's transplants are separated by at least three consecutive months.

Infertility Treatment

The Plan provides benefits for infertility treatment including evaluation, artificial insemination, in-vitro fertilization, and prescribed drugs and medications for you and your Dependent spouse. The maximum benefit the Plan pays is $10,000 per person per lifetime.

Case Management

Case Management is the planning and coordination of health services with you and your physician to provide assistance and coordinate care for serious illness, such as, cancer or chronic illnesses, such as diabetes or heart disease.

Medical Management

Medical Management is a collaborative process that evaluates and facilitates recommended treatment plans to assure that appropriate, efficient and medically necessary care is provided. Pre-notification of services is required for all inpatient hospital services, including treatment for mental health and substance abuse. The provider should contact Hines & Associates, Inc. as indicated on the participant's ID card prior to admitting the patient. Prior authorization is required for all transplant surgeries and bariatric surgeries.

Pre-Notification of Services

Pre-notification of services is required for all inpatient hospital services, including treatment for mental health and substance abuse.

Prior Authorization

Prior authorization is required for all transplant surgeries and bariatric surgeries.

Miscellaneous

The Plan also covers medically necessary:

- physician office visits;
- blood and blood derivative, if not donated or replaced, and blood processing fees;
- artificial limbs and eyes, due to injury or illness (except for replacement due to growth for Dependent children);
- surgical dressings or supplies;
- oxygen and rental equipment for its administration;
- allergy testing and injections;
- charges for voluntary sterilization procedures, including, but not limited to, a vasectomy, tubal legation, or salpingectomy for you and your spouse;
- use of X-ray and radium treatment and chemotherapy;
- X-ray and laboratory services;
- prescription drugs administered in an inpatient or outpatient facility setting or physician's office. Prior authorization is required for prescription drugs such as Spinraza™ (nusinersen) or Brineura™ (cerliponase alfa);
- coverage of gender dysphoria and reassignment surgery subject to medically necessary clinical guidance; and
- hospital confinement, surgery, medical treatment, X-ray or laboratory exams, or other expenses incurred while confined in a U.S. government hospital or in any other hospital operated by a governmental unit, unless an expense is the result of a service-related illness or injury to you or your Dependent.

MEDICAL EXPENSES NOT COVERED

In addition to any general Plan exclusions, the following expenses are not covered under the Plan:

- illness or injury that is related to any occupation or employment for wages or profit;
- illness or injury caused by war or any act of war, declared or undeclared, or incurred during service in the Armed Forces of any country. This includes confinement in a government hospital, surgery, medical treatment, X-ray or laboratory exams, or other expenses incurred for a service-related condition. Care in a government hospital for a non-service related condition is covered;
- cosmetic surgery, except for operations necessary to repair disfigurement due to an accident, for congenital anomaly in Dependent children, for surgery and reconstruction of a breast as mandated by applicable law, or reconstructive surgery to improve bodily function and/or to correct deformity resulting from disease (as pre-approved by the Plan);
- any operation or treatment in connection with the fitting or wearing of dentures or for treatment of teeth or gums except:
  -tumors;
  -treatment of accidental injury to sound natural teeth (including their replacement); and
  -fractures due to an accident, provided the treatment or X-rays are received within six months following the injury;
- eye examinations for refractive errors or the fitting of glasses or contact lenses, except as described on page 41;
- hearing aids or the fitting of hearing aids and cochlear implants, except as described on page 22;
- routine physical examinations, except as described on page 21;
- travel for health care;
- care in a place of rest, a place for the aged, a place for the care of training of mentally or physically handicapped persons, a nursing home, hotel, or similar institution;
- illness or injury caused by participation in a criminal enterprise or unlawful behavior;
- chelation therapy, except in cases of heavy metal poisoning;
- expenses that exceed allowable charges;
- care and treatment that is not medically necessary for the treatment of an injury or illness except for sterilization benefits;
- any services, procedures, or substances that are considered experimental in treating a condition or that have not been recognized as accepted standards of medical practices through established medical review mechanisms (such as the Federal Drug Administration or the American Medical Association);
- marriage counseling;
- any expenses that are not specifically described in this Plan;
- ecological or environmental medicine, diagnosis, and/or treatment;
- herbal medicine, holistic or homeopathic care, including drugs;

MEDICAL EXPENSES NOT COVERED (continued)

- long-term maintenance therapy or group exercise programs;
- nutritional counseling;
- telephone consultations;
- weight loss programs, such as “Jenny Craig,” “Nutri-System,” etc.;
- outpatient prescription drugs, except as described beginning on page 31;
- wigs (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving, or any drug if such drug is used in correction with baldness;
- personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, and hot tubs;
- any services or supplies related to temporomandibular joint dysfunction, including surgery performed on the temporomandibular joint;
- any services or supplies in connection with the treatment of infertility for Dependent children;
- any services or supplies in connection with weight reduction, gain, or control except surgery as provided on page 24 if you or your Dependent has a Body Mass Index (BMI) [weight (kilograms)/height (meters)^2] of 40 or higher, or BMI of 35 or higher with one or more related co-morbid conditions, as determined in the sole and absolute discretion of the Board of Trustees or its Delegate, limited to one surgery per lifetime; and, prior authorization is required; and, services are required to be incurred at an in-network bariatric surgery Center of Excellence;
- custodial care;
- surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, radial keratotomy (RK) and anterior lens keratotomy (ALK) surgery, except as described on page 41;
- dental implants, except as described on page 39;
- complications from non-covered procedures;
- vision therapy, unless provided by an optometrist instead of a surgical procedure; and
- reversal of voluntary sterilization.

FAMILY SUPPLEMENTAL BENEFITS

If you or your Dependent incur medically necessary out-of-pocket expenses for covered medical expenses, other than expenses used to meet your deductible or out-of-pocket amount, or a medically necessary expense for a service or supply that is not covered under the Plan, the expenses may be reimbursed under the Family Supplemental Benefit.

Expenses eligible under this benefit include unreimbursed medical, prescription drug, dental, and vision expenses that you or your Dependent incurs that is deductible under Section 213(d) of the Internal Revenue Code.

FAMILY SUPPLEMENTAL BENEFITS (continued)

Examples include, but are not limited to, medical supplies, speech therapy, and prescription drugs not otherwise covered by the Plan.

Each year, the Plan will pay 100% of these expenses up to the following maximums:

Years of Service:	Calendar Year Benefit Amount:
Less than 10	$1,000 per family
10 – 19	$1,500 per family
20 – 29	$2,000 per family
30 or more	$2,500 per family

The Administrative Office must receive requests for reimbursement within one year of the date of service. However, please note that benefits are not paid for:

- expenses that apply toward deductibles;
- co-insurance amounts that are used to satisfy out-of-pocket maximums;
- medicine and drugs purchased without a prescription, including, but not limited to antacids, pain relievers, allergy medications, and cold medicine; and
- expenses that are not deductible under Section 213(d) of the Internal Revenue Code.

PRESCRIPTION DRUG BENEFITS

Prescription drug coverage can play an important role in your overall health, especially in light of the rising cost of prescription drugs. Recognizing the importance of this coverage, the Plan's prescription drug benefits offers two programs, including:

- Contract Pharmacy Network program for your short-term prescription needs, up to a 30-day supply; and
- Mail Order Drug program for your long-term prescription needs, up to a 90-day supply at one time. (Mail order is mandatory for *maintenance* medications after two (2) pharmacy refills.)

