Heartland Healthcare Fund

Summary Plan Description
Effective April 1, 2018

HEARTLAND HEALTHCARE FUND

2018 Summary Plan Description

April 1, 2018

HEARTLAND HEALTHCARE FUND
FUND ADMINISTRATOR
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, Minnesota 55425
(952) 854-0795
(800) 535-6373

BOARD OF TRUSTEES
(Administrator, as defined by law)

UNION TRUSTEES:	**EMPLOYER TRUSTEES:**
Mr. David Argubright Carpenters Local Union No. 195 1001 Boyce Memorial Drive Ottawa, Illinois 61350	Mr. Daniel F. Aussem Illinois Valley Contractors Associations 1120 First Street LaSalle, Illinois 61301
Mr. David Foy Millwrights Local Union No. 2158 2707 62nd Street Court Bettendorf, Iowa 52722	Mr. Greg Mulherin Newell Machinery Company 1405 Mitchell Drive Hiawatha, Iowa 52233
Mr. Bruce Werning Heartland Regional Council of Carpenters 1503 1st Avenue, Suite A Rock Falls, Illinois 61071	Mr. Steven P. Tondi AGC of the Quad Cities 520 24th Street Rock Island, Illinois 61201
FUND COUNSEL Nathan Hill, Esq. Blake and Uhlig, P.A. 753 State Avenue, Suite 475 Kansas City, Kansas 66101 (913) 321-8884	**FUND CONSULTANT** The Segal Company 3800 American Blvd. West Suite 870 Bloomington, MN 55431 (952) 259-2600

About This Booklet
This booklet, which replaces and supersedes any prior Summary Plan Description (SPD), contains only highlights of certain features of the Heartland Healthcare Fund (Plan). Full details are contained in the contracts, policies, and other legal documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the language in the documents will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

No Employer, Union, or any representative of any Employer or Union, in such capacity, is authorized to interpret the Plan; nor can any such person act as agent of the Trustees.

April 1, 2018

Dear Participant:

We are pleased to provide you with the new Summary Plan Description (SPD) that outlines the benefits provided on behalf of Eligible Members and Eligible Dependents of the Heartland Healthcare Fund (Fund) as of April 1, 2018.

This Plan provides you and your eligible family members with health care coverage that can help protect you against serious financial loss should you ever become ill or injured, including benefits for medical and prescription drugs.

Whether you are getting married or divorced, having a child or adopting one, or battling an Illness or disability, the Plan offers health coverage that is designed to help you meet the needs of you and your family. This booklet will show you how your health benefits fit into the different stages of your life.

We have tried to describe your benefits as completely as possible in everyday language. We have also tried to organize this SPD to be useful to you. Please read this SPD carefully as it is important that you understand your benefits and the protections they provide. If you are married, please share it with your spouse.

This SPD replaces and supersedes all prior SPDs and announcements provided before April 1, 2018. We recommend that you keep this with your important papers so you can refer to it when needed.

The Plan may be amended from time to time—to revise benefits, change the eligibility for benefits, or to bring the Plan into compliance with changes in the law. If this occurs, you will be provided with written notification explaining the change(s).

If you have any questions about your benefits or if you need further information about this SPD, please call the Fund Administrator, Wilson-McShane Corporation, at (952) 854-0795 or toll free at (800) 535-6373.

Sincerely,

The Board of Trustees

This SPD contains details of the benefits provided under the Heartland Healthcare Fund as of April 1, 2018. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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SCHEDULE OF BENEFITS – REGULAR PLAN

DEATH BENEFIT **(Active Employees Only)**	
Benefit	$10,000
DISABILITY BENEFIT(Active Employees Only)	
Weekly Benefit	$250
Maximum Number of Weeks Payable	26
Benefits are Payable From the:	1st Day of an Injury 8th Day of an Illness
COMPREHENSIVE MEDICAL EXPENSE BENEFITS **(Active Employees, Pre-Medicare Retirees, and Dependents)**	
Calendar Year Deductible	
Per Covered Individual	$250
Per Family	$750
Calendar Year Out-of-Pocket Maximum	
Per Covered Individual	$2,000 (plus $250 deductible)
Per Family	$6,000 (plus $750 deductible)
Medical (Inpatient is Covered In-Network Only Except for Emergencies)	
Plan Coinsurance	80%
Participant Coinsurance	20%
Alcohol and Substance Abuse (Inpatient is Covered In-Network Only Except for Emergencies)	
Plan Coinsurance	80%
Participant Coinsurance	20%
Mental Health (Inpatient is Covered In-Network Only Except for Emergencies)	
Plan Coinsurance	80%
Participant Coinsurance	20%
Preventive Care	
Plan Coinsurance	100%
Participant Coinsurance	0%
Transplant Benefit (In-Network Only)	
Transportation, Lodging, Meals	$200 Per Day, up to $10,000 Per Transplant Benefit Period
Private Nursing Care	$10,000 Per Transplant Benefit Period
Chiropractic Treatment	
Maximum Visits Per Calendar Year	24
Emergency Room	
Per-Incident Deductible	$200
Note: The deductible is waived if admitted to the Hospital during that visit.	
Foot Orthotics (orthopedic shoes or other supportable appliances for the feet) **Adults -** Payable once every 12 months. **Children under age 19** - Payable once every six months when replacement is required due to growth.	Annual Maximum $400 Per Person Not Subject to Deductible or Copayments

SCHEDULE OF BENEFITS - REGULAR PLAN (CONTINUED)

PRESCRIPTION DRUG BENEFIT (Active Employees, Pre-Medicare Retirees, and Dependents)		
The prescription drug benefit covers drugs and medicines legally obtained from a licensed pharmacist only upon prescription of a currently licensed Physician, including birth control pills/devices, and up to 12 pills per month for treating Erectile Dysfunction (such as Viagra).		
Individual Out-of-Pocket Maximum	**$4,900**	
Family Out-of-Pocket Maximum	**$7,550**	
	Retail	**Mail**
Generic Co-pay	$5	$10
Brand (Formulary & Non-Formulary) Coinsurance	20%	20%
Minimum Brand Drug Co-pay	$20	$40
Maximum Brand Drug Co-pay	$70	$140
Maximum Day Supply	34 Days	90 Days
Note: Specialty Drugs must be filled through the Plan's specialty drug vendor.		
DENTAL BENEFITS (Active Employees, Pre-Medicare Retirees, and Dependents)		
Maximum Payment Per Calendar Year	$1,500[1]	
Deductible Per Covered Individual	$50	
Deductible Per Family	$150	
Plan Copayment for Preventive Care	100%	
Plan Copayment for Basic Services	80%	
Plan Copayment for Major Services	50%	
VISION CARE BENEFIT (Active Employees, Pre-Medicare Retirees, and Dependents)		
Maximum Benefit	$500 Every 2 Years[2]	
HEARING BENEFIT (Active Employees, Pre-Medicare Retirees, and Dependents)		
Maximum Benefit	$800 Every 3 Years	

[1] Not applicable for Eligible Dependents under the age of 19.

