Chicago Regional Council of Carpenters Welfare Fund

Summary Plan Description for Retirees

Effective January 1, 2019
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A Message from the Trustees

It is very important that our Retirees and their family members are provided with quality, affordable health care. It’s equally important that you know what benefits are available to you and how to use them to your best advantage — both financially and for your health.

This Summary Plan Description or SPD is given to all of our Retirees and their family members as a reference document and a resource you can use to become better acquainted with your benefits and the processes involved in using them. It is meant to be easy to read and understand. When we use the word “he,” it refers to both genders throughout the SPD. We have tried to present the information in a straightforward and logical way.

While we have made an effort to explain things in everyday language, you may come across some words and phrases that have specific meaning within the context of the Plan. To help you identify them, they are bolded and italicized when first used and then capitalized throughout the rest of the SPD. You can find their definitions in the Glossary that starts on page 81.

As always, our Fund Office staff remains ready to serve you and your family, answering questions and providing updates on our benefits as they occur.

Here’s to your very good health and wellness, now and in the future.

The Board of Trustees

If the language in this Summary Plan Description differs in any way from the official Plan Documents that legally govern the terms and conditions of the Welfare Fund, the official Plan Documents rule.
About this Booklet

This booklet provides you with a summary of the Retiree Plan of Benefits (the “Plan” or the “Retiree Plan”) as of January 1, 2019, and replaces and supersedes any prior Summary Plan Descriptions (SPDs). It does not contain all Plan details. In determining any aspect of Plan coverage, the full provisions of the formal Plan Documents always govern.

You may obtain a copy of those documents by making a written request to the Plan Administrator. The Trustees reserve the right to change benefits in any way or terminate the Plan or any part of the Plan at any time, as allowed under law.

Highlights of eligibility requirements and Plan coverage along with the Schedule of Benefits begin on page 25. Plan highlights, including these listed below, start on page 34.

- Detailed benefits coverage;
- Limits and exclusions;
- What happens when benefits terminate under the Retiree Plan;
- How to file Claims and appeals; and
- Other administrative Plan information.

Certain terms used in this document have specific meanings within the context of the Plan and are defined in the Glossary on page 81. You will notice that the first time they appear in the SPD they are bolded and italicized.

Notify Us If:

If you have a change in status, you must notify the Retirement Benefits Department at 312-787-9455, menu option 4, within 90 days to update your information. Changes in status include:

- Change of address;
- Marriage;
- Changes in Dependent eligibility, or if you have a baby, adopt a child or become a step-parent;
- Death of a Dependent;
- Adding or dropping other insurance coverage, including coverage with Medicare or Medicaid; and
- Returning to work.

You must notify the Retirement Benefits Department within 60 days of the following events, in order to avoid forfeiting continuation of coverage rights under COBRA:

- A divorce or legal separation; or
- When your Dependent child no longer meets the Plan’s definition of a Dependent.

You will be required to provide original documentation for the above changes. For more information on required documentation, see page 9.

Furnishing Required Information and Documentation

From time to time, the Fund Office will request that you provide the Board of Trustees with certain documents, information or proof that is needed to determine eligibility for benefits or payment of benefits. If you do not supply the requested information, your benefits may be denied or suspended until you provide the documentation.
### Important Contact Information

The chart below shows phone numbers and website addresses for the providers and Administrators of the Chicago Regional Council of Carpenters Welfare Fund benefit programs.

<table>
<thead>
<tr>
<th>If You Have a Question or Need Information About</th>
<th>Call or Access Online</th>
<th>Phone Number/Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility, premiums, or adding or dropping Dependents</td>
<td>Fund Office – Retirement Benefits Department</td>
<td>312-787-9455, menu option 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.crccbenefits.org">www.crccbenefits.org</a></td>
</tr>
<tr>
<td>Claims status (Hospital and medical claims)</td>
<td>BlueCross BlueShield of Illinois</td>
<td>855-354-1858</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.bcbsil.com">www.bcbsil.com</a></td>
</tr>
<tr>
<td>Finding a Physician, Hospital or Surgi-Center in the BCBS PPO Network</td>
<td>BlueCross PPO Hospital &amp; Physician Finder</td>
<td>800-810-2583</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.bcbsil.com">www.bcbsil.com</a></td>
</tr>
<tr>
<td>Appointments for services provided at the Health Center</td>
<td>Carpenters Center for Health</td>
<td>312-337-4150</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.crcchealthcenter.org">www.crcchealthcenter.org</a></td>
</tr>
<tr>
<td>Behavioral Health and Substance Use Disorders</td>
<td>BlueCross BlueShield of Illinois</td>
<td>800-851-7498</td>
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<tr>
<td></td>
<td></td>
<td>Representatives are available 8:00 a.m. to 6:00 p.m. (CT) Monday – Friday</td>
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<tr>
<td>Prescription drugs and Mail Order Program</td>
<td>Express Scripts Inc.</td>
<td>800-939-2089</td>
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<tr>
<td></td>
<td></td>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
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<tr>
<td>Specialty pharmacy</td>
<td>Diplomat Specialty Pharmacy</td>
<td>866-722-6110</td>
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<tr>
<td></td>
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<td><a href="http://www.diplomatpharmacy.com">www.diplomatpharmacy.com</a></td>
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<tr>
<td>Dental care</td>
<td>Delta Dental of Illinois</td>
<td>800-323-1743</td>
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<tr>
<td></td>
<td></td>
<td><a href="http://www.deltadentalil.com">www.deltadentalil.com</a></td>
</tr>
<tr>
<td>Vision care</td>
<td>DeltaVision in association with EyeMed Vision Care</td>
<td>866-723-0513</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.deltadentalil.com/deltavision">www.deltadentalil.com/deltavision</a></td>
</tr>
<tr>
<td>Comprehensive Health Evaluation and Physical Exam</td>
<td>Health Dynamics</td>
<td>414-443-0200</td>
</tr>
<tr>
<td>Hearing aid instruments</td>
<td>EPIC Hearing Service Plan</td>
<td>866-956-5400</td>
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<td></td>
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<td><a href="http://www.epichearing.com">www.epichearing.com</a></td>
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<tr>
<td>Smoking Cessation Program</td>
<td>Quit for Life</td>
<td>866-Quit-4-Life (866-784-8454)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.quitnow.net/crcc">www.quitnow.net/crcc</a></td>
</tr>
<tr>
<td>Continuation Coverage under COBRA, options and eligibility</td>
<td>Fund Office – Retirement Benefits Department</td>
<td>312-787-9455, menu option 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.crccbenefits.org">www.crccbenefits.org</a></td>
</tr>
<tr>
<td>COBRA Premium Payments</td>
<td>Health Care Service Corporation (HCSC)</td>
<td>888-541-7107</td>
</tr>
</tbody>
</table>
Eligibility

The protection offered through the Chicago Regional Council of Carpenters Welfare Fund (“Fund”) is designed to help keep you and your family in good health. Eligibility requirements determine whether you and your family members are eligible to enroll in coverage.

Eligibility for Benefits

You are eligible to enroll in the Retiree Plan of Benefits if:

- You are receiving pension benefits from the Chicago Regional Council of Carpenters Pension Fund or the Chicago Regional Council of Carpenters Millmen Pension Fund based on at least 10 years of vesting credit under the applicable Pension Fund. If at some time you did not earn vesting credit for a period of three or more consecutive Calendar Years, the pension must be based on at least 15 years of vesting credit under the applicable Pension Fund. Pension credit granted under the Chicago Regional Council of Carpenters Millmen Pension Fund for the period prior to June 1, 1975 will also be counted as vesting credit for determining eligibility for coverage under the Retiree Plan;

- You began receiving pension benefits from the Carpenters Pension Fund of Illinois as a member of Local Union Nos. 363, 916 or 2087 on or after March 1, 2003 based on at least 10 years of vesting credit earned under that Pension Fund. If at some time you did not earn vesting credit for a period of three or more consecutive Calendar Years, the pension must be based on at least 15 years of vesting credit under that Pension Fund;

- You were receiving self-pay retiree medical insurance benefits from the Carpenters Welfare Fund of Illinois at the time of the merger on March 1, 2003 and continued making self-payments for retiree coverage under this Plan;

- You began receiving pension benefits from the Carpenters Local 496 Pension Fund on or after September 1, 2009 with a pension based on at least 10 years of service credit defined as follows. If at some time you did not earn service credit for a period of three or more consecutive Calendar Years, the pension must be based on at least 15 years of service credit defined as follows:

<table>
<thead>
<tr>
<th>Hours of Service under the Carpenters Local 496 Pension Fund within a Plan Year</th>
<th>Fractional Years of Service Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 250</td>
<td>Zero</td>
</tr>
<tr>
<td>250 but less than 500</td>
<td>.25 year</td>
</tr>
<tr>
<td>500 but less than 750</td>
<td>.50 year</td>
</tr>
<tr>
<td>750 but less than 1,000</td>
<td>.75 year</td>
</tr>
<tr>
<td>1,000 or more</td>
<td>1.00 year</td>
</tr>
</tbody>
</table>

  Years of service credit, as determined by the above chart, will be considered to have been earned during the Calendar Year in which the plan year of the Carpenters Local 496 Pension Fund ended;

- You were receiving self-pay retiree medical insurance benefits from the Carpenters Local 496 Welfare Fund at the time of the merger on September 1, 2009 and continued making self-payments for retiree coverage under this Plan;
• You began receiving pension benefits from the Will County Local 174 Carpenters Pension Fund on or after January 1, 2019 with a pension based on at least 10 years of service credit defined as follows. If at some time you did not earn service credit for a period of three or more consecutive Calendar Years, the pension must be based on at least 15 years of service credit defined as follows:

<table>
<thead>
<tr>
<th>Hours of Service under the Will County Local 174 Carpenters Pension Fund within a Plan Year</th>
<th>Fractional Years of Service Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 250</td>
<td>Zero</td>
</tr>
<tr>
<td>250 but less than 500</td>
<td>.25 year</td>
</tr>
<tr>
<td>500 but less than 750</td>
<td>.50 year</td>
</tr>
<tr>
<td>750 but less than 1,000</td>
<td>.75 year</td>
</tr>
<tr>
<td>1,000 or more</td>
<td>1.00 year</td>
</tr>
</tbody>
</table>

Years of service credit, as determined by the above chart, will be considered to have been earned during the Calendar Year in which the plan year of the Will County Local 174 Carpenters Pension Fund ended; or

• You were receiving self-pay retiree medical insurance benefits from the Will County Local 174 Carpenters Welfare Fund at the time of the merger on January 1, 2019 and continued making self-payments for retiree coverage under this Plan.

If you earned vesting credit or service credit under more than one of the Pension Funds and are currently receiving monthly pension benefits from each of the Pension Funds in which you earned credit, your combined credit shall be considered when determining your eligibility for benefits under the Retiree Plan. However, not more than one year of combined credit shall be counted in any Calendar Year.

The Trustees reserve the right to change, modify or discontinue all or part of the eligibility rules at any time with written notice in accordance with federal law.

**Types of Coverage Available**

If you satisfy the eligibility criteria described in the preceding section, the type of coverage available depends on your (and your eligible Dependent’s) Medicare eligibility status and your pension effective date, as described below. Note that eligible Dependents may be enrolled only in the types of coverage in which you (the Retiree) are enrolled.

**Prescription Drug Benefits**

• Prescription drug benefits are provided through Express Scripts Inc. and specialty pharmacy benefits are provided through Diplomat Specialty Pharmacy.

• Eligible retirees (except for Deferred Lathers) and their Dependents may enroll in the prescription drug benefit as described starting on page 21.

• If you, your spouse, or your Dependent children are Medicare-eligible and choose to enroll in Medicare Part D (prescription drug) coverage, the individual who enrolls in Medicare Part D will not be eligible for prescription drug benefits under this Plan.

**NOTE:** If the retiree is not enrolled in prescription drug benefits under this Plan, his spouse and Dependent children will not be eligible to enroll in prescription drug benefits either.
Comprehensive Medical Coverage for Non-Medicare-Eligible Retirees and Dependents

- Comprehensive Medical Benefits are provided through a Network of providers administered by the Fund’s Contracted Provider, BlueCross BlueShield of Illinois (BCBSIL).
- Eligible retirees or Dependents who are not Medicare-eligible may enroll in Comprehensive Medical Benefits, as detailed in the Schedule of Benefits (see page 25).
- These benefits include preventive care, Doctor Office Visits, Hospital care (inpatient and outpatient), hearing aids and other benefits as detailed in the Schedule of Benefits.

Comprehensive Medicare Supplement Coverage for Medicare-Eligible Retirees and Dependents

- Comprehensive Medicare Supplement Benefits are provided through a Network of providers administered by the Fund’s Contracted Provider, BCBSIL.
- Eligible retirees or Dependents who are Medicare-eligible may enroll in the Comprehensive Medicare Supplement Benefits, as detailed in the Schedule of Benefits (see page 31).
- The Plan pays secondary to Medicare up to Medicare’s allowed amount; however, if the service is not covered by Medicare, it is not covered by this Plan.

Will County Local 174 Pension Fund pensioners with a pension effective date of December 1, 2018 or earlier:
The Comprehensive Medical coverage and/or Comprehensive Medicare Supplement coverage are combined with prescription drug coverage. The coverages cannot be separately elected or separately cancelled.

IMPORTANT

As soon as you, your spouse or a Dependent child become Medicare-eligible, it is important to enroll in Medicare Parts A and B.

You are required to send a copy of your Medicare card to the Retirement Benefits Department as soon as you receive it.

You may reach the Retirement Benefits Department Monday–Friday from 8:00 a.m. to 4:30 p.m. (CT) at 312-787-9455, menu option 4.

Hospital-Only Medicare Supplement Coverage for Medicare-Eligible Retirees and Dependents

- Hospital Medicare Supplement benefits are provided through a Network of providers administered by the Fund’s Contracted Provider, BCBSIL.
- Eligibility for hospital-coverage-only Medicare Supplement benefits, as detailed in the Schedule of Benefits, is limited to Medicare-eligible retirees with pension effective dates on or before June 1, 2006 and their Medicare-eligible Dependents.
- These individuals elected to enroll in the hospital-only coverage during the one-time-only enrollment period for January 1, 2011. This option is no longer available for new enrollments.
- The Plan pays secondary to Medicare Part A up to Medicare’s allowed amount; however, if the service is not covered by Medicare Part A, it is not covered by this Plan.
**Dental Benefits**

- Dental benefits are insured by Delta Dental of Illinois (Delta Dental).
- Eligible retirees and their Dependents may enroll in dental benefits as described on page 24.

**Vision Benefits**

- Vision benefits are insured by DeltaVision, in association with EyeMed Vision Care Network.
- Eligible retirees and their Dependents may enroll in vision benefits as described on page 24.

**NOTE:** If the retiree is not enrolled in a particular type of coverage under this Plan (prescription drug, comprehensive medical, dental, or vision), his spouse and Dependent children will not be eligible to enroll in that coverage either.

**Dependent Eligibility**

If you are eligible for benefits under the Retiree Plan, you may elect to enroll your eligible spouse and Dependent children (up to age 26) in benefits. An individual cannot be covered as both an Employee and a Dependent child or as both a Dependent spouse and a Dependent child under the Plan to the extent permitted by law.

A minor Dependent child is a child from birth through age 18. An adult Dependent child is a child age 19 to 26.

The following individuals are considered eligible Dependents under the Plan:

- Your lawful spouse, as recognized under applicable state law and in a manner consistent with governing federal law and for whom all required documentation is submitted, if not legally separated or divorced from you;
- Your biological child through the end of the calendar month in which he attains age 26;
- Your adopted child or a child placed in your home for legal adoption (before attaining the age of 18) through the end of the calendar month in which he attains age 26; and
- Your biological or adopted child with a physical or mental disability who is unmarried and age 26 or older, if:
  - The child was covered by the Plan upon reaching age 26;
  - The disability is considered permanent and began prior to the child attaining age 26, while the child was covered as a Dependent under this Plan or the *Active Plan*, and proof of such is provided to the Retirement Benefits Department;
  - The child is chiefly dependent on you for more than 50% of the child’s financial support and maintenance during the Calendar Year and proof of such is provided to the Retirement Benefits Department;
  - The disability is a severe physical or mental impairment that causes the child to be incapable of self-support; and
  - The child qualifies as your “qualifying child” or “qualifying relative” within the meaning of Internal Revenue Code Section 152(c) or (d).

Note that a child, regardless of age, is not considered an eligible Dependent if he is serving full time in the *Military Service*, to the extent permitted by law.

- Your unmarried stepchild through the end of the calendar month in which he turns age 26, who is in a regular parent-child relationship with you, for whom you provide more than 50% of financial support for the Calendar Year and who lives with you for more than one-half the Calendar Year.

A stepchild must be a child of your current spouse who was born to your spouse or legally adopted by your spouse before your marriage.
As requested, you must provide proof of your stepchild’s eligibility to the Retirement Benefits Department. The Plan may allow coverage to continue beyond age 26 for an eligible stepchild who is disabled. Contact the Retirement Benefits Department at the Fund Office at 312-787-9455, menu option 4, if you need more information.

Primary coverage by this Plan for stepchildren is provided only in the event that no other person is obligated to provide insurance and no other insurance is available through the biological or adoptive parents. Coverage for stepchildren terminates the last day of the month of the divorce, death or legal separation from the retiree.

- Your eligible child who is named as a Dependent under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice. (See page 61 for more information on QMCSOs.)

Enrollment for the Retiree Plan of Benefits

The Retirement Benefits Department will provide you with required enrollment forms for the Retiree Plan when you apply for a pension benefit. You must complete the required enrollment forms and return them to the Retirement Benefits Department, along with required documentation establishing the eligibility of your Dependents. See Furnishing Required Information and Documentation on page 9.

You, your spouse, or your Dependent children may postpone coverage under the Retiree Plan as long as the individual postponing has coverage with Another Health Care Plan, a State Children’s Health Insurance Program (“CHIP”) or Medicaid. However, your spouse or your Dependent children may enroll in the Retiree Plan only if you are enrolled and they may only enroll in the types of coverage in which you are enrolled.

If you chose to postpone coverage under the Retiree Plan, please be aware that future coverage under the Retiree Plan must begin immediately following the termination of coverage under the Other Health Care Plan. You or any of your Dependents may have one or more gaps in coverage under the other health care plan provided that the duration of all coverage gaps combined does not exceed 105 days, and provided that you have coverage under another health care plan, CHIP or Medicaid at the time of your enrollment in the Retiree Plan.

You will be required to provide proof of coverage from the other health care plan showing that the coverage from the other health care plan was held continuously from the date of postponement to the date of enrollment in the Retiree Plan. Proof of coverage from an outside plan will not be required for you to enroll in vision benefits or dental benefits during the annual open enrollment period.
You can only postpone coverage until the first day of the month during which the other health care plan terminates. If the other health care plan ends on the last day of the month, coverage under the Retiree Plan may be postponed until the first day of the following month.

**Example:** If your other health care plan terminates on October 10th, your coverage under the Retiree Plan must begin October 1st; however, if your other health care plan terminates on October 31st, coverage under the Retiree Plan must begin November 1st.

It is important to note:

- **Postponement:** Postponement of coverage for you and your Dependents is allowed only for the type(s) of coverage you enrolled in under the other health care plan;

  **Example:** If you are not enrolled in prescription drug coverage through the other health care plan, you cannot postpone prescription drug coverage under the Retiree Plan.

- **Election of Dependent Coverage:** Your Dependents may enroll only in the coverage in which you are enrolled;

  **Example:** If you enroll in the Retiree Plan prescription drug coverage, but you do not enroll in the Comprehensive Medical Benefits, your Dependents are eligible to enroll only in the prescription drug coverage and cannot independently elect to enroll in the Comprehensive Medical Benefits.

- **Premium Payments:** You are responsible for payment for any required premium(s) for the full month during which coverage under the Retiree Plan begins.

- **Enrollment Forms and Documentation:** It is your responsibility to request enrollment forms from the Retirement Benefits Department at least 30 days before coverage under the other health care plan ends. The enrollment forms and any required supporting documentation must be returned to the Retirement Benefits Department no later than 90 days after coverage with the other plan ends.

- **Dental and vision coverage:** If you did not enroll yourself and any Dependents in dental and/or vision benefits when you were first eligible to do so, you may enroll in dental and/or vision benefits during the annual open enrollment period. Additionally, if you enroll in coverage, receive benefits for dental and/or vision care services and then cancel coverage before being enrolled for one full year, you will not be able to re-enroll in dental and/or vision coverage for a period of two years from the date of cancellation.
Furnishing Required Information and Documentation

Prior to the start date of coverage under the Retiree Plan and from time to time as required by the Trustees, you must complete all required forms and provide supporting documentation about your Dependent’s eligibility for coverage to the Retirement Benefits Department.

Failure on the part of the Covered Individual to comply with any request for information shall be grounds for denying or discontinuing benefits to such Covered Individuals until the request is complied with.

Document requirements change from time to time. For more information, call the Retirement Benefits Department at 312-787-9455, menu option 4.

### Dependent

<table>
<thead>
<tr>
<th>Dependent</th>
<th>Examples of Proof of Dependent Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>• Original county-certified marriage certificate</td>
</tr>
<tr>
<td>Child</td>
<td>• Original county-certified birth certificate</td>
</tr>
</tbody>
</table>
| Child for whom court order mandates coverage | • Original county-certified birth certificate  
 |                                  | • Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice                  |
|                                  | • Original county-certified divorce decree (if the parents are divorced)                             |
| Newly adopted child              | • Interim order of placement and/or final adoption order                                               |
| Stepchild                        | • Original county-certified birth certificate  
 |                                  | • Original county-certified divorce decree (if the parents are divorced) or a stepchild Dependent affidavit or the death certificate of the biological parent |

**Note:** Church marriage certificates and hospital birth announcements are not acceptable forms of proof.

You may obtain a copy of the Plan’s QMCSO procedures free of charge from the Retirement Benefits Department at 312-787-9455, menu option 4, or visit the Fund’s website at [www.crccbenefits.org](http://www.crccbenefits.org).
Adding a New Dependent

**Spouse:** If you are enrolled for coverage under the Retiree Plan and you marry after your benefits become effective, your new spouse will become eligible for coverage on the date of your marriage, provided that you notify the Retirement Benefits Department and submit an enrollment form and all of the required documentation within 90 days of your marriage. Coverage will be effective as of the marriage date and you will be responsible for payment of any retroactive premiums.

**IMPORTANT**

If you don’t submit proof within the 90 day period, enrollment for your new spouse will be allowed only if the spouse was covered by another health care plan from the date of your marriage to the date of enrollment in the Retiree Plan. See pages 7–8 for coverage effective date information.

**Newborn Child or Child Placed with You for Adoption:** If you are enrolled for coverage under the Retiree Plan and you have a baby, adopt a child or have a child placed with you for adoption, you must submit an enrollment form and the required documentation proving your Dependent child’s status within 90 days of the event.

**IMPORTANT**

If you don’t supply proof of Dependent status within 90 days, coverage will be suspended until the required documentation is received. Once the Retirement Benefits Department receives the required documentation, coverage will be reinstated to the date of the newborn’s birth or the date of adoption or placement for adoption. You will be required to pay premiums retroactive to the first of the month of initial eligibility for the new Dependent.

**Stepchild:** If you are enrolled for coverage under the Retiree Plan and you acquire a stepchild after your benefits become effective, your stepchild will become eligible for coverage on the date of your marriage to the stepchild’s parent, provided that you notify the Retirement Benefits Department and submit an enrollment form and all of the required documentation within 90 days of your marriage. Coverage will be effective as of the marriage date and you will be responsible for payment of any retroactive premiums.

**IMPORTANT**

If you don’t submit proof within the 90 day period, enrollment for your stepchild will be allowed only if the stepchild was covered by another health care plan from the date of your marriage to the stepchild’s parent to the date of enrollment in the Retiree Plan. See pages 7–8 for coverage effective date information.

**Questions?** Call the Retirement Benefits Department at 312-787-9455, menu option 4. Retirement Benefit Representatives are available Monday–Friday, from 8:00 a.m. to 4:30 p.m. (CT).
Other Special Enrollments

Open Enrollment for Adult Dependent Children Ages 19 to Age 26: The Affordable Care Act (ACA) requires an annual open enrollment opportunity be provided for enrolling adult Dependent children, ages 19 to 26, in health coverage. The open enrollment period generally runs from January 1st through March 15th with coverage becoming effective April 1st.

In order to enroll the adult Dependent child, you are required to submit an enrollment form and required documentation to the Retirement Benefits Department during the annual open enrollment period.

CHIP: You and your Dependents may enroll in the Retiree Plan within 90 days if you or your Dependent had other coverage under Medicaid or the State Children’s Health Insurance Program (“CHIP”) and later lost eligibility for such coverage; or you or your Dependents became eligible for a financial assistance program through Medicaid or CHIP for coverage under the Plan.

To obtain an enrollment form, you can either call the Retirement Benefits Department at 312-787-9455, menu option 4, or you can download a form from the Fund’s website at www.crccbenefits.org.

IMPORTANT

If you fail to enroll your adult Dependent child on a timely basis, your next opportunity for enrollment will be the following year’s open enrollment period, unless there is continuous coverage under another health care plan (see pages 7–8).

When Coverage under the Retiree Plan Begins

You and your eligible Dependents will become eligible for benefits under the Retiree Plan on the first day of the month that your initial pension check is processed. You are responsible for any required premium for the full month during which coverage begins, as described on page 8.