Contract Pharmacy Network

The Fund offers you the opportunity to purchase prescription drugs at a greatly reduced cost through a Contract Pharmacy Network. CVS/Caremark continually review medicines and products for the Plan and makes changes to the network formulary list. Drugs that are not on the Contract Pharmacy Network formulary list are not covered under this Plan. If you choose to use a drug that is not on the network formulary list, you will pay the full price for the drug. If your physician believes there are special circumstances with regard to the drug being removed, your physician can contact CVS/Caremark. Here's how it works:

Contract Pharmacy Network (continued)

Each time you need a prescription filled, simply present your identification card to a participating network pharmacist. Your cost for a 30-day supply of a covered prescription drug is $8 for a *generic drug* or $15 for a *brand name drug*. If the brand name drug does not have a generic equivalent your cost is $15. If there is a generic equivalent for the brand name drug, then your cost is $15 plus the cost differential between the brand name and the generic drug.

A *generic drug* is a drug that is called by its basic chemical name and is identical in make-up to a commonly known brand name drug. Generic drugs may be manufactured by a different company than the brand name drug and are usually less expensive.

A *brand name drug* is a drug that is commonly recognized by the name given by the pharmaceutical company that first produced it.

Prescription Drugs Purchased Outside the Contract Pharmacy Network

If you go to a pharmacy that does not participate in the Contract Pharmacy Network, the Fund will pay 50% of the charges after you pay, for a 30-day supply, $8 for a generic or $15 for a brand name covered prescription drug.

If there is no participating pharmacy within your zip code and none within the zip code of the dispensing pharmacy, then the Fund will pay 80% of the charge, after you pay your $8 or $15 share, based on the prescription drug.

Specialty Drugs

These are generally high cost drugs that require education and support from a pharmacist. All specialty drugs prescribed by your physician must be dispensed by CVS/Caremark's specialty pharmacy. In addition to dispensing the drugs, the specialty pharmacy provides you with:

- personalized pharmacy care management services;
- convenient delivery to you, your doctor's office or a local CVS pharmacy;
- medicine and disease-specific education and information; and
- ongoing support.

Contact CVS/Caremark at 1-800-824-6349 for more information. If the specialty drug is obtained in accordance with the established procedures from CVS/Caremark’s specialty pharmacy, the Plan shall pay all but $8 of the cost of each specialty drug which is dispensed with the generic equivalent of a brand name drug or medication, or all but $15 of the cost of such drug which is dispensed with a brand name drug or medication.

Mail Order Drug Program

The Fund also pays benefits for any prescription or refill that is purchased through the Mail Order Drug program. If you use the Mail Order Drug program, your cost for any generic or brand name drug will be $15 generic and $30 brand, for the amount prescribed by your physician, up to a 90-day supply. If there is a generic equivalent for the brand name drug, then your cost is $30 plus the cost differential between the brand name and the generic drug. Mail order is mandatory for maintenance medications after two (2) pharmacy refills.

Generic Substitutions

When available, generic drugs will be substituted for all brand name drugs or medications. If you request a brand name drug when a generic substitution would be available, you must pay the applicable copayment and the difference between the price of the generic and brand name drug.

Covered Prescription Drugs

The Plan covers the following prescription drugs:

- drugs that, under federal or State of Illinois law, require the written or oral prescription of a licensed physician or dentist;
- certain prescription drugs with grandfathered status under the Federal Food, Drug, and Cosmetic Act (FFDCA) that may be legally marketed despite lacking approval from the U.S. Food and Drug Administration (FDA);
- drugs for transgender care subject to established clinical criteria;
- insulin and diabetic supplies, including:

insulin syringe	sugar test tape
needles	acetone test tablets
disposable needles	Benedict's Solution or equivalent
sugar test tablets	

Clinical Management Programs

The prescription drug vendor provides certain programs to help determine the appropriateness of the prescribed drug therapy including specialty medications. These programs evaluate the appropriateness of certain therapies according to evidence-based guidelines both before the initiation of the therapy and on an ongoing basis. These types of clinical programs help ensure patient safety, efficacy and optimal therapeutic benefit. These programs are periodically reviewed and adjusted. These programs include but are not limited to the following:

Clinical Management Programs (continued)

Prior authorization: Prior authorization is required for certain medications to determine the appropriateness of therapy using evidence-based criteria. Approval is needed from CVS/Caremark before the drug is covered by the Plan.

Days Supply Limits and Quantity Limits: Certain categories of prescription drugs are subject to quantity limits per day supply, per dispensing event or both based on recommended dosage, usage, and FDA guidelines.

Generic Step Therapy: Generic Step Therapy is required for certain brand name drugs. Two generic drugs must be tried before the brand name drug is covered. Examples of conditions subject to generic step therapy are high cholesterol, acne and high blood pressure. If you need to take a prescription that is part of this program, please ask your doctor to prescribe the generic first. If you are prescribed a brand drug and the prescription rejects at the pharmacy, please contact your doctor and ask the office to send a prescription for the generic to the pharmacy. If you or your Dependent has a unique medical situation that requires you to keep taking the brand name drug, your doctor can contact CVS/Caremark to request a prior authorization for the brand name drug. If you or your Dependent requests a brand name drug when a generic substitution is required, you will pay the copayment for the brand name drug and the difference between the contracted price of the brand name drug less the remaining contracted price of the generic substituted drug.

Compound Drugs: A compound drug is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized drug that is not otherwise commercially available. Compound drugs generally require prior authorization. If you or your eligible Dependent are prescribed a drug that requires compounding by the pharmacy, CVS/Caremark will conduct a prior authorization review and provide authorization to your doctor before the drug is covered by the Plan. Coverage will be denied for any compound drug, including patches or creams, that includes a component which is not FDA approved for that use, such as certain bulk powders.

Specialty Guideline Management and Specialty Preferred Drug Programs: Specialty guideline management evaluates the appropriateness of therapy for specialty medications according to evidence-based guidelines both before the initiation of therapy and on an ongoing basis. It applies to therapies such as cardiac disorders, pain management, inflammatory bowel disease, pulmonary arterial hypertension, renal disease, rheumatoid arthritis, alcohol and opioid dependency, etc. This is not a complete list. Contact CVS/Caremark at 1-800-824-6349 for more information. If you are taking or starting to take a drug that requires review, CVS/Caremark will work with you and your doctor to assist you through the review process. If a medication that is preferred under the Specialty Preferred Drug program is an option for the patient but the patient chooses to use a non-preferred drug, that drug may not be covered.

Clinical Management Programs (continued)

Opioid Management Program: This program is based on morphine milligram equivalents (MMEs) which is a measure of the number of equivalent milligrams of morphine a drug contains. This program will:

Limit Days Supply: The length of the first fill (when appropriate) will be limited to seven days for immediate release, new, acute prescriptions for members who do not have a history of prior opioid use, based on their prescription claims. A physician can submit a prior authorization request if it is important to exceed the seven-day limit.

Limit Quantity of Opioids: The quantity of opioid products prescribed (including those that are combined with acetaminophen, ibuprofen or aspirin) will be limited up to 90 MME per day (based on a 30-day supply). Prescribers who believe their patient should exceed CDC Guideline recommendations can submit a prior authorization request for up to 200 MME per day unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME per day. Quantities higher than that would require an appeal. Opioid products containing acetaminophen, aspirin, or ibuprofen will be limited to 4 grams of acetaminophen or aspirin, and 3.2 grams of ibuprofen per day.

Require Step Therapy: Use of an immediate-release (IR) formulation will be required before moving to an extended-release (ER) formulation, unless the member has a previous claim for an IR or ER product, or the prescriber submits a prior authorization.