[2] Not applicable for Eligible Dependents under the age of 19 for eye exams.

SCHEDULE OF BENEFITS – REDUCED PLAN

DISABILITY BENEFIT (Active Employees Only)	
Weekly Benefit	$250
Maximum Number of Weeks Payable	26
Benefits are Payable From the:	1st Day of an Injury 8th Day of an Illness
COMPREHENSIVE MEDICAL EXPENSE BENEFITS (Active Employees, Pre-Medicare Eligible Retirees, and Dependents)	
Calendar Year Deductible	
Per Covered Individual	$250
Per Family	$750
Calendar Year Out-of-Pocket Maximum	
Per Covered Individual	$2,000 (plus $250 deductible)
Per Family	$6,000 (plus $750 deductible)
Medical (Inpatient is Covered In-Network Only Except for Emergencies)	
Plan Coinsurance	80%
Participant Coinsurance	20%
Alcohol and Substance Abuse (Inpatient is Covered In-Network Only Except for Emergencies)	
Plan Coinsurance	80%
Participant Coinsurance	20%
Mental Health (Inpatient is Covered In-Network Only Except for Emergencies)	
Plan Coinsurance	80%
Participant Coinsurance	20%
Preventive Care	
Plan Coinsurance	100%
Participant Coinsurance	0%
Transplant Benefit (In-Network Only)	
Transportation, Lodging, Meals	$200 Per Day up to $10,000 Per Transplant Benefit Period
Private Nursing Care	$10,000 Per Transplant Benefit Period
Chiropractic Treatment	
Maximum Visits Per Calendar Year	24
Emergency Room	
Per-Incident Deductible	$200
Note: The deductible is waived if admitted to the Hospital during that visit.	
Foot Orthotics (orthopedic shoes or other supportable appliances for the feet) **Adults -** Payable once every 12 months. **Children under age 19** - Payable once every six months when replacement is required due to growth.	Annual Maximum $400 Per Person Not Subject to Deductible or Copayments

SCHEDULE OF BENEFITS – REDUCED PLAN (CONTINUED)

PRESCRIPTION DRUG BENEFIT (Active Employees, Pre-Medicare Eligible Retirees, and Dependents)		
The prescription drug benefit covers drugs and medicines legally obtained from a licensed pharmacist only upon prescription of a currently licensed Physician, including birth control pills/devices, and up to 12 pills per month for treating Erectile Dysfunction (such as Viagra).		
Individual Out-of-Pocket Maximum	**$4,900**	
Family Out-of-Pocket Maximum	**$7,550**	
	Retail	**Mail**
Generic Co-pay	$5	$10
Brand (Formulary & Non-Formulary) Coinsurance	20%	20%
Minimum Brand Drug Co-pay	$20	$40
Maximum Brand Drug Co-pay	$70	$140
Maximum Day Supply	34 Days	90 Days
Note: Specialty Drugs must be filled through the Plan's specialty drug vendor.		

SCHEDULE OF BENEFITS – MILLWRIGHT LOCAL 2158 PRE-APPRENTICE PLAN

COMPREHENSIVE MEDICAL EXPENSE BENEFITS **(Active Employees and Dependent Children)**		
Calendar Year Deductible		
Per Covered Individual	$250	
Per Family	$750	
Calendar Year Out-of-Pocket Maximum		
Per Covered Individual	$2,000 (plus $250 deductible)	
Per Family	$6,000 (plus $750 deductible)	
Medical (Inpatient is Covered In-Network Only Except for Emergencies)		
Plan Coinsurance	80%	
Participant Coinsurance	20%	
Alcohol and Substance Abuse (Inpatient is Covered In-Network Only Except for Emergencies)		
Plan Coinsurance	80%	
Participant Coinsurance	20%	
Mental Health (Inpatient is Covered In-Network Only Except for Emergencies)		
Plan Coinsurance	80%	
Participant Coinsurance	20%	
Preventive Care		
Plan Coinsurance	100%	
Participant Coinsurance	0%	
Transplant Benefit (In-Network Only)		
Transportation, Lodging, Meals	$200 Per Day, up to $10,000 Per Transplant Benefit Period	
Private Nursing Care	$10,000 Per Transplant Benefit Period	
Chiropractic Treatment		
Maximum Visits Per Calendar Year	24	
Emergency Room		
Per-Incident Deductible	$200	
Note: The deductible is waived if admitted to the Hospital during that visit.		
Foot Orthotics (orthopedic shoes or other supportable appliances for the feet) **Adults -** Payable once every 12 months. **Children under age 19** - Payable once every six months when replacement is required due to growth.	Annual Maximum $400 Per Person Not Subject to Deductible or Copayments	
PRESCRIPTION DRUG BENEFIT (Active Employees, Pre-Medicare Retirees, and Dependents)		
The prescription drug benefit covers drugs and medicines legally obtained from a licensed pharmacist only upon prescription of a currently licensed Physician, including birth control pills/devices, and up to 12 pills per month for treating Erectile Dysfunction (such as Viagra).		
Individual Out-of-Pocket Maximum	**$4,900**	
Family Out-of-Pocket Maximum	**$7,550**	
	Retail	**Mail**
Generic Co-pay	$5	$10
Brand (Formulary & Non-Formulary) Coinsurance	20%	20%
Minimum Brand Drug Co-pay	$20	$40
Maximum Brand Drug Co-pay	$70	$140
Maximum Day Supply	34 Days	90 Days
Note: Specialty Drugs must be filled through the Plan's specialty drug vendor.		

ELIGIBILITY

INITIAL ELIGIBILITY

You initially become eligible on the first day of a calendar month immediately following the month in which Posted Contributions in your Dollar Bank equal or exceed the Required Contribution amount. Posted Contributions are the Employer contributions made to the Fund on your behalf to your Dollar Bank that are posted on the last day of the month following the work month they were accrued. The amount required to receive a month of eligibility under the Regular Plan or Reduced Plan, called the Required Contribution amount, will be subtracted from the Dollar Bank on the first day of any month for which eligibility is granted. Any amount in a Dollar Bank that is attributable to Posted Contributions more than six months old for an Employee who is not yet eligible will be forfeited.

> Your dependents become Eligible Dependents on the date your eligibility is effective or on the date you acquire an Eligible Dependent, whichever is later.

Your dependents become Eligible Dependents on the date your eligibility is effective or on the date you acquire an Eligible Dependent, whichever is later.