Please note that if your pension is processed with a retroactive pension effective date, your coverage under the Retiree Plan will not be retroactive to your pension effective date. Coverage under the Retiree Plan of Benefits can be postponed past the initial date of eligibility only under the specific circumstances described below:

- If you and your Dependents are still eligible for coverage under the Active Plan when you begin receiving pension benefits, you may postpone your retiree coverage and Premium Payments until the first day of the month following termination of your Active Plan coverage.

- If you and your Dependents are eligible for and elect Continuation Coverage under COBRA following the termination of your Active Plan benefits, you may postpone your retiree coverage and Premium Payments until the first day of the month following termination of your Continuation Coverage under COBRA. Postponement is allowed only for the type of coverage you and your Dependents enrolled in during Continuation Coverage under COBRA.
• If you and your Dependents are already covered by the **Low Cost Medical Plan** when you begin receiving pension benefits, you may postpone your coverage and Premium Payments under the Retiree Plan until the first day of the month following termination of your Low Cost Medical Plan benefits. Postponement is allowed only for the type of coverage available under the Low Cost Medical Plan. Retirees or their Dependents are not eligible to elect the Low Cost Medical Plan after they have begun receiving pension benefits.

• If you and your Dependents are eligible for and elect coverage through another health care plan, CHIP or Medicaid, you may postpone your retiree coverage and Premium Payments until the other health care coverage ends (see [page 8]).

**QUESTIONS?** Call the Retirement Benefits Department at 312-787-9455, menu option 4. Retirement Benefit Representatives are available Monday–Friday, from 8:00 a.m. to 4:30 p.m. (CT).

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**Premium Payments**

If you elect to enroll in the Retiree Plan benefits for which you and your Dependents are eligible, the appropriate coverage premiums are determined according to the criteria described below:

**Pension effective date of July 1, 2006 or later:** For retirees with a pension effective date of July 1, 2006 or later, and their Dependents, or for Covered Individuals eligible for Comprehensive Medical Benefits and prescription drug benefits as of December 31, 2010, and any retiree or Dependent added to retiree coverage on or after January 1, 2011:

- A retiree and his eligible Dependents must each pay a monthly premium for Comprehensive Medical Benefits; a separate monthly premium for prescription drug benefits (except for Deferred Lathers and their Dependents, who are not eligible for prescription drug benefits); a separate monthly premium for dental benefits; and a separate monthly premium for vision benefits.

- Each Covered Individual’s medical and prescription drug premiums will be determined on a tiered basis, using the number of vesting credits the retiree earned with the Chicago Regional Council of Carpenters Pension Fund, Chicago Regional Council of Carpenters Millmen Pension Fund, or the Carpenters Pension Fund of Illinois, or by the number of service credits earned with either the Carpenters Local 496 Pension Fund, as defined on [page 3] or the Will County Local 174 Carpenters Pension Fund, as defined on [page 4]. In addition, pension credit granted under the Chicago Regional Council of Carpenters Millmen Pension Fund for the period prior to June 1, 1975 will also be counted as vesting credit for determining your tier level for medical and prescription drug premiums. Dental and vision premiums are not on a tiered basis but are determined by the Insurance Company.
• If you were receiving self-pay retiree medical insurance benefits from the Carpenters Welfare Fund of Illinois at the time of the merger on March 1, 2003, or from the Carpenters Local 496 Welfare Fund at the time of the merger on September 1, 2009, and you continued making self-payments for this Plan, but you have less than 10 years of vesting service or service credits under the respective pension fund, medical and prescription drug premiums will be determined for each Covered Individual as if you had earned 10 years of vesting credit.

• If you earned vesting credit or service credit under more than one of the Pension Funds and are receiving pension benefits from each of the Pension Funds in which you earned credit, your combined credit shall be considered when determining your tier level for medical and prescription drug premiums. However, not more than one year of combined credit shall be counted in any Calendar Year.

• The monthly medical and prescription drug premium rates for spouses and Dependent children (who are not yet Medicare-eligible) of pensioners receiving disability pensions is not based on the number of vesting credits, but is reduced and set by the Board of Trustees from time to time. For additional information, contact the Retirement Benefits Department at 312-787-9455, menu option 4.

• If you earn additional vesting credit or service credits after your initial pension effective date and your medical and prescription drug premium tier level changes as a result, you will be subject to the new premium tier level on the first day of the Calendar Year following the Calendar Year in which you earned the additional credit.

• **Pension effective date of June 1, 2006 or earlier:** Retirees with a pension effective date of June 1, 2006 or earlier, and their Dependents, who are not covered by Comprehensive Medical Benefits, are not subject to the tiered Premium Payments described on the previous page. However, a separate premium is required for prescription drug benefits (except for Deferred Lathers and their Dependents, who are not eligible for prescription drug benefits); a separate monthly premium is required for dental benefits; and a separate monthly premium is required for vision benefits.

    **Premiums after a return to work:** The tiered Premium Payment will apply if you return to work and your pension benefit is reinstated with an annuity starting date of July 1, 2006 or later. Tiered Premium Payments will apply to any individual added to coverage on or after July 1, 2006. Dental and vision premiums are not on a tiered basis but are determined by the Insurance Company.

**Will County Local 174 Pension Fund pensioners with a pension effective date of December 1, 2018 or earlier:** At the time of the merger on January 1, 2019, Will County Local 174 retirees with a pension effective date of December 1, 2018 or earlier, and their Dependents, are not subject to the tiered Premium Payments described above. However, a separate monthly premium is required for dental benefits and a separate monthly premium is required for vision benefits. Premiums are for Comprehensive Medical Benefits and for Prescription Drug Benefits combined and are set by the Board of Trustees from time to time. For additional information, contact the Retirement Benefits Department at 312-787-9455, menu option 4.
Making Your Premium Payments

Premiums are deducted from the retiree’s monthly pension benefit. If the premium for coverage is greater than the amount of the monthly pension benefit, the retiree must submit payments directly to the Fund. Payments are due on the first business day of each month for coverage during that month; however, there is a 30-day grace period. Coverage will be continued as long as payment for that month is received by the Fund with a postmark date no later than 30 days after the due date or, for months with 31 days, the last day of the month in which the Premium Payment is due.

If a monthly payment is paid later than the first day of the month, coverage will be suspended as of the first day of the month. Coverage will be reinstated retroactive to the first day of the month as long as payment for that month is received by the Fund with a postmark date no later than 30 days after the due date or, for months with 31 days, the last day of the month in which the Premium Payment is due.

The obligation to pay a Premium Payment for coverage from the retiree’s monthly pension benefit will not apply to the extent that the Fund is required to accept a third-party Premium Payment on behalf of the retiree pursuant to a Qualified Medical Child Support Order.

IMPORTANT

- If you acquire new Dependents while covered under the Retiree Plan, you are responsible for payment of any premium for the coverage of the new Dependent(s), effective the first day of the month of eligibility for the new Dependent(s), and for all subsequent months.
- If your spouse or Dependent dies, you should notify the Retirement Benefits Department as soon as possible so that premiums can be adjusted. Call 312-787-9455, menu option 4.
- Coverage and Premium Payments are adjusted for an individual who becomes Medicare-eligible. Therefore, you are required to submit a copy of the Medicare card to the Retirement Benefits Department as soon as it is received.
- Premiums will not be adjusted and/or refunded for any period of time exceeding 24 months.
For Individuals Who Are Not Yet Medicare-Eligible

To keep you and your family healthy and well, the Plan provides comprehensive coverage for medical care due to a Non-Occupational Illness or Injury. The Plan covers preventive care to the extent required under the Affordable Care Act (ACA) at 100% if a BlueCross BlueShield of Illinois (BCBSIL) PPO Provider is used. The Plan also provides an annual comprehensive physical exam and health evaluation for you and your spouse, including blood glucose, cholesterol tests as well as mammogram and prostate screenings—all at no cost to you when the Fund’s Contracted Provider, Health Dynamics, is used.

For more details, refer to page 25 for the Retiree Plan Schedule of Benefits.

IMPORTANT

Individuals who are Medicare-eligible are not eligible to participate in the Comprehensive Medical Benefits.

How Comprehensive Medical Benefits Work

The Plan contracts with BlueCross BlueShield of Illinois (BCBSIL) to offer a Preferred Provider Organization (PPO). Using a PPO Provider saves you and the Fund money, because these contracted providers agree to a discounted rate for services. This means charges from a PPO Provider, Doctor or Hospital are discounted, so you and the Fund share the cost of a lower Negotiated Rate, and you and the Fund pay less for health care.

You may find a PPO Provider in your area by calling BCBSIL at 800-810-2583 or by visiting their website at www.bcbsil.com (in Illinois) or www.bcbs.com (out-of-state).

To locate a PPO Provider call BCBSIL at 800-810-2583 or visit their website at www.bcbsil.com (in Illinois) or www.bcbs.com (out-of-state).

Deductible

You (and each of your covered Dependents) must first meet a Calendar Year Deductible before the Plan will begin to pay benefits for certain Covered Services. This means you are responsible for paying for charges in full up to the Deductible amount.

The Deductible does not apply to preventive care, hearing aids, prescription drug or vision benefits. There is a separate Deductible for dental services, as shown on the Schedule of Benefits. The Comprehensive Medical Benefit Deductible and the Deductible for dental services cannot be combined.

Family Deductible: A family Deductible applies when three or more family members’ Covered Expenses accumulate to meet the family Deductible. Once the family Deductible is met, all family members are considered to have met their Deductible.

Separate PPO and Non-PPO Deductibles: The Plan has a separate PPO Deductible and Non-PPO Deductible. This means that charges you incur from a PPO Provider count only toward meeting your PPO Deductible. If you use a Non-PPO Provider, you must meet a separate Non-PPO Deductible. The two Deductible amounts cannot be combined.

Deductibles from the Active Plan and/or the Low Cost Medical Plan do not transfer to or from the Retiree Plan.

Deductible carryover: Any Covered expense applied to the Deductible in October, November or December of the Calendar Year will apply toward meeting the Deductible for the next Calendar Year.

What’s not included in the Deductible: Emergency Room Co-payment (Co-pay), Coinsurance amounts, amounts you are charged above the Reasonable and Customary Allowance for Out-of-Network services, amounts you pay for hearing aids and vision care and excluded services do not count toward the Comprehensive Medical Benefit Deductible. Dental coverage has a separate Deductible.
**Coinsurance and Co-payments**

The Coinsurance amount is your share of the cost of Covered Services after you have satisfied the Calendar Year Deductible. Coinsurance amounts are only applicable to expenses covered by the Plan. Each year, after you satisfy the Calendar Year Deductible (either individual or family), the Plan generally pays a percentage of covered charges and you pay your share, up to the **Out-Of-Pocket Maximum**. See **Out-Pocket Maximum** below.

A Co-payment is a flat dollar amount. For example, when you go to the Emergency Room you pay a Co-payment in addition to your Coinsurance. Co-payments do not apply to the Deductibles.

Refer to the **Schedule of Benefits** on page 25 for the individual and family PPO and Non-PPO Calendar Year Deductibles and **Out-of-Pocket Maximums**.

**Out-of-Pocket Maximum**

Once you meet the Deductible, the Plan will begin to pay benefits for Covered Services. Your portion of the cost of Covered Services is limited by the Plan’s annual Out-of-Pocket Maximum. This means that once you meet the annual Out-of-Pocket Maximum, the Plan will pay for **Covered Medical Expenses** at 100% for the rest of the Calendar Year.

There are individual and family Out-of-Pocket Maximums that apply when you receive care from a PPO Provider. This means three or more covered family members’ expenses can be combined to meet a family Out-of-Pocket Maximum.

Out-of-Pocket Maximums from the Active Plan and/or the Low Cost Medical Plan do not transfer to or from the Retiree Plan.

**Separate PPO and Non-PPO Out-of-Pocket Maximums:** There is also a separate, higher Out-of-Pocket Maximum when you use a Non-PPO Provider. This means that charges you incur from a PPO Provider count only toward meeting your PPO Out-of-Pocket Maximum. If you use a Non-PPO Provider, you must first meet a separate Non-PPO Out-of-Pocket Maximum before the Plan will pay 100% of Covered Expenses for the rest of the Calendar Year. The two Out-of-Pocket Maximums are not combined.

**Separate Out-of-Pocket Maximums for Comprehensive Medical and Prescription Drug Benefits:** There are Out-of-Pocket Maximums for prescription drug benefits and specialty pharmacy prescription drug benefits that are separate from the Out-of-Pocket Maximums for Comprehensive Medical Benefits. This means that charges you incur from prescription drug Co-payments count only toward meeting your prescription drug Out-of-Pocket Maximums and do not count toward the Comprehensive Medical Benefit Out-of-Pocket Maximum.

Some expenses are not applied to the Comprehensive Medical Plan Out-of-Pocket Maximum, including:

- Co-pays for prescription drugs;
- Vision and dental expenses;
- Amounts above the Plan’s Reasonable and Customary Allowance for covered Out-of-Network medical expenses;
- Expenses not considered Covered Medical Expenses; and
- Amounts in excess of a benefit maximum or lifetime maximum for non-essential benefits, as described under the Affordable Care Act.
Example: Compare what John pays when using a PPO Hospital versus a Non-PPO Hospital. This example assumes that John has already met the PPO and Non-PPO Deductibles.

<table>
<thead>
<tr>
<th></th>
<th>PPO Hospital</th>
<th>Non-PPO Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenses charged for a two-day Hospital stay</td>
<td>$5,000 billed charges $2,500 (PPO discounted rate)</td>
<td>$5,000 billed charges $4,000 (Reasonable and Customary Allowance)</td>
</tr>
<tr>
<td>Plan pays</td>
<td>$2,000 (80% of PPO discounted rate)</td>
<td>$2,400 (60% of Reasonable and Customary Allowance)</td>
</tr>
<tr>
<td>John pays</td>
<td>$500 (20% of PPO discounted rate)</td>
<td>$2,600 (40% of Reasonable and Customary Allowance, plus difference between provider’s charge and Reasonable and Customary Allowance)</td>
</tr>
</tbody>
</table>

Bottom line: John saves $2,100 by using a PPO Hospital.

Hospital Recovery Incentive Program

If you find and correct overcharges on your inpatient Hospital bill, you can earn a reward of up to 25% of the savings up to $500 maximum in a Calendar Year. Overcharges that total less than $25 and Physician charges do not apply to the Hospital Recovery Incentive Program. Call the Retirement Benefits Department at 312-787-9455, menu option 4, for additional information if you believe your bill contains erroneous charges.
Comprehensive Medicare Supplement Benefits

For Individuals Who Are Medicare-Eligible

The Plan provides a Comprehensive Medical Supplement for individuals who are eligible for Medicare. It is designed to work with Medicare Parts A and B to give you broad coverage. While the Plan is designed to supplement Medicare Parts A and B, it is not intended to pay all amounts that Medicare does not cover.

The Plan also provides an annual comprehensive physical exam and health evaluation for you and your spouse, including blood glucose, cholesterol tests as well as mammogram and prostate screenings—all at no cost to you when you use the Fund’s Contracted Provider, Health Dynamics.

Information contained in this section also applies to individuals who are covered by the Hospital-Only Medicare Supplement; however, this type of coverage only supplements Medicare Part A, as described in the Schedule of Benefits on page 31.

IMPORTANT

If you enroll in the Comprehensive Medicare Supplement but choose not to enroll in Medicare Parts A and B, the Plan will pay benefits as if you had enrolled in Medicare Parts A and B.

What the Plan Pays

Health benefits under the Retiree Plan for Covered Individuals who are eligible for Medicare will be paid in coordination with Medicare and, generally, Medicare pays first. If Medicare covers an expense, the Plan will pay secondary to Medicare. It is important to know that the Plan excludes coverage for services and items not covered by Medicare. Refer to the Schedule of Benefits on page 31.

Eligibility for Medicare

In general, you are eligible for Medicare if you are at least 65 years of age or have received Social Security disability benefits for 24 consecutive months. Anyone, including children, can be eligible for Medicare by virtue of a disability as defined and determined by the Social Security Administration.

However, no one becomes eligible for Medicare by simply being a Dependent of someone who is eligible for Medicare.

For example:

• If you are 65 years of age and your spouse is 58 and not disabled, you are eligible for Medicare but your spouse is not; or
• If you are under age 65 and not disabled and have a spouse either over age 65 or eligible due to disability, your spouse is eligible for Medicare but you are not.

Enrolling in Medicare

If you are receiving Social Security benefits, your Social Security office should contact you with information about Medicare. This usually occurs at least three months before your 65th birthday. If you are not receiving Social Security benefits or if you have not been contacted by Social Security and are nearing your 65th birthday, you should contact your local Social Security office. To receive maximum benefits from the Retiree Plan and Medicare, you must enroll in:

• Medicare Part A: This covers hospital care and care in a Skilled Nursing Facility. Generally, for most people, there is no Medicare premium for Medicare Part A coverage; and
• Medicare Part B: This covers Physician bills and some out-of-Hospital expenses. Most people are required to pay a premium for Medicare Part B and it is deducted from their Social Security check.
**Medicare Advantage Plans**
If you are enrolled in a Medicare Advantage Plan or a Medicare Part C Plan that replaces traditional Medicare coverage, this Plan pays benefits as if you were enrolled in traditional Medicare, so long as you follow the rules of the replacement plan, including seeking services from the Plan’s participating providers.

**Individuals with ESRD**
This Plan will be primary for a period of 30 months if your initial eligibility for Medicare is due to End-Stage Renal Disease (ESRD).

**What Is a Medicare-Participating Doctor or Provider?**
Doctors and suppliers may sign agreements to become Medicare-participating providers. This means that these providers have agreed to accept the amount approved by Medicare as total payment for Covered Services (which includes Medicare’s payment, the Deductible, and Coinsurance). This is called “accepting Medicare assignment.”

**IMPORTANT**
Medicare periodically publishes a handbook called “Medicare & You.” This handbook details the Medicare benefits available and can be obtained directly from Medicare by calling 800-633-4227 or from the Medicare website at [www.medicare.gov](http://www.medicare.gov).
The Carpenters Center for Health ("Health Center") is a health care facility in partnership with Premise Health, a nationwide manager of onsite health clinics. The Health Center offers a range of primary and urgent care services at no cost to you and your eligible Dependents (age two and older), provided you meet the Plan’s eligibility requirements.

To take advantage of the services provided at the Health Center, you must be eligible for and enrolled in Comprehensive Medical Coverage (for non-Medicare-eligible retirees and/or Dependents) or Comprehensive Medicare Supplement Coverage (for Medicare-eligible retirees and/or Dependents).

Using the Health Center

It is best to have a scheduled appointment when visiting the Health Center, even if you want to be seen the same day. You can either call 312-337-4150 or schedule online through the Health Center’s patient portal, [www.crcchealthcenter.org](http://www.crcchealthcenter.org). The Patient Portal is a secure online tool that houses your electronic health records and enables you to make appointments, review lab results, communicate with your health care team and more. All of your personal information is private and secure.

Carpenters Center for Health
4979 Indiana Avenue, 3rd Floor
Lisle, IL 60532-3847
312-337-4150
[www.crcchealthcenter.org](http://www.crcchealthcenter.org)
Open Monday, Tuesday, Wednesday and Friday 8:00 a.m. to 5:00 p.m. and Thursday 10:00 a.m. to 7:00 p.m. (CT).

Health Center Services

Services available through the Health Center are provided at no cost to you, and include, but are not limited to:

- Primary care services;
- Preventive care services;
- Acute/urgent care services;
- Clinical laboratory services, including diagnostic tests performed onsite and specimen collection and diagnostic testing for routine Physician-ordered tests sent by the Health Center to a qualified offsite laboratory;
- Disease management services for chronic diseases and conditions, including onsite Physician services and counseling; and
- Health and wellness services, including but not limited to biometric testing, health risk assessments and education and counseling for disease prevention and wellness promotion.

The Health Center does not have a full-service onsite pharmacy; however, it carries a variety of common generic medications onsite for treatment of an acute illness such as sinus infection, strep throat, etc.

Additionally, limited starter generic medications will be provided onsite as part of your visit to the Health Center in support of disease/condition management (such as a cholesterol-lowering drug for a diagnosis of high cholesterol).

The Health Center’s staff can prescribe medications and send them to your local pharmacy for pick-up or electronically submit to the Express Scripts Mail Order Program. Normal Co-payments will apply. Controlled substances, including narcotics, are not dispensed at the Health Center.

Health Center services do not include:

- Services for Dependents younger than age two;
- Services covered under any Workers’ Compensation law, Employers’ Liability law, Occupational Diseases Law or any similar law, except as may be covered under the Plan’s acute/urgent care services;
- Services covered by any other liability insurance (see page 67); and
- Services subject to subrogation, unless the Covered Individual has entered into a reimbursement agreement with the Plan. (See page 69.)
Prescription Drug Benefits

Prescription drugs can play an important role in your overall health. Recognizing this importance, the Plan provides an option for comprehensive prescription drug coverage that is designed to help you pay for the medications you need.

About Your Prescription Drug Coverage

Benefits for prescription drugs depend on whether the prescription is for a generic, single- or multi-source brand-name medication and whether a brand-name medication has a generic substitute available. A single-source brand-name drug is one where there is currently no generic drug available as a substitute. A multi-source brand-name drug is one where there are one or more generic drugs available. If you need a specialty medication, one that is used to treat complex chronic or rare medical conditions, the Plan provides benefits for those drugs as well. The Plan has contracted with two Networks to provide you access to affordable prescription drug therapy.

For most prescriptions, the Fund’s Contracted Provider is Express Scripts Inc. (Express Scripts). Express Scripts offers an extensive retail Network of pharmacies and a Mail Order Program (home delivery program). You can contact Express Scripts at 800-939-2089 or visit www.express-scripts.com.

Important: If you are Medicare-eligible and choose to enroll in Medicare Part D (prescription drug) coverage, you and your Dependents will become ineligible for the Prescription Drug benefit under the Retiree Plan. However, you may continue coverage under the Prescription Drug benefit if your Dependents choose to enroll in Medicare Part D.

Out-of-Pocket Maximums for Prescription Drugs: The Plan maintains a limit on the amounts a Covered Individual pays out-of-pocket for prescription drugs in a Calendar Year. (See page 33 of the Schedule of Benefits.)

Retail Pharmacy Program

You can use your Express Scripts ID card to fill prescriptions at any participating Express Scripts pharmacy. When you use your ID card, there are no Claims for you to file. Consider generics whenever possible as they will save you money.

For more details, refer to page 33 of the Retiree Plan Schedule of Benefits.

On the rare occasion that you use a pharmacy that is out of the Contracted Provider’s Network, you are required to pay the full cost of the drug at the retail pharmacy. You may then submit a Claim to Express Scripts. Reimbursement is based on the discounted amount Express Scripts would have paid to a participating pharmacy for that drug.

Quantity Limits for Long-Term Medications at Retail Pharmacies

If you use a participating retail pharmacy to fill your Long-Term Medications, the Plan will pay benefits only for the initial prescription and up to two refills. After the third fill, you are required to use the Mail Order Program. After the third fill, the Plan will only cover the medication through the Mail Order Program.
Mail Order Program  
(Home Delivery Program)

Participation in the Mail Order Program is required if you take Long Term Medications on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes and asthma.

If your Doctor prescribes a medication that you will be taking for more than 30 days, ask your Doctor to give you two prescriptions at once: one for a 30 day supply and one for a 90 day supply (with appropriate refills). You can then fill the 30 day prescription at your local participating retail pharmacy and send the 90 day prescription to the Mail Order Program. For more information about the Mail Order Program, contact Express Scripts at 800-939-2089 or visit their website at www.express-scripts.com.

For more details, refer to page 33 for the Retiree Plan Schedule of Benefits.

Preferred Drug Step Therapy Program

The Plan also provides for a Preferred Drug Step Therapy Program that identifies generic or brand medications in certain drug classes and recommends FDA-approved lower-cost generic options to the brand-name medication. If your Doctor prescribes a non-preferred brand, you will need to switch to a generic or preferred brand for the Plan to cover the medication. In certain cases, if your Doctor believes you cannot switch medications, he can request a coverage review by contacting Express Scripts.

To find out more about the Mail Order Program or the Preferred Drug Step Therapy Program, or to locate participating pharmacies, contact Express Scripts at 800-939-2089 or visit their website at www.express-scripts.com. Service Representatives are available 24 hours a day, seven days a week.

Formulary

The Plan participates in Express Scripts’ National Preferred Formulary. The formulary is a broad list of preferred medications used by Express Scripts clients nationwide. The formulary is subject to change from time to time. In the event that your medication is removed from the Express Scripts formulary, they will notify you in advance and inform you of alternative drugs available to you in the same therapeutic class. Medications not on the National Preferred Formulary are not covered by the Plan.

Extended Care/Skilled Nursing Facility Exception

The Fund Office will make an exception to the mandatory Mail Order Program if you are or your eligible Dependent is a resident of an Extended Care/Skilled Nursing Facility and the facility is unable to use the Mail Order Program. You must provide documentation verifying residency and stating the specific reason why the facility is unable to utilize the Mail Order Program. Contact the Retirement Benefits Department at 312-787-9455, menu option 4, for more information.
Specialty Medications
The Plan has contracted with Diplomat Specialty Pharmacy (Diplomat) for specialty medications used to treat chronic and rare conditions. Specialty medications may include oral, injectables and Infusion Therapy, which often require special handling.