Prescription Drug Expenses Not Covered

In addition to any general Plan exclusions, the following expenses are not covered:

- drugs or medications that are payable under any other benefits provided by this Plan;
- medicines not requiring a prescription;
- appliances, devices, prosthetics, bandages, heat lamps, braces, splints, and other non-drug items;
- contraceptives or contraceptive materials to prevent pregnancy, except when medically necessary for other than pregnancy and must be pre-authorized by the Administrative Office;
- blood and blood plasma, immunization agents, and biological sera;
- drugs or medications prescribed as a result of occupational injuries or illnesses;
- any drugs or medications not medically necessary for the care or treatment of bodily injuries or illnesses;
- Viagra, Cialis, Levitra, or any similar drug;
- smoking deterrents;

Prescription Drug Expenses Not Covered (continued)

- drugs that are considered experimental or not approved by the FDA; except that certain prescription drugs with grandfathered status under the FFDCA that may be legally marketed despite lacking approval from the FDA;
- drugs for infertility treatment in excess of the combined maximum of $10,000 per person per lifetime for medical evaluation, treatment and prescription drugs;
- Sprinraza™ (nusinersen) or Brineura™ (cerliponase alfa); or
- drugs that are not on the Contract Pharmacy Network formulary list.

DENTAL BENEFITS

Dental benefits can help pay for a broad range of dental services and treatment. You and your Dependents are covered for dental benefits for services performed by a *dentist*.

A *dentist* is a licensed dentist or physician licensed to provide certain dental services while practicing within the scope of his or her license.

Dental benefits cover expenses you have for preventive, basic, major, and implant dental services. In addition, orthodontia benefits are available for Dependent children only.

DENTAL NETWORK

To help control the high costs often associated with quality dental care, the Plan has entered into an agreement with a Dental Network. The Dental Network is a network of dentists who have a special arrangement with the Plan to provide you with high quality dental benefits at reduced, pre-negotiated rates. The benefits of utilizing a provider that participates in the Dental Network include:

- reduced out-of-pocket expenses due to negotiated fee discounts;
- protection from balance billing;
- no referral required for specialty dentists; and
- contracting dentists submit claims on your behalf.

Of course you may go to any dentist you wish. However, if you use a dentist that does not participate in the network, you may pay more than you would if you went to a Dental Network provider. For more information about the Plan's Dental Network provider or for a listing of Dental Network providers, contact the Administrative Office.

DNoA is currently the Plan's dental network. To find a contracting dentist and maximize your savings, visit www.dnoa.com, or call 866-LABOR-L-U (866-522-6758) from 8:00 a.m. to 6:00 p.m. (central time), Monday through Friday.

HOW THE DENTAL PLAN WORKS

Annual Deductible

Before the Plan pays certain benefits, you must first meet the deductible. The annual deductible is $50 per person. The deductible applies to Type B, Type C, and Type E Services described below.

How the Plan Pays Benefits

After you meet the calendar year deductible (except for Type A and D Services), the Plan will reimburse you for covered expenses. You are covered for services and supplies customarily used for treatment of that condition and only if it's provided according to accepted standards of dental practice.

Plan Maximums

The maximum benefit the Plan will pay for Type A, Type B, and Type C Services is $1,500 per calendar year for each covered person.

The calendar-year limit on pediatric dental services is removed, defining "pediatric" as for a child up to age 18; and, defining "services" as essential services such as dental exams, dental preventive, general and replacement treatment (Dental Type A, B, and C Services).

There is a lifetime orthodontic benefit of $2,000 for each Dependent child (Type D services).

There is a $3,500 lifetime maximum for each covered person for implants (Type E Services).

COVERED EXPENSES

Type A Services – Preventive

The Plan pays at 100% of covered expenses, no deductible, for the following preventive services up to the $1,500 annual maximum. There is no maximum for "pediatric" dental services.

- routine oral examinations and prophylaxis (scaling and cleaning of the teeth). This benefit is limited to twice in a calendar year;
- topical application of fluoride for children up to age 19. This benefit is limited to one application each calendar year;
- sealants for children up to age 19. This benefit is limited to one application each calendar year;
- space maintainers that replace prematurely lost deciduous (baby) teeth; and
- emergency palliative treatment (treatment of pain or toothache).

Type B and Type C Services – General and Replacement

The Plan pays 85% of covered expenses for the following general replacement services after the calendar year deductible is met, up to the $1,500 annual maximum. There is no maximum for “pediatric” dental services.

- dental X-rays, including full mouth X-rays (but not more than once in any 36 consecutive month period), supplementary bitewing X-rays (but not more than once in any consecutive six-month period), and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment;
- extractions;
- oral surgery;
- amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations;
- general anesthetics when medically necessary and administered in connection with oral or dental surgery;
- treatment of periodontal and other disease of the gums and tissues of the mouth;
- endodontic treatment, including root canal therapy;
- repair or re-cementing of crowns, inlays, onlays, bridgework or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any 36-consecutive month period;
- inlays, onlays, gold fillings, or crown restorations, but only when the tooth, as a result of extensive cavities or fracture, cannot be restored with amalgam, silicate, acrylic, synthetic porcelain, or composite filling;
- treatment for temporomandibular joint syndrome;
- initial installation of fixed bridgework (including inlays and crowns as abutments);
- initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation); and
- replacement of an existing or partial or full removable dentures or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial, removable denture, or bridgework, or to replace extracted natural teeth, but only if:
  - the replacement or addition of teeth is required to replace one or more additional natural teeth and after the existing denture or bridgework was installed;
  - the existing denture or bridgework was installed at least five years before its replacement and cannot be made serviceable; and
  - the existing denture is an immediate temporary denture that cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

Type D Services – Orthodontia

The Plan pays 85% of covered expenses for the following orthodontic services, up to the $2,000 lifetime maximum, for Dependent children:

- orthodontic diagnostic procedures;
- initial and subsequent, if any, installations or orthodontic appliances; and
- surgical therapy and functional therapy, including related oral examinations, surgery, and extractions.

Type E Services – Implants

The Plan pays 85% of covered expenses for implants after the calendar year deductible is met, limited to the $3,500 lifetime maximum. Implants are covered only if:

- the treatment is pre-approved; and
- the implant is FDA approved and ADA acceptable or provisionally acceptable.

PRE-DETERMINATION

Often there is more than one way to treat a dental condition and the differences in cost may be substantial. Pre-determination helps you make an informed decision before a treatment begins by letting you know in advance how much the Plan will pay for certain services. So, when your dentist recommends treatment that is expected to be $500 or more, he or she may submit a pre-treatment plan to the Administrative Office before the work begins.

The dentist must supply complete dental records, including X-rays and details concerning the services your dentist proposes to complete and the charges for those services. After reviewing the pre-treatment plan, the Administrative Office will determine the level of benefits the Fund will provide.

Alternative Course of Dental Treatment

In determining the amount of benefits payable, the Administrative Office may consider alternate courses of treatment appropriate to your condition and capable of accomplishing the desired results. They may base their determination on such an alternative that is:

- customarily employed nationwide in the treatment of the condition; and
- recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice, taking into account the total oral condition of you or your Dependent.

If this happens, and both you and your dentist agree to proceed with the original course of treatment, or agree to a charge higher than the amount allowed by the Administrative Office, you will be responsible for paying any excess cost incurred.

DENTAL EXPENSES NOT COVERED

In addition to any general Plan exclusions, the following expenses are not covered under the Plan:

- treatment by other than a licensed dentist, except for cleaning of teeth performed by a licensed dental hygienist, under the supervision and direction of a dentist;
- dental care that is included as a covered expense under any medical or comprehensive major medical expense benefit;
- a dental expense that is due to illness or injury that is related to any occupation or employment for wages or profit;
- courses of dental treatment that are received or started before the date you became entitled to dental care benefits or the date dental coverage begins for your participating Union. Treatment is considered started:
  -for restorative services and endodontic services, when the tooth is prepared; or
  -for fixed or removable prosthodontics, when the impression for the appliance is taken;
- treatment of any condition caused by war, or by any act of war, declared or undeclared, or by participating in a criminal enterprise or unlawful behavior;
- replacement of a lost or stolen prosthetic device;
- charges for failure to keep a scheduled appointment with a dentist;
- charges for porcelain or plastic pontics or facings on crowns posterior to the second bicuspid;
- extraction of exfoliating deciduous (baby) teeth;
- service with respect to congenital or development malformations or dentistry for purely cosmetic reasons, including, but not limited to, cleft palate, maxillary and mandibular malformation, enamel hypoplasia, fluorosis, and anadenia except for Type D Services;
- charges for the completion of dental care claim forms;
- orthodontia or correction of malocclusion, except as specifically provided in the Plan;
- replacement of an existing prosthodontic appliance unless evidence satisfactory to the Board of Trustees is presented that the existing appliance:
  -was installed at least five years before its replacement and the existing appliance cannot be made serviceable; or
  -is a temporary appliance;
- charges for implants, except as specifically provided by the Plan; and
- expenses that exceed allowable charges.