INITIAL ELIGIBILITY FOR MILLWRIGHT LOCAL 2158 PRE-APPRENTICE PLAN

As a Local 2158 Pre-Apprentice, you initially become eligible on the first day of a calendar month immediately following the month in which Posted Contributions in your Dollar Bank equal or exceed the Required Contribution amount. Posted Contributions are the Employer contributions made to the Fund on your behalf to your Dollar Bank that are posted on the last day of the month following the work month they were accrued. The amount required to receive a month of eligibility under the Millwright Local 2158 Pre-Apprentice Plan, called the Required Contribution amount, will be subtracted from the Dollar Bank on the first day of any month for which eligibility is granted. Any amount in a Dollar Bank that is attributable to Posted Contributions more than six months old for an Employee who is not yet eligible will be forfeited.

> Eligibility will continue for each month as long as you have at least the Required Contribution amount in your Dollar Bank on the last day of the preceding month.

You can also elect to cover your Eligible Dependent children by paying a monthly premium amount as set by the Trustees. Spouses of Local 2158 Pre-Apprentices are not eligible for coverage.

Special Requirements for Shop Premium Employees

If you work under a Collective Bargaining Agreement that requires premium contributions, you will be eligible for coverage if your Employer makes the Required Contributions on your behalf according to the Collective Bargaining Agreement.

SPECIAL REQUIREMENTS FOR NON-BARGAINED EMPLOYEES

If you do not work under a Collective Bargaining Agreement, but work for a Union or Contributing Employer who has signed a participation agreement with the Fund, you will be eligible for coverage if your Employer makes the Required Contributions on your behalf according to the written participation agreement with the Fund.

CONTINUED ELIGIBILITY

Eligibility will continue for each month as long as you have at least the Required Contribution amount in your Dollar Bank on the last day of the preceding month.

In the event you have an amount less than the Required Contribution in your Dollar Bank, eligibility for benefits is subject to termination unless eligibility is continued as the result of:

- Self-contributions or COBRA premium payments from the Plan's Health Reimbursement Arrangement (HRA), if applicable and available (see the *Health Reimbursement Arrangement* section for details);
- Self-contributions;
- Payment of a COBRA premium; or,
- Credited Posted Contributions due to a Total Disability for which you are receiving Weekly Disability Benefits or a Total Disability caused by an on-the-job injury or occupational illness while you were an Eligible Employee.

In the event of your death, coverage for your Eligible Dependents will continue according to the Continued Eligibility for Survivors of Eligible Employees section below.

CONTINUED ELIGIBILITY THROUGH SELF-CONTRIBUTION

If you do not have at least the Required Contribution amount in your Dollar Bank on the last day of a month, you may self-contribute according to the following rules:

- You may make unlimited consecutive self-contributions as long as the amount in your Dollar Bank is greater than zero.
- The amount of the self-contribution must equal the difference between the balance in your Dollar Bank and the Required Contribution amount.
- Self-contributions are due by the due date listed on the self-contribution notice. Failure to make self-contributions by the due date will result in termination of coverage.

ELIGIBILITY DURING DISABILITY

If you are receiving Weekly Total Disability benefits, you will be credited with Posted Contributions toward continued eligibility, for each week or partial week of disability for which Weekly Total Disability benefits are received, to a maximum of the Required Contribution subtracted each month. Posted Contributions will be at a weekly rate equal to the Required Contribution in effect multiplied by 12 and divided by 52. However, in no event will more than 26 consecutive weeks of Posted Contributions be credited for each disabling Illness or Injury.

If you are disabled as the result of an on-the-job injury or occupational illness, you will be credited with Posted Contributions toward continued eligibility, for each week or partial week of disability, to a maximum of the Required Contribution subtracted each month. Posted Contributions will be at the weekly rate of the Required Contribution in effect. However, in no event will more than 26 weeks of Posted Contributions be credited for each on-the-job injury or occupational illness.

CONTINUED ELIGIBILITY FOR SURVIVORS OF ELIGIBLE EMPLOYEES

If you die while eligible for benefits, your surviving spouse and other Eligible Dependents may remain eligible for benefits by applying the unused portion of your Dollar Bank (including yet-to-be Posted Contributions due for work prior to your death) to the Required Contribution necessary to maintain eligibility for benefits. If the Dollar Bank at any point does not have the full amount of the Required Contribution for a month, your surviving spouse may use your HRA, if available, to continue eligibility for benefits. Otherwise, your surviving spouse may make one self-contribution to bring the Dollar Bank up to the Required Contribution amount to continue eligibility for benefits for only that month. After eligibility for benefits has terminated, your surviving spouse or any Eligible Dependent may make the required premium payment for COBRA Continuation Coverage, if your surviving spouse or Eligible Dependent is a Qualified Beneficiary.

However, if your surviving spouse is employed and covered under a group benefits plan through his or her employment, coverage through this Plan will not be available.

Dependents covered for benefits will continue to remain covered under the provisions of the Plan so long as your surviving spouse remains eligible and as long as your dependents continue to be Eligible Dependents as defined in this Plan. If your spouse dies prior to the end of COBRA Continuation Coverage, your dependents may elect to continue COBRA coverage. See the *COBRA Continuation Coverage* section for more information about continuing coverage.

If you have no surviving spouse or if your surviving spouse dies before the Dollar Bank balance is exhausted, the remaining amount in your Dollar Bank will be forfeited.

TERMINATION OF ELIGIBILITY

Eligibility will terminate upon the earliest of the following dates:

- The date the Plan terminates;
- The last day of the month that you do not have the Required Contribution in your Dollar Bank or HRA and eligibility is not continued according to Continued Eligibility Rules;
- The date you or your Eligible Dependent enters military service (subject to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
- The date of your local union's or district council's withdrawal from participation in the Plan; or,
- The date a Covered Individual ceases to be an Eligible Dependent.

RIGHTS UPON TERMINATION

The Board of Trustees reserves the right to terminate the Fund and provide for the distribution of the Fund's assets, including the HRA Accounts, for the benefit of you and your eligible beneficiaries. The Board intends to continue the Fund indefinitely. However, it is difficult to predict the future so the Board of Trustees reserves the right to modify or terminate the Fund at any time should it become necessary at the sole discretion of the Board of Trustees.

EMPLOYMENT BY A NON-CONTRIBUTING EMPLOYER

Notwithstanding any provision or eligibility rule to the contrary, if you are employed in the industry and within the Fund's geographical jurisdiction by an employer having no obligation to contribute to the Plan, you will be ineligible for Employee and dependent coverage under the Plan and will forfeit your entire Dollar Bank and HRA balance. The loss of coverage for you and your Eligible Dependents, as well as the forfeiture of your Dollar Bank and HRA balance, will be effective the first day of the month following the month during which work for the non-contributing employer was first performed. The loss of coverage will continue until you reestablish eligibility in the Plan. You and your Eligible Dependents will not be entitled to use your Dollar Bank and HRA balance or to make self-payments (other than under any continuation rules required by applicable law). No benefits will be payable as of the date of the loss of coverage regardless of any precertification or the initiation of provider services prior to that date. You and/or your Eligible Dependent(s) will be responsible and liable for the reimbursement to the Plan of any benefits paid by the Plan on or after the date of the loss of coverage.