Specialty medications are generally dispensed in 30 day supply increments only. Diplomat offers you the opportunity to speak with pharmacists and clinicians about your condition, symptoms, drug side effects and more. You may contact Diplomat at 866-722-6110 or visit www.diplomatpharmacy.com.

Partial Fill Program
Specialty medications can have severe side effects and some patients cannot tolerate the reactions and complications that may accompany taking them. Diplomat manages a Partial Fill Program that limits the initial prescription to a 15 day supply for certain medications. This prevents waste in case the patient cannot tolerate the medication and in those instances, saves the patient and the Plan money. Generally, for a partial fill, you will pay 50% of the Co-payment.

Prior Authorization Program for Specialty Medications
Any Covered Individual who is diagnosed with a serious disease or chronic condition may be prescribed a specialty medication. Most initial prescriptions for specialty drugs are reviewed by Diplomat before the prescription is filled. This is called the Prior Authorization Program. Diplomat communicates directly with your prescribing Physician during this process to ensure the medication is being dispensed for its intended use and in accordance with manufacturer recommendations. For example, with some medications, certain diagnostic and/or lab tests must be completed before the medications can be dispensed and Diplomat confirms all requirements have been met. Specialty medications that are a part of a long-term Treatment Plan, generally extending more than a year, are subject to annual review.

Out-of-Pocket Maximum for Specialty Medications
The Plan maintains a limit on the amounts a Covered Individual pays out-of-pocket for specialty medications in a Calendar Year. (See page 33 of the Schedule of Benefits.) This means that once your combined Co-pay charges for specialty medications reach the annual Out-of-Pocket Maximum, the Plan pays 100% of eligible charges for specialty medications for the rest of the Calendar Year. The annual maximum on specialty medications is separate from and cannot be combined with the annual maximum on single-source brand-name drugs.

For Specialty medications, your Physician should call Diplomat Specialty Pharmacy at 866-722-6110 or visit their website at www.diplomatpharmacy.com. Service Representatives are available Monday–Friday from 7:00 a.m. to 10:00 p.m. and Saturday from 8:00 a.m. to 4:00 p.m. (CT).
Good health goes hand in hand with good dental care, which is why the Plan includes an option for comprehensive dental care. This includes an option for preventive dental care, such as routine exams, cleanings and X-rays; as well as basic, major dental care for you and your covered Dependents. Dental benefits are provided through the Fund’s fully insured policy maintained by the Insurance Company, Delta Dental of Illinois (Delta Dental).

For more details on covered dental services or to locate a Delta Dental Network Provider, call 800-323-1743 or visit their website at www.deltadentalil.com. Service Representatives are available Monday–Thursday from 7:00 a.m. to 7:00 p.m. and Friday from 7:00 a.m. to 6:00 p.m. (CT).

There are two Networks offered by Delta Dental—the Delta Dental PPO and Premier Networks. This program has the largest Network of participating dental providers in the nation. Both Networks offer discounts and charge lower fees for their services.

You will receive an ID card directly from Delta Dental when you first become eligible for benefits. Be sure to present your Delta Dental ID card to the staff at your Dentist’s office.

Using a Delta Dental Network provider means taking advantage of the Negotiated Rate and having lower out-of-pocket costs. For more details on covered dental services or to find a Network dental provider, contact Delta Dental at 800-323-1743 or visit their website at www.deltadentalil.com.

Healthy eyes and sight are important to overall good health, which is why the Plan includes an option for vision care for you and your covered Dependents through the Fund’s fully insured policy maintained by the Insurance Company, DeltaVision, in association with EyeMed Vision Care (EyeMed).

For more details on covered vision services or to locate a DeltaVision provider call 866-723-0513 or visit their website at www.deltadentalil.com/deltavision. Representatives are available Monday–Saturday from 6:30 a.m. to 10:00 p.m. and Sunday from 10:00 a.m. to 7:00 p.m. (CT).

The DeltaVision program uses the EyeMed Network, so you will receive in-Network benefits by visiting an EyeMed Network provider. For more details on covered vision services or to locate an EyeMed provider call 866-723-0513 or visit their website at www.deltadentalil.com/deltavision. You will also receive a certificate of coverage from DeltaVision that will provide additional detail on the vision benefits.
The schedule on the following pages highlights key features of the Retiree Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.

- The amounts charged for Covered Medical Expenses provided by Out-of-Network Providers are subject to the Reasonable and Customary Allowance (R&C Allowance). R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule, National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

## COMPREHENSIVE MEDICAL BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE-ELIGIBLE

<table>
<thead>
<tr>
<th></th>
<th>PPO Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinsurance</td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>Deductible per Calendar Year</td>
<td>$300 per Covered Individual</td>
<td>$600 per Covered Individual</td>
</tr>
<tr>
<td></td>
<td>$600 per family</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum per Year</td>
<td>$2,000 per Covered Individual</td>
<td>$6,000 per Covered Individual (does not include the Calendar Year Deductible)</td>
</tr>
<tr>
<td></td>
<td>$4,000 per family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(includes the Calendar Year Deductible)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO Deductibles and Out-of-Pocket Maximums are separate and cannot be combined.</td>
<td></td>
</tr>
</tbody>
</table>

## BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE-ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

**Contracted Network Provider:** BlueCross BlueShield of Illinois (BCBSIL)

<table>
<thead>
<tr>
<th></th>
<th>BCBS PPO Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture Care</td>
<td>See <em>Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit), page 26</em></td>
<td></td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>80% paid by Plan subject to the PPO Deductible</td>
<td></td>
</tr>
<tr>
<td>Anesthesia or Sedation</td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>Bariatric Surgery (only for the diagnosis and treatment of morbid obesity)</td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td></td>
<td>A Covered Individual is required to contact BCBSIL before any treatment is given and must be approved for surgery.</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Care</td>
<td></td>
<td>See page 30</td>
</tr>
</tbody>
</table>
### BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE-ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

**Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>BCBS PPO Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
</table>
| Breast-Feeding Support and Equipment **as required under the Affordable Care Act**  
  - Lactation support and counseling  
  - Breast pump rental, up to the purchase price, and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy.  
  - Hospital-grade breast pump must be medically necessary. | 100% paid by Plan, Calendar Year Deductible does not apply | No coverage |
| Chiropractic, Acupuncture and Naprapathic Care **(Combined Benefit)** | 80% paid by Plan | 60% paid by Plan |
|  | Maximum visit limit per Retired Employee: 50 visits per Calendar Year  
  Maximum visit limit per spouse: 30 visits per Calendar Year  
  No coverage for Dependent children | No coverage |
| Clinical Trials **to the extent required under the Affordable Care Act** | 80% paid by Plan | 60% paid by Plan |
|  | See page 36 | No coverage |
| Contraceptives, including related Office Visits, to the extent required under the Affordable Care Act for FDA-approved methods for females with reproductive capacity:  
  - Contraceptive support and counseling  
  - Diaphragms, sponges, cervical caps, female condoms and spermicides  
  - Vaginal rings  
  - Emergency contraceptives (generic morning-after pill only)  
  - Implants and implantable rods  
  - Oral contraceptives, generic only  
  - Patch  
  - Injectables  
  - IUD | 100% paid by the Plan Calendar Year Deductible does not apply | No coverage |
| Cosmetic Surgery **solely to improve appearance** | No coverage | No coverage |
| Dental Services **for a Non-Occupational Injury to teeth** | No coverage | No coverage |
### BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE-ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

**Contracted Network Provider:** BlueCross BlueShield of Illinois (BCBSIL)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BCBS PPO Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td><strong>Diagnostic X-Rays and Lab Tests</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>80% paid by Plan</td>
<td>80% paid by Plan</td>
</tr>
<tr>
<td>Facility fee</td>
<td>80% paid by Plan</td>
<td>80% paid by Plan</td>
</tr>
<tr>
<td>Physician fees</td>
<td>80% paid by Plan</td>
<td>80% paid by Plan</td>
</tr>
<tr>
<td><strong>Emergency Room Co-payment</strong></td>
<td>$250 per Emergency Room visit</td>
<td>Waived if admitted to the Hospital as an inpatient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum</td>
</tr>
<tr>
<td><strong>Extended Care/Skilled Nursing Facility</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
</tbody>
</table>

**Maximum of 120 days per convalescent period**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BCBS PPO Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genetic Testing Benefit</strong></td>
<td>100% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>Genetic testing to the extent required under the Affordable Care Act</td>
<td>Calendar Year Deductible does not apply</td>
<td>Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500</td>
</tr>
<tr>
<td>Diagnostic genetic testing</td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>Non-diagnostic genetic testing</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)</th>
<th>BCBS PPO Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing Benefit</strong></td>
<td><strong>Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)</strong></td>
<td>BCBS PPO Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>Hearing evaluation/exam</td>
<td>No coverage, except as required by the Affordable Care Act under the Wellness and Preventive Care benefit</td>
<td>[\text{Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)}]</td>
<td>[\text{BCBS PPO Provider}]</td>
</tr>
<tr>
<td>Hearing aid instrument</td>
<td>Paid at 100% up to $1,500 maximum per Covered Individual once every three consecutive Calendar Years Calendar Year Deductible does not apply</td>
<td>Paid at 100% up to $1,500 maximum per Covered Individual once every five consecutive Calendar Years Calendar Year Deductible does not apply</td>
<td>Paid at 100% up to $1,500 maximum per Covered Individual once every five consecutive Calendar Years Calendar Year Deductible does not apply</td>
</tr>
<tr>
<td>Dependent children through age 18</td>
<td>Paid at 100% up to $1,500 maximum per Covered Individual once every three consecutive Calendar Years Calendar Year Deductible does not apply</td>
<td>[\text{Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)}]</td>
<td>[\text{BCBS PPO Provider}]</td>
</tr>
<tr>
<td>Participant, spouse and dependent children age 19 and older</td>
<td>Paid at 100% up to $1,500 maximum per Covered Individual once every five consecutive Calendar Years Calendar Year Deductible does not apply</td>
<td>[\text{Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)}]</td>
<td>[\text{BCBS PPO Provider}]</td>
</tr>
</tbody>
</table>
### BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE-ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

**Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BCBS PPO Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health Care</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td></td>
<td>Maximum of 120 Days per convalescent period</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td></td>
<td>Lifetime maximum of 180 days per individual</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Care</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td></td>
<td>Confinement maximum 180 days per Calendar Year for inpatient care</td>
<td></td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>Including Hospital, Physician, prescription drugs and treatments, etc. except diagnostic genetic testing which is covered above testing. See page 27 for Genetic Testing coverage</td>
<td>Combined lifetime maximum of $10,000 for services provided to the Retired Employee and spouse</td>
<td></td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>for the administration of an intravenous prescription drug</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Naprapathic Care</strong></td>
<td>See <em>Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)</em>, page 26</td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional Counseling</strong></td>
<td>100% paid by Plan, except to the extent required under the Affordable Care Act</td>
<td>No coverage</td>
</tr>
<tr>
<td>to the extent required under the Affordable Care Act</td>
<td>Calendar Year Deductible does not apply</td>
<td></td>
</tr>
<tr>
<td><strong>Oral and Maxillofacial Surgery</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td><strong>Organ Transplant</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td><strong>Pregnancy Care</strong></td>
<td>80% paid by Plan, except to the extent required under the Affordable Care Act</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetics</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>• Artifical limbs and eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis</td>
<td>100% paid by Plan, subject to a $500 lifetime maximum Calendar Year Deductible does not apply</td>
<td></td>
</tr>
<tr>
<td><strong>Reconstructive Breast Surgery</strong></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>Benefits</td>
<td>BCBS PPO Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Sterilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Females to the extent required under the Affordable Care Act</td>
<td>100% paid by Plan Calendar Year Deductible does not apply</td>
<td>No coverage</td>
</tr>
<tr>
<td>• Males</td>
<td>80% paid by Plan</td>
<td>No coverage</td>
</tr>
<tr>
<td>• Sterilization reversals (female/male)</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td></td>
<td>See page 43</td>
</tr>
<tr>
<td>Surgi-Center Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital affiliated</td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>• No hospital affiliation</td>
<td>80% paid by Plan</td>
<td>No coverage</td>
</tr>
<tr>
<td>Surgical Assistant or Assistant Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan, limited to 20% of surgical procedure’s R&amp;C Allowance</td>
</tr>
<tr>
<td>Surgical Consultations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>Temporomandibular Joint Care (TMJ)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician and therapy services</td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>• Appliances, and their adjustments, for TMJ and bruxism (occlusal)</td>
<td>80% paid by Plan once every three consecutive years Maximum of 2 appliances per lifetime</td>
<td></td>
</tr>
<tr>
<td>Therapy Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical and Speech Outpatient Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td></td>
<td>Maximum 50 visits per Calendar Year</td>
<td></td>
</tr>
<tr>
<td>• Occupational Outpatient Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60% paid by Plan</td>
<td>40% paid by Plan</td>
</tr>
<tr>
<td></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td></td>
<td>Maximum 50 visits per Calendar Year</td>
<td></td>
</tr>
<tr>
<td>• Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities (Habilitative or to teach; for Covered Individuals through age 18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60% paid by Plan</td>
<td>40% paid by Plan</td>
</tr>
<tr>
<td></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>Urgent/Immediate Care Facilities and Retail Clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td>Vision Surgery (excluding Cosmetic or refractive corrections)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% paid by Plan</td>
<td>60% paid by Plan</td>
</tr>
</tbody>
</table>
### BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE-ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

**Contracted Network Provider:** BlueCross BlueShield of Illinois (BCBSIL)

<table>
<thead>
<tr>
<th>Wellness and Preventive Care</th>
<th>100% paid by Plan</th>
<th>No coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness and Preventive Care</strong> to the extent required under the Affordable Care Act, including routine screenings, immunizations and other services (see <a href="http://www.healthcare.gov">www.healthcare.gov</a> for list of services)</td>
<td>Calendar Year Deductible and Coinsurance do not apply</td>
<td></td>
</tr>
<tr>
<td><strong>Comprehensive Health Evaluation and Physical Exam</strong> (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Preferred Contracted Provider:** Health Dynamics

- 100% paid by Plan for Retired Employee and spouse once every Calendar Year
- Calendar Year Deductible does not apply
- Not available to Dependent children

### HEALTH CENTER BENEFITS

**For Covered Individuals That Are Not Medicare-Eligible and Are Enrolled in Comprehensive Medical Benefits**

<table>
<thead>
<tr>
<th>Health Center Services</th>
<th>100% paid by Plan</th>
<th>Calendar Year Deductible does not apply</th>
</tr>
</thead>
</table>

### BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

**For Covered Individuals That Are Not Medicare-Eligible and Are Enrolled in Comprehensive Medical Benefits**

**Contracted Network Provider:** BlueCross BlueShield of Illinois (BCBSIL)

<table>
<thead>
<tr>
<th>BCBS PPO Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Room</strong></td>
<td></td>
</tr>
<tr>
<td>Facility fee</td>
<td>80% paid by Plan</td>
</tr>
<tr>
<td>Physician fees</td>
<td>80% paid by Plan</td>
</tr>
<tr>
<td><strong>Emergency Room Co-payment</strong></td>
<td>$250 per Emergency Room visit</td>
</tr>
<tr>
<td>Waived if admitted to the Hospital as an inpatient within 72 hours or held in the observation unit for more than 24 hours</td>
<td>80% paid by Plan</td>
</tr>
<tr>
<td>Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum</td>
<td>80% paid by Plan</td>
</tr>
<tr>
<td><strong>Hospital Care and Residential Treatment Facilities</strong></td>
<td>80% paid by Plan</td>
</tr>
<tr>
<td>Confinement maximum: 180 days per Calendar Year combined for Hospital and residential treatment inpatient care</td>
<td>60% paid by Plan</td>
</tr>
<tr>
<td><strong>Outpatient Therapy</strong> (including partial hospitalization)</td>
<td>80% paid by Plan</td>
</tr>
<tr>
<td>60% paid by Plan</td>
<td></td>
</tr>
<tr>
<td><strong>Custodial or Group Homes</strong></td>
<td>No coverage</td>
</tr>
</tbody>
</table>
### BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE-ELIGIBLE AND ARE ENROLLED IN HOSPITAL BENEFITS ONLY

**Per Benefit Period***

*A “benefit period” begins on the first day the Covered Individual receives services as an inpatient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row*

**Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)**

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum per Calendar Year</th>
<th>$2,000 per Covered Individual $4,000 per family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Part A Supplement (Hospital Benefit)</strong></td>
<td><strong>Plan Pays secondary to Medicare Maximum 180 inpatient days per Calendar Year</strong></td>
</tr>
<tr>
<td>• First 60 days</td>
<td>Plan pays Medicare Part A Deductible</td>
</tr>
<tr>
<td>• 61st through 90th days</td>
<td>Plan pays Medicare Part A Co-payment</td>
</tr>
<tr>
<td>• 91st day and after while using 60 lifetime reserve days</td>
<td>Plan pays Medicare Part A Co-payment</td>
</tr>
<tr>
<td>• Additional 365 days</td>
<td>Plan pays 100% of Medicare Part A eligible expenses</td>
</tr>
</tbody>
</table>

### BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE-ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS

**Per Benefit Period***

*A “benefit period” begins on the first day the Covered Individual receives services as an inpatient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row*

**Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)**

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum per Calendar Year</th>
<th>$2,000 per Covered Individual $4,000 per family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Part A Supplement (Hospital Benefit)</strong></td>
<td><strong>Plan Pays secondary to Medicare Maximum 180 inpatient days per Calendar Year</strong></td>
</tr>
<tr>
<td>• First 60 days</td>
<td>Plan pays Medicare Part A Deductible</td>
</tr>
<tr>
<td>• 61st through 90th days</td>
<td>Plan pays Medicare Part A Co-payment</td>
</tr>
<tr>
<td>• 91st day and after while using 60 lifetime reserve days</td>
<td>Plan pays Medicare Part A Co-payment</td>
</tr>
<tr>
<td>• Additional 365 days</td>
<td>Plan pays 100% of Medicare-eligible expenses</td>
</tr>
<tr>
<td><strong>Medicare Part B Supplement</strong></td>
<td><strong>Plan Pays secondary to Medicare</strong></td>
</tr>
<tr>
<td>• Medicare Part B Deductible</td>
<td>Not covered by Plan</td>
</tr>
<tr>
<td>• Medical expenses</td>
<td>Plan pays 20% of Medicare-eligible expenses at the Medicare-approved amount, after the Medicare Part B Deductible</td>
</tr>
<tr>
<td><strong>Blood</strong></td>
<td>Plan pays for first three pints</td>
</tr>
</tbody>
</table>
### BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE-ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS

**Per Benefit Period**

*A “benefit period” begins on the first day the Covered Individual receives services as an inpatient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row*

**Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)**

<table>
<thead>
<tr>
<th><strong>Skilled Nursing Facility Care</strong> – Covered Individual must meet Medicare’s requirements, including having been in a Hospital for at least three days and enter a Medicare-approved facility within 30 days of leaving the Hospital</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• First 20 days</td>
<td>Medicare pays all approved amounts</td>
</tr>
<tr>
<td>• 21st through 100th day</td>
<td>Plan pays Medicare Part A Co-payment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>At-Home Recovery Services</strong> – Home care certified by a Covered Individual’s Doctor, for care during recovery from an injury or sickness for which Medicare-approved a home Treatment Plan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Benefit for each visit</td>
<td>Plan pays up to $40 per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Foreign Travel</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Calendar Year Deductible</td>
<td>$250 per Covered Individual</td>
</tr>
<tr>
<td></td>
<td>Plan pays 80%</td>
</tr>
<tr>
<td></td>
<td>The Plan does not pay for expenses in excess of the R&amp;C Allowance for Non-PPO Out-of-Network Providers</td>
</tr>
<tr>
<td></td>
<td>Amounts over the R&amp;C Allowance are the Covered Individual’s responsibility</td>
</tr>
<tr>
<td>• Lifetime maximum for foreign travel</td>
<td>$50,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hearing Benefit</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hearing aid instrument</td>
<td>Plan pays 100% up to $1,500 maximum per Covered Individual once every five consecutive Calendar Years</td>
</tr>
<tr>
<td>• Hearing evaluation/exam</td>
<td>Not covered by Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Wellness Care</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Health Evaluation and Physical Exam (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostrate screening and more)</td>
<td>Preferred Contracted Provider: Health Dynamics</td>
</tr>
<tr>
<td></td>
<td>100% paid by Plan for Retired Employee and spouse once every Calendar Year</td>
</tr>
<tr>
<td></td>
<td>Not available to Dependent children</td>
</tr>
</tbody>
</table>

### HEALTH CENTER BENEFITS

**For Covered Individuals That Are Medicare-Eligible and Are Enrolled in Comprehensive Medicare Supplement Benefits**

Health Center Services 100% paid by Plan

Calendar Year Deductible does not apply
# PRESCRIPTION BENEFITS
Contracted Network Provider: Express Scripts, Inc. and Diplomat Specialty Pharmacy. Not available to Deferred Lathers or to Medicare-eligible individuals with Medicare Part D coverage.

<table>
<thead>
<tr>
<th></th>
<th>Express Scripts Retail Pharmacy Network (Lesser of 100 units or a 30 day supply)</th>
<th>Express Scripts Mail Order Program (Up to a 90 day supply through mail order)</th>
<th>Diplomat Specialty Pharmacy (For specialty drugs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic Co-payment</strong></td>
<td>$5</td>
<td>$12.50</td>
<td>Does not apply</td>
</tr>
<tr>
<td><strong>Single-Source Brand Co-payment</strong> (A generic is not available)</td>
<td>20% $10 minimum Co-pay per drug with a $100 maximum</td>
<td>20% $25 minimum Co-pay per drug with a $250 maximum</td>
<td>Does not apply</td>
</tr>
<tr>
<td><strong>Multi-Source Brand Co-payment</strong> (A generic is available)</td>
<td>35% $20 minimum Co-pay</td>
<td>35% $50 minimum Co-pay</td>
<td>Does not apply</td>
</tr>
<tr>
<td><strong>Specialty Medications Co-payment</strong> (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc.)</td>
<td>Does not apply</td>
<td>20% $20 minimum Co-pay per drug with a $100 maximum</td>
<td>Does not apply</td>
</tr>
<tr>
<td><strong>Generic/Multi-Source Brand Out-of-Pocket Maximum per Calendar Year</strong></td>
<td>$1,500 per Covered Individual/$3,000 per family</td>
<td>Does not apply</td>
<td>$1,500 per Covered Individual/$3,000 per family</td>
</tr>
<tr>
<td><strong>Single-Source Brand Out-of-Pocket Maximum per Calendar Year</strong></td>
<td>$1,500 per Covered Individual/$3,000 per family</td>
<td>Does not apply</td>
<td>$1,500 per Covered Individual/$3,000 per family</td>
</tr>
<tr>
<td><strong>Specialty Medication Out-of-Pocket Maximum per Calendar Year</strong></td>
<td>Does not apply</td>
<td>Does not apply</td>
<td>$1,500 per Covered Individual/$3,000 per family</td>
</tr>
</tbody>
</table>

## Excluded Coverage

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Coverage Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Term Disability Benefit</td>
<td>No coverage</td>
</tr>
<tr>
<td>Life Insurance Benefits</td>
<td>No coverage</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment Insurance Benefits</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

## Insured Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Benefits</td>
<td>Delta Dental of Illinois</td>
</tr>
<tr>
<td>Vision Benefits</td>
<td>DeltaVision with EyeMed Vision Care Network</td>
</tr>
</tbody>
</table>
How Certain Services Are Covered under Comprehensive Medical Benefits

If you are not yet Medicare-eligible, the Welfare Fund covers many Medically Necessary expenses. The information below provides more detail on how certain services are covered, limited or excluded from coverage.

The Plan does not restrict coverage for a pre-existing medical condition.

Non-PPO charges will be considered at the applicable PPO Calendar Year Deductible and Coinsurance rate.

Important: Charges in connection with travel for the patient’s or the family’s convenience, Hospital-to-home charges (unless Medically Necessary) and non-Emergency transports (except as mentioned above) are NOT covered.

Questions? Contact BCBSIL at 855-354-1858 Monday–Friday from 8:00 a.m. to 6:00 p.m. (CT).

Acupuncture Care

See Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit) on page 36.

Ambulance Service

The Plan covers professional ambulance service when used to transport you to the nearest hospital for treatment. Also covered is transportation to another Hospital, rehabilitation facility, Extended Care, Skilled Nursing Facility or Hospice Facility.

Air or water ambulance is provided for Emergency transportation to the nearest facility for a life-threatening condition that dictates that the time needed to transport by ground ambulance would endanger health and/or survival, or the point of pick-up is inaccessible by land vehicle.

Anesthesia or Sedation

The Plan covers Medically Necessary general anesthesia or sedation used in treatment of an Illness or Injury.

General anesthesia or sedation for the convenience of the Covered Individual or Physician; or to alleviate fear, stress or anxiety is not covered.

Bariatric Surgery (also known as Gastrointestinal Surgery)

The Plan provides coverage for bariatric surgery for morbid obesity based on Medical Necessity. To qualify for coverage contact BCBSIL at 855-354-1858.
**Behavioral Health Care**

The Plan provides benefits for Behavioral Health care and treatment through the Plan’s Contracted Provider, BCBSIL.