VISION CARE BENEFITS

The Vision Care portion of the Plan helps pay for your eye care needs. The annual maximum benefit is $300 per person for all covered services. There is no maximum for pediatric vision essential services, defining "pediatric" as for a child up to age 18; and, defining "services" as essential services such as vision exams.

While you may go to any qualified provider, the Fund offers you discounted prices on covered services and supplies through the EyeMed Vision Care Network. To find a network provider, call 1-866-723-0514 or visit their website at www.eyemedvisioncare.com.

HOW THE VISION CARE PLAN WORKS

Eye Examinations

Benefits are available for an eye examination that is performed by an ophthalmologist, optometrist, or another physician who is licensed to perform vision examinations and prescribe lenses.

Lasik Surgery

Lasik surgery is covered for you and your spouse up to a lifetime maximum of $1,000 per eye per person. Lasik surgery includes:

- FDA-approved indications and indications accepted by the American Academy of Ophthalmology, refractive surgical procedures, such as radial keratotomy (RK), anterior lens keratotomy (ALK), astigmatic keratotomy (AK), photorefractive keratectomy (PRK), photo astigmatic refractive keratectomy (PARK), laser-assisted in situ keratomileusis (LASIK), keratomileusis, epikeratophakia implementation of intrastromal corneal ring segments and other refractive surgical procedures.

Lenses/Frames or Contact Lenses

Coverage is available for lenses and frames or contact lenses each calendar year up to the annual maximum.

VISION CARE EXPENSES NOT COVERED

In addition to any general Plan exclusions, the following expenses are not covered under the Plan:

- services or supplies payable under any other benefits provided by the Plan;
- sunglasses, plain or prescription. Tinted glasses with a tint above two will be considered sunglasses;

VISION CARE EXPENSES NOT COVERED (continued)

- orthoptics, vision training, or aniseikonia lenses, except as provided otherwise by the Plan;
- any material furnished before the date on which you or your Dependents become eligible for benefits;
- charges for failure to keep a scheduled appointment;
- care or services provided free, or that would have been provided free if this Plan were not available;
- expenses that may be paid under Workers' Compensation, occupational disability, or similar laws; and
- expenses incurred for surgical correction of refractive errors and refractive keratoplasty procedures that are not FDA-approved, including, but not limited to, radial keratotomy (RK) and anterior lens keratotomy (ALK), except as described on page 40.

EXTENDED BENEFITS

If you order frames while you are eligible for benefits under the Plan, but receive them after your coverage terminates, your purchase of frames or lenses will still be covered if they are received within 31 days after coverage ends.

GENERAL EXCLUSIONS

In addition to any exclusions already mentioned, the Fox Valley Laborers Health and Welfare Fund will not cover the following expenses:

- charges that exceed the allowable charge for the services provided or for which payment is not legally required;
- injury or illness that is related to any occupation or employment for wage or profit;
- injury or illness for which you or your Dependent are not under the care of a provider who is recognized by the Fund as an eligible provider;
- injury or illness arising out of war, declared or undeclared, or service in any military or civilian noncombatant unit serving with such forces;
- injury or illness arising out of the voluntary participation in the commission of a felony or involvement in a criminal enterprise except where the injury results from an act of domestic violence or a medical condition (including both physical and mental health condition);
- service or supplies provided by a hospital owned or operated by the United States government or agency, or a physician employed by the United States government or agency if the service or supplies is provided as a result of a service-related illness or injury;
- care or treatment in any penal institution or jail facility or jail ward of any state or political subdivision;
- any care or treatment not specifically covered under the Plan, regardless of whether or not the provider is licensed to perform the treatment;

GENERAL EXCLUSIONS (continued)

- transplants not specifically listed as covered under the Plan;
- complications of non-covered procedures (i.e. removal of breast implants when originally performed as a cosmetic procedure);
- vision therapy (orthoptics) unless it is performed by an optometrist in lieu of a surgical procedure;
- treatment rendered by you or your Dependent's spouse, child, brother, sister, or parent;
- court-ordered care;
- injuries incurred by you or your Dependent caused by the use of or as a result of the influence of an illegal substance as established by the Fund through a review of medical evidence;
- injuries sustained in a motor vehicle accident if you or your Dependent was operating the vehicle and if the Fund is able to establish through medical evidence that you or your Dependent's blood alcohol content at the time of the accident was in excess of twice the legal limit of the jurisdiction in which the accident occurred; or
- any service or supplies provided without charge or paid for by a governmental unit, employer, benefit association, union, or similar group, or for which no charge would be made in the absence of benefits.

LOSS OF TIME BENEFITS

The Plan can help replace part of your income if you become disabled and cannot work. Loss of time benefits help you meet your financial obligations when you are unable to work because of a non-occupational accident or illness. To receive this benefit, you must be eligible under the Plan, totally disabled, unable to perform your job, and under the care of a medical doctor.

Benefits begin on the first day of your injury or illness. Successive periods of disability not separated by a return to active employment of at least 90 consecutive days will be considered as one period of disability.

Your weekly Loss of Time benefit cannot begin until a claim form is completed by you and your physician and returned to the Administrative Office. In addition, you must submit an updated claim form to the Administrative Office every four weeks. No benefits are payable if Workers' Compensation or similar benefits are available.

For Active Participants, the maximum benefit you may be eligible to receive is $600 per week for up to 26 weeks of disability.

LOSS OF TIME BENEFITS (continued)

For Non-Bargained Participants, the weekly amount is a percentage of your weekly salary, up to a maximum of $600 per week for up to 26 weeks of disability. The percentage is equivalent to:

$$\frac{\text{A Journeyman Laborer's Weekly Loss of Time Benefit}}{\text{The Journeyman Laborer's Weekly Wages}}$$

DEATH AND ACCIDENTAL DISMEMBERMENT BENEFITS

Providing for your family in the event of your death or accidental dismemberment is an important part of your overall financial protection. That's why the Fund offers death benefits and an accidental dismemberment benefit.

Participant Death Benefit

The Fund offers financial protection to your designated beneficiary by providing a benefit if you die from any cause while you are eligible. The amount of the benefit is based on your length of service under the Plan, as follows:

Years of Service	Amount of Benefit
Less than 5	$20,000
5 – 29	$40,000
30 or more	$50,000

This benefit is paid to your designated beneficiary, see page 45.

Dependent Death Benefit

If your spouse or child dies from any cause while you are covered as an Active participant under the Fund as your Dependent, you will receive a Dependent death benefit. The amount of the benefit is shown on the following chart:

Eligible Dependent	Amount of Benefit
Spouse	$3,000
Child	$2,000

This benefit is paid directly to you, the Participant.

Accidental Dismemberment Benefit

The Fund provides a benefit up to $10,000 if you have a serious injury that occurs solely through accidental means--either on or off the job. This benefit is in addition to any other benefit you may be eligible to receive. The amount you receive as an accidental dismemberment benefit is based on your specific loss.

Accidental Dismemberment Benefit (continued)

The loss must have occurred within 90 days from the date of the accident. In addition, if one accident results in more than one loss, only one amount--the largest to which you are entitled--is payable.

Dismemberment means severance of a limb at or above the wrist or ankle joint. Loss of sight means the total and permanent loss of sight.