WITHDRAWAL OF PARTICIPATING UNION

In the event that a participating local union elects to withdraw from the Fund and that local union is a member of a labor organization that is a settlor of the Fund then:

- The withdrawal will become effective not earlier than 30 days following written notification to the Fund by the withdrawing union of its decision to withdraw; and

- Notwithstanding any provision of the Trust Fund or eligibility rules to the contrary, each and every individual who regularly performs work in a bargaining unit under the jurisdiction of a withdrawing local union will forfeit and terminate all rights as a Participant, including all accumulated eligibility in his Dollar Bank and all benefits rights for himself/herself and his/her Eligible Dependents, as of midnight of the thirtieth (30) day following the effective date of the withdrawal, excepting the right of self-contribution, which will cease immediately upon receipt of the notice of withdrawal.

In the event that a participating local union elects to withdraw from the Fund, and said local union is not a member of a labor organization that is a settlor of the Fund, then such withdrawal will become effective immediately upon the Fund's receipt of the withdrawing union's written notification of its decision to withdraw.

To the extent that any provision conflicts with Federal law regarding continued coverage, such provision shall be inapplicable and considered null and void.

ELIGIBILITY FOR RETIRED AND TOTALLY DISABLED EMPLOYEES AND THEIR SURVIVING SPOUSES

If you exhaust your Active eligibility, you may become eligible for coverage as a Retired Employee by meeting the following requirements:

- You must be at least age 55 and have at least 10 Years of Service. For this purpose, a Year of Service means a calendar year in which you have at least 500 hours of work for which Employer contributions are made to the Fund or a Predecessor Fund.
- You must have at least 60 months of continuous eligibility immediately preceding the commencement of retiree coverage under this Fund or a Predecessor Fund. For the purpose of this provision, eligibility continued through self-contributions will be included.
- You must waive your right to COBRA Continuation Coverage.

If you become Totally Disabled and satisfy the requirements for coverage as a Retired Employee, but have not reached age 55, you will become eligible for benefits as a Totally Disabled Employee.

If you are a Retired Employee or Totally Disabled Employee, your coverage will commence on the first day of the month following the month in which your Dollar Bank is exhausted, provided you make the required self-contribution charged by the Trustees. Your surviving spouse may continue coverage by making self-payments, provided he or she was covered by this Plan immediately prior to your death. However, if your surviving spouse is employed and covered under a group benefits plan through employment, coverage will not be available.

Self-contributions are due before the beginning of the eligibility month. Failure to make self-contributions prior to the beginning of an eligibility month will result in termination of coverage.

Benefits at Retirement

As a Retired Employee, coverage for you and your Eligible Dependents is based on age, as follows:

- You and any Eligible Dependent under age 65 may continue coverage under the Regular Plan or the Reduced Plan.
- You and any Eligible Dependent age 65 or older will be covered under the Medicare Supplement Plan.

For example: You are a 67-year-old Retired Employee with a spouse who is age 64. Because you are over age 65, you are covered under the Medicare Supplement Plan. However, since your wife is under age 65, she may continue coverage under the Regular or the Reduced Plan. Upon turning age 65, her coverage will continue under the Medicare Supplement Plan.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

QUALIFYING EVENTS

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

The Plan is required to offer COBRA Continuation Coverage that is identical to health coverage provided under the Plan to similarly situated Employees, Retired Employees, and their Eligible Dependents. It does not include ancillary benefits, such as a death benefit or disability benefit.

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

- Your hours of employment are reduced, or,
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your Eligible Dependent children will become Qualified Beneficiaries if they lost coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as an "Eligible Dependent child."

WHEN COBRA COVERAGE BECOMES AVAILABLE

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator determines or has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator will determine whether a qualifying event has occurred. The Plan Administrator will provide you with notice of your right to elect COBRA Continuation Coverage within 30 days after making a determination of your eligibility for COBRA Continuation Coverage.

Once COBRA eligibility has been established, premiums are to be mailed monthly, and premiums are due **prior to the first day of the month of coverage**, but will be considered timely if postmarked within the grace period prescribed by law. Regardless of any delay in enrollment and remittance of the initial payment, **the first payment must include all coverage months commencing with the first day of COBRA eligibility.**

NOTICE OF QUALIFYING EVENTS

Participating Employers are not required to provide notice of qualifying events to the Plan Administrator. The Plan Administrator will determine whether a qualifying event has occurred due to your termination of employment or reduction in hours of employment.

To make a determination whether a qualifying event has occurred as a result of termination of employment or reduction of hours of employment, the Plan Administrator will review the monthly Employer contribution reports to determine the number of hours to be credited to you based on the number of hours worked and whether full contributions are received for all hours worked. If Employer contribution reports are submitted timely, the Plan Administrator will generally have sufficient information to determine whether you will lose coverage as a result of a termination of employment or reduction of hours of employment within 45 days after the last day of the qualification period that you do not have sufficient hours or contributions credited to maintain coverage.

The Plan Administrator will send a COBRA election notice of the qualifying event and all Qualified Beneficiaries' rights to elect COBRA Continuation Coverage as soon as possible after receiving notice that a qualifying event has occurred.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (**divorce** or **legal separation** from your spouse, a **dependent child losing eligibility for coverage** as a dependent child, or your **attainment of Medicare eligibility**) you must notify the Plan Administrator in writing *within 60 days* after the Qualified Beneficiary would lose coverage due to the qualifying event. Your beneficiary must notify the Plan Administrator **if you die**. The notice must be accompanied by documentation of the qualifying event, if applicable, and be provided to Wilson-McShane Corporation, Plan Administrator, Heartland Healthcare Fund, 3001 Metro Drive, Suite 500, Bloomington, MN 55425.

PERIODS OF COVERAGE

Once the Plan Administrator determines or receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. As a covered Employee, you may elect COBRA Continuation Coverage on behalf of your spouse and your children. A Qualified Beneficiary

will have up to 60 days to elect COBRA Continuation Coverage after receiving a COBRA notice and 45 days after electing COBRA Continuation Coverage to make the first COBRA premium payment. Thereafter, all premium payments must be made by the first day of the month for which coverage is being provided.

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is your death, becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continues coverage for your Qualified Beneficiaries until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA Continuation Coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement. That is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of your hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. The 18-month period of COBRA Continuation Coverage can be extended in two ways.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of continuation coverage. In order to get the 11-month disability extension, you must provide a copy of your notice from the Social Security Administration granting disability benefits. You must provide notice to the Plan Administrator no later than 30 days after you receive the Social Security notice, or by the 60th day of your COBRA Continuation Coverage, whichever is later.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA Continuation Coverage, your spouse and dependent children can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to your spouse and any dependent children receiving continuation coverage if you, as the Employee or former Employee, die, become entitled to Medicare benefits (under Part A, Part B, or both), get divorced or legally separated, or if the dependent child stops being eligible under the Plan as an Eligible Dependent child. The second event only counts if the event would have caused your spouse or Eligible Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

SECOND QUALIFYING EVENT AND DISABILITY

If a Qualified Beneficiary experiences a second qualifying event while on COBRA Continuation Coverage that is subject to a maximum period of 18 or 29 months, the Qualified Beneficiary must provide written notice to the Plan Administrator within 60 days of the second qualifying event in order to extend the maximum COBRA Continuation Coverage period to 36 months.