The Plan does not cover:

- Treatment for educational disorders related to learning, motor skills, communication and pervasive developmental conditions, except as allowed under the *Therapy Services (Physical, Speech and Occupational)*, as described on page 44.
- Services including custodial services, educational training, vocational rehabilitation, hypnosis, sleep therapy, employment counseling, back-to-school counseling, return-to-work services, work hardening programs, driving safety and services, training, educational therapy or non-medical ancillary services for learning disabilities and *Developmental Disabilities*, except as allowed under the *Therapy Services (Physical, Speech and Occupational)*, as described on page 44.
- Charges for treatment of a medical condition that are covered under any other portion of the Plan;
- Charges for treatment of a condition that requires care in a custodial facility or group home;
- Room and Board Charges beyond the discharge time;
- Private room charges for the patient’s convenience; and
- Charges for personal services or items and guest food trays.

**Breast-Feeding Support and Equipment**

The Plan covers counseling and *Durable Medical Equipment (DME) and Supplies* when provided through a PPO Provider, including support and counseling for prenatal and postnatal lactation and equipment for a female Covered Individual who is lactating and requests a breast pump following the delivery date of a child. The Durable Medical Equipment is covered as follows:

- Purchase of one breast pump and related initial supplies (tubing, shields and bottles);
- Rental of a Hospital-grade breast pump for the period a newborn is confined in the Hospital after the mother is discharged (generally a Hospital-grade breast pump is not considered Medically Necessary once the newborn is discharged); or
- Rental of a Hospital-grade breast pump is considered Medically Necessary for up to 12 months of age for babies who have congenital disorders that interfere with feeding.

The Plan does not cover:

- Breast pumps purchased at a retail location;
- The purchase or rental of Hospital-grade breast pumps, unless Medically Necessary;
- Ongoing supplies, replacement tubing, bottles or storage bags, nursing bras, pads or creams;
- Services provided by individuals who are not licensed under state law to provide medical services or an individual who is not a certified lactation consultant; and
- Donor breast milk and all related services and fees.
**Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**

The Plan covers chiropractic, acupuncture and naprapathic care, up to the benefit maximums as shown in the *Schedule of Benefits*, when performed by a licensed provider acting within the scope of his license.

Services rendered or provided by a chiropractor, acupuncturist or naprapath, including office visits, evaluations, X-rays, laboratory, orthotics, manual manipulations or adjustments, diathermy and all other therapeutic physical therapy modalities for musculoskeletal conditions will be considered and applied to the benefit maximum.

The Plan does not cover:
- Services for Dependent children;
- Prescription drugs, nutritional supplements and homeopathic medicine(s);
- Educational materials, such as books or videos;
- Exercise equipment; and
- Services which are not consistent to the diagnosis.

**Clinical Trials**

The Plan covers routine patient costs incurred in connection with certain approved clinical trials to the extent required under the Affordable Care Act. You must use a PPO provider if a PPO Provider is participating in the approved clinical trial and the PPO Provider will accept you as a participant in the approved clinical trial. The Plan does not otherwise cover charges for services or items defined by the Plan as *Experimental or Investigational*. For more information on the specific services and clinical trials covered, please call BCBSIL at 855-354-1858.

**Contraceptives**

The Plan covers education, counseling and contraceptive methods for women with reproductive capacity, to the extent required under the Affordable Care Act, as follows:

- The following FDA-approved contraceptives are covered under the Prescription Drug benefit when prescribed by a Physician:
  - Generic oral contraceptives;
  - Generic Emergency contraceptives;
  - Patches; and
  - Vaginal rings.
- FDA-approved contraceptive/contraceptive methods (including insertion and removal of devices and associated procedures) are covered under the Comprehensive Medical Benefit when prescribed by a Physician:
  - Diaphragms, sponges, cervical caps, female condoms and spermicide;
  - Intrauterine devices (IUDs);
  - Implants or implantable rods; and
  - Injectables.

The Plan does not cover:
- Brand-name oral contraceptives; and
- Abortion/abortifacient drugs.

**Contraceptives obtained through a prescription are covered only if the Covered Individual is enrolled in the Prescription Drug benefit.**
Cosmetic Surgery
The Plan covers Cosmetic surgery to repair defects that result from a surgery, provided the subsequent repair is performed within one year from the date of the surgery that caused the defect.

The Plan does not cover:
• Cosmetic surgery that is not Medically Necessary or is performed solely to improve appearance;
• Charges for vein treatments that are Cosmetic or are not Medically Necessary; and
• Liposuction.

Diagnostic X-Ray and Lab Tests
The Plan covers diagnostic X-rays and laboratory tests for services that are consistent with the diagnosis.

The Plan does not cover pre-employment physicals.

Diagnostic Imaging
The Plan covers diagnostic imaging (MRI, CAT/CT, PET, bone scans, mammography, etc.) for services that are consistent with the diagnosis. The Plan does not cover routine charges outside the wellness care benefit as described on page 45.

Durable Medical Equipment (DME) and Supplies
The Plan covers DME and supplies from a licensed and accredited Durable Medical Equipment Provider when prescribed by a Physician. You must submit documentation establishing Medical Necessity for all DME purchases or rentals to BCBSIL.

Repair, maintenance and replacement of equipment is based on Medical Necessity and limitations may apply. Sealed batteries required for electric wheelchairs are covered under the DME and Supplies benefit.

The Plan does not cover:
• Rental fees in excess of the purchase price for the DME;
• Non-sealed lead acid or alkaline batteries;
• Home modifications to accommodate equipment;
• Repair, maintenance or replacement of DME due to misuse or abuse;
• Replacement of DME that has been lost or stolen;
• Repairs, replacement and maintenance of rented items; and
• Charges for air purifiers, humidifiers, water purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation for patient convenience, pillows, mattresses, water beds, air conditioners, exercise equipment, exercise programs or for any personal convenience items that are not corrective devices or appliances.

Submit DME documentation establishing Medical Necessity to:
BlueCross BlueShield of Illinois
P.O. Box 805107
Chicago, IL 60680
Fax: 217-442-4809
**Emergency Room Care**
The Plan covers Emergency Room care for a condition that:

- Results from symptoms that occur suddenly and unexpectedly;
- Requires immediate Physician care to prevent death or serious impairment of health; and
- Poses an imminent serious threat to you or to others.

For Emergency Room visits that do not require a Hospital admission, a Co-payment applies. The Co-payment will not apply if you are admitted to the Hospital as an inpatient within 72 hours of the Emergency Room visit for the same condition or held in the observation unit for more than 24 hours for the same condition. Non-PPO charges will be considered at the applicable PPO Coinsurance rate and subject to the Non-PPO Deductible.

The Plan does not cover charges for Emergency Room care incurred due to a Work-Related Illness or Injury.

**Extended Care/Skilled Nursing Facility**
The Plan covers Medically Necessary inpatient care following a hospitalization for a convalescent period in a facility that may be known as a Convalescent Facility, Extended Care Facility/Skilled Nursing Facility.

An “approved confinement” is one where the:

- Attending Physician certifies that such confinement and nursing care are Medically Necessary for recuperation from an Illness or Injury and that it is not for Custodial Care;
- Confinement is due to an Illness or Injury that required and was preceded by at least three consecutive days of a Hospital confinement for which Plan benefits are payable;
- Confinement begins within 30 days after termination of a Hospital confinement or within 14 days after termination of an Extended Care/Skilled Nursing Facility confinement for which Plan benefits are payable;
- Assessment of the condition is performed by the attending Physician and skilled nursing staff (the first assessment must be within the first eight days); and
- The attending Physician continues to personally treat you and assessments are recorded on days 14, 30, 60 and 90 until you are discharged.

A new convalescent period starts when you are free of confinement for 60 days and are readmitted to the Hospital for a minimum of three consecutive days.

Covered services include:
- **Room and Board Charges**, including charges for services such as general nursing care made in connection with occupying a room; coverage is limited to the most common semi-private room rate.
- **Other Medically Necessary Services and Supplies**, including the use of special treatment rooms; X-ray and laboratory examinations; physical, occupational or speech therapy; medications, medical supplies and equipment used in the facility; medical social services; dietary counseling and Medically Necessary ambulance transportation to the nearest medical facility that renders needed services that are not available at the Extended Care/Skilled Nursing Facility.

The Plan does not cover personal services and items, guest food trays and private rooms for patient convenience.
**Genetic Testing**

The Plan covers the following genetic testing, when ordered by a treating Physician:

- Genetic testing required under the Affordable Care Act, including Cologuard; and
- Diagnostic genetic testing.

The Plan does not cover genetic testing that is considered to be non-diagnostic testing. Non-diagnostic genetic testing includes, but is not limited to:

- Forensic testing used to identify an individual for legal purposes;
- Genetic testing used to determine the paternity of an individual;
- Genealogical testing used to determine the ancestry of an individual; and
- Genetic testing performed for the purpose of research.

**Hearing Aid Instruments**

The Plan covers charges for a hearing aid instrument or its repair. If you use a Non-PPO Provider for these services, you must file a Claim with BCBSIL or the Contracted Provider and submit a copy of itemized bills for the hearing aid indicating the name, model number, battery power and frequency response of the recommended hearing aid.

The Plan does not cover:

- Hearing exams;
- A hearing aid instrument not specifically prescribed by an otologist or otolaryngologist or, as appropriate, another provider acting within the scope of his license; and
- Hearing aid batteries.

**Home Health Care**

The Plan covers home health services and supplies in your home when ordered by a treating Physician and provided by a [Home Health Agency] in order to obtain a specified medical outcome. Each house call made by a member of the home health care team counts as one visit. Each house call up to four hours made by a home health aide also counts as one visit. However, if all visits are performed on the same day, by the same agency, they count as only one visit. Medically Necessary home health services provided in your home as an appropriate cost-effective alternative to care in another setting (such as a Hospital, inpatient Skilled Nursing Facility or long-term care facility), include:

- Physical, occupational, respiratory and speech therapy when used to restore loss of an established function caused by an illness or injury;
- Medical supplies, DME, prescription drugs, enteral feeding, diagnostic X-ray and laboratory tests for services, if these services and supplies would have been covered had you been confined in a Hospital or Convalescent Facility;
- Skilled nursing care on a part-time or intermittent basis, including services and care that can only be performed safely and effectively by a licensed nurse (either a Registered Nurse [RN] or Licensed Practical Nurse [LPN], licensed vocational nurse [LVN]) or another provider acting within the scope of the provider's license; and
- Medical social services, under the direction of a Physician.

A written Treatment Plan must outline treatment goals and be submitted with the request for specific services and supplies. Periodic review of the Treatment Plan and progress toward those goals may be required. The Plan does not cover:

- 24-hour-a-day home health care;
- Home delivery of meals;
- Homemaker services, such as shopping, cleaning and laundry, when this is the only care needed and when these services are not related to your Treatment Plan;
- Custodial care, domiciliary care, respite care, rest cures or personal care given by a home health aide such as bathing, dressing and using the bathroom when this is the only care provided; and
- Private duty nursing.
**Hospice Care**

The Plan covers Hospice care for up to 180 days per Covered Individual's lifetime if a Physician certifies the Covered Individual has six months or less to live with a condition that would benefit from Hospice care at home, in an outpatient setting or in an institutional setting that is approved by Medicare as an approved Hospice program. The Plan provides Hospice care benefits beginning on the date your attending Physician certifies a diagnosis of terminal illness and you are accepted into a Hospice program.

Covered Hospice care expenses include Room and Board Charges, up to the facility's semi-private room rate and other services and supplies including Doctor services, nursing care and equipment, supplies and prescription drugs for pain management.

The Plan does not cover:

- Room and Board Charges if Hospice services are provided in the home;
- Long-term inpatient care;
- Prescription drugs to cure an Illness;
- Administrative services;
- Homemaker or caretaker services and any services or supplies not solely related to the care of a Covered Individual, including sitter or companion services for the Covered Individual who has an Illness, house cleaning, general maintenance of the Covered Individual's home or childcare;
- Transportation, except when Medically Necessary;
- Any services or supplies not provided as core services by the Hospice program providing the Hospice care;
- Home-delivered meals;
- Funeral arrangements;
- Pastoral or bereavement counseling; and
- Respite care services.

**Hospital Care**

The Plan covers Hospital care for up to 180 days per Calendar Year as follows:

- Inpatient Hospital including a semi-private room with nursing services and supplies, nursery charges for newborns and all operating rooms and supplies, equipment, appliances and drugs as furnished for care. Charges for a private room if Medically Necessary for conditions that include, but are not limited to, contagious or communicable diseases;
- Outpatient Hospital, including services and supplies otherwise provided on an inpatient Hospital basis, facility fees for outpatient surgery and treatment including X-rays, radium therapy and other radioactive substances, chemotherapy, laboratory and diagnostic radiology and imaging.

The Plan does not cover:

- Room and Board Charges beyond the discharge time;
- Charges for personal services or items and guest food trays;
- Hospital admission charges solely for X-rays, laboratory, electrocardiographic examinations or physical therapies;
- Private rooms or private nursing charges for patient convenience; and
- Charges for medical records or to review medical records, write evaluations or special reports, to complete school, camp or immunization records, or to complete Claim forms.
Infertility

The Plan covers infertility services and supplies for the diagnosis and treatment of infertility or the promotion of conception for you, the Employee, and your spouse. Infertility prescription drugs are covered under the Plan’s Comprehensive Medical Benefits, subject to applicable PPO and Non-PPO Deductibles and Coinsurance. Genetic testing is covered under the Plan’s Genetic Testing benefit.

The Plan does not cover:

• Reversal of an elective sterilization procedure;
• Infertility treatments after the reversal of an elective sterilization procedure;
• Medical services rendered to a surrogate for purposes of childbearing when the surrogate is not a Covered Individual;
• Cryopreservation or similar procedures for the storage of sperm, eggs and embryos;
• Any expenses incurred by an egg or sperm donor;
• Harvesting of eggs or semen from a donor other than you or your spouse;
• Infertility treatments that are Experimental or Investigational in nature;
• Ovulation kits, sperm testing kits and supplies; and
• Infertility treatment or services for a Dependent child.

Infusion Therapy

The Plan covers Infusion Therapy ordered by a Physician, including the services and supplies required. In general, if a medication is administered in a Physician’s office rather than an infusion center, the medication should be obtained through the Diplomat Specialty Pharmacy, the Fund’s Contracted Provider for specialty drugs. In most cases, chemotherapy drugs received by infusion are covered under the Plan’s Comprehensive Medical benefits.

The Plan does not cover wellness infusions or infusions of vitamins or iron.

If you have any questions about Infusion Therapy, please contact Diplomat at 866-722-6110.

Naprapathic Care

See Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit) on page 36.

Nutritional Counseling

The Plan covers nutritional counseling for chronic diseases as required by the Affordable Care Act when ordered by a Physician, or if appropriate, another provider acting within the scope of his license, and a Network Provider is used. The services may be rendered by a registered dietitian or a Medicare-approved nutrition professional for the diagnosis of obesity, diabetes, cardiovascular and kidney disease, or other Network Provider acting within the scope of his license. The Plan also covers nutritional counseling when you participate in the bariatric program through BCBSIL.
**Oral and Maxillofacial Surgery**

The Plan covers oral and maxillofacial surgery by a Doctor of Medicine (MD) or, as appropriate, another provider acting within the scope of his license, for Medically Necessary services.

The Plan does not cover:

- Orthodontic, periodontics, endodontic and prosthetic services;
- Dental services, including:
  - Restorative care to the dentition including crowns, fillings, bridges, partial and full dentures;
  - Occlusal adjustments or equilibration to the teeth unless for the treatment of temporomandibular joint (TMJ) disorder (see page 44);
  - Dental applications, including bite splints and metal-based occlusal appliances;
  - Extraction of unerupted or partially erupted, malpositioned or impacted teeth;
  - Surgical preparation of mouth for dentures;
  - Surgeries for gum disease or orthodontic treatment;
  - Alveolectomy and alveoplasty;
  - Frenulectomy when performed by a Dentist;
  - Vestibuloplasty;
  - Services for oral surgery procedures performed by a Dentist; and
  - Unsubstantiated or unproven accidental injuries.

**Organ Transplants**

The Plan covers organ and tissue transplants, including procurement, surgery and complications that result from the procurement and surgery. The Plan covers donor expenses associated with living donor evaluations, the donation surgery procedure and required postoperative care.

The Plan does not cover:

- Expenses for treatment of any other donor health-related concerns that may be identified during the donor evaluation process;
- Expenses that fall outside the transplant donor evaluation, such as, but not limited to, annual physicals, travel, lodging, lost wages and other non-medical expenses;
- Costs of anti-rejection drugs following discharge, other than those covered under the Prescription Drug benefit; and
- Charges incurred by organ donors that are not related to the original donor transplant procedure or complications that result from such surgeries, procedures or treatments.

**Physician Services**

The Plan covers services provided by a Physician, as defined in the Glossary.

The Plan does not cover:

- Services that are inconsistent with the diagnosis;
- Charges for medical records or to review medical records, write evaluations or special reports, to complete school, camp or immunization records, or to complete Claim forms;
- Multiple charges for Office Visits for the same condition or diagnosis from the same Physician for the same date of service;
- Charges for telemedicine or virtual appointments;
- Charges for telephone or email consultations or interviews; and
- Charges for missed appointments.
Pregnancy Care
Obstetrical, pre-natal and post-natal care and delivery are covered when provided by a Physician or a Certified Nurse Midwife. For lactation coverage, see Breast-Feeding Support and Equipment on page 35. For genetic testing coverage, see Genetic Testing on page 39.

The Plan does not cover:
- Prenatal classes;
- Services provided by a doula, unless licensed by a recognized state licensing entity;
- Home pregnancy tests;
- Paternity testing; and
- Non-prescription prenatal vitamins.

Prosthetics
The Plan covers artificial limbs, including artificial legs, arms and eyes when prescribed by a Physician. The Plan also covers hair prosthesis, including a wig or hairpiece due to hair loss from chemotherapy or radiation therapy resulting from a cancer diagnosis. The Plan may cover replacement prosthetics if determined to be Medically Necessary.

The Plan does not cover:
- Hair transplants, hair plugs or hair weaves;
- The cost of maintenance for a wig, hairpiece or scalp prosthetic, including styling and cleaning;
- Diagnostic or therapeutic methods intended to encourage hair regrowth;
- Wigs, hairpieces or other scalp prosthetics for hair loss caused by something other than a cancer diagnosis; and
- Replacements due to loss or theft.

Reconstructive Breast Surgery
The Plan covers post-mastectomy reconstructive breast surgery and breast prosthesis, without regard to the time elapsed since the mastectomy, as follows:
- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast for the purpose of achieving reasonable breast symmetry; and
- Prostheses and treatment for physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending provider and the patient.

Sterilization
The Plan covers elective sterilization as shown in the Schedule of Benefits. The Plan does not cover reversal of a sterilization procedure or sterilization for a Dependent child, except as required by the Affordable Care Act.

Substance Use Disorders
The Plan covers inpatient and outpatient Covered Services for treatment of Substance Use Disorders through the Plan’s Contracted Provider, BCBSIL.

The Plan does not cover:
- Charges for treatment of a medical condition that is covered under any other portion of the Plan;
- Care in a custodial facility or group home;
- Room and Board Charges beyond the discharge time;
- Private room charges for the patient’s convenience; and
- Charges for personal services or items and guest food trays.

Surgi-Centers
The Plan covers Surgi-Center services and supplies only when you use a PPO Surgi-Center, or a Surgi-Center affiliated with a Hospital, whether PPO or Non-PPO Hospital.

The Plan does not cover any freestanding Non-PPO Surgi-Center facilities that are not affiliated with a Hospital.
Surgical Assistants and Assistant Surgeons
The Plan covers fees for surgical assistants and/or assistant surgeons when the surgical procedure warrants the necessary assistance of another Physician (assistant surgeon) or other trained personnel such as a Physician Assistant (PA) or Registered Nurse First Assistant (RNFA), acting within the scope of their license.

Surgical Consultations
The Plan covers charges for a surgical consultation and associated laboratory or X-ray examinations.

Temporomandibular Joint (TMJ) Dysfunction
The Plan covers the following services and supplies for the diagnosis and treatment of temporomandibular joint (TMJ) disorders:

- Diagnostic imaging procedures;
- Physical or occupational therapy;
- Appliances and their adjustments for TMJ and bruxism (occlusal);
- Non-surgical treatments; and
- Surgical procedures, including related hospitalization.

The Plan does not cover treatment of restorations of the dentition, supporting tissues and bone.

Therapy Services (Outpatient Physical, Speech and Occupational)
The Plan covers outpatient physical, speech and occupational therapies as described below:

- **Restorative/Rehabilitative Therapy**: The Plan covers outpatient physical, speech and occupational therapies up to the benefit maximums shown in the *Schedule of Benefits*. After the benefit maximum has been reached, no other payment is made under the Plan with the following exception: If the maximum benefit is reached for the outpatient treatment of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed or other head traumas, spinal cord injuries, multiple or complicated fractures or other catastrophic diagnoses with neurological implications, significant or multiple injuries and/or illnesses. Medical records will be required for additional benefit consideration.

- **Developmental Delay/Habilitative Therapy**: The Plan covers Medically Necessary outpatient habilitative (to teach) physical, occupational and speech therapies for eligible Dependents through age 18 diagnosed to have Developmental Disabilities. Before the Plan will consider benefits, you must submit to BCBSIL a letter of Medical Necessity from the attending Physician for the therapies prescribed.

Urgent/Immediate Care Facilities and Retail Clinics
The Plan covers Urgent/Immediate Care Facilities and retail clinics for conditions that are not life-threatening. You may be able to save time and money by going to your local PPO Urgent/Immediate Care Facility or Retail Clinic. These types of facilities allow walk-ins, have extended hours, their Doctors can treat non-life-threatening medical situations, perform basic X-rays and lab work and prescribe prescription drugs.

You can locate a PPO Urgent/Immediate Care Facility or Retail Clinic by calling BCBSIL at 800-810-2583 or you can log on to their website at www.bcbsil.com.
Vision Surgery
The Plan covers vision surgery (e.g., glaucoma, cataract surgery). The Plan does not cover vision surgery and related expenses for correction of refractive disorders, refractive lenses, refractive keratoplasty procedures and Cosmetic blepharoplasty.

Wellness Care
The Plan covers certain wellness care services at 100% if a PPO Provider is used. The Plan intends to comply with all preventive care requirements of the Affordable Care Act.
- The Plan covers preventive items or services with an A or B rating as recommended or defined by the U.S. Preventive Service Task Force, immunizations recommended by the Centers for Disease Control (CDC), preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA) and screenings for women supported by the HRSA subject to the following:
  - Wellness care services required under the Affordable Care Act are not payable under other portions of the Plan.
  - The Plan will use reasonable medical management techniques to control costs of wellness care services provided under the Affordable Care Act.
  - If a wellness care item or service is billed separately from an Office Visit, and the primary purpose is not the delivery of the wellness care item or service covered under the Affordable Care Act, then the Plan will impose the applicable Deductible and Coinsurance for the Office Visit.
  - Wellness and preventive care does not cover the following services, unless otherwise required under the Affordable Care Act:
    » Services related to a symptomatic or diagnostic condition;
    » Examinations and tests to diagnose or verify a pregnancy;
    » Premarital examinations;
    » Paternity testing;
    » Pre-employment physicals;
    » Services that are not consistent with preventive services, as defined by the Affordable Care Act;
    » Additional testing or services to confirm an Illness or Injury diagnosed as a result of a wellness care examination or procedure;
    » Wellness care services under the Affordable Care Act are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Other services are covered under the applicable Plan benefit, not the wellness care benefit; and
    » Travel immunizations (e.g., typhoid, yellow fever, cholera, plague and Japanese encephalitis virus) are not covered.
- Smoking cessation interventions based on requirements under the Affordable Care Act. For more information, contact Quit for Life at 866-784-8454. To enroll online, visit www.quitnow.net/crcc.
- Comprehensive Health Evaluation and Physical Exam: The Health Dynamics Preventive Care Program offers a valuable look at your total health with an annual comprehensive health screening called the Preventive Care Exam. This exam is offered to you and your spouse at no charge, to help you understand your health risks and where you may need to make healthy changes. The Health Dynamics program is not available to Dependent children.

The Exam includes a comprehensive health history questionnaire, a thorough blood chemistry analysis, screenings for prostate or breast cancer, a complete Physician-directed physical and much more.