The benefit is paid directly to you. The amount of benefit is shown in the chart below:

Covered Loss	Benefit
Both hands, both feet, or sight of both eyes	$10,000
One hand and one foot	$10,000
One hand or foot and the sight of one eye	$10,000
One hand or one foot	$ 5,000
Sight of one eye	$ 5,000

Designating a Beneficiary

A beneficiary is the person or persons you designate to receive your benefit in the event of your death. To designate or change your current beneficiary, you must complete a Beneficiary Designation form. This form is available at the Administrative Office.

If you do not designate a beneficiary, or if the person you name dies before you, your death benefit will be paid to the first living family member(s) on the following list:

First:	to your spouse; if your spouse is not alive, then
Second:	to your children (including legally adopted children), in equal shares; if none are alive, then
Third:	to your parents, in equal shares; if none are alive, then
Fourth:	to your brothers or sisters, in equal shares; if none are alive, then
Fifth:	to your estate.

MEMBER ASSISTANCE PROGRAM (MAP)

The Health and Welfare Fund provides a Member Assistance Program (MAP) with integrated Work-Life Services through Employee Resource Systems (ERS) to our Participants.

The Member Assistance Program provides you with access to free counseling services designed to help you and your family deal with a variety of challenges. MAP Counselors and WORK-LIFE Consultants are available to provide support, resources and referrals.

MAP can provide support with challenges such as:

- alcohol and substance abuse
- marital and family problems
- parenting challenges
- divorce and separation adjustment
- death of a loved one
- stress management
- budgeting and finances
- legal concerns
- identity theft recovery
- gambling additions
- other personal and emotional problems

WORK-LIFE Consultants are available to provide resources and referrals for:

- home maintenance and repair
- childcare/eldercare resources
- pet care/daily living
- dining and entertainment
- skill builder online courses

When you or a family member has a personal challenge, you can contact an ERS counselor 24 hours-a-day, 7 days-a-week by calling 1-800-292-2780. Local ERS representatives are available from 8:30 a.m. until 5:30 p.m. (central time), Monday through Friday. After standard business hours, the ERS phones are answered by a clinical response team who can provide immediate assistance.

The Union Select Work-Life Services program also offers free access to web-based resources such as monthly webinars and information for daily living, emotional well-being, family and care giving as well as health and wellness issues. You can access this program by going to www.ers-eap.com and entering the following login:

Username: laborers
Password: foxvalley

MEMBER ASSISTANCE PROGRAM (MAP) (continued)

Through the MAP, you and your family members can receive up to three (3) free counseling sessions per incident with an ERS counselor. There is no cost to you for these sessions. If the ERS counselor believes an issue relating to mental health or alcohol and substance abuse cannot be addressed in three sessions or if a more intensive level of care is required, you or your family member will be referred to an in-network provider for continued treatment under the terms and conditions of our health plan. The cost of additional services to treat your problem or other issues, beyond the sessions provided by the MAP, will be your responsibility.

RETIREE COVERAGE

Benefits

As a retiree receiving a pension benefit from the Fox Valley and Vicinity Laborers Pension Fund, you are eligible for all medical, prescription drugs, dental, vision and member assistance program benefits under the Plan. (See page 58 for additional information regarding Coordination of Benefits with Medicare.) In addition, you are eligible for the Death Benefit. Please note that only Active Participants are eligible for the spouse and Dependent Death Benefit, the Accidental Dismemberment Benefit, and the Loss of Time Benefit. The Trustees reserve the right to amend the Retiree plan of benefits and/or the self-payment rules.

Non-Bargained Participants

If you are a Non-Bargained Participant whose employment terminates due to retirement and you are not receiving pension benefits from the Fox Valley and Vicinity Laborers Pension Fund, you shall not be eligible to continue coverage under the Plan as a Retiree.

Eligibility

Retiree health care benefits are available to you if you meet the following requirements:

- you have at least 15 years of service under the:
  -Fox Valley and Vicinity Laborers Pension Fund, with a maximum of 50% of those years granted under reciprocal agreements; or
  -Fox Valley Laborers Health and Welfare Plan (for retiree eligibility purposes, a year of service is 500 or more hours of contributions made to this Plan on your behalf in a Plan year, which is June 1 – May 31); and
- you are receiving early, normal, or disability pension benefits each month from the Fox Valley and Vicinity Laborers Pension Fund and you were eligible for welfare benefits under this Fund for at least one benefit quarter within the four benefit quarters immediately before you retired; or

Eligibility (continued)

- you are receiving a 30-and-out pension benefit each month from the Fox Valley and Vicinity Laborers Pension Fund and you had at least 1,000 hours in the four contribution quarters (through employer contributions, self-payment, or disability hours) immediately before you retired.

At least 60 days before your retirement, you must complete the application form provided, and return it to the Administrative Office. You are required to self-pay for coverage for you and your Dependents.

Your participation begins on the later of the first day of the benefit quarter following the date your written application and first self-payment are received by the Administrative Office or the first day of the benefit quarter following the date of your retirement. You will then be sent a quarterly status report informing you of the amount payable and the date that your next payment is due.

Self-payment amounts are based on your age and number of years of service under the Fox Valley and Vicinity Laborers Pension Fund. However, for those who are eligible due to service under the Fox Valley Laborers Health and Welfare Plan, the self-payment amount will be the full cost of the coverage, as determined by the Trustees. Your coverage cannot start before you start receiving your pension.

Failure to make quarterly payments will end your rights to make further payments. If you lose benefit coverage through this program because you fail to make the required self-payments, you will not be eligible to have your coverage reinstated. The payment schedule is shown on the following chart:

Quarterly Payment	Due in Administrative Office No Later Than	Determines Eligibility for 3 Months Beginning
November, December, January	March 31	April, May, June
February, March, April	June 30	July, August, September
May, June, July	September 30	October, November, December
August, September, October	December 31	January, February, March

Surviving Spouse Coverage

Under certain circumstances, in the event of your death while covered under the Plan as a retiree, your surviving spouse may be eligible to continue coverage by making self-payments at the monthly rate specified by the Board of Trustees. For your surviving spouse to be eligible, you must have:

- been eligible as a retiree under this Plan at the time of your death; and
- had 20 years of service with the Fox Valley and Vicinity Laborers Pension Fund, with no more than 10 of those years earned under a reciprocal plan.

Surviving Spouse Coverage (continued)

Your surviving spouse's eligibility for coverage will end on the earliest of the date:

- the required self-payment is not made;
- your surviving spouse remarries;
- your surviving spouse becomes covered under another employer sponsored group health coverage plan; or
- the date your surviving spouse dies.

COBRA continuation coverage may be elected instead of this surviving spouse coverage or, if your surviving spouse chooses surviving spouse coverage and it ends before 36 months after your death, your surviving spouse may elect COBRA continuation coverage for the balance of the 36-month period.

When Coverage Ends

Your eligibility for retiree health care coverage will end on:

- the first day of the benefit quarter that your self-payment is not received by the Administrative Office;
- the date this Fund ends or terminates coverage for retired Participants;
- the date you no longer meet the requirements for a disability pension, if you are a disabled pensioner; or
- the date of your death.

Your Dependents' eligibility will end on:

- the date your coverage ends. However, if you die, coverage for your Dependents will continue until the last day of the benefit quarter in which you died;
- the last day of the month in which the date your Dependent no longer meets the definition of a Dependent occurred (see page 4);
- the first day of the benefit quarter that self-payment is not received by the Administrative Office; or
- the date the Fund ends or terminates coverage for retired Participants.

ADMINISTRATIVE INFORMATION

This section describes how to file claims, the procedure for having claims reviewed, the Fund's rules about right to recovery and subrogation, your legal rights under the Fund, and other administrative information.