If a Qualified Beneficiary or any member of the Qualified Beneficiary's family is disabled, as determined by the Social Security Administration, at any time within the first 60 days of COBRA Continuation Coverage, the Qualified Beneficiary must provide written notice of such disability to the Plan Administrator within the first 60 days of COBRA Continuation Coverage or, if later, within 60 days from the Social Security Administration's determination that the Qualified Beneficiary or family member is disabled. The notice must be accompanied by a copy of the Social Security Administration's determination letter. A Qualified Beneficiary may, but is not required to, use a form provided by the Plan Administrator to provide this notice. If the Social Security Administration determines that the person's disability has ended while the person is on COBRA Continuation Coverage, the Qualified Beneficiary must provide a copy of the Social Security Administration's letter stating that the person is no longer disabled, to the Plan Administrator within 30 days after the Social Security Administration's determination.

The Plan Administrator will send notice of right to elect an extended period of continuation coverage, or notice of the unavailability of an extension of continuation coverage, within 14 days after receiving notice from the Qualified Beneficiary.

A Participant or beneficiary with respect to whom a qualifying event has occurred will be a Qualified Beneficiary entitled to elect COBRA Continuation Coverage. Any person who has properly elected continuation coverage will remain a Qualified Beneficiary until continuation coverage is terminated.

COBRA PREMIUMS

COBRA rates are not the same as self- contributions, but the rates will be shown in your COBRA election notice.

Change of Premium Rate
In the event COBRA premiums change, the Plan Administrator will send notice of such change to all Qualified Beneficiaries at least one month prior to the effective date of the change.

Deficient Premium Payment
In the event a Qualified Beneficiary submits a payment for COBRA Continuation Coverage that is less than the full premium amount due, and the deficiency is not more than $50.00 (or the deficiency is not more than 10% of the applicable premium amount, if 10% of the premium is less than $50.00), the Plan Administrator will provide notice of deficiency to the Qualified Beneficiary, demanding payment of the deficiency in full within 30 days from the date of the notice of deficiency. The deficient premium will be considered full payment until the end of the 30-day period. If the Plan Administrator fails to provide notice of the deficiency to the Qualified Beneficiary within 30 days after receipt of the payment, the amount paid will be deemed to constitute full payment of the applicable premium.

In the event a Qualified Beneficiary submits a payment for COBRA Continuation Coverage that is significantly less than the full amount due (that is, the deficiency exceeds the lesser of $50.00 or 10% of the applicable premium), no additional time will be granted to make up the deficiency. If the deficiency is not paid within the initial 30-day grace period, coverage will be retroactively terminated as of the first day of the month for which full payment was not made.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage will be terminated:

- For failure to make payment of monthly premiums on time and postmarked within the grace period prescribed by law;
- Upon completion of the 18, 29, or 36-month COBRA continuation period, as applicable;
- On the date the individual first becomes covered under any other group health plan as an employee or otherwise, after the date of election of COBRA Continuation Coverage;
- On the date the individual first becomes, after the date of election of COBRA, entitled to Medicare benefits; or,
- On the date the Plan no longer provides Health Care Benefits.

NOTICE OF TERMINATION/INELIGIBILITY

When the Plan Administrator receives a notice from an Employee or beneficiary relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration regarding a covered Employee, Qualified Beneficiary, or other individual; and the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage or an extension of COBRA Continuation Coverage; the Plan Administrator will provide a notice to the person who sent the notice to the Plan Administrator explaining why the individual is not entitled to COBRA Continuation Coverage. The unavailability notice will be sent within 14 days from receipt of the notice from the Employee or other individual.

If the address of your spouse, former spouse or other adult dependent is different from yours; you, your spouse, or adult dependent are responsible for providing current address information to the Plan Administrator.

If You Have Questions
Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information
Wilson-McShane Corporation, Fund Administrator
Heartland Healthcare Fund
3001 Metro Drive, Suite 500
Bloomington, MN 55425
(952) 854-0795
(800) 535-6373

Other available coverage

If you, your spouse or dependents lose coverage under the Plan, you may be able to enroll in coverage other than COBRA. One alternative is the Health Insurance Marketplace. Generally, an Employee or dependent has 60 days after the loss of coverage to enroll in a plan in the Marketplace. You or your dependents may be eligible for cost-sharing subsidies or tax credits to pay all or part of the monthly premium.

Another option may be to enroll in your spouse's plan if he or she has coverage through their employer. Generally, an employer-sponsored group health plan has to allow a spouse who loses employment-based coverage to enroll within 30 days after losing coverage.

These alternatives may be less expensive than COBRA, but it is important to remember that there are deadlines for all of these options, including COBRA.

LIFE EVENTS

IF YOU ADD A DEPENDENT

If you add a new dependent (due to marriage, birth, adoption, or placement for adoption), your new dependent will be eligible for benefits under the Plan on the day that he/she acquires the status of Eligible Dependent. You should inform the Fund Office within 30 days of the marriage, birth, adoption, or placement for adoption to ensure coverage. If you do not inform the Fund Office within 30 days of the event, your new Eligible Dependent might not be covered under the Plan on the first day of the month in which you enroll him/her.

If you enroll a child but do not supply the child's birth certificate and/or Social Security number in a timely manner, claims for the child will be delayed or denied until the Fund Office receives the documents.

IF YOU LEGALLY SEPARATE OR DIVORCE

In the event of a legal separation or divorce, your ex-spouse will no longer be eligible for coverage as an Eligible Dependent under the Plan. Your stepchildren also become ineligible when you and your spouse divorce or legally separate, unless they are party to a Qualified Medical Child Support Order (QMCSO). If your ex-spouse wants to continue coverage under COBRA Continuation Coverage, you or your ex-spouse must contact the Fund Office within 60 days from the date of your divorce or legal separation.

Refer to the *COBRA Continuation Coverage* section for more information .

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

You should notify the Fund Office if your situation involves a QMCSO. The Plan has written QMCSO procedures that describe the Plan's and your rights and responsibilities regarding a QMCSO. You may contact the Fund Office to obtain a free copy of the Plan's QMCSO procedures.

IF YOUR CHILD REACHES AGE 26

In general, your child is no longer eligible for coverage at the end of the month in which he or she turns age 26. You should notify the Fund Office within 60 days of your child's 26th birthday.

Your child may elect COBRA Continuation Coverage for up to 36 months after losing eligibility as an Eligible Dependent. Refer to the *COBRA Continuation Coverage* section for more information.