To locate a Health Dynamics Provider call 414-443-0200 or go to their website at www.healthdynamics.com/locations99. Representatives are available Monday–Friday from 8:00 a.m. to 5:00 p.m. (CT).
General Plan Limitations and Exclusions

What Is NOT Covered under Comprehensive Medical Benefits

The exclusions below are not all-inclusive, because exclusions will be applied based on facts and circumstances of each Claim. Pages 34–45 list specifics on how the Plan covers certain services, as well as limits and exclusions that apply to those services. In general, no benefits are payable under the Plan for the following:

- Any expenses incurred during a period in which you or a Dependent are not enrolled for benefits under the Plan.
- Any expenses incurred by a person who does not meet the Plan’s definition of a Covered Individual.
- Charges for services or supplies that exceed the Reasonable and Customary Allowance.
- Charges that would not have been made if no coverage existed or charges that you would not be required to pay.
- Expenses that may result from your failure to use an HMO provider when required to do so by another insurance plan.
- Charges that exceed the various benefit maximums that apply to the different benefits under this Plan.
- Charges for services and supplies that are:
  - Not Medically Necessary for treatment of a Non-Occupational Illness or Injury;
  - Inconsistent to the diagnosis;
  - Inconsistent with industry standards; or
  - Not recommended, performed or approved by the attending Physician; or another provider acting within the scope of his license.
- Charges incurred due to any Occupational Illness or Injury sustained while performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit.
- Charges for items defined by the Plan as Experimental or Investigational. However, to the extent required under the Affordable Care Act, the Plan will not deny you the right to participate in certain approved clinical trials; deny, limit or impose additional conditions on the coverage of routine patient costs furnished in connection with participation in the clinical trial; and will not discriminate against you for participating in the clinical trial. For more information on clinical trials, see page 36 or contact BCBSIL.
- Expenses excluded under the Plan’s Coordination of Benefits provisions.
- Charges in connection with the services of blood donation, storage of autologous blood or umbilical-cord blood banking.
- Charges for physical examinations required for employment purposes or court-ordered examinations.
- Food supplements or baby formulas, unless administered through a feeding tube.
- Penile implants, erect-aids or erectile enhancement prescription drugs, except if the prescription drugs are prescribed as a Medically Necessary Treatment Plan for an Illness, other than impotency.
- Premarital examinations or counseling.
- Paternity testing.
- Expenses of an elective abortion or the abortion pill, except when the mother’s life is in danger as determined by a medical diagnosis, or in instances of verifiable rape or incest.
- Charges for care or services, including prescription drugs, implants, hormone therapy and surgery for any operation or treatment in connection with a sex transformation, transsexualism, gender dysphoria or sexual reassignment or transfer, except for services provided by the Contracted Provider for Behavioral Health and/or Substance Use Disorders.
- Personality or emotional testing and/or examinations, except to the extent covered under the Behavioral Health and Substance Use Disorders benefit.
- Charges for bereavement counseling, pastoral counseling, financial or legal counseling, marital counseling and funeral arrangements.
• Vitamin supplements, except to the extent required under the Affordable Care Act.
• Colonics or homeopathic remedies or procedures.
• Vitamin K-1, except when used to counteract a prescription blood thinner such as Warfarin or Coumadin.
• Vitamin B-12 injections, except for treatment of pernicious anemia and cancer-related chemotherapy.
• Charges for massage therapy, unless prescribed for therapeutic purposes to treat an illness or injury in a clinical setting.
• Charges for hypnosis therapy.
• Charges for chelation therapy, except when approved by the FDA as an appropriate Medically Necessary course of treatment. Prior authorization and appropriate laboratory testing may apply.
• Charges for smoking cessation therapies or products, except to the extent required under the Affordable Care Act or the Quit for Life Program.
• Charges for hair prostheses, wigs, toupees, hair implant plugs or hair loss products, except for wigs, hairpieces or hair prosthetics for hair loss due to chemotherapy or radiation treatment after a cancer diagnosis.
• Charges for treatment of alopecia or hirsutism.
• Charges for excessive hair removal, electrolysis, depilatories or other hair removal treatments and products.
• Charges for care or treatment in a health resort, at an alternative medical center or a holistic center.
• Charges for homemaker or caretaker services, such as sitter or companion services for transportation, housecleaning and house maintenance.
• Custodial care.
• Instruction, classes or testing relating to motor vehicle Accidents.
• Charges for services or supplies that are paid for or otherwise provided for under any law of a government, except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian Employees and their Dependents.
• Charges for services or supplies that are furnished, paid for or otherwise provided for, by reasons of past or present service of any person in the Military Service.
• Charges from a Veterans Administration Hospital or a Physician employed by such Hospital when the Veterans Administration Hospital has the responsibility to provide the service or care for an illness or injury related to Military Service.
• Charges for treatment that requires care in a group home.

**IMPORTANT**
If you are Medicare-eligible and covered by the Medicare Supplement benefits, the Plan excludes coverage for services and items not covered by Medicare.

What Is NOT Covered under the Dental Benefit
Contact Delta Dental of Illinois at 800-323-1743 for what’s not covered under the Dental benefit.

What Is NOT Covered under the Vision Benefit
Contact DeltaVision at 866-723-0513 for what’s not covered under the Vision benefit.
What Is NOT Covered under the Prescription Drug Benefit

The Plan does not cover:

- Prescription drugs, indications and/or dosage regimens determined to be not Medically Necessary or Experimental, Investigational or unproven medication or therapies, or drugs not approved by the United States Food and Drug Administration (FDA) for the intended use (off label).
- Prescription drugs requiring prior authorization that are dispensed without prior authorization from the Contracted Provider.
- Any medication prescribed in a manner other than in accordance with criteria developed by the Contracted Provider.
- Erectile dysfunction drugs, except if Medically Necessary and prescribed as a Treatment Plan for an Illness, other than erectile dysfunction.
- Drugs or medicines lawfully obtainable without a prescription from a Physician or Dentist, except to the extent required under the Affordable Care Act.
- Therapeutic devices, support garments or other appliances regardless of their intended use.
- Any charges for the administration of a prescription drug.
- Medication that is to be taken by or administered to the Covered Individual, in whole or in part, while a patient in a licensed Hospital, Extended Care/Skilled Nursing Facility or similar institution that operates a facility for dispensing pharmaceuticals on its premises or allows to be operated on its premises, except as provided for in the exception for Extended Care/Skilled Nursing Facilities.
- A prescription in excess of the quantity specified by the Physician or Dentist, or any refill dispensed after one year from the order of a Physician or Dentist.
- Prescription drugs that may be properly received without charge under local, state or federal programs, including Workers’ Compensation.
- Weight loss drugs.
- Smoking cessation products, except as coordinated with Quit for Life or as required for preventive care under the Affordable Care Act.
- Drugs to stimulate hair growth.
- Infertility drugs (when treatment of infertility is covered, infertility prescriptions are covered under Comprehensive Medical Benefits).
- Acne drugs for Cosmetic reasons.
- Vitamins, food supplements, infant formulas or homeopathic drugs.
- Growth hormones unless Medically Necessary, as determined by the Contracted Provider and obtained through the Specialty Care Pharmacy Program.

What Is NOT Covered under the Hearing Aid Instrument Benefit

The Plan does not cover:

- Hearing evaluations/examination.
- A hearing aid instrument not made by a provider acting within the scope of his license.
- Hearing aid batteries.
Claims and Appeals

This section describes the procedures for filing Claims for benefits from the Plan. It also describes the procedures for you to follow if your Claim is denied, in whole or in part, and you wish to appeal the decision.

**Required Forms**

When you are first eligible for benefits and thereafter on an annual basis or upon request, you must complete certain required forms that validate census data including information about your spouse, Dependent child(ren), and other insurance coverage. Coverage will not be effective for Dependents until the required forms are fully completed and accepted by the Retirement Benefits Department.

As described on page 61, you must update information on file with the Fund Office by notifying the Fund Office as soon as possible of any change. Coverage may be delayed or suspended if the update or the required forms are not received in a timely manner.

**General Rules Governing Claims**

Covered Individuals and providers may submit Claims in paper form or through Electronic Data Interchange. Claims must be submitted to the Plan’s Contracted Provider of service.

If a Covered Individual’s provider and service(s) were obtained outside the Contracted Provider’s Network area, the provider must file the Claim with the Contracted Provider or the local affiliate of the Contracted Provider, if applicable.

Each Claim must include:

- Patient name and date of birth;
- The Participant’s name and Social Security number or other ID number assigned by the Fund;
- Date of service or date of fill or refill for prescription drug Claims;
- Specific services performed and expenses charged for each service;
- Diagnosis and type of service defined by HCPCS, CPT, ICD, CDT, or other nationally recognized codes, including individual charges, for each service;
- Attending Physician’s or care provider’s name and federal tax ID number (not required for prescription drug Claims);
- Place of service;
- Billing address; and
- Previous balances paid.

A Covered Individual must pay any amounts not paid by the Fund, with the exception of PPO Network discounts or discounts that may be negotiated between the Plan and the provider on Out-of-Network Claims. PPO or other negotiated discounts do not apply to expenses that are not covered by the Plan.

A Covered Individual is prohibited from assigning his rights under the medical portion of the Plan to a third party or in any way alienating the Covered Individual’s Claims for benefits. Any attempt to assign rights or in any way alienate a Claim for benefits will be void and will not be recognized by the Fund as an assignment. The Fund will treat any document attempting to assign your rights, or to alienate a Claim for benefits to a provider, as an authorization for direct payment by the Fund to the provider. In the event that the Fund receives a document Claiming to be an assignment of benefits, the Fund may send payments for the Claims to the provider, but will send all Claim documentation, such as an explanation of benefits, and any procedures for appealing a Claim denial directly to the Covered Individual. If the Fund denies the Claim, only you, your spouse, the patient or his Authorized Personal Representative will have the right to appeal.

The Fund will pay Claims only when covered under the terms of the Plan provisions under which a Covered Individual is eligible. If the Fund pays Claims that it is not required to pay, it may recover and collect payments from a Covered Individual or any other entity or organization to whom the Fund was not required to make the payment or that received an erroneous payment. The Fund may recover such erroneous payments through, but not limited to, an offset or reduction of any future benefits a Covered Individual, or other eligible Dependent(s), may be entitled to receive from the Fund. The Fund shall be permitted to pursue legal and equitable remedies to recover overpayments.
For purposes of this section, the Claims Fiduciary means the entity that has full discretionary authority to interpret the terms of the Plan and to decide benefit Claims under the Plan and the appeal of such decision, and to maintain any applicable external review process. The Plan’s Claims Fiduciary is the Board of Trustees unless the Trustees take action to delegate such authority to a third party Claims Fiduciary, such as to an insurance carrier or to a third party service provider responsible for maintaining a benefit program under the Plan.

Please note that the Trustees have designated Claims Fiduciaries for the Plan who have the authority to decide and review all benefit Claims and all denied Claims upon appeal under the Plan as follows:

- **Fund Office** for eligibility, premiums and enrollment.
- **BCBSIL** for Medical, Behavioral Health and Substance Use Disorder Claims.
- **Delta Dental of Illinois** for dental Claims.
- **Express Scripts, Inc.** for prescription drug Claims.
- **Diplomat Specialty Pharmacy** for specialty drug Claims.
- **DeltaVision in association with EyeMed Vision Care** for vision Claims.

Please see Important Contact Information on page 2 for telephone numbers and website addresses.

The above Claims Fiduciaries are named fiduciaries under the Retiree Plan and have the authority to make final decisions regarding Claims for benefit consideration under the Plan.

**Authorized Personal Representative**

You may designate an **Authorized Personal Representative** to act on your behalf by notifying the Retirement Benefits Department and completing and submitting an Authorized Personal Representative Form or other form or procedure required by a designated third party Claims Fiduciary. Only the Authorized Personal Representative Form issued by the Fund or other form or procedure required by a designated third party Claims Fiduciary will be accepted. If an Authorized Personal Representative is designated, correspondence relating to the Claim or subsequent appeal may be shared with the designated Authorized Personal Representative, unless otherwise specified. **An individual who holds a health care power of attorney is deemed an Authorized Personal Representative.**

**Only the Authorized Personal Representative Form issued by the Fund or other form or procedure required by a designated third party Claims Fiduciary will be accepted.**

You may obtain an Authorized Personal Representative Form from the Fund’s website at www.crccbenefits.org, or by calling 312-787-9455, menu option 4. To inquire regarding necessary forms or procedures for designating an Authorized Personal Representative for benefits administered on behalf of the Plan through a third party, please contact the appropriate service provider listed on page 2 of this Summary Plan Description.
Types of Health Care Claims
There are several types of Claims under the Plan:

- **Health Care Claims** include Medical, Behavioral Health and Substance Use Disorders, prescription drug, dental, hearing, and vision Claims. Health Care Claims fall into the following categories:

  - **Pre-Service Health Care Claim:** Any Claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before the Covered Individual obtains medical care;

  - **Urgent Health Care Claim:** A subset of pre-service health Claims for which the application of the periods for making pre-service Claim determinations would, in the opinion of a Physician with knowledge of the Covered Individual’s condition, seriously jeopardize the Covered Individual’s life or health or ability to regain maximum function if normal pre-service standards were applied; or would subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment for which approval is sought;

  - **Post Service Health Care Claim:** Any Claim for health care benefits for which the Covered Individual has already received the services in the Claim; and

  - **Concurrent Care Claim:** Any Claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits, an extension of benefits, or a termination of benefits.

Submission of Claims
Claims may be submitted in paper form specified by the designated Claims Fiduciary or through Electronic Data Interchange. A provider may submit a Claim on the Claimant’s behalf. Claims recognized under the Plan include requests for Medical benefits, when accompanied by a Hospital, Physician, prescription, Behavioral Health and Substance Use Disorder, dental, hearing, or vision bill; or other type of invoice that includes the details specified below.

Incomplete Claims: If the Plan receives a document or transmission that contains, at a minimum, the following six items, it will be considered a Claim, even if additional information is required to process the Claim. If additional information is required, the Claimant will receive an extension for filing the Claim.

- Patient name and date of birth;
- Participant name and Social Security number or other ID number assigned by the Fund Office;
- Date of service or date of fill or refill for prescription drug Claims;
- Specific services performed and itemized charges for each service;
- Diagnosis and type of services as defined by HCPCS, CPT, ICD, CDT, or other nationally recognized codes, including individual charges for each service; or
- Attending Physician’s or care provider’s name and federal tax ID number (not required for prescription drug Claims).

Items not treated as Claims for Benefits include any general inquiry about benefits or the circumstances under which benefits might be paid under Plan terms.
When a Claim Must Be Filed

A Claim for benefits must be filed with the designated Claims Fiduciary within 24 months from the date of service, or other period specified by a third party Claims Fiduciary.

Processing Procedures for Initial Claims

When a Claim is submitted for benefits, the designated third party Claims Fiduciary on behalf of the Trustees will determine if the Covered Individual is eligible for benefits and will calculate the amount of any benefits payable.

The deadlines for processing the initial determination of a Claim vary by Claim category, as follows:

- **Urgent Health Care Claims**: Within 72 hours of receipt of the Claim.
- **Pre-Service Health Care Claims**: Within 15 days of receipt of the Claim.
- **Post-Service Health Care Claims**: Within 30 days of receipt of the Claim.
- **Concurrent Care Claims**: As soon as possible and in time to receive a decision before reduction or termination of the benefit.

Extension of initial determination period:

In some instances, an extension of the initial determination period may be required due to matters beyond the Claims Fiduciary’s control. The Claimant will be notified by the Claims Fiduciary if an extension is necessary. The Claims Fiduciary’s notice will include the special circumstances requiring the extension and the date the Claims Fiduciary expects to render a decision, as follows:

- **Urgent Health Care Claims**: The deadline for urgent Health Care Claim cannot be extended.
- **Pre-Service Health Care Claims**: You will be notified within the 15 day initial determination period that one 15 day extension is necessary.
- **Post-Service Health Care Claims**: You will be notified within the 30 day initial determination period that one 15 day extension is necessary.

Within the 15 day or 30 day period the Claimant will be notified when additional information is needed to process a Claim. The Claimant (or his provider, if his provider is notified) has up to 45 days to provide the requested information. If the Claims Fiduciary receives the requested information in the 45 day period, the Claim will be processed within 15 days following the receipt of the additional information. For an Urgent Care Claim, the deadline for additional information is as soon as possible but within 24 hours of the receipt of the Claim. The Claims Fiduciary must notify the Claimant of the specific information needed and the Claimant has at least 48 hours to provide the information.
If a Claim is denied, in whole or in part, the Claims Fiduciary will send the Claimant a written notice of the Adverse Benefit Determination that includes the following information:

- For Health Care Claims:
  - The specific reason or reasons the Claim was denied, in whole or in part;
  - Reference to the specific Plan provisions on which the denial was based;
  - A description of any additional information that the Claimant must submit in support of his Claim and an explanation of why the additional information is needed;
  - An explanation of the Plan’s Claim review procedures and applicable time;
  - Copy of any internal rule, guideline, protocol or similar criteria that was relied on, or the notice will include a statement that a copy is available at no cost, upon request, if relevant;
  - Copy of the scientific or clinical judgment, or the notice will include a statement that a copy of the scientific or clinical judgment is available at no cost, upon request, and
  - A statement of the Claimant’s rights under ERISA to bring a civil action and the applicable deadlines.

- For Health Care Claims, except dental and vision:
  - Information sufficient to identify the Claim, including: date of service; provider; Claim amount; the denial codes and their respective meanings: a description of any standard used in determining the denial; a provision stating that diagnosis and treatment codes and their corresponding meanings are available upon request without charge; and disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal Claims and appeals and external review processes; and

- Notice that the Claimant may request an external review with an independent review organization after the Plan’s Claims procedures have been exhausted.

**Adverse Benefit Determination Appeals**

A Claimant has the right to appeal certain denied Claims, as described for each Claim type in the sections that follow.

**Health Care Claims**

An adverse benefit determination is:

- A denial, reduction, or termination of a benefit, or failure to provide or make payment in whole or in part for a benefit; or
- Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage, as described more fully on page 78, is a cancellation or discontinuation of coverage that has a retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions in a timely manner, or other events (such as fraud).

The Explanation of Benefits (EOB) that the Claimant will receive serves as the notice of an adverse benefit determination for a Health Care Claim.

- All appeals must be in writing on the forms required by the applicable Claims Fiduciary and addressed to the applicable Claims Fiduciary. The forms must include your signature or the signature of your spouse or Authorized Personal Representative.
- A written appeal should include evidence or specific facts and Plan provisions that support a Claim for benefits. Submit a completed Appeal Form and any additional information to substantiate the appeal to the applicable Claims Fiduciary.
– An appeal must contain all of the information listed on page 51 as well as any denial codes and corresponding meanings. An appeal for Claims from an applicable third party Claims Fiduciary must contain all of the information required by the applicable Claims Fiduciary on the forms required by such Claims Fiduciary.

• Only the Claimant or his Authorized Personal Representative has the right to appeal a Claim for benefits that was denied in whole or in part. General inquiries for information on whether a certain medical procedure, prescription, Treatment Plan or other similar request is covered by the Plan are not considered a Claim for benefits.

• If a post-service Claim has been denied, in whole or in part, the Claimant or his Authorized Personal Representative have no more than 180 days after the receipt of an adverse benefit determination to file an appeal.

• Upon appeal, the Claimant has the right to:
  – Designate an Authorized Personal Representative (who may be an attorney);
  – Submit additional material, including comments, statements, or documents; and
  – Be advised of the identity of any medical expert.

• Upon appeal of all Health Care Claims except dental and vision, the Claimant also has the right to receive copies, free of charge, of all new or additional evidence considered, relied upon or generated by the Plan or the Trustees, or any new or additional rationale relied upon in connection with the Claim. Such new or additional evidence or rationale shall be provided as soon as possible and sufficiently in advance of the Trustees’ final decision in order to give the Claimant a reasonable opportunity to respond. If the new or additional evidence is received so late that the Claimant will not have a reasonable opportunity to respond within the prescribed time frame, the time period for the Claims Fiduciary to issue a decision will be tolled until the Claimant has an opportunity to respond. After the Claimant responds, or fails to respond, the Claims Fiduciary will issue its decision as soon as reasonably practicable.

• Preliminary Review. For post-service Health Care Claims, enrollment, premium payment and eligibility Claims for which the Board of Trustees is the Claims Fiduciary, the Fund Office will complete a preliminary review of the request within five business days of the Fund’s receipt of the request for an appeal to determine if:
  – The Claimant was eligible under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
  – The Adverse Benefit Determination relates to the Claimant’s failure to meet the requirements for enrollment, premium payment and eligibility under the terms of the Plan; and
  – The Claimant has completed and provided all of the required information and forms to process the appeal.

If the additional information provided in the course of an appeal is found to clearly fall within the guidelines and protocols for Claim payment, the Claim will be reconsidered. The Claimant will receive a new EOB showing the additional benefits paid. In the case of an eligibility reversal, coverage will be updated to cover any additional period of eligibility supported by the additional information provided, the Claimant will be notified of the extension and Claims denied for that period will be reopened and reconsidered.

• Review of appeals by the Appeals Committee of the Board of Trustees: Properly filed appeals for post-service Health
Care Claims and eligibility, premiums and enrollment Claims for which the Board of Trustees is the Claims Fiduciary will be reviewed at the next regularly scheduled appeals meeting of the Trustees, who meet at least quarterly. However, if the request for review is received within 30 days of the next regular meeting, the request for review will be considered at the second regularly scheduled meeting following receipt of the request. If special circumstances require a further extension of time for processing, a determination will be made at the third regularly scheduled meeting following receipt of the request for review. Prior to the start of the extension, the Claimant will be advised in writing in advance if this extension will be necessary, and will be notified of the special circumstances and the date by which a determination will be made. Once the decision has been made, the Trustees will mail their decision to the Claimant within five business days after making the determination. The Trustees’ determination on review is binding on all parties.

- Review of appeals where the Claims Fiduciary is a third party: The designated Claims Fiduciary will review the Claims appeal and provide its written decision to the Claimant within 60 days of receiving the appeal. The Claimant will receive written notice of the decision within 30 days after the appeal was received if the Claims Fiduciary has two levels of appeal.

- The Claimant has the right to access and copy (free of charge) all documents, records and other information relevant to his appeal. The Claimant also has the right to bring a civil action suit under Section 502(a) of ERISA. Any such civil action must be commenced within 12 months following the date of determination letter.

**Notice of Appeals Decision**

When the Plan notifies a Claimant of its decision on a Claim on appeal, it will provide certain information, as described in the sections that follow.

**For Health Care Claims**

- The specific reason or reasons for its decision.
- Reference to the specific Plan provisions on which the determination was based.
- An explanation of the basis for the adverse benefit determination.
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the Claimant’s Claim for benefits. Information is considered relevant if it:
  - Was relied upon by the Claims Fiduciary in making the decision;
  - Was submitted, considered, or generated regardless of whether it was relied upon; or
  - Demonstrates compliance with Claim processing requirements.

- Relevant information includes but is not limited to:
  - Relevant internal rules, guidelines, protocol or other similar criteria;
  - Explanation of the scientific or clinical judgment that formed the basis of the adverse benefit determination if the Claim is denied based on Medical Necessity, Experimental treatment or similar exclusion or limit; and
  - The identity of any medical expert who provided a determination for a Claim.
• A statement describing any further appeal procedures offered by the Plan including the Claimant’s right to obtain the information about such procedures.

• Copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that a copy is available at no cost upon request, if relevant to a Claim.

• A statement that a copy of the scientific or clinical judgment is available at no cost upon request, if relevant to a Claim that is denied due to a medical judgment which includes but is not limited to Medical Necessity, Experimental or Investigational treatment, or similar exclusion or limit.

• A statement that if the appeal is denied, the Claimant has the right to initiate a lawsuit under ERISA section 502(a). Any lawsuit must be initiated within 12 months of the denial on appeal.

For Health Care Claims, Except Dental and Vision

• Information sufficient to identify the Claim involved, including: date of service; provider; Claim amount; and any denial codes and their respective meanings; a description of any standard used to determine the denial; and a provision stating that diagnosis and treatment codes and their corresponding meanings are available upon request without charge.

• New or additional information considered, relied upon or generated during the appeal as well as any new or additional rationale for the denial, if any;

• For a Claim based on medical judgment, to request an external review from an independent review organization after the Plan’s Claims appeal procedures have been exhausted.

• Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal Claims and appeals and external review processes for Health Care Claims.

External Review of Health Care Claims

If an appealed Health Care Claim, other than a dental or vision Claim, is denied by the Appeals Committee of the Board of Trustees or a third party Claims Fiduciary, the Claimant may request further review by an independent review organization (“IRO”) as described below. External review does not apply to dental and vision Claims. Only denied Health Care Claims, other than dental or vision Claims that involve medical judgment and rescission Claims are eligible for external review.

Generally, a Claimant may request an external review only after exhausting the internal review and appeals process described above. If a Claim is denied due to failure to meet the requirements for eligibility and/or enrollment under the terms of the Plan, an external review is not available. The external review of Claims is intended to comply with applicable law and regulations and guidance as issued by the Department of Labor, Department of Health and Human Services and the Internal Revenue Service.

The External review process is as follows:

• A request for external review of a non-urgent Claim must be made, in writing, within four months of the date of the EOB indicating an adverse benefit determination or the date of the letter advising of an adverse appeal Claim benefit determination, whichever is later.
• The Claims Fiduciary will complete a preliminary review of the request within five business days of the Claims Fiduciary’s receipt of the external review request to determine whether the Claimant has:
  – Exhausted the Plan’s internal Claims and appeals process (except, in limited, exceptional circumstances); and
  – Completed the proper form to request an external review. Additional information is not required, as the information submitted for the earlier appeal of the denied Claim is deemed complete. However, if additional information is available, it may be submitted for evaluation.

The Claims Fiduciary will notify the Claimant in writing within one business day of completing its preliminary review if the request meets the requirements for external review. If applicable, the notification will inform the Claimant that the request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (EBSA) (toll-free number 866-444-EBSA (3272)).

• If the request is complete and eligible, the Claims Fiduciary will assign the request to an IRO and provide, within five business days after the assignment to the IRO, documents and information it considered in making its adverse benefit determination. The IRO is not eligible for any financial incentive or payment based on the likelihood that it would support the denial of benefits. The Claims Fiduciary will rotate assignment among IROs with which it contracts.