How to Claim Benefits

Claim forms are available from your Local Union or the Administrative Office and should be completed by you and your attending physician. Claims should be submitted as follows:

COVERAGE	CLAIMS ADMINISTRATOR
Vision, family supplemental, loss of time, death or accidental dismemberment	Administrative Office 2371 Bowes Rd, Suite 500 Elgin, IL 60123-5523
Medical – Network and Out of Network	BCBS P.O. Box 805107 Chicago, IL 60680
Medical – Medicare and Coordination of Benefits	Administrative Office 2371 Bowes Road, Suite 500 Elgin, IL 60123-5523
Dental	DNoA P.O. Box 21553 Eagan, MN 55121
Prescription Drugs	CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467

If you wish the Fund to pay the hospital or doctor directly, you should sign an assignment of benefit form when you establish your claim, or payment will be made to you.

To complete your claim payment, the Administrative Office needs the following information, as applicable:

- a claim form completed by both you and your attending physician;
- an itemized statement from the hospital;
- an itemized physician's bill;
- a completed assignment form, if you want the Fund to pay benefits directly to the hospital or provider of services;
- all other medical bills;
- prescription drug bills not reimbursed through the Contract Pharmacy Network should state the name of medication, prescription number and prescribing physician's name;
- if your spouse is employed and covered through group insurance, submit a copy of the other carrier's Explanation of Benefits (EOB) form; and
- any provider medical records deemed necessary by the Administrative Office.

How to Claim Benefits (continued)

No claim will be paid unless an enrollment form is on file at the Administrative Office.

When to File Your Claim

Medical, Prescription Drug, Dental, or Vision Care (health care claims). Your claim for all medical, prescription drug, dental or vision care benefits should be submitted within one year of the date charges were incurred to be paid. **However, failure to submit a claim on a timely basis will not invalidate any claim if you can provide proof that the claim was furnished as soon as reasonably possible.** Contact information for medical, prescription drug and dental claims is referenced on your benefit identification card.

Family Supplemental. To file a Family Supplemental Benefit claim, you must submit a Family Supplemental Benefit Claim Form, along with your itemized bill and receipt of payment or your Explanation of Benefits (EOB) from the Administrative Office relating to the claim. You must file your Family Supplemental Benefit within one year from the date the expense is incurred. Remember, if you do not use a Family Supplemental Benefit Claim Form, the Administrative Office may not recognize your claim as being submitted for this benefit, which may result in your claim being delayed or denied. Family Supplemental Benefit claims will then be processed like all other health care claims.

Loss of Time, Death, or Accidental Dismemberment. Your beneficiary should apply for death benefits. You need to apply for loss of time, Dependent death, and dismemberment benefits. To apply for death benefits, a death certificate and a completed beneficiary form must be submitted. To apply for loss of time or dismemberment benefits, a claim form completed by you and your doctor must be submitted. All applications should be submitted to the Administrative Office within 90 days following disability, death, or injury, or as soon as is reasonably possible.

Notify the Administrative Office by completing a new enrollment form of any change in your:

- home address;
- Local Union membership;
- beneficiary;
- marital status; or
- dependents.

You may be required to provide additional information to process your claim. Enrollment forms may be obtained at your Local Union office, the Administrative Office, or online at www.fvlab.com.

It is extremely important to keep the Administrative Office informed of any change in address, marital status, or desired change in beneficiary. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility for benefits.

CLAIM DECISIONS

When you submit a claim for benefits, the Administrative Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any.

Generally, all claims will be paid as soon as possible after acceptable proof is received. The deadlines differ for the different types of claims as shown in the following information. 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. 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.

Health Care Claims. An initial determination will be made within 30 days from receipt of your claim. If the Administrative Office determines 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.

Loss of Time Claims. An initial determination will be made within 45 days from receipt of your claim. If the Administrative Office determines 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 deadline that up to 30 additional days may be needed.

Death and Accidental Dismemberment Claims. Generally you will receive written notice on a decision on your claim within 90 days after the Plan receives your claim. If the Administrative Office determines 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 your claim is denied (in whole or in part), you will be notified by the deadlines previously described. The notice will include:

- the specific reason or reasons for the decision;
- reference to the Plan provisions on which the decision 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; and
- a copy of the Plan's claims review procedures and time periods to appeal your claim, plus a statement of your right to bring a lawsuit under ERISA Section 502(a) following the denial of your appeal.

In addition, for ***health care*** claims, the notice will include a statement that a copy is available to you at no cost, upon request, of:

- any internal rule, guideline, protocol, or similar criteria if such internal rule, guideline, protocol, or similar criteria was relied on in deciding your claim; or

Death and Accidental Dismemberment Claims (continued)

- any scientific or clinical judgment if your claim is denied due to medical necessity, experimental treatment, or similar exclusion or limit; or
- in the case of an urgent care claim, a description of the expedited review process.

You have the right to request and receive reasonable access to and copies of relevant documents, records and other information free of charge. Relevant documents, records and other information are those that:

- were relied upon in making the benefit determination;
- were submitted, considered or generated in the course of making the benefit determination;
- demonstrate compliance with the Plan's processes or safeguards; and
- in the case of health care benefit, constitute a statement of the Plan's policy or guideline regarding the benefit for your diagnosis, whether relied upon or not.

For ***loss of time*** claims, the denial will include an explanation in a culturally and linguistically appropriate manner for any disagreement with:

- the findings of the health care and vocational professionals who evaluated or treated you;
- the views of medical or vocational professionals obtained on the Plan's behalf without regard to whether the advice was relied upon in making the benefit determination;
- a determination made by the Social Security Administration; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appealing a Denied Claim

If your claim is denied (in whole or in part) or you disagree with the determination in regards to your eligibility for benefits or the amount of the benefit, you have the right to have the initial decision reviewed. In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Administrative Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered. 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 Administrative Office as soon as possible. However, you must file your written appeal within:

- 180 days after you receive the notice of denial for ***health care*** or ***loss of time*** claims; or
- 60 days after you receive the notice of denial for ***death*** or ***accidental dismemberment*** claims.

Appealing a Denied Claim (continued)

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Administrative Office authorizing this representative. A health care professional that has knowledge of your medical condition may act as your authorized representative for health care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- submit additional materials, including comments, statements, or documents; and
- request to review all relevant information (free of charge).

Post-Service Claims

A decision of your appeal will be made by the Board of Trustees at the Trustees' meeting following the receipt of your appeal. If your appeal is received within 30 days of a Trustees' meeting, then the decision will be made at the next scheduled Trustees' meeting. If there are special circumstances, then the decision will be made at the third meeting following receipt of your claim. You will be notified of the determination on the claim within five days of the determination.

If you receive an adverse benefit determination following the final appeal, you have the right to bring a civil action under Section 502(a) of ERISA.

Pre-Service and Urgent Care Claims

If your appeal involved pre-approval of urgent care, you will be notified of the Trustee's decision about your appeal as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of your request for review.

An urgent care claim is a claim for medical treatment of a condition that would seriously jeopardize your life or subject you to severe pain that cannot be adequately managed without medical care. In the case of other (non-urgent) pre-approvals, you will be notified no later than 30 days after receipt of your request for review.

If the Trustees do not respond to your appeal within 72 hours for urgent care claims or 30 days for other pre-service claims, the appeal will be considered approved.

Appeal Decisions

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 Plan will not take into consideration the initial benefit decision. An appropriate fiduciary of the Plan, the Appeal Review Committee, will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, of the decision on any appeal within five calendar days after the determination is made. The notice will include all legally required information. A determination of your appeal will be made at the next quarterly Appeal Review Committee meeting. However, the determination may be made at the second quarterly meeting if the appeal is received within 30 days of the first quarterly meeting. If special circumstances require an extension of time, a decision may be made at the third quarterly meeting following receipt of your request for review. Although it is not necessary, you (and/or your designated representative) may attend the meeting.

If circumstances require an extension of time for deciding your appeal, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision.