IF YOUR CHILD IS DISABLED

Age limits may be waived if an unmarried Eligible Dependent child is incapable of self-sustaining employment due to mental or physical handicap and became handicapped prior to the termination age stated above. The child may remain covered under the Plan if he/she is chiefly dependent upon the Eligible Employee for support and maintenance, and if the Plan Administrator receives due proof of incapacity within 31 days of the date the child's coverage under the Plan would otherwise terminate. The child's coverage may be continued under the Plan as long as the Eligible Employee's coverage remains in force and the child remains incapacitated. The Plan Administrator may request proof of the continued existence of such incapacity from time to time.

IF YOU TAKE MILITARY LEAVE

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or other Federal law, you may be entitled to continued eligibility for coverage or COBRA benefits during certain periods of service in the United States Uniformed Services. You should contact the Plan Administrator immediately upon receiving notification that you are being called to duty.

Uniformed Services include services in:

- The United States Armed Forces;
- The Army National Guard;
- The Air National Guard;
- The Commissioned Corps of the United States Public Health Service; and,
- Any other category of persons designated by the President in time of war or emergency.

After completing active duty, you must report to work to a Contributing Employer or apply for reemployment within the specified time frames shown below. If you meet these requirements and return to work, you will be covered on the first day of the month following the date of honorable discharge or release from active duty.

If your military service is:	**You must:**
1 to 30 days	Report for re-employment to a Contributing Employer and the Union by the beginning of the first regularly scheduled workday after the completion of your service (allowing 8 hours for travel).
31 to 180 days	Submit an application for re-employment to a Contributing Employer and the Union within 14 days after the completion of your service.
More than 180 days	Submit an application for re-employment to a Contributing Employer and the Union within 90 days after the completion of your service.

The Plan Administrator may request that you provide documentation to establish the timelines of your application for re-employment. Documentation may include a copy of your discharge papers, which show the date of enlistment, the date of discharge, and whether the discharge was honorable.

IF YOU TAKE A FAMILY OR MEDICAL LEAVE (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), eligibility for benefits must be extended to you and your Eligible Dependents if you are eligible and have been granted leave by your Employer pursuant to FMLA and if your Employer makes the Required Contributions to the Fund.

Your Employer will determine eligibility for benefits under FMLA.

HEALTH REIMBURSEMENT ARRANGEMENT

The Health Reimbursement Arrangement ("HRA") is designed to provide reimbursement of Allowable Medical Care Expenses on a tax-free basis. If you are eligible, you may use your HRA to pay for Allowable Medical Care Expenses for you and your family, including premiums for continuing coverage under the Plan. The Plan has established the HRA for eligible Participants effective January 1, 2010.

ELIGIBILITY

You are eligible for the HRA if you are an eligible Active or retired Plan Participant. Participation in the HRA begins on the first day of the month after your Dollar Bank exceeds six months of the Required Contribution amount.

Non-Bargaining Unit Employees are not eligible for the HRA.

INDIVIDUAL ACCOUNTS

Once you are eligible for the HRA, the Plan will establish and maintain an Individual Account in your name. Your Individual Account is used to receive your contributions and to pay your benefits. Although each account will be separately identified, the combined assets of each account will be held by the Fund in reserves. The Individual Account established for you will be only a record-keeping account for keeping track of contributions and available reimbursement amounts from the Fund. Individual Accounts will not be credited with any interest income earned on the HRA reserves. Additionally, Individual Accounts will not be charged with any Expenses for administration of the HRA and do **not** constitute a vested benefit.

Your Individual Account will be credited at the end of each month with the contributions based on the prior month's hours worked. For example, contributions made for hours worked in March will be credited to your account on April 30. Only amounts actually received by the Fund and in excess of six months of the Required Contribution amount will be credited to your account.

Your Individual Account will be debited during each calendar year for all eligible reimbursements. The amount available for reimbursement for Allowable Medical Care Expenses is the balance available in your HRA, which is the contributions credited to your Individual Account less any reimbursements paid.

TERMINATION OF ELIGIBILITY

Your eligibility for the HRA ends on any of the following (whichever occurs first):

- The date on which the Fund terminates.
- The first day of the month in which you do not have the Required Contribution in your Dollar Bank and eligibility is not continued according to the Continued Eligibility Rules.
- Upon termination of coverage from the Plan for any other reason including, but not limited to, employment in the industry and within the Fund's geographical jurisdiction by an Employer having no obligation to contribute to the Plan.

SELF-PAYMENTS

If your Dollar Bank does not have the Required Contribution amount, you may use your HRA to pay the premium for continued eligibility. You may also use your HRA to pay COBRA premiums **only** if you elect COBRA Continuation Coverage within 60 days of receiving the COBRA election notice and authorize the payment of your COBRA premium from the HRA within 45 days of your COBRA election. If you do not

have enough in your Individual Account to pay a COBRA premium, you must self-pay the COBRA premium. Failure to pay monthly premiums on time and postmarked within the period set by law will result in termination of your COBRA Continuation Coverage.

If you do not pay the premium for continued eligibility or COBRA Continuation Coverage, any balance in your HRA will be forfeited. If the Plan terminates your COBRA Continuation Coverage for any reason, any balance in your HRA will be forfeited. For more information regarding the COBRA rules under the Plan, see the *COBRA Continuation Coverage* section.

FUNDING

For hours worked on and after January 1, 2010, each Individual Account will be credited with the amount of contributions made on your behalf with a Dollar Bank exceeding six months of the Required Contribution amount.

CARRYOVER OF ACCOUNTS

Any balance remaining in your HRA after payment of reimbursements for a calendar year will be carried over to reimburse you for Allowable Medical Care Expenses incurred during a following calendar year.

As long as you remain eligible to participate in the Plan, your account will remain available to pay benefits. If you should die, your spouse may use the HRA to pay benefits as defined in Internal Revenue Code Section 213(d)(8) for you (before your death) and your Eligible Dependents. If you die and have no surviving spouse or surviving Eligible Dependents, any remaining balance in the account will be forfeited.

BENEFITS

You may use the contributions deposited into the HRA for the payment of Allowable Medical Care Expenses incurred by you, your spouse as defined in Internal Revenue Code Section 213(d)(8), and/or your eligible, non-spouse dependents. Benefits will not be provided in the form of cash or any other taxable or non-taxable benefit other than reimbursement of Allowable Medical Care Expenses.

ALLOWABLE MEDICAL EXPENSES

Under the HRA, you may receive reimbursement for Allowable Medical Care Expenses incurred during a calendar year. A medical Expense is “incurred” at the time the medical care or service is provided, not when the individual incurring the Expense is formally billed for, is charged for, or pays for the medical care. Allowable Medical Care Expenses incurred before you became covered by the Plan are not eligible. However, an Allowable Medical Care Expense incurred during one calendar year may be paid during a later calendar year, provided you participated in the Plan during both calendar years.