• Once the Claim is assigned to an IRO, the following procedures will apply:
  – If additional information is needed, the assigned IRO will notify the Claimant in writing of how he may submit additional information regarding his Claim. The Claimant has 10 business days following receipt of notice from the IRO to submit the information.
  – If the Claimant submits additional information related to the Claim, the assigned IRO will, within one business day, forward that information to the Claims Fiduciary. Upon receipt of any such information, the Claims Fiduciary may reconsider its adverse benefit determination that is the subject of the external review. Reconsideration by the Claims Fiduciary will not delay the external review. However, if upon reconsideration, the Claims Fiduciary reverses its adverse benefit determination, it will provide written notice of its decision to the Claimant and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
The IRO will review all information and documents received in a timely manner. In reaching a decision, the IRO will review the Claim as if it is new and will not be bound by any decisions or conclusions reached during the Claims Fiduciary's internal Claims and appeals process. However, the IRO will be bound to abide by the terms of the Plan to ensure that the decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must abide by the Plan's requirements for benefits, including:

» The Plan's standards for clinical review criteria;
» Medical Necessity;
» Industry standards or appropriateness;
» Health care setting; and
» Level of care of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including:

» Information from the Claimant's medical records;
» Any recommendations or other information from his treating health care providers;
» Any other information from the Claimant or the Claims Fiduciary;
» Reports from appropriate health care professionals;
» Appropriate practice guidelines; or
» The Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

After the IRO receives the request for the external review, the assigned IRO will provide written notice of its final external review decision to the Claimant and the Claims Fiduciary within 45 days. The assigned IRO's decision notice will contain:

» A general description of the reason for the request for external review, including information sufficient to identify the Claim, including the date or dates of service; the health care provider; the Claim amount (if applicable); a statement that the diagnosis and treatment codes, and their corresponding meanings, are available upon request; and the reason for the previous denial.

» The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.

» References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.

» A discussion of the principal reason(s) for its decision, including the rationale for the decision and any evidence-based standards that were relied upon in making its decision; including a statement that the determination is binding except to the extent that other remedies may be available under applicable State or Federal law; a statement that judicial review may be available to the Claimant; and current contact information, including phone number, for the health insurance consumer assistance or ombudsman established under law to assist with external review processes.
• A Claimant may request an expedited external review if:
  – The Claimant receives an initial adverse benefit determination that involves a medical condition for which the time frame for completion of an internal appeal would seriously jeopardize his life or health, or would jeopardize his ability to regain maximum function, and the Claimant has filed a request for an urgent care internal appeal; or
  – The Claimant receives an adverse appeal benefit determination that involves a medical condition for which the time frame for completion of a standard external review would seriously jeopardize his life or health or would jeopardize his ability to regain maximum function; or, he receives an adverse appeal benefit determination that concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency services, but has not yet been discharged from a facility.

The process of the expedited external review will not differ from that explained on page 56, but the following time frames will apply.
» The Claims Fiduciary’s preliminary review will be completed immediately.
» The Claims Fiduciary will immediately notify the Claimant whether the request meets the requirements for an external review.
» If requirements are met, the Claims Fiduciary will assign an IRO and provide the documents and information it considered in making its adverse benefit determination to the IRO expeditiously.
» The IRO will provide a decision in accordance with the requirements in this section within 72 hours. If the notice is not in writing, the IRO must provide written confirmation of its decision within 48 hours of providing the notice.

• After external review:
  – If the final external review reverses the Claims Fiduciary’s adverse benefit determination, upon the Claims Fiduciary’s receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed Claim.
  – If the final external review upholds the Claims Fiduciary’s adverse benefit determination, the Plan will uphold the denial of coverage or payment for the reviewed Claim. If the Claimant is dissatisfied with the external review determination, he may seek judicial review as permitted under ERISA section 502(a). Any lawsuit must be initiated within 12 months of the denial on appeal.

Powers of the Trustees, Claims Fiduciaries and Other Delegates
The Trustees, the Appeals Committee or their designated Claims Fiduciaries, have sole, full and discretionary authority to make final determinations regarding any Claim for benefits, the interpretation of the Plan and all documents, rules, procedures and terms of the Plan, and any administrative rules adopted by the Claims Fiduciaries. It is the Trustees’ intention that the decisions of the Trustees will be accorded judicial deference in any subsequent administrative or court proceeding, to the extent the decisions do not constitute an abuse of discretion. Benefits will be paid under the Plan if the Trustees or their delegate Claims Fiduciaries decide, in their discretion, that the Claimant is entitled to them.
Exhaustion of Remedies
Generally, you must follow and completely exhaust the Plan’s appeal procedures (including time limits) before you can file a lawsuit under ERISA or initiate proceedings before any administrative agency. If the Plan fails to adhere to all Claims and Claims appeal requirements, you are deemed to have exhausted the claims appeal process and may seek an external review or file a lawsuit, unless the Plan’s failure is minor. In the event you submit a Claim for review and the Claim is denied, any legal action must begin within 12 months of the date the Fund provides an adverse benefit appeal determination.

Facility of Claims Payment
In the event the Fund becomes aware that you have been deemed incompetent or incapable of executing a valid receipt and no guardian has been appointed, the Fund may pay any amount otherwise payable to you, to your spouse, or any other person or institution determined by the Fund to be equitably entitled to payment. Any payment in accordance with this provision discharges the Fund from any further obligation.

Right to Information in Claims and Appeals Process
You have the right to receive, upon written request, copies of all documents relevant to the decision made on your appeal. You may also submit a request in writing to receive the identification of medical or other experts whose advice was obtained for reviewing your appeal. Any and all disclosures will be made in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Status Changes

If you have a change in status, you must notify the Retirement Benefits Department within 90 days to update your information. Changes in status include:

- Change of address;
- Marriage;
- Changes in Dependent eligibility or if you have a baby, adopt a child or become a step-parent;
- Death of a Dependent spouse or child;
- Adding or dropping other insurance coverage, including coverage with Medicare or Medicaid; and
- Returning to work.

For more information on enrolling a new spouse or a new Dependent, see page 10.

You must notify the Retirement Benefits Department within 60 days of the following events, in order to avoid forfeiting continuation of coverage rights under COBRA:

- A divorce or legal separation; or
- When your Dependent child no longer meets the Plan's definition of a Dependent.

You will be required to provide original documentation for the above changes. For more information on required documentation, see page 9.

Change of Home Address

You must immediately notify the Retirement Benefits Department of a change in your home address or that of your Dependents.

You should provide an alternate address for a Dependent that permanently resides outside of your home so that Explanations of Benefits (EOBs) and other materials can be mailed directly to him.

Contact the Retirement Benefits Department regarding any change of status at 312-787-9455, menu option 4.

Service Representatives are available Monday–Friday, from 8:00 a.m. to 4:30 p.m. (CT).

Documents should be mailed or delivered to:
Chicago Regional Council of Carpenters Welfare Fund
Attn: Retirement Benefits Department
12 E. Erie Street
Chicago, IL 60611

Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice, as defined under ERISA, means a court order requiring a medical plan to provide medical benefits to the children of parents seeking divorce or other state domestic relations actions where financial support of children is involved.

A child covered under a QMCSO or a National Medical Support Notice will be enrolled as a Dependent under the coverage option in which you are enrolled. You may not voluntarily cancel a Dependent child's coverage when the child is covered by a QMCSO.

Contact the Retirement Benefits Department at 312-787-9455, menu option 4, to request a copy of the Plan's QMCSO procedures free of charge or visit the Fund's website at www.crccbenefits.org.
This section discusses the circumstances in which your coverage or your Dependents’ coverage under the Retiree Plan is terminated, and the available options for continuing coverage.

Your coverage will terminate:

- The date of your death;
- The last day of the month prior to the month in which your pension benefit is suspended due to recovery from disability or return to work in prohibited employment;
- The first day of the month for which you fail to make a required Premium Payment on time, as described on page 14;
- When you voluntarily cancel coverage (you must complete required forms and return them to the Retirement Benefits Department by the 15th day of the month before coverage is cancelled) (see page 63);
- The date the Retiree Plan is discontinued; or
- The date you enter the Military Service.

Your spouse or Dependent’s eligibility for coverage will terminate:

- Upon your death;
- When you no longer meet the eligibility requirements for coverage under the Retiree Plan, as described beginning on page 3;
- If you fail to provide the required documentation to verify Dependent status;
- The last day of the month prior to the month in which your pension benefit is suspended due to recovery from disability or return to work in prohibited employment;
- If you fail to make a required Premium Payment on time, as described on page 14;
- When you voluntarily cancel coverage (see page 63);
- The date the Retiree Plan is discontinued;
- Upon your Dependent’s death; or
- When your Dependent no longer meets the Plan’s definition of a Dependent, as described on page 6.

If your spouse’s or Dependent’s eligibility terminates, coverage will end as follows:

- On the last day of the month in which you die;
- Spouse, as of the last day of the month of the effective date of your divorce or legal separation;
- Dependent child, as of the last day of the month in which the child attains age 26 unless the child is disabled and satisfies the requirements, as described on page 6;
- Newborn child, 90 days after the date of the child’s birth if the required documentation is not received; however, eligibility will be retroactively reinstated once documentation is received and the applicable premiums are paid;
- Stepchild, as of the last day of the month in which the Retiree divorces or legally separates from the stepchild’s parent;
- The first day of the month for which you fail to make a required Premium Payment on time, as described on page 14;
- Dependent spouse who enters Military Service as of the last day of the month in which he enters the Military Service, to the extent permitted by law;
- When a Dependent child becomes an eligible Employee under the Active Plan, to the extent permitted by law; or
- When a Dependent child becomes a Dependent spouse of another Covered Individual.

Refer to pages 63–66 for details about their options for continuing coverage.
Dependents will lose eligibility under the Retiree Plan:

- **All Dependents** – On the last day of the month in which you, the carpenter, die.
- **Spouse** – Coverage terminates on the last day of the month of the effective date of your divorce or legal separation. You must provide the Retirement Benefits Department with a complete copy of the divorce decree.
- **Stepchildren** – Coverage terminates on the last day of the month in which you divorce or legally separate from the stepchild’s parent. You must provide the Retirement Benefits Department with a complete copy of the divorce decree.
- **Children** – Coverage terminates on the last day of the month in which the child reaches age 26.

Call the Retirement Benefits Department at 312-787-9455, menu option 4, with questions.

Voluntary Cancellation

You may voluntarily cancel your coverage or coverage for your spouse or Dependent children. Canceling your coverage will automatically cancel your Dependents’ coverage. **To cancel coverage, you are required to complete a Cancellation Form and return it to the Retirement Benefits Department by the 15th day of the month prior to the month for which you want to cancel coverage.**

Following voluntary cancellation, coverage may not be reinstated unless there is coverage from another health care plan from the date of cancellation to the date of reinstatement. You may obtain a Cancellation Form by contacting the Retirement Benefits Department at 312-787-9455, menu option 4, or you may download a Cancellation Form from the Fund’s website at www.crccbenefits.org.

Continuation Coverage under COBRA

The Fund provides health care Continuation Coverage under COBRA for qualified beneficiaries whose coverage under the Plan would otherwise end because of your death or certain other qualifying events. If your qualified beneficiaries’ coverage under the Plan terminates, they may choose to pay for and receive Continuation Coverage under COBRA for coverage identical to the type of coverage the Covered Individual was enrolled while receiving coverage under the Retiree Plan.

A qualified beneficiary under the Retiree Plan means your spouse (or your former spouse, legally separated spouse or surviving spouse) or your Dependent who is covered under the Retiree Plan upon termination of coverage under the Retiree Plan, subject to the Plan receiving timely notice of the loss of coverage (where notice is required).

A Dependent child born to, adopted by or placed for adoption with a surviving spouse during a period of Continuation Coverage under COBRA is also considered a qualified beneficiary. The Retirement Benefits Department must be notified of this event, in writing, and be provided with documentation verifying the birth, adoption or placement of a child for adoption to have this child added to the surviving spouse’s Continuation Coverage under COBRA.

A qualifying event is one of the following:

- Your death;
- You and your spouse becoming legally separated or divorced; or
- Your child loses Dependent status under the Plan.

**IMPORTANT**

A Retiree’s return to work in prohibited employment, recovery from disability, or voluntary cancellation of coverage are **not** qualifying events.
Continuation Coverage under COBRA is offered for the continuation periods shown in the chart below.

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Qualified Beneficiaries</th>
<th>Maximum Coverage Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your death</td>
<td>Your spouse</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>Your Dependent child</td>
<td></td>
</tr>
<tr>
<td>Divorce or legal separation</td>
<td>Your spouse</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>Your Dependent stepchild</td>
<td></td>
</tr>
<tr>
<td>Your child no longer qualifies as a Dependent child under the Plan</td>
<td>Your Dependent child</td>
<td>36 months</td>
</tr>
</tbody>
</table>

If your Dependents are covered under the Plan and experience a qualifying event resulting in termination of coverage (such as your death), the Plan will offer them Continuation Coverage under COBRA.

**General Rules**

The Fund has developed notice and election procedures in accordance with COBRA as follows:

1. The Trustees will provide written notice of the provisions of Continuation Coverage under COBRA to you and your covered Dependents within 90 days of the date coverage under the Plan begins, or within 90 days of a significant change in procedures. Notice provided to the Participant will be deemed notice to all Dependents, unless the Fund has notice that your Dependent resides at a different address.

2. You are or your covered Dependent is responsible for notifying the Fund and providing documentation within 60 days of divorce, legal separation or a Dependent no longer being eligible for coverage. If the Retirement Benefits Department is not notified within 60 days of a qualifying event, your Dependent will lose eligibility for Continuation Coverage under COBRA.

3. Once you notify the Retirement Benefits Department of a qualifying event, the Fund will send a COBRA notice and enrollment form within 14 days.

4. There is a 60 day election period to complete and return the enrollment form to the Health Care Service Corporation (HCSC). If the form is not returned within 60 days, eligibility for Continuation Coverage under COBRA is lost.

5. Your spouse may elect Continuation Coverage under COBRA for herself and/or your eligible Dependents. If your spouse declines coverage for herself, your eligible Dependents may elect coverage independently from your spouse.

6. Any qualified beneficiary who elects Continuation Coverage under COBRA must notify HCSC at 888-541-7107 within 14 days of becoming covered under another group health plan.

7. A qualified beneficiary may elect Continuation Coverage for his Dependents. However, each qualified beneficiary has an independent right to elect Continuation Coverage under COBRA.
Paying for Continuation Coverage under COBRA

The Fund Office will notify your Dependent of the cost of Continuation Coverage under COBRA when it notifies your Dependent of their right to continue coverage. The cost for Continuation Coverage under COBRA will be determined by the Trustees on an annual basis, and will not exceed 102% of the cost to provide that coverage.

The first Premium Payment for Continuation Coverage under COBRA must include payments for any months retroactive to the day your Dependent’s coverage under the Retiree Plan ended. This Premium Payment is due no later than 45 days after the date your Dependent signed the election form and returned it to HCSC.

Subsequent Premium Payments are due on the first business day of each month for which coverage is provided (due date). There is a grace period from the due date of the Premium Payment by which time the Premium Payment must be paid. Coverage will be provided as long as payment for that month is received by HCSC with a postmark date no later than 30 days after the due date, or, for months with 31 days, the last day of the month in which the Premium Payment is due. However, if a monthly payment is paid later than the first day of the month, but before the end of the grace period, coverage will be suspended as of the first day of the monthly coverage period. Upon receipt by HCSC of the monthly Premium Payment, coverage will be retroactively reinstated going back to the first day of the month. Any claim submitted for benefits while coverage is suspended will be denied by the Plan and must be resubmitted for payment once coverage is reinstated.

If payment is not received within the grace period, all benefits will end immediately. Once your Continuation Coverage under COBRA is terminated, it cannot be reinstated.

Questions? Call HCSC at 888-541-7107.

Termination of Continuation Coverage under COBRA

The Fund will automatically terminate Continuation Coverage under COBRA in all instances permitted by the COBRA statute and its regulations, including if:

- Your Dependent does not make timely Premium Payments;
- Your Dependent becomes covered under another health care plan that does not exclude coverage for pre-existing conditions that are covered by this Plan; or
- The Trustees discontinue all coverage under the Plan.

It is the intent of the Trustees to provide Continuation Coverage under COBRA benefits in accordance with the federally required minimum benefits provisions of COBRA. The Fund has developed administrative guidelines and interpretive procedures to be used in complying with the continuation of benefits provisions of COBRA. To the extent that this or any administrative guidelines or interpretive procedures inadvertently conflict with COBRA, the applicable sections of COBRA will prevail.
Continuation of Group Health Coverage under USERRA

Upon returning from Military Service, you may be able to continue health coverage (medical, prescription drug, dental and vision benefits, as applicable) under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

Continuation coverage under USERRA will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after your regular Plan coverage ends.

To continue coverage, you must elect continuation of coverage under USERRA and pay for it, as described on page 65, in the same manner your Dependent would pay for continuation of coverage under COBRA. If you go into active Military Service for less than 31 days, your coverage will be continued at the rate you were paying for coverage prior to your military leave.

However, in the event of a conflict between the provisions of Continuation Coverage under USERRA and COBRA, if you are eligible to continue coverage under both provisions, you will be entitled to the more generous coverage provisions of USERRA or COBRA. Continuation coverage under USERRA and COBRA will run concurrently. The administrative procedures with regard to notice, election and payment for Continuation Coverage under COBRA apply to Continuation Coverage under USERRA.

When Continuation Coverage under USERRA Ends

Continuation coverage under USERRA may end sooner than described above for any of the following reasons:

- You lose your rights under USERRA, such as for a dishonorable discharge;
- You fail to pay the premium for Continuation Coverage under USERRA;
- The Plan ceases providing group health plan coverage; or
- You fail to return to work or apply for reemployment within the time required under USERRA.

In the event that health coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which the premium is paid in whole or in part by an Employer, then the premium you are required to pay may increase for the remainder of the period provided above.

Other Continuation Coverage Options—Health Insurance Marketplace

In addition to Continuation Coverage under COBRA, there may be other less expensive coverage options for you and your family if you are a non-Medicare-eligible Retiree and you lose coverage under the Plan. You may be able to buy coverage through the Health Insurance Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days after losing other health insurance.
If you and/or your Dependents are covered for health care under more than one health plan, this Plan will coordinate benefits with another plan, which means that the total payment from all plans will not exceed 100% of Covered Expenses.

“Another plan” means any of the following, whether insured or uninsured, that provide benefits or services for Hospital, medical, Behavioral Health and Substance Use Disorders, prescription drug, hearing, or dental care treatment:

- Group insurance coverage other than school Accident-type coverage;
- Group subscriber contracts;
- Coverage through HMOs and other prepayment, group practice and individual practice plans;
- The medical benefits coverage in group, group-type and individual automobile “no fault” and traditional automobile “fault”-type contracts;
- A governmental plan, including Medicare as provided for under the Social Security Act and coverage required or provided by law (such as through the Veterans Administration) but not Medicaid; or
- Individual insurance policies.

This Plan will follow the general Coordination of Benefits (COB) rules that apply throughout the insurance industry. Under COB rules, one plan has “primary” responsibility and is called the primary plan. The primary plan pays benefits first. When a plan pays second, it is called the secondary plan. When there is a third payer, it is called the tertiary plan. This Plan will follow COB rules as follows:

- The plan that covers you as a participant is primary. (This applies to eligible Dependents, too. If a Dependent has coverage through his Employer, that plan will be his primary plan.)
- If you are married, you have coverage through the Retiree Plan and your spouse has coverage through an Employer, and you have a child eligible for Dependent coverage, the plan of the parent whose birthday (month and day) falls first in the Calendar Year will be the primary plan. If both parents have the same birthday, the plan covering the parent for the longer period of time will be the primary plan.
- If you are covered as a participant under more than one plan, the plan that has been in effect for you the longest will be the primary plan.
- If you are covered as a participant under another group plan and the other group plan excludes you from eligibility due to your coverage under this Plan; shifts coverage liability to this Plan to avoid any liability or to avoid the customary operation of this Plan’s COB rules; or modifies, limits, or reduces your benefits because of your coverage under this Plan; this Plan considers such provision(s) to have no effect. As a result, this Plan coordinates benefits payable under this Plan with benefits that would have been payable under the other group plan (as if such provision had not existed).

Contact the Retirement Benefits Department Monday–Friday, from 8:00 a.m. to 4:30 p.m. (CT) at 312-787-9455, menu option 4, if you have questions on Coordination of Benefits.
Coverage of Dependent Children in Divorce Situations: If the parents of a Dependent child are divorced or legally separated, a divorce decree or court order must be furnished to the Plan to ensure proper Coordination of Benefits. The plan of the parent who has responsibility for providing medical insurance for that Dependent as determined by the court order or divorce decree will be primary. See the Qualified Medical Child Support Orders section on page 61.

If there is no court order or divorce decree establishing responsibility for providing medical insurance, the plan covering the custodial parent will be the primary plan, the plan covering the spouse of the custodial parent will be secondary, the plan covering the non-custodial parent third and the plan covering the spouse of the non-custodial parent will be last.

Primary coverage by this Plan for stepchildren is provided only in the event that no other person is obligated to provide insurance and no other insurance is available through the biological or adoptive parents’ employment. Coverage for stepchildren terminates the last day of the month of the divorce or legal separation.

If your Dependent spouse has other group insurance coverage available at no cost through their Employer, this Plan will coordinate with the other plan on the same basis as if the Dependent spouse had elected such coverage.

Insurance for an Adult Dependent Child: If an adult Dependent child under the age of 26 has insurance coverage through his Employer, the adult Dependent child’s Employer plan will pay first and this Plan will pay second.

HMO and POS Coverage Not Used: If your Dependent’s primary coverage is a Health Maintenance Organization (HMO) or a Point of Service (POS) Plan and he does not use the HMO’s or POS Plan’s services, no benefits will be paid by this Plan.

Services Provided by the Veterans Administration: The Veterans Administration (VA) is secondary to the Plan when a Participant receives treatment at a VA facility for an Illness or Injury not related to Military Service.

Medicare: Health benefits under the Retiree Plan for Covered Individuals who are also eligible for Medicare will be paid as required by law. Generally, Medicare is primary and this Plan will be secondary. Benefits payable for a Covered Individual under this Plan will be reduced as necessary so that the sum of the benefits payable under this Plan and the amounts paid under Medicare Part A and Part B will not exceed the total allowable expense as defined by Medicare. This Plan will be primary for a period of 30 months if your initial eligibility for Medicare is due to End-Stage Renal Disease (ESRD).

For Retirees and their Dependents who are eligible for Medicare, the Retiree Plan will take benefits under Medicare Part A and Part B into account when coordinating coverage, whether or not the Covered Individual enrolls in Medicare.

For Retirees and their Dependents enrolled in a Medicare health plan offered by a private insurer (such as a Medicare Advantage Plan), the Retiree Plan remains secondary. The Retiree Plan will coordinate coverage with such plans as if the services were covered under Medicare Parts A and B (regardless of whether the Covered Individual has obtained such coverage).

The Retiree Plan will not coordinate coverage with Medicare Part D.

Medicaid: For Retirees and Dependents eligible for Medicaid, the Retiree Plan will be primary to Medicaid.
Subrogation and Reimbursement

The subrogation and reimbursement provisions for the Fund are described below.

A. The Fund provides no benefits for Claims of a Covered Individual that are related to any Illness or Injury which is caused by third parties or which is Work-Related or the responsibility of any other entity. The Fund will deny any Claim for an Illness or Injury which is caused by third parties, which is Work-Related or the responsibility of any other entity except as otherwise provided in this section on subrogation and reimbursement.