You must exhaust the appeal process before you can take any legal action.

In addition, for ***loss of time*** claims, you are entitled to the following:

a. prior to the date the Plan issues an adverse benefit determination on an appeal of a loss of time benefit claim, the Plan shall provide you, free of charge, with any new or additional evidence considered and relied upon in making the benefit determination 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 you a reasonable opportunity to respond prior to that date; and
b. prior to the date the Plan can issue an adverse benefit determination on an appeal of loss of time benefit claim based on a new or additional rationale, the Plan shall provide you, free of charge, with 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 you a reasonable opportunity to respond prior to that date.

Medical Judgments

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

- has appropriate training and experience in the field of medicine involved in the medical judgment; and

Medical Judgments (continued)

- 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, upon request, of any medical experts consulted in making a determination of your appeal.

Board of Trustees' Discretion and Authority

All benefits under the Plan are subject to the Trustees' authority under the terms of the Plan. 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 terms, the Trustees or persons acting for them have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan 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 awarded judicial deference. Benefits under this Plan will be paid only when the Board of Trustees (or persons delegated by the Trustees) decides, in their discretion, that the 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.

COORDINATION OF BENEFITS

You may be entitled to receive benefits under the Fox Valley Laborers Health and Welfare Fund and *another group health insurance plan,* for example, if your spouse works and also has group health insurance.

For purposes of this coordination of benefits provision, another group health insurance plan is:

- another group, blanket, or franchise plan;
- service plan contracts, group practice, individual practice, and other prepayment coverage;
- labor-management trustee plans, union welfare plans, or employee benefit organization plans; and
- any coverage under governmental programs and any coverage required or provided by any statute that provides benefits or services for hospital, medical, prescription drug, dental, and vision care or treatment.

COORDINATION OF BENEFITS (continued)

In these situations, the two plans will coordinate their benefit payments so that the combined payments of both plans will not be more than your actual covered expenses. One plan (the primary plan) will pay its full benefits. Then, the second plan will consider any covered expenses that are not completely covered by the first plan's benefits. No plan pays more than it would without the coordination of benefits provision.

If the other plan seeks to limit benefits payments in the presence of secondary coverage to a nominal amount, this plan will pay benefits only up to an amount not to exceed 20% of the allowable expenses incurred.

The order of payment between the plans is as follows:

- the health care plan without a coordination provision similar to this one will always pay first;
- if the patient is both covered as an active employee or as a Dependent of an active employee and coverage under another health care plan as either a laid-off employee, a retired employee, or a Dependent, then the active employee's health care plan will have primary responsibility;
- the health care plan listing the patient as the employee (rather than a Dependent) will pay first;
- a Dependent child whose parents are not separated or divorced and who is covered under both parents' health care plans will receive coverage as follows:
  - the plan of the parent having his or her birthday earlier in the calendar year, (i.e., month and day) will have primary responsibility;
  - the health care plan covering the parent longer will have primary responsibility, if the parents have the same birthday; or
  - if the other health care plan does not have a "birthday" provision and uses another rule to determine primary responsibility, that rule will determine which plan is primary;
- a Dependent child covered either by divorced or separated parents that have no court decree of financial responsibility for the child's health care expenses, will receive primary coverage under the custodial parent's health care plan.
  If the parent with custody remarries, we use the following order to determine primary responsibility:
  - the plan of the parent with legal custody;
  - the plan of the stepparent with legal custody; then
  - the plan of the parent without legal custody.

A Dependent child covered by either divorced or separated parents that has a court decree specifying which parent has financial responsibility for the child's health care expenses will have primary coverage under that parent's plan if that parent's plan has actual knowledge of that decree.

COORDINATION OF BENEFITS (continued)

This Plan will pay first for a Dependent child enrolled in Medicaid or a state CHIP.

- If none of the above apply, or if there is a conflict, the plan that has covered the person for the longer time will pay first.
- If the other plan that covers the patient is Medicare, the benefits of this Plan will be determined before the benefits of Medicare are determined, unless federal law specifies otherwise.

Coordination of Benefits with Medicare

You don't have to be retired to be eligible for Medicare. Once you or your spouse reach age 65, you are eligible for Medicare benefits even if you are still working. Some people become eligible for Medicare before age 65, such as people who are disabled as defined by the Social Security Administration or people with end stage renal disease (ESRD). However, you must enroll in Medicare to receive Medicare benefits. To avoid any delay in receiving Medicare benefits, you should apply to your local Social Security office at least three months before you reach age 65.

Medicare consists of four parts: Part A, which provides hospital benefits, Part B which provides medical benefits, and Part C, Medicare Advantage, which is the managed care portion of Medicare and Part D which is prescription drug coverage. Part A is generally provided at no cost to you. There is, however, a premium for Part B and Part D. The Fund does not reimburse the cost of the Medicare Part B or Part D premium. The Fund will pay its benefits as if you have enrolled in Medicare Part B, whether you do or not. If you have enrolled in Medicare Part D you will lose eligibility for all Plan benefits.

The Fund will be primary over Medicare for expenses if you are age 65 or over and covered as an Active Participant. In all other instances, the Fund will have secondary responsibility for you and your Dependents. The Fund will also have secondary responsibility for expenses if you or your Dependent is eligible for Medicare benefits solely because of end stage renal disease where Medicare has primary responsibility.

The Fund will have primary responsibility for expenses for the first 30 months if you or your Dependent is eligible for Medicare benefits solely because of end stage renal disease where Medicare has secondary responsibility. In addition, the Fund will have primary responsibility for expenses if you are an Active Participant and have received Social Security benefits for 24 consecutive months. However, if you or your Dependent is covered under a Medicare private contract arrangement (Part C), services covered under that plan will not be considered a covered expense by the Fund.

Right of Recovery

If you or a Dependent receive any benefits from the Fox Valley Laborers Health and Welfare Fund for services that result from an injury received for which you can make or have made a claim against a third party, the Fund has the right to collect payment from the third party or to be repaid from benefits you recover from a third party.

When you or your Dependents file for benefits under these circumstances, you agree to reimburse the Fund in full for any benefit payments you receive out of the money you recover from the third party. You or your Dependents also agree to take whatever action is necessary and to provide all information, assistance, and paperwork that the Fund requires to enforce its rights.

In order to process the claim(s) related to the injury and comply with the provisions of the Fund, you must complete and sign a Subrogation Acknowledgement and Accident Form acknowledging the Fund's right to reimbursement.

You and your Dependents' rights to receive benefits from the Fund will not be affected in any way by this provision. A failure to execute or honor this assignment may result in the denial of future payment of claims to the extent of such recovery.

Assignment of Benefits

Benefits cannot be assigned, sold, pledged, or transferred to anyone. You may, however, direct benefits that are due to you to be paid to an institution in which you are hospitalized or to any other medical, dental, or vision care provider who provided services.

In addition, the Fund is not liable for or subject to the debts or liabilities of you, your Dependents, or your beneficiary who may be entitled to any benefits under this Plan.

TERMINATION OF BENEFITS

The Board of Trustees intends to continue the benefits described in this booklet indefinitely. However, the Board of Trustees reserves the right to change, discontinue, or terminate the type and amounts of benefits offered by the Fund.

The nature and amount of Fund benefits are always subject to the actual terms of the Plan as it exists at the time a claim occurs.

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 protected health information, as applicable;
- see and copy your health information usually within 30 days of your request;
- 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.

PRIVACY NOTICE

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the Fox Valley Laborers Health and Welfare Fund protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice, which is available for review, free of charge, at the Administrative Office or online at www.fvlab.com. You must make an appointment to review the Privacy Notice.

The Notice explains the possible uses and disclosures of protected health information by the Fund. It also outlines your rights in regards to your health information and the steps the Trust has taken to protect health information and prevent unnecessary disclosures. The Fund distributes the Notice of Privacy Practices at certain times required by law, such as when you became a Participant. You can obtain another copy from the Administrative Office at 2371 Bowes Road, Suite 500, Elgin, Illinois 60123-5523 or online at www.fvlab.com.