Allowable Medical Care Expenses are all Expenses incurred by you, your spouse, or your Eligible Dependents that are recognized as properly deductible under Section 213(d) of the Internal Revenue Code.

The following contains only a **partial** list of medical Expenses considered Allowable Medical Care Expenses under this HRA. Contact the Fund Office for questions about a particular Expense.

EXAMPLES OF ALLOWABLE MEDICAL CARE EXPENSES ELIGIBLE FOR REIMBURSEMENT

▪ Amounts exceeding payments made by insurance companies for eligible Expenses in connection with dental, vision care, and hearing benefits ▪ Laser eye surgery ▪ Braille books and magazines ▪ Nursing services in connection with dental, vision care, and hearing benefits ▪ Contact lenses and solutions ▪ Physicians fees for dental, vision care, and hearing benefits ▪ Deductibles for medical insurance only ▪ Radial Keratotomy ▪ Dental fees ▪ Seeing-eye dog and its upkeep	▪ Dentures ▪ Self-payments to the Heartland Healthcare Fund ▪ Eyeglasses, including the examination fee ▪ Surgical fees in connection with dental, vision care, and hearing benefits ▪ Special telephone for the hearing impaired ▪ Hearing devices ▪ Television audio display equipment for the deaf ▪ Home improvements/modifications motivated by medical considerations in connection with dental, vision care, and hearing benefits ▪ X-rays in connection with dental, vision care, and hearing benefits ▪ Hospital bills in connection with dental, vision care, and hearing benefits

ALLOWABLE MEDICAL CARE EXPENSE EXCLUSIONS

Allowable Medical Care Expenses do not include Expenses covered by any other benefit plan. Allowable Medical Care Expenses can only be reimbursed to the extent that you and any other person incurring them were not reimbursed for the Expense through other insurance, including any other accident or health plan. Allowable Medical Care Expenses do not include any item that does not constitute "medical care," as defined under Internal Revenue Code Section 213(d)(1).

CLAIMS AND REIMBURSEMENT PROCEDURES

Within 30 days of receiving your reimbursement claim, the Plan will reimburse you for your Allowable Medical Care Expenses provided the claim form is completed in its entirety, it is accompanied by the required itemized statements/receipts, and the Plan Administrator has approved the claim for payment.

FILING A CLAIM

You may apply for reimbursement by submitting an application in writing to the Plan Administrator on a form provided by the Fund Office. Reimbursement must be sought no later than two years after the Allowable Medical Care Expense was incurred. The application for reimbursement must include the following information:

- The person or persons on whose behalf the Allowable Medical Care Expenses have been incurred;
- The nature and date of the Expenses incurred;
- The amount of the requested reimbursement; and,
- A statement that these Expenses would not have otherwise been reimbursed and are not reimbursable through any other source.

The application must be accompanied by bills, invoices, statements from an independent party, and any additional documentation that the Fund Administrator may request. Documentation must show that the Allowable Medical Care Expenses have been incurred, as well as the amount of each Expense. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement are at least $25.00.

Claim payments may never exceed the balance remaining in the HRA.

APPEAL PROCEDURE

If you or your beneficiary wants to appeal a decision by the Fund Administrator to deny, or partially deny, any claim for reimbursement, you must follow the procedure contained within the *Claims and Appeals* section of the SPD.

COORDINATION OF BENEFITS

This Fund is intended to pay benefits only for Allowable Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise Allowable Medical Care Expense is payable or reimbursable from another source, that source must make the payment before payment is made from this Plan.

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

(ACTIVE EMPLOYEES, RETIREES, AND DEPENDENTS)

Comprehensive Medical Expense Benefits will be paid if you incur covered Expenses as the result of an Injury or Illness that is not employment-related.

If two or more Covered Individuals in the same family are injured in the same accident, only one deductible will be applied to the total covered Expenses resulting from that accident.

BENEFITS

The Plan will pay 80% of covered Expenses after the deductible has been met. Once you reach the out-of-pocket maximum ($2,000 per Covered Individual [excluding the deductible]), the Plan will pay your covered Expenses at 100%. When three or more Covered Individuals in the same family accumulatively satisfy the $6,000 family out-of-pocket maximum (excluding the deductible), covered expenses for all Covered Individuals in that family will be paid at 100% for the remainder of the calendar year.

The Plan will pay 80% of covered Expenses after the deductible has been met. Once you reach the out-of-pocket maximum, the Plan will pay your covered Expenses at 100%.

Doctor on Demand

Doctor on Demand is an on-line service, provided in partnership with Blue Cross and Blue Shield of Minnesota. If you or your Eligible Dependent is under the weather, getting a private, secure, and convenient on-line medical visit through Doctor on Demand is a great option (especially when you are away from home or your doctor is unavailable). Doctor on Demand can answer medical questions, make a diagnosis, and even prescribe medication for you in most instances, if needed. They can help with minor injuries and common medical ailments like colds, flu symptoms, fevers, allergies, infections, headaches, sore throats, minor rashes, and earaches.

The Plan will cover 100% of the cost each time you visit a Doctor through Doctor on Demand. The deductible will not apply to Doctor on Demand visits, and each session generally lasts around 10 minutes.

You can save time and get the care you need without having to schedule a doctor's appointment. Doctor on Demand is available to answer your questions as well as for medical visits 24 hours a day, seven days a week, 365 days a year.

You can connect face-to-face with Doctor on Demand board-certified Doctors using a computer with a webcam, or through your mobile device. Visit www.DoctorOnDemand.com/bluecrossmn to learn more.

DEDUCTIBLE

The deductible is the amount of covered Expenses the Covered Individual pays out of his or her pocket before the Plan begins paying Comprehensive Medical Expense Benefits. The deductible is $250.00 per Covered Individual.

When three or more Covered Individuals in the same family accumulatively satisfy the $750.00 family deductible, no other deductible will be required of other Covered Individuals in that family for the remainder of the calendar year.

If two or more Covered Individuals in the same family are injured in the same accident, only one deductible will be applied to the total covered Expenses resulting from that accident.

Any portion of a deductible that is satisfied in the last three months of the calendar year will be applied to the following year's deductible.

PREVENTIVE CARE

The Plan pays 100% of Preventive Services received In-Network and 100% of the Usual and Customary fees out-of-network. These services are not subject to the annual deductible or coinsurance. In addition, the Plan pays 100% of services, including flu shots and major medical services (such as treatment for strep throat) you receive in a "retail clinic" or County Health Department.

The following benefits are available under the Fund's Preventive Services benefit.