B. If the Fund chooses to advance benefits for the Injuries and Illnesses caused by third parties or that are Work-Related or the responsibility of any other entity, a Covered Individual:

1. Upon final adjudication, settlement and/or receipt of case proceeds, agrees to reimburse the Fund up to (i) the amount of benefits paid by this Fund or amounts that the Fund is obligated to pay as well as (ii) any future benefits to be paid relating to the Illness or Injuries caused by the third party or for which a third party is responsible from any recovery received from any third party, insurer or any other source (including but not limited to persons, insurance carriers, estates, special trusts or other entities, hereinafter collectively referred to as “Source”) or from any no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, Employers’ Workers’ Compensation insurance policies, personal Injury protection coverage, medical payments coverage, financial responsibility, other insurance policies, funds or any other sources of recovery (hereinafter collectively referred to as “Coverage”);

2. Agrees, without limiting what is stated in subsection (1) above, to allow the Fund to subrogate against or seek reimbursement with regard to any and all Claims, causes of action or rights that a Covered Individual has against any Source who has or who may have caused, contributed to or aggravated the Injuries or conditions for which a Covered Individual claims benefits from this Fund and to any Claims, causes of action or rights that a Covered Individual may have against any Coverage. The Covered Individual agrees to cooperate fully with the Fund in the prosecution of any Claims, causes of action or rights against any Source and/or Coverage;

3. Agrees to enter into a subrogation and reimbursement agreement (hereinafter collectively referred to as “Agreement”) that is given to a Covered Individual by the Fund, which Agreement the Fund may require before a Covered Individual can receive any advancement of benefits (hereinafter collectively referred to as “Advance”). The Fund may withhold benefits until such Agreement is signed. If the Agreement is not executed by the Covered Individual(s), at the Fund’s request, or if the Agreement is modified in any way without the consent of the Fund, the Fund may refuse to make any Advance. However, in its sole discretion, if the Fund makes an Advance in the absence of an Agreement, or if the Fund makes an Advance in error, that Advance will not waive, compromise, diminish, release or otherwise prejudice any of the Fund’s rights to reimbursement or subrogation. The Agreement shall be in a form provided by or on behalf of the Fund. If the Covered Individual is a minor or incompetent to execute that Agreement, that person’s parent, the Participant (in the case of a minor Dependent child), the Participant’s spouse, or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Fund. A Covered Individual must comply with all of the terms of the subrogation and reimbursement agreement, including the establishment of a trust for the benefit of the Fund. In this regard, the Covered Individual agrees that out of any recovery he receives from any Source or Coverage, as described in subsection (1) above, the identified amount that the Fund has advanced or is obligated to Advance in benefits will be immediately deposited into a trust for the Fund’s benefit and the Fund shall have an equitable lien by agreement in the amount set forth in this
paragraph which shall be enforceable as part of an action to enforce the Plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed;

4. The Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Covered Individual, as opposed to the general assets of the Covered Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received be traced to a specific account or other destination after they are received by the Covered Individual;

5. The Agreement will grant the Fund a priority, first dollar security interest and a lien in any recovery received from any Source or from any Coverage, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such Illness or Injury;

6. Acknowledges that the Fund specifically disavows the common fund doctrine, attorneys fund doctrine, fund doctrine, the double-recovery rule or any similar doctrine or theory, including the contractual defense of unjust enrichment. This means that the Fund’s subrogation and reimbursement rights apply on a priority, first dollar basis to any recovery by the Covered Individual from any Source or Coverage without regard to legal fees and expenses of the Covered Individual. This also means the Covered Individual will be solely responsible for paying all legal fees and expenses in connection with any recovery from any Source or Coverage for the underlying Illness or Injury, and the Fund’s recovery shall not be reduced by such legal fees or expenses;

7. Acknowledges that the Fund specifically disavows the make-whole rule or any other similar doctrine or theory. This means that the Fund’s subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery by a Covered Individual from any Source or Coverage, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the Covered Individual believes he did not receive the amount that he is entitled to receive, or if the amounts are categorized or described as medical expenses or as amounts other than for medical expenses;

8. Agrees that if the recovery is reduced due to a Covered Individual's negligence (sometimes referred to as contributory negligence) or any other common law defense, the amount of the Plan’s reimbursement is not affected or reduced;

9. Agrees that the Fund’s right to reimbursement applies regardless of the existence of any state law or common law rule (including, but not limited to, the Illinois Workers’ Compensation Act, 820 ILCS 305/1, et seq. and the Illinois Wrongful Death Act, 740 ILCS 180/0.01, et seq.) that would serve to ban or limit recovery of the Advance by the Fund from the Covered Individual or from any other Source;

10. Agrees that the Fund’s right to reimbursement applies regardless of the existence of any state law or common law rule that would ban recovery from a person or entity that caused the Illness or Injury, or from the insurer of that person or entity (sometimes referred to as the “collateral source” rule);

11. Agrees not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Fund’s reimbursement rights or subrogation rights;
12. Agrees to notify and consult with the Fund or its designee in writing before starting any legal action or administrative proceeding against a Third Party alleged to be responsible for the Illness or Injury that resulted in the Advance, and before entering into any settlement agreement with that Third Party or Third Party’s insurer based on those allegations;

13. Agrees that the Fund has the right to suspend all benefit payments due to the Covered Individual and family member of the Covered Individual arising out of the current incident or any other unrelated future Illness or Injury until the Fund is fully reimbursed related to the Covered Individual;

14. Recognizes that no loan transaction is intended to be created under any subrogation or reimbursement agreement;

15. Agrees not to assign a Covered Individual’s rights with respect to subrogation and reimbursement to anyone (except as otherwise stated in this section). This means that a Covered Individual cannot give anyone else the right to pursue whatever rights that a Covered Individual has or had with respect to subrogation and reimbursement. Any attempt to do so will be void and have no effect.

C. For purposes of these provisions on subrogation and reimbursement, the term “Covered Individual” shall also include representatives, guardians, trustees, estate representatives, heirs, executors, administrators of special needs trusts and any other agents, persons or entities that may receive a benefit on behalf of or for Covered Individuals.

D. The Fund’s subrogation and reimbursement rights and the Covered Individual’s obligation set forth above shall apply regardless of whether the Covered Individual executes a subrogation and reimbursement agreement.

E. For purpose of the subrogation and reimbursement provisions, benefits that are paid for medical, Hospital, Behavioral Health and Substance Use Disorders, Dental, Vision and the Prescription Drug benefit are recoverable through subrogation or reimbursement.

Recovery of Erroneous or Fraudulent Claims

The Fund will pay Claims only when covered under the terms of the Plan provisions under which you are eligible. If the Fund pays Claims that it is not required to pay, it may recover and collect payments from you or any other entity or organization that it was required to make the payment to or that received an erroneous payment. The Fund will be permitted to pursue legal and equitable remedies to recover overpayments. The Fund may recover such erroneous payments and related amounts by offsetting or reducing any future benefit amounts payable to the Covered Individual and eligible Dependents of the Covered Individual.

You and your eligible Dependents may lose eligibility for coverage if you knowingly commit fraud against the Plan, for example, by filing Claims for benefits to which you are not entitled, or for failing to report other available benefits coverage or your rights against a third party or insurance company in connection with a health Claim, and will be required to repay any monies paid. You may also be subject to legal action by the Fund.
Women’s Health and Cancer Rights Act of 1998 (WHCRA)

You or your Dependents may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Plan limits, Deductibles, Co-payments, and Coinsurance apply to these benefits. For more information on WHCRA benefits, contact the Retirement Benefits Department at 312-787-9455, menu option 4.

Coverage for Maternity Hospital Stay

Under federal law, the Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider, in consultation with the mother of the newborn, from discharging the mother or newborn earlier than 48 or 96 hours, as appropriate.

Privacy of Health Information

Under federal law, the Plan protects your health information and keeps it strictly confidential. This includes protecting your health information from unauthorized disclosure. Health information includes personal health information that is transmitted or maintained by electronic media or in any other format. You will receive a notice of the Plan’s practices and procedures regarding protecting health information, or you may obtain a copy of the Plan’s Privacy Notice at www.crccbenefits.org. On the left-hand side of the navigation bar, under Health Plan, select “Forms.” Scroll down to “Privacy Notice.”

In general, the Plan will use or disclose your health information only for treatment, payment or health care operations. The Plan will disclose your health information for other purposes only if you authorize this disclosure. You are entitled to know when and to whom disclosure has been made for any reason that is not for treatment, payment and health care operations, with certain exceptions.

The Plan will disclose your health information to you. You will be allowed to inspect and obtain a copy of your information, except for psychotherapy notes. You have the right to amend and correct your own health information. The Plan will not use or disclose health information without the consent or authorization of the patient, except as required or permitted under the law.
In the unlikely event that your protected health information is breached, the Plan will comply with breach notification rules under the Health Insurance Portability and Accountability Act (HIPAA).

In the administration of the Plan, the Plan will make every effort to use only summarized health information or to only disclose health information that has been stripped of all identifying data. The Plan will take all necessary steps to ensure that health information is not used to perform any function that is not related to the Plan.

To protect your health information, the Plan has designated a privacy officer, to ensure that all health information is protected. Reasonable administrative, physical and technical safeguards are in place to protect against intentional or accidental disclosure or misuse. The Plan makes every attempt to ensure that any agent, vendor, subcontractor, etc., to whom it provides health information agrees to do the same, and to report to the Plan any security incident. If possible, the Plan will return or destroy your health information when it is no longer needed for the purpose for which the disclosure was made.

If you believe that your health information has been misused or disclosed when it should not have been disclosed, you may contact the Privacy Officer of the Plan to challenge or dispute the use or disclosure of your health information. If the Plan determines that your health information has been misused or disclosed to anyone who should not have received it, then the Plan will do everything possible to minimize any harm that has been done. The Plan makes every effort to ensure that its vendors, subcontractors or any individual that performs any function for the Plan or assists the Plan in any function, protect your health information in the same way.
Nondiscrimination Statement

The Chicago Regional Council of Carpenters Welfare Fund (the “Plan”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The Plan provides language assistant services to persons whose primary language is not English, and free aids and services where necessary to people with disabilities to communicate effectively with us. If you need these services, contact the Fund Office.

If you believe that the 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 by contacting the Fund Office by mail, telephone or in person at: Chicago Regional Council of Carpenters Welfare Fund, Attn: Cindy Rivera, Civil Rights Coordinator, 12 E. Erie Street, Chicago, IL 60611, Phone: 312-787-9455.


ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-312-787-9455.

UWAGA: Jezeli mówisz po polsku, możecz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-312-787-9455.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-312-787-9455 (번으로 전화해 주십시오).

PAUNAWA: Kung nasasaliw ka ng Tagalog, maari kang gumamit ng mga serbisyo ng tulong sa wika nang walang hayad. Tumawag sa 1-312-787-9455.


ATTENZIONE: In caso la lingua parlatà sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-312-787-9455.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-312-787-9455 पर कॉल करें।

ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-312-787-9455.

ПРОСОХИ: آن میلے اسپانیئی، ست دیکھیسے سی اس تیونگوں نے پرنسیپیلی یہ لوئیسیکی یاپورےی، ایسی چروں کر رہاں دویروں। 1-312-787-9455.

### Administrative Plan Information

**Plan Name**
The Plan is the Chicago Regional Council of Carpenters Welfare Fund.

**Plan Sponsor**
A Board of Trustees is responsible for the operation of the Plan. Although the Trustees are legally designated as the *Plan Administrator*, they have delegated certain administrative responsibilities to an *Administrator*. The Administrator and the Fund staff, under the Administrator’s supervision, maintain eligibility records, account for Employer contributions, answer Participant inquiries, process claim and benefit payments and handle other administrative functions.

**Trust Fund**
The Board of Trustees holds all assets in trust pursuant to the *Trust Agreement*. All benefits and administrative expenses are paid from the Fund’s assets, except for dental and vision benefits under the Retiree Plan. The Trust Agreement consists of all the documents, including all amendments that establish the *Trust Fund* and its rules of operation.

**Plan Identification Number**
36-2229735

**Plan Number**
501

**Plan Type**
The Plan is an Employee welfare benefits plan maintained to provide medical, prescription drug, dental and vision insurance for those who meet the eligibility requirements described in this SPD.

**Plan Year**
July 1 – June 30

**Type of Funding**
The benefits described in this SPD are self-funded, except for dental and vision benefits under the Retiree Plan, which are currently insured by Delta Dental of Illinois. All self-funded benefits are limited to the Plan’s assets available for payment of such benefits.

**Collective Bargaining Agreements**
The Plan is maintained pursuant to *Collective Bargaining Agreements*. The Fund Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Plan on behalf of Participants working under the Collective Bargaining Agreements.

Copies of the Collective Bargaining Agreement may be obtained upon written request to your Local Union Office or:

The Chicago Regional Council of Carpenters
Attn: Contract Dept.
12 E. Erie Street
Chicago, Illinois 60611

312-787-3076

The Collective Bargaining Agreements are also available for examination by the Participants at the Regional Council offices.

**Agent for Service of Legal Process**
For disputes arising under the Plan, service of legal process may be made on:

Kristina M. Guastaferri, Administrator
Chicago Regional Council of Carpenters Welfare Fund
12 E. Erie Street
Chicago, IL 60611

312-787-9455

Service of any legal process may also be made on any individual Trustee at the address for the Fund Office.

**Amendment and Termination**
The Board of Trustees has the right to amend or terminate the Plan in whole or in part at any time.
<table>
<thead>
<tr>
<th><strong>Claims Fiduciary</strong></th>
<th><strong>Eligibility, Premiums and Enrollment</strong></th>
<th><strong>Specialty Prescription Drugs</strong></th>
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<td>Chicago Regional Council of Carpenters Welfare Fund</td>
<td>Chicago Regional Council of Carpenters Welfare Fund</td>
<td>Diplomat Specialty Pharmacy</td>
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<tr>
<td>Attn: Appeals Committee</td>
<td>Attn: Appeals Committee</td>
<td>4100 S. Saginaw Street</td>
</tr>
<tr>
<td>12 E. Erie Street</td>
<td>12 E. Erie Street</td>
<td>Flint, MI 48507</td>
</tr>
<tr>
<td>Chicago, IL 60611</td>
<td>Chicago, IL 60611</td>
<td>866-722-6110</td>
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<tr>
<td><a href="http://www.crccbenefits.org">www.crccbenefits.org</a></td>
<td><a href="http://www.crccbenefits.org">www.crccbenefits.org</a></td>
<td><a href="http://www.diplomatpharmacy.com">www.diplomatpharmacy.com</a></td>
</tr>
</tbody>
</table>

**Medical, Behavioral Health, and Substance Use Disorder**

Blue Cross Blue Shield of Illinois

Attn: Claim Review Section

Health Care Service Corporation

P.O. Box 2401

Chicago, Illinois 60690

855-354-1858

[www.bcbsil.com](http://www.bcbsil.com)

**Prescription Drugs and Mail Order**

Express Scripts, Inc.

Attn: Appeals Department

P.O. Box 66587

St. Louis, MO 63166-6587

800-946-3979—Administrative Appeals

800-935-6103—Clinical Appeals

[www.express-scripts.com](http://www.express-scripts.com)

**Dental**

Delta Dental of Illinois

Attn: Appeals Committee

111 Shuman Blvd.

Naperville, IL 60563

800-323-1743

[www.deltadentalil.com](http://www.deltadentalil.com)

**Vision**

DeltaVision

Attn: Appeals Committee

111 Shuman Blvd.

Naperville, IL 60563

866-723-0513

[www.deltadentalil.com/deltavision](http://www.deltadentalil.com/deltavision)

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**No Vesting**

No benefits vest under the Fund.

**Restatement Date of SPD**

This SPD for Retirees is effective as of January 1, 2019.
**Board of Trustees**

The Board of Trustees consists of Employer and Union Trustees selected by the Employer Associations and Chicago Regional Council of Carpenters that have entered into Collective Bargaining Agreements related to the Chicago Regional Council of Carpenters Welfare Fund. You may contact the Board of Trustees by using the following address and phone number:

**Board of Trustees**  
Chicago Regional Council of Carpenters Welfare Fund  
12 E. Erie Street  
Chicago, Illinois 60611  
312-787-9455

<table>
<thead>
<tr>
<th>Union Trustees</th>
<th>Employer Trustees</th>
</tr>
</thead>
</table>
| Gary Perinar   | Gerald W. Thiel, Jr.  
Chicago Regional Council of Carpenters  
12 E. Erie Street  
Chicago, IL 60611  
G. W. Thiel, Inc.  
2872 Corporate Parkway  
Algonquin, IL 60102 |
| Jeffrey Isaacson | Mike Forest  
Chicago Regional Council of Carpenters  
12 E. Erie Street  
Chicago, IL 60611  
RB Construction, Inc.  
600 N. Villa Avenue  
Villa Park, IL 60181-1771 |
| Keith Jutkins   | George Tuhowski III  
Chicago Regional Council of Carpenters  
12 E. Erie Street  
Chicago, IL 60611  
Leopardo Companies, Inc.  
5200 Prairie Stone Parkway  
Hoffman Estates, IL 60192 |
| Joseph Pastorino| Kevin Geshwender  
Chicago Regional Council of Carpenters, Local No. 181  
7432 W. Grand Avenue  
Elmwood Park, IL 60707  
Berglund Construction  
8410 S. Chicago  
Chicago, IL 60617 |
| Bruce Werning   | Daniel G. Rosenberg  
Chicago Regional Council of Carpenters – Western Region  
1503 First Avenue, Suite A  
Rock Falls, IL 61071  
James McHugh Construction Company  
1737 S. Michigan Ave.  
Chicago, IL 60616 |
| Kristina M. Guastaferri | Mike Sudol  
Chicago Regional Council of Carpenters Welfare Fund  
12 E. Erie Street  
Chicago, IL 60611  
Bulley & Andrews, LLC  
1755 W. Armitage Avenue  
Chicago, IL 60622 |

**Plan Administrator**

Kristina M. Guastaferri  
Chicago Regional Council of Carpenters Welfare Fund  
12 E. Erie Street  
Chicago, IL 60611

**Plan Inspection**

If you want to inspect or receive copies of additional documents relating to the Plan, contact the Administrator at the Fund Office. You will be charged a reasonable fee to cover the cost of copying any documents requested.
**Rescission**

The Plan will not rescind health coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan.

For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage for health benefits that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance has only a prospective effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. Retroactive elimination of coverage back to the date of termination of employment is not a rescission if, due to a delay in administrative recordkeeping, the Employee does not pay any premiums for coverage after termination of employment. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactive to the date of divorce.

The Plan is required to provide at least 30 days advance written notice to each Participant who is affected by a rescission of coverage before the coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group. Retroactive termination of coverage in cases of an unreported divorce or failure to timely pay premiums is not an Affordable Care Act rescission and, therefore, the 30-day advance notice requirement does not apply.

**Discretionary Authority**

The Trustees have the power and authority to amend or terminate the Plan, to increase, decrease, or change benefits and premiums, or change eligibility rules or other provisions of the Plan of Benefits for the Plan, including the Retiree Plan, in their discretion as may be proper or necessary for the sound and efficient administration of the Fund, provided that such changes are not inconsistent with law or with the provisions of this Plan or with the provisions of the Trust Agreement.

The Trustees and other Plan fiduciaries and individuals, to whom responsibility for the administration of the Plan has been delegated, have the full discretionary authority available under applicable law to construe the Trust Agreement, Summary Plan Description, the Plan, the Plan documents and related documents including but not limited to Collective Bargaining Agreements, Participation Agreements and reciprocity agreements, and the procedures of this Fund, to interpret any facts relevant to such construction. This authority extends to every aspect of their administration of the Plan including benefit determinations, eligibility determinations and entitlement to Plan benefits. Any interpretation or determination made under this discretionary authority will be given full force and effect and will be accorded judicial deference, unless it can be shown that the interpretation or determination was arbitrary and capricious. Benefits under the Plan will be paid only if the Trustees (or other Plan fiduciaries, such as a third party Claims Fiduciary), decide in their discretion that the Claimant is entitled to them. In addition, any interpretation or determination made pursuant to this discretionary authority is binding on all involved parties.
**Plan Amendment and Plan Termination**

Any amendment made by the Trustees will be reduced to writing and may be effective prospectively or retrospectively, to the extent allowed under the law, provided, however, no amendment to the Plan will retroactively reduce benefit entitlement or benefit levels then in effect. All amendments are subject to the limitation of the Trust Agreement and the applicable law and administrative regulations. The Trustees reserve the right to terminate the Plan or any part of the Plan and its benefits at any time. Written notice of amendment or termination of the Plan will be provided to you in accordance with federal regulations.

**Furnishing Required Information and Documentation**

Every Covered Individual shall, upon reasonable request, furnish the Board of Trustees such information or proof as may be reasonably necessary or helpful in determining eligibility or benefit payments. Failure on the part of the Covered Individual to comply with any request for information shall be grounds for denying or discontinuing benefits to such Covered Individual until the request is complied with. If any Covered Individual knowingly makes any false statement or omits information concerning any fact material to his claims for benefits, the Board of Trustees shall have the right to recover any payment made to such person in reliance on such false statements.

**ERISA Rights**

As a Participant in the Chicago Regional Council of Carpenters Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), which provides that all Plan Participants will be entitled to:

- Examine, without charge, at the Fund Office, all documents governing the Plan. These include insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);

- Obtain, upon written request to the Fund 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 Fund Administrator may make a reasonable charge for the copies; and

- Receive a summary of the Fund’s annual financial report. The Fund Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

**Continue Group Health Plan Coverage**

You have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event, as described in the section titled *Continuation Coverage Under COBRA*. You have to pay for such coverage, if it is elected. Review this Summary Plan Description and the documents governing the Plan for rules governing Continuation Coverage under COBRA.
Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the individuals who are responsible for the operation of the Employee benefit plan. The individuals who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and those of your beneficiaries. No one, including your Employer, your Union or any other individuals 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.

Enforcing Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and if you do not receive them within 30 days, you may file suit in 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 unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim 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 claim and appeal procedures. 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 may file suit in a federal court. The court will decide who should pay costs and legal fees. If you are successful, the court may order the person sued to pay costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds the claim is frivolous.

Assistance with Questions

If you have any questions about Plan benefits, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, or if assistance is needed in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration (EBSA) at:

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

Local Office
Employee Benefits Security Administration
Chicago Regional Office
200 W. Adams Street Suite 1600
Chicago, Illinois 60606

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the website at www.dol.gov/ebsa. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at 866-444-3272.
Glossary of Terms

Whenever a word or phrase defined in this section is used in this Plan, it shall have the same meaning as defined below unless a different meaning is plainly required by the context. The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender and the singular shall be deemed to include the plural, unless the context clearly indicates to the contrary.

**Active Plan/Active Plan of Benefits**
“Active Plan” or “Active Plan of Benefits” means the Plan and the Plan of Benefits as described in the Summary Plan Description dated January 1, 2019 for the Active Plan of Benefits and the Schedule of Benefits for the Active Plan.

**Administrator/Plan Administrator/COBRA Administrator**
“Administrator,” “Plan Administrator” and “COBRA Administrator” means the entity or individual designated by the Trustees to act as the executive administrative officer of the Trust Fund who has the authority to control and manage the administration of the Plan.

**Affordable Care Act**
The “Affordable Care Act” means the Patient Protection and Affordable Care Act, Public Law No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 and the regulations and guidance promulgated thereunder (the “Affordable Care Act”).

**Another Health Care Plan**
See definition of “Outside Plan” on page 89.

**Appeals Committee**
“Appeals Committee” means a committee of Trustees appointed by the Board of Trustees to handle appeals brought pursuant to the procedures set forth in the Plan Document for claims appeals related to eligibility, premiums or enrollment.

**Authorized Personal Representative**
“Authorized Personal Representative” means the person designated by a Covered Individual by means of the Fund’s Authorized Personal Representative Form or Health Care Power of Attorney to act on his behalf in receiving any information that is (or would be) provided to a Covered Individual as a Participant/beneficiary of the Plan, including but not limited to, any and all information that relates to his Claim for coverage or benefits under the Plan and any individual rights that a Covered Individual has regarding his protected health information under HIPAA.

**Behavioral Health/Substance Use Disorders**
“Behavioral Health/Substance Use Disorders” means a neurosis, psychoneurosis, psychopathy, psychosis, or a mental or emotional disease of any kind that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Substance Use Disorders. “Substance Use Disorders” is psychological and/or physiological dependence on or addiction to alcohol, drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined in the current edition of the ICD or DSM.

**Calendar Year**
“Calendar Year” means a 12 month period starting on January 1 and ending on the following December 31.

**Claim**
“Claim” means a demand for payment under the Plan on behalf of a Claimant pursuant to the procedures for making such requests set forth in the Plan Document.

**Claimant**
“Claimant” means a Covered Individual who requests a benefit to be paid to him under the procedures set forth in the Plan Document. A Claimant includes a Participant or the Participant’s spouse, Participant’s Dependent or Authorized Personal Representative authorized by the Covered Individual.
Claims Fiduciary
A “Claims Fiduciary” is the entity that has full discretionary authority to interpret the terms of the Plan and to decide benefit claims under the Plan and the appeal of such decision, and to maintain any applicable external review process. The Plan’s Claims Fiduciary is the Board of Trustees unless the Trustees take action to delegate such authority to a third party Claims Fiduciary such as to an insurance carrier or to a third party service provider responsible for maintaining a benefit program under the Plan, e.g., a service provider maintaining the Plan’s dental, vision, Behavioral Health, prescription drug or medical benefits as designated in this Summary Plan Description.

COBRA/Continuation Coverage under COBRA
“COBRA” or “Continuation Coverage under COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. “Continuation Coverage under COBRA” means coverage offered pursuant to COBRA.

Coinsurance
“Coinsurance” means the portion, expressed as a percentage, of Covered Services a Covered Individual will pay after the Calendar Year Deductible is satisfied, but before the Calendar Year Out-of-Pocket Maximum is met.

Collective Bargaining Agreement
“Collective Bargaining Agreement” means a written agreement between the Union and an Employer (or an association on behalf of an Employer) providing for Contributions by the Employer to the Trust Fund for an Employee, and pursuant to which an Employer consents to be bound by the Trust Agreement and the terms of the Plan and any amendment thereto.

Contracted Provider
“Contracted Provider” means an organization with which the Fund contracts for services on behalf of Participants and Covered Individuals, including, but not limited to provisions of a Preferred Provider Network, Utilization Review management, and other services related to Plan benefits.

Convalescent Facility
“Convalescent Facility” means an institution that:
A. Provides skilled nursing care under 24-hour-a-day supervision of a Physician or graduate Registered Nurse;
B. Has available, at all times, the services of a Physician who is a staff member of a Hospital;
C. Provides 24-hour-a-day nursing service by a graduate Registered Nurse, licensed vocational nurse, or skilled practical nurse and has a graduate Registered Nurse on duty at least eight hours per day;
D. Maintains a daily medical record for each patient; and
E. Is not a place for rest, a place for Custodial Care, a place for the aged, or a hotel or similar institution.

Coordination of Benefits
“Coordination of Benefits” means the provisions used to establish the order in which two or more plans coordinate their respective benefits so the total benefits paid do not exceed 100% of the total allowable charge.

Co-payment or Co-pay
“Co-payment” or “Co-pay” means the dollar amount a Covered Individual will pay for certain services before the Plan pays.

Cosmetic
“Cosmetic” means a procedure or treatment that is intended primarily to improve physical appearance, and/or to restore form, is not Medically Necessary and is not a treatment requirement.