This Plan, and the Plan Sponsor (the Board of Trustees) will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health Plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist in providing health care benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy rules.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an

PRIVACY NOTICE (continued)

accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

If you have questions about the privacy of your health information, please contact the Administrative Manager. If you wish to file a complaint about a privacy issue, please contact the Administrative Manager.

GOVERNMENT ASSISTANCE FOR CHILDREN'S COVERAGE

If your eligible child qualifies for health coverage under the Children's Health Insurance Program (CHIP), you may qualify for a government subsidy of the cost of covering the child through the Fund. This subsidy became available April 1, 2009. If this applies to you, please contact the Administrative Office.

NOTICE OF NON-DISCRIMINATION

The Fox Valley Laborers Health and Welfare Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Fox Valley Laborers Health and Welfare Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Fox Valley Laborers Health and Welfare Plan:

- provides free aid and services to people with disabilities to communicate effectively with us, such as:
    - qualified sign language interpreters
    - written information in other formats (large print, audio, accessible electronic formats, or other formats)
- provides free language services to people whose primary language is not English, such as:
    - qualified interpreters
    - information written in other languages

If you need these services, contact Deborah L. French, Compliance Officer at 1-847-742-0900.

If you believe that The Fox Valley Laborers Health and Welfare Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

NOTICE OF NON-DISCRIMINATION (continued)

Deborah L. French, Compliance Officer
2371 Bowes Road, Suite 500
Elgin, IL 60123-5523
1-847-742-0900 or dfrench@fvlab.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Deborah L. French is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Fox Valley Laborers Health and Welfare Fund complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Language assistance services, free of charge, are available.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-696-6775.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-696-5776
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-696-6775。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-696-6775.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-696-6775.
Greek	ΠΡΟΣΟΧΗ: Εάν μιλάτε αγγλικά, οι υπηρεσίες γραμματείας, δωρεάν, είναι διαθέσιμες σε εσάς. Καλέστε 1-877-696-6775.
Gujarati	સાવધાન: જો તમે ઇંગલિશ બોલતા હો, ભાષા સહાય સેવાઓ, નિઃશુલ્ક, તમારા માટે ઉપલબ્ધ છે. 1-877-696-6775 પર કૉલ કરો

Hindi	सावधानी: यदि आप अंग्रेजी बोलते हैं, तो भाषा सहायता सेवाएं निःशुल्क, आपके लिए उपलब्ध हैं। 1-877-696-6775 पर कॉल करें।
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-696-6775.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-696-6775 번으로 전화해 주십시오.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-696-6775.
Russian	В Н И М А Н И Е: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-696-6775.
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-696-6775.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-696-6775.
Urdu	انتباہ: اگر آپ انگلش بولتے ہیں، مفت خدمات، کی مدد کی زبان تو ہیں دستیاب لئے کے آپ چارج 1-877-696-6775. کریں کال کو.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-696-6775.

PATIENT PROTECTION AND AFFORDABLE CARE ACT REQUIREMENTS

Effective June 1, 2011, it was the decision of the Board of Trustees to elect Grandfathered status under the Patient Protection and Affordable Care Act (PPACA) requirements. This means that the Trustees approved amending the Plan to include child coverage to age 26, remove annual and lifetime dollar limits on essential benefits, and to not rescind coverage except for fraud or intentional misrepresentation.

GRANDFATHERED STATUS

The Fox Valley Laborers Health and Welfare Fund believes this Plan is a "grandfathered health plan" under PPACA. As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of PPACA 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 consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 1-847-742-0900. 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 protections do and do not apply to grandfathered health plans.

YOUR ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights:

Receive Information about Your Plan and Benefits

You have the right to:

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

Receive Information about Your Plan and Benefits (continued)

- 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); and
- receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each Participant.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself and 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 any 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 or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures.

Enforce Your Rights (continued)

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 you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been 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 legal 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 nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory or at:

Division of Technical Assistance and Inquires
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

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

- calling 1-866-444-3272; or
- visiting the website of the EBSA at www.dol.gov/ebsa.

OTHER IMPORTANT ADMINISTRATIVE INFORMATION

The Administrative Office will help to resolve any questions or concerns you might have about your rights to benefits. All Plan Documents and other related information are available if you want to review these materials. If, for some reason, it becomes necessary to contact the U.S. Labor Management Services Administration, Department of Labor, you will need the following information to properly identify the Fund:

Name and Address of Plan

Fox Valley Laborers Health and Welfare Fund
2371 Bowes Road, Suite 500
Elgin, IL 60123-5523
1-847-742-0900
1-866-828-0900

Plan Sponsor

Fox Valley Laborers Health and Welfare Fund

Board of Trustees

Employer Trustees

Mr. John P. Bryan
Geneva Construction Company
1350 Aurora Avenue
Aurora, IL 60507
1-630-892-4357

Mr. Brian T. Rausch
IHC Construction Companies LLC
1500 Executive Drive
Elgin, IL 60123
1-847-742-1516

Mr. Michael G. Shales
Shales McNutt LLC
425 Renner Drive
Elgin, IL 60123
1-847-622-1214

Union Trustees

Mr. Vernon A. Bauman
Laborers Local #1035
3819 N. Route 23, Suite A
Marengo, IL 60152
1-815-568-6190

Mr. Martin D. Dwyer
Laborers Local #582
2400 Big Timber Road, Suite 112A
Elgin, IL 60124
1-847-741-7420

Mr. David B. Sheahan
Laborers Local #1035
3819 N. Route 23, Suite A
Marengo, IL 60152
1-815-568-6190

Employer Identification Number (EIN)

36-6219639

Plan Number

501

Type of Plan

The Plan described in this SPD is a “welfare benefit plan” for purposes of ERISA.

Type of Administration

Fox Valley Laborers Health and Welfare Fund is liable for all benefits under the Plan, but the Administrative Office administers payment of claims.

Funding

Employers contribute amounts in accordance with the collective bargaining agreements between union and employer. Participants and beneficiaries may receive from the Fund Administrator, upon written request, information as to whether a participating employer is a sponsor of the Fund, and if so, the sponsor's name and address.

In addition, self-payments are used to finance the benefits described in this booklet.

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.

Plan Year

June 1 to May 31

Plan Administration

The Fund is administered by an Administrative Office as designated by the Board of Trustees.

Agent for Service of Legal Process

For disputes arising under the Plan, legal process may be delivered to:

The Board of Trustees or the Administrative Manager
Fox Valley Laborers Health and Welfare Fund
2371 Bowes Road, Suite 500
Elgin, IL 60123-5523

Or

Baum, Sigman, Auerbach & Neuman, Ltd.
200 West Adams Street, Suite 2200
Chicago, IL 60606-5231

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. All Plan benefits are made available to you and your Dependents by the Plan as a privilege and not as a right.

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.

A FINAL WORD

This booklet provides a summary of the Plan provisions that are of most interest to Fund Participants. The complete details are found in the Plan Document. If there are any discrepancies between the wording of this booklet and the Plan Document, the wording of the Plan Document will govern.

Every effort has been made to accurately explain this Plan in straight-forward language, but you should feel free to contact the Administrative Office if you have any questions.

The benefits described in this booklet are current as of the publication date, but are not guaranteed for the future. The Trustees, to protect the Fund, have the right to amend, delete, add, or change the Plan rules and regulations as they apply to Active and Retired Participants, including the right to add or delete benefits, monetary or otherwise, as circumstances may warrant.

Any changes will be made and adopted by formal action of the Trustees by written resolution and execution. You will be notified in writing of any changes made to the Plan.

This Summary Plan Description in no way creates a contract of employment between the employee and any employer who participates in the Fund.