Covered Individual
“Covered Individual” means a Participant and each Dependent eligible under the Retiree Plan or an individual who elects continuation of coverage under COBRA.
Covered Medical Expenses, Covered Expenses or Covered Services

“Covered Medical Expenses,” “Covered Expenses” or “Covered Services” means expenses for medical, prescription drugs, vision and/or dental services or supplies that are Medically Necessary and required for treatment as a result of a Non-Occupational Illness or Injury for which benefits are payable by the Plan in accordance with Plan provisions.

Custodial Care

“Custodial Care” means services and supplies for care:

A. Provided mainly to help the patient with activities of daily living (ADL), including, but not limited to, walking, getting in or out of bed, exercising or moving the person, bathing, using the toilet, administering enemas, dressing and assisting with hygiene needs, assistance with eating, tube feeding, or gastronomy feeding, cleaning, preparation of meals, acting as companion or sitter, administering or supervising the administration of medication, or as part of a Maintenance Care Treatment Plan not reasonably expected to improve the patient’s condition, Illness, Injury or functional ability, rather than to provide medical treatment;

B. That can safely and adequately be provided by persons who do not have the technical skills of a health care provider; and

C. That meet one of the conditions above regardless of:
   1. Who recommends, provides or directs the care;
   2. Where the care is provided; or
   3. Whether or not the patient or another caregiver can be or is being trained to care for himself.

Deductible

“Deductible” means the amount of Covered Medical Expenses a Covered Individual pays each Calendar Year before benefits are payable by the Plan.

Deferred Lather

“Deferred Lather” means a Participant who is vested in Local No. 74, Wood, Wire, and Metal Lathers’ International Union of Chicago and Vicinity Pension Plan (“Lather Plan”) and:

A. Was not actively working as a Lather at the time of the merger in 1983; if a Participant stopped earning credit with the Lather Plan in 1979 or earlier, the Participant is considered “inactive” at the time of the merger; and

B. The Participant did not earn credit under the Chicago Regional Council of Carpenters Pension Plan, or the Participant earned less than 10 years of vesting service under the Chicago Regional Council of Carpenters Pension Plan.

Dentist

For a definition of “Dentist,” see the definition of “Physician” on page 90.

Dependent

See page 6 for definition.

Developmental Disability

“Developmental Disability” means a severe, chronic impairment which originated at birth or during childhood, is expected to continue indefinitely, and substantially restricts the individual’s functioning in several major life activities. More specifically, a Developmental Disability is a severe, chronic impairment which satisfies each of the following requirements:

A. Is attributable to a mental or physical impairment or a combination of mental and physical impairments;

B. Is manifested while a Dependent;

C. Results in substantial functional limitations in three or more of the following areas of major life activity:
   1. Self-care;
   2. Receptive and expressive language;
   3. Learning;
   4. Mobility;
   5. Self-direction;
6. Capacity for independent living; and

D. Results in the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

**Doctor**

For a definition of “Doctor,” see the definition of “Physician” on page 90.

**Durable Medical Equipment (DME) and Supplies**

“Durable Medical Equipment (DME) and Supplies” means a device or instrument of a durable nature approved by the Food and Drug Administration (FDA) that:

A. Can withstand repeated use;
B. Is primarily and customarily used to serve a medical purpose, rather than a comfort or convenience purpose and is not generally useful in the absence of an Illness or Injury;
C. Is not disposable or non-durable;
D. Is appropriate for home use, ordered or prescribed by a Physician and is exclusively needed by the recipient for whom it was approved;
E. Generally includes, but is not limited to, wheelchairs, walkers, Hospital beds, respiratory supplies including nebulizers, breast pumps and supplies required for sleep apnea;
F. Repair, maintenance and replacement of equipment is limited and is based on Medical Necessity; and
G. Does not include home modifications to accommodate equipment.

**Durable Medical Equipment (DME) Provider**

“Durable Medical Equipment (DME) Provider” means a supplier of DME that is licensed by a state and accredited as a supplier of DME.

**Emergency or Emergencies**

“Emergency” means a severe condition that:

A. Results from symptoms that occur suddenly and unexpectedly and are non-occupational;
B. Pose an imminent serious threat to a Covered Individual's health; or
C. Require immediate Physician's care to prevent death or serious impairment of health.

**Emergency Room**

“Emergency Room” means the section of a legally licensed Hospital facility staffed and equipped to provide rapid treatment for victims of sudden Illness, Injury or trauma.

**Employee**

“Employee” means any individual employed by an Employer:

A. In a bargaining unit represented by the Union for whom the Employer is obligated to contribute to the Welfare Fund pursuant to a Collective Bargaining Agreement.
B. For whom the employer is obligated to contribute to the Welfare Fund pursuant to a written Participation Agreement or other written agreement.
C. Sole proprietors, partners and other unincorporated owner/operators do not qualify as “Employees.”

**Employer or Contributing Employer**

“Employer” or “Contributing Employer” has the meaning assigned to it in the Trust Agreement.

**ERISA**

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or successor provisions of any legislation that amends, supplements, or replaces such section or subsection.
Experimental or Investigational

“Experimental” or “Investigational” means the use of any treatment modality, service, procedure, facility, equipment, drug, device, surgery, or supply if it meets one or more of the following criteria:

A. It has failed to obtain final approval for use of a specific service, procedure, drug, device, surgery or treatment modality for specific diagnosis from the appropriate governmental regulatory body;

B. Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of the specific service, procedure, drug, device, surgery, or treatment modality on health outcomes for a specific diagnosis;

C. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, surgery, treatment or procedure, was reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, which makes it Experimental/Investigational, or if federal law requires such review or approval;

D. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerant dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

E. If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental study or investigational arm of ongoing phase III experimental or research clinical trials, or is otherwise under study by corresponding trials sponsored by the FDA, the National Cancer Institute, the National Institute of Health or similar body to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis.

Notwithstanding the foregoing, to the extent required under the Affordable Care Act, the Plan will not deny you the right to participate in certain approved clinical trials; deny, limit or impose additional conditions on the coverage of routine patient costs furnished in connection with participation in the clinical trial; and will not discriminate against you for participating in the clinical trial. For more information on the specific services and clinical trials covered, please call BCBSIL.

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

The Trustees or a delegated third party Claims Fiduciary shall have authority to determine, in their discretion, whether a service, procedure, facility, equipment, drug, device, surgery, supply or treatment modality is Experimental/Investigational. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, facility, equipment, drug, device, surgery or treatment modality does not, in itself, make it eligible for payment.
Extended Care/Skilled Nursing Facility

“Extended Care/Skilled Nursing Facility” means a nursing facility that:
A. Is an institution, or a distinct part of an institution that has in effect a transfer agreement with one or more Hospitals;
B. Is primarily engaged in providing inpatient skilled nursing care and related services for individuals who require medical or nursing care;
C. Is duly licensed by the appropriate governmental authorities;
D. Has one or more Physicians and one or more registered professional nurses responsible for the care of inpatients;
E. Requires that every patient must be under the supervision of a Physician;
F. Maintains clinical records on all patients;
G. Provides 24-hour-a-day nursing services;
H. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
I. Has in effect a Utilization Review management plan;
J. Is eligible to participate under Medicare;
K. Is not an institution that is primarily for the care and treatment of mental diseases or tuberculosis; and
L. Rehabilitation services are for the rehabilitation of a Covered Individual with an Injury, Illness or disability.

Fund, Trust Fund, or Welfare Fund


HIPAA

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996 as amended from time to time.

Home Health Agency

“Home Health Agency” means a program of care provided by a public agency or private organization or a subdivision of such agency or organization that:
A. Is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;
B. Has established policies for governing the services it provides, such policies being established by a group of professional personnel associated with the agency or organization, including one or more Physicians and one or more registered professional nurses;
C. Provides for the supervision of its services by a Physician or registered professional nurse acting under a Physician’s direction;
D. Maintains clinical records of all patients;
E. Is licensed according to the applicable law of the state in which it is located or provides services;
F. Is certified or approved by Medicare and is eligible to participate under Medicare; and
G. Is not primarily for the care of Behavioral Health and Substance Use Disorders.
**Hospice or Hospice Facility**

“Hospice” or “Hospice Facility” means an agency or organization that administers a program of palliative and supportive health care services (also known as “core services”) providing physical, psychological, nursing, dietary, social, and spiritual care for terminally ill persons assessed to have a life expectancy of six months or less. The agency must:

A. Be approved by Medicare as a Hospice program; and

B. Be licensed or certified as a Hospice by the regulatory authority having responsibility for the licensing or certification under the laws of the jurisdiction in which it is located; or, if licensing is not required, the agency must:

1. Provide service 24 hours per day, seven days per week;

2. Be under the direct supervision of a duly qualified Physician;

3. Have a full-time administrator;

4. Have a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience (two of these years must involve caring for terminally ill patients);

5. Have a main purpose of providing Hospice services;

6. Maintain written records of services provided to the patient;

7. Maintain malpractice insurance coverage; and

8. Have established policies governing the provision of Hospice care, assess the patient’s medical and social needs, develop a Hospice care program and provide or otherwise arrange for services to meet those needs.

**Hospital**

“Hospital” means an institution engaged primarily in providing medical care and treatment to individuals who have an Illness or Injury on an inpatient basis at the patient’s expense, and that fully meets one of the following requirements:

A. It is a Hospital accredited by the Joint Commission;

B. It is a Hospital, as defined by Medicare, that is qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare; or

C. It is an institution that:

1. In return for payment from its patients, provides on an inpatient basis, diagnosis and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and ill individuals under the supervision of a staff of Physicians licensed to practice medicine;

2. Provides on the premises 24-hour-a-day nursing services by or under the supervision of a registered graduate nurse; and

3. Operates continuously with organized facilities for operative surgery on the premises and is not a place for rest, for the aged, a Residential Treatment Facility, a nursing or convalescent center or rehabilitation center.

**Illness**

“Illness” means a sickness, disorder, or disease that is Non-Occupational. Pregnancy is included in the definition of “Illness” under this Plan.

**Infusion Therapy**

“Infusion Therapy” means the administration of medications, nutrients or other solutions into the blood stream/digestive system, or the membranes surrounding the spinal cord, or under the skin, which are prescribed by a Physician and obtained at a licensed, accredited pharmacy for conditions that include but are not limited to infections, cancer, blood disorders and other comparable health problems.
**Injury or Accident**
“Injury” or “Accident” means any damage to a body part resulting from trauma from an external source that is Non-Occupational.

**Insurance Company**
“Insurance company” means the Contracted Provider providing dental and vision benefits.

**Long-Term Medication**
“Long-Term Medication” means a medication that must be taken on a regular basis to treat a chronic health condition.

**Low Cost Medical Plan**
“Low Cost Medical Plan” means the Plan and the plan of benefits as described in the Summary Plan Description dated January 1, 2019 for the Active Plan of Benefits. The “Low Cost Medical Plan” is the portion of the Plan that covers Employees who elect to continue health coverage, in lieu of continued coverage under COBRA, when Active Plan eligibility terminates.

**Maintenance Care**
“Maintenance Care” means services and supplies provided primarily to maintain, support, or preserve a level of physical or mental function rather than to improve such function.

**Medicaid**
“Medicaid” means a health insurance program under Title XIX of the Social Security Act for certain people and families with low incomes and resources as provided under Title 42, Chapter IV of the Code of Federal Regulations.

**Medically Necessary or Medical Necessity**
A. “Medically Necessary” means only those services, treatments, or supplies provided by a Hospital, a Physician or other qualified provider of medical services and supplies that are required in the judgment of the Trustees, based on the opinion of a qualified medical professional, to identify or treat the Illness or Injury of a Covered Individual. A medical service, treatment or supply shall not be considered to be Medically Necessary solely because a Physician or Doctor orders or recommends it. “Medical Necessity” refers to a service, treatment or supply that is “Medically Necessary.”

B. To be considered “Medically Necessary,” the service, treatment, or supply must:
1. Be consistent with the symptoms or diagnosis and treatment of the eligible Covered Individual’s condition, Illness, Injury, disease, or ailment;
2. Be appropriate according to industry standards of good and generally accepted medical practice;
3. Not be solely for the convenience of a Covered Individual, a Physician or a Hospital;
4. Be the most appropriate treatment, services or supplies that can safely be provided to a Covered Individual; and
5. Not be considered Experimental or Investigational.

C. A medical service or supply will be considered “appropriate” if, both with respect to the Illness or Injury involved and the Covered Individual’s overall health condition:
1. It is a diagnostic procedure that is called for by the health status of the Covered Individual and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than any alternate service or supply, both with respect to the Illness or Injury involved and the Covered Individual’s overall health condition; and
2. It is care or treatment that is as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than any alternate service or supply, both with respect to the Illness or Injury involved and the Covered Individual’s overall health condition.
Medicare
“Medicare” means the federal health insurance program for individuals 65 years or older, younger than 65 with disabilities or with end stage renal disease, designated as the Health Insurance for the Aged Program under Title XVIII of the Social Security Act, as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97), and as such program is currently constituted, and as it may be amended from time to time.

Member in Good Standing
The Fund will deem a Participant to be a “Member in Good Standing” for periods in which the Chicago Regional Council of Carpenters advises that the Participant is in good standing under the Constitution of the United Brotherhood of Carpenters and Joiners.

Negotiated Rate
“Negotiated Rate” means an amount for services rendered that does not exceed the amount agreed upon under the contract between the Welfare Fund’s Contracted Provider and the service provider who participates in the Contracted Provider’s Network.

Network
“Network” means a group of independent Doctors, Hospitals or other health care providers who have agreed to contract with a single organization with which the Plan contracts for services.

Non-Occupational or Non-Occupational Illness or Injury
“Non-Occupational” or “Non-Occupational Illness or Injury” means:
A. Any Injury that does not arise out of and in the course of the Covered Individual’s employment, or
B. Any Illness that is not caused or aggravated by employment, for which benefits are not payable in whole or in part under any Workers’ Compensation Law, Employer’s Liability Law, Occupational Diseases Law, or similar law.

Non-Preferred Provider, Non-PPO or Out-of-Network
“Non-Preferred Provider,” “Non-PPO” or “Out-of-Network” means Doctors, Hospitals or other health care providers who do not participate in the Networks of the Fund’s Contracted Providers.

Occupational or Work-Related Illness or Injury
“Occupational Illness or Injury” or “Work-Related Illness or Injury” means:
A. Any Injury arising out of and in the course of the Covered Individual’s employment, or
B. Any Illness caused or aggravated by employment, for which benefits are, or may be, payable in whole or in part under any Workers’ Compensation Law, Employer’s Liability Law, Occupational Diseases Law, or similar law.

Office Visit
“Office Visit” means a direct personal contact between a Physician or other health care practitioner and a Covered Individual as a patient in the office of the Physician or health care practitioner for diagnosis or treatment associated with the use of the appropriate Office Visit Code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirements of such CPT coding. Neither a telephone discussion with a Physician or other health care practitioner, nor a visit to a health care practitioner’s office solely for such services as blood drawing, leaving a specimen, receiving a routine injection or completing medical forms is considered to be an “Office Visit” for the purpose of this Plan.

Out-of-Pocket Maximum
“Out-of-Pocket Maximum” means the maximum amount that a Covered Individual is required to pay for Covered Expenses within a specified period of time. After a Covered Individual satisfies the Plan’s applicable Out-of-Pocket Maximum the Plan will pay 100% of any additional Covered Expenses a Covered Individual incurs for the remainder of the Calendar Year.
Outside Plan, Other Health Care Plan or Another Health Care Plan

“Outside Plan,” “Other Health Care Plan” or “Another Health Care Plan” means a plan, other than this Plan, providing health coverage to a Participant or a Dependent of a Participant.

Participant

“Participant” means an Employee employed or previously employed in Covered Employment who meets the eligibility requirements or an individual who elects continuation of Plan coverage.

Participation Agreement

“Participation Agreement” means a written agreement between an Employer (as defined in the Trust Agreement) and the Trustees, in which the Employer agrees to become an Employer hereunder obligating the Employer to make contributions to the Fund on behalf of the Employer’s covered Employees whether or not subject to the terms of a Collective Bargaining Agreement. The Trustees may also enter Participation Agreements with Employers covering independent contractors retained by the Employer.

Pension Funds

“Pension Funds” means collectively the Chicago Regional Council of Carpenters Pension Fund, the Chicago Regional Council of Carpenters Millmen Pension Fund, the Carpenters Pension Fund of Illinois, the Carpenters Local 496 Pension Fund, and the Will County Local 174 Carpenters Pension Fund.

Pension Plans

“Pension Plans” means collectively the Chicago Regional Council of Carpenters Pension Plan, the Chicago Regional Council of Carpenters Millmen Pension Plan, the Carpenters Pension Fund of Illinois Plan, the Carpenters Local 496 Pension Plan and the Will County Local 174 Carpenters Pension Plan.

Physician or Doctor

A. “Physician” or “Doctor” means an individual licensed in the state where such individual renders treatment and/or is acting within the scope of his license at the time and place the services are performed. Additionally, to the extent required by the Affordable Care Act, if an individual’s service is covered under the Plan, the Plan will not discriminate based on the practitioner’s license or certification, if the practitioner is licensed to provide such services in the state in which the services are performed and the practitioner is acting within the scope of that license; and

B. “Physician” shall include a Doctor of Medicine (MD), a Doctor of Osteopathy (DO), a Doctor of Podiatric Medicine (DPM), a Doctor of Naprapathy (DN), a Doctor of Acupuncture and Oriental Medicine (DAOM), a Doctor of Acupuncture (DAC), a Doctor of Dental Science/Surgery (DDS), a Doctor of Medical Dentistry (DMD), a Doctor of Optometry (OD), a Doctor of Ophthalmology (MD-Ophthalmology), a Doctor of Chiropractic Medicine (DC), a Doctor of Psychology (PsyD), a Master of Social Work (MSW), a Licensed Clinical Professional Counselor (LCPC), a Licensed Clinical Social Worker (LCSW), a Board Certified Behavioral Analyst (BCBA), a Licensed Physical Therapist (LPT), a Licensed Occupational Therapist (OTR), a Licensed Speech/Language Pathologist (CCC-SLP), a Certified Registered Nurse Anesthetist (CRNA), a Certified Surgical Assistant (SA, CSA), an Advanced Practice Nurse (APN), a Nurse Practitioner (LPN, RN or NP), a Certified Nurse Practitioner (CNP), a Clinical Nurse Specialist (CNS), a Physician Assistant (PA), a Registered Nurse First Assistant (RNFA), a Certified Nurse Midwife (CNM), a Licensed Midwife (LM), and a Certified Pediatric Nurse (CPN).
Plan, Benefit Plan, Plan of Benefits or Health and Welfare Plan

“Plan,” “Benefit Plan,” “Plan of Benefits” or “Health and Welfare Plan” means this Chicago Regional Council of Carpenters Welfare Plan, or the plan or program of benefits provided by the Plan set forth in this document, including any other written document designated by the Trustees as constituting a part of the Plan, established, and as it may be amended from time to time by the Board of Trustees pursuant to the provisions of the Trust Agreement.

Preferred Provider Organization (PPO)

“Preferred Provider Organization (PPO)” means a group of independent Doctors, Hospitals or other health care providers who have agreed to contract with a single organization or Network with which the Plan contracts for services, also referred to as a Contracted Provider Network.

Premium Payment

“Premium Payment” means the amount a Covered Individual pays for coverage under the Retiree Plan or Continuation Coverage under COBRA. Premium Payments are subject to change from time to time.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice

“Qualified Medical Child Support Order” (QMCSO) or “National Medical Support Notice” as defined under ERISA, means a court order requiring a medical plan to provide medical benefits to the children of the parties pursuant to a marriage dissolution, divorce, child custody action, paternity suit, family non-support action, or other state domestic relations actions, where financial support of children is involved. The Fund will treat children who are the subject of a QMCSO or National Medical Support Notice as Dependents under the Plan pursuant to the Fund’s procedures governing QMCSOs and National Medical Support Notices.

Reasonable and Customary Allowance, Reasonable and Customary Allowable Charge or Reasonable and Customary Charge

A. “Reasonable and Customary Allowance,” “Reasonable and Customary Allowable Charge” or “Reasonable and Customary Charge” means the allowance or percentage for Medically Necessary services or supplies as determined by the Trustees (or their designee such as a third party Claims Fiduciary) in their sole discretion, and amended from time to time, to be the lowest of (1) the usual charge by the provider or facility for the same or similar service or supply in the locality; (2) the applicable prevailing charge for medical, dental, vision, prescription drug or Behavioral Health/Substance Use Disorders for services or supplies rendered by, or on behalf of, an Out-of-Network Provider; or (3) an amount not to exceed the negotiated charge.

B. Complexity of service will also be considered, but in no case will the Reasonable and Customary Allowance exceed charges actually incurred.

Residential Treatment Facility

A “Residential Treatment Facility” meets the following requirements:

A. It is established and operated in accordance with any applicable state law.

B. It is accredited by either the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF).

C. It provides a program of treatment approved by a Physician and the Treatment Plan administrator.

D. It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.

E. It provides at least the following basic services:

1. Room and Board (if the medical plan provides for inpatient benefits at a treatment center).
2. Conducts evaluation, diagnosis and Treatment Plans.
3. Offers individual, group and/or family counseling.
4. Provides referral and orientation to specialized community resources.

F. A treatment center that qualifies as a Hospital is covered as a Hospital and not as a treatment center.

G. The treatment provided meets the generally accepted Behavioral Health standards of care for the condition or impairment for which the individual is being treated for, and no alternative or lower level of care is available for the individual to be safely treated.

**Retiree**

“Retiree” means an individual who worked for an Employer that paid contributions to the Fund for the work performed in accordance with a written agreement requiring such contributions, and is receiving a pension benefit from a Pension Fund. The term “Retiree” may also include retired participants of other plans that merge into the Fund provided the Trustees have agreed to permit such individuals to qualify as “Retirees.”

**Retiree Plan or Retiree Plan of Benefits**

“Retiree Plan” or “Retiree Plan of Benefits” means this Plan and the Plan of Benefits as described in this Summary Plan Description dated January 1, 2019 for the Retiree Plan of Benefits and the Schedule of Benefits for the Retiree Plan.

**Room and Board or Room and Board Charges**

“Room and Board” or “Room and Board Charges” means charges made by a Hospital, a Skilled Nursing/Extended Care Facility, or a Hospice Facility, on its own behalf for Room and Board at a semi-private room rate, general duty nursing, and any other charges that are regularly made by the Hospital or facility as a condition of occupancy of the class of accommodations occupied, but not including charges for professional services of a Physician or private duty nurse. Such charges are based on a confinement or stay of 24 hours or any shorter period for which the Hospital or facility regularly charges a full day’s Room and Board rate.

**Schedule of Benefits**

“Schedule of Benefits” means the descriptive summary that highlights key features of the Plan of Benefits as determined by the Board of Trustees for the Retiree Plan. The descriptive summary provides information regarding plan Deductibles, Coinsurance and Co-pays.

**Surgi-Center or Ambulatory Surgical Center**

“Surgi-Center,” also referred to as an “Ambulatory Surgical Center,” means a facility that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization. The term does not include:

A. A facility that is licensed as part of a Hospital;

B. A facility that provides services and/or accommodations for patients who stay overnight; or

C. A facility that is used as an office or clinic for the private practice of a Physician, Podiatrist or Dentist except when:

1. It holds itself out to the public or other health care providers as a freestanding surgical center or similar facility; or

2. It is operated or used by a person or entity different from the Physician(s) that owns it; or

3. Patients are charged a fee for the use of the facility in addition to the Physicians’ professional services.
**Treatment Plan**

“Treatment Plan” means a written report, showing the recommended treatment of any Illness or Injury, prepared by a Covered Individual’s attending Physician as a result of an examination made by a Physician.

**Trust Agreement**

“Trust Agreement” means the Chicago Regional Council of Carpenters Welfare Trust Agreement as amended from time to time, establishing the Trust Fund and its rules of operation.

**Trustee, Trustees, or Board of Trustees**

“Trustee,” “Trustees,” or “Board of Trustees” means a Trustee or the Trustees of the Chicago Regional Council of Carpenters Welfare Fund.

**Uniformed Services or Military Service**

“Uniformed Services” or “Military Service” means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty. Uniformed Services or Military Service covers the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

**Union or Council**

“Union” or “Council” means the Chicago Regional Council of Carpenters, United Brotherhood of Carpenters and Joiners of America and affiliated local Unions as identified in the Trust Agreement.

**Urgent/Immediate Care Facilities and Retail Clinics**

“Urgent/Immediate Care Facilities” means a licensed facility outside of a Hospital Emergency Room, primarily engaged in providing minor Emergency and episodic medical care to its patients. A Physician, RN and a registered X-ray technician must be in attendance at all times when the facility is open. The Urgent/Immediate Care Facility must include X-ray and laboratory equipment and a life-support system. A “Retail Clinic” means a licensed facility primary engaged in treatment of uncomplicated minor Illnesses and may provide preventive health care services. A nurse practitioner or Physician’s assistant must be in attendance at all times when the Retail Clinic is open.

**USERRA**

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).

**Utilization Review**

“Utilization Review” means a process to determine whether certain health care services are Medically Necessary, appropriate, provided at a reasonable location and/or cost-effective.

**Work-Related**

For a definition of “Work-Related,” see the definition of “Occupational or Work-Related Illness or Injury” on page 89.