COVERED PREVENTIVE CARE FOR ADULTS

- Abdominal Aortic Aneurysm, a one-time screening for men ages 65-75 who have ever smoked.
- Alcohol misuse screening and counseling, and screening and behavioral counseling interventions provided in primary care settings to reduce alcohol misuse by adults (including pregnant women).
- Aspirin use for men and women of certain ages. Aspirin is not payable, nor is counseling for aspirin use, if the service is included in the payment for a Physician visit.
- Blood pressure screening for all adults age 18 and older; blood pressure screening is not payable as a separate claim, as it is included in the payment for a Physician visit.
- Cholesterol screening (Lipid Disorders Screening) for men aged 35 and older; men aged 20-35 if they are at increased risk for coronary heart disease; and women aged 20 and older if they are at increased risk for coronary heart disease.
- Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. Removal of polyps during a preventive colonoscopy are covered at 100%.
- Depression screening for adults.
- Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
- Diet counseling for adults at higher risk for chronic disease.
- HIV screening for all adults at higher risk.
- Obesity screening, intensive counseling, and behavioral interventions to promote sustained weight loss for obese adults. Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting.
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
- Tobacco use screening for all adults and cessation interventions for tobacco users.
- Syphilis screening for all adults at increased risk of infection.

COVERED PREVENTIVE CARE FOR WOMEN, INCLUDING PREGNANT WOMEN

- Anemia screening on a routine basis for pregnant women.
- Prenatal vitamins for pregnant women, covered only if the woman obtains a prescription.
- Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every one to two years for women aged 40 and older.
- BRCA genetic testing for breast cancer for women whose family history is associated with an increased risk for BRCA 1 or BRCA 2 genetic mutations; genetic counseling; and BRCA genetic testing.
- Breast cancer chemoprevention counseling for women at higher risk. The Plan will pay for Physician counseling to discuss the risks and benefits of chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Breast cancer risk-reducing medications for women, such as tamoxifen or raloxifene, will also be covered at 100%.
- Breast-feeding interventions to support and promote breast-feeding. Breast-feeding intervention is not payable as a separate claim, because the service is included in the payment for a Physician, gynecologist, or obstetrician visit.
- Cervical cancer screening for sexually active women who have a cervix, at intervals to be determined by the Plan, based on age and whether the woman has had a recent screening with normal Pap results.
- Chlamydia infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
- Folic acid supplements for women who are planning to become pregnant or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid, covered only if the woman obtains a prescription.
- Gonorrhea screening for all sexually active women, including those who are pregnant, if they are at increased risk for infection (i.e., are young or have other individual or population-risk factors). The Plan will pay for the most cost-effective test methodology only.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Osteoporosis screening for women. Women age 65 and older will be eligible for routine screening for osteoporosis. Routine screening will begin at age 60 for women at increased risk for osteoporotic fractures. The Plan will pay for the most cost-effective test methodology only.
- Rh incompatibility screening for all pregnant women during their first visit for pregnancy-related care, and follow-up testing for all unsensitized Rh (D) negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- Syphilis screening for all pregnant women or other women at increased risk.

- Well-woman visits; screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women age 30 and older; sexually transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breast-feeding support, supplies, and counseling; and domestic violence screening and counseling, without charging a copayment, coinsurance or deductible.

COVERED PREVENTIVE CARE FOR CHILDREN

- Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:
    - Developmental screening for children under age three, and surveillance throughout childhood.
    - Behavioral assessments for children of all ages.
- Vision screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age five years.
- Hearing screening.
- Height, weight, and body mass index measurements for children.
- Autism screening for children ages nine, 18, and 30 months.
- Alcohol and drug use assessments for adolescents.
- Hematocrit or hemoglobin screening for children.
- Lead screening for children at risk of exposure.
- Tuberculin testing for children at higher risk of tuberculosis.
- Dyslipidemia screening for children at higher risk of lipid disorders.
- STI prevention counseling for adolescents at higher risk.
- Cervical dysplasia screening for sexually active females.
- Oral health risk assessment.
- Newborn screenings:
- Hemoglobinopathies or sickle cell screening.
- Phenylketonuria (PKU) screening.
- Hypothyroidism screening for newborns.
- Screening for oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than age six months whose primary water source is deficient in fluoride.
- Screening for iron supplementation for asymptomatic children age six to 12 months who are at increased risk for iron deficiency anemia.
- Oral fluoride supplementation for preschool children older than six months whose primary water source is deficient in fluoride.

- Iron supplementation for asymptomatic children ages six to 12 months who are at increased risk for iron deficiency anemia.
- Obesity screening for children age six years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
- HIV screening for adolescents at increased risk of infection.

IMMUNIZATIONS

Routine adult immunizations are covered for covered persons who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

- Immunization vaccines for adults—doses, recommended ages, and recommended populations must be satisfied—including:
  - Diphtheria/tetanus/pertussis (DTP).
  - Measles/mumps/rubella (MMR).
  - Poliomyelitis.
  - Influenza.
  - Human papillomavirus (HPV).
  - Pneumococcal (polysaccharide).
  - Hepatitis A.
  - Hepatitis B.
  - Meningococcal.
- Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied—including:
  - Hepatitis B.
  - Rotavirus.
  - Diphtheria, Tetanus, Pertussis.
  - Haemophilus influenzae type B.
  - Pneumococcal.
  - Inactivated Poliovirus.
  - Influenza.
  - Measles/Mumps/Rubella (MMR).
  - Varicella.
  - Hepatitis A.
  - Meningococcal.
  - Human papillomavirus (HPV).

COVERED CHARGES

Covered charges are the Reasonable and Customary Charges for the following Medically Necessary services and supplies recommended by a Physician for the treatment of an Injury or Illness:

Inpatient and Outpatient Hospital Expenses - including:

- Out-of-network inpatient Expenses are covered in the case of an Emergency Medical Condition only.
- Hospital Room and Board, up to the average semi-private room rate charged by the Hospital.
- Operating room, medicines, drugs, blood and blood plasma (including administration thereof), anesthetic (including administration when billed as part of Hospital charges), X-ray examinations, radiation treatments, physiotherapy, laboratory tests, surgical dressings, and medical supplies.

Inpatient Expenses incurred at facilities not participating in any Blue Cross and Blue Shield Association-affiliated or BlueCard network will no longer be covered except in an Emergency.

Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or,
- Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions, an Emergency Medical Condition is one for which:

- There is inadequate time to effect a safe transfer to another Hospital before delivery; or,
- The transfer may pose a threat to the health or safety of the woman or the unborn child.

In Emergency Medical Condition situations, the Fund will only pay for what is Reasonable and Customary. If an out-of-network provider bills more than what is Reasonable and Customary, the Participant may be balance billed and held responsible for paying 100% of the difference between what the provider bills and what is deemed Reasonable and Customary.

If you or your covered dependent will be admitted to the Hospital or any other facility for any reason, be sure to ask and confirm that the facility is an **"In-Network participating provider" in the Blue Cross network of providers**. Understand that confirmation that a provider "accepts Blue Cross insurance" does not mean the provider is a Blue Cross participating provider. Therefore, inpatient services provided at a facility that states it "accepts" Blue Cross insurance but does not verify that it is an "In-Network participating provider" will not be covered by the Plan.

When you or your covered dependents go to receive treatment for which an overnight stay is anticipated, it is always a good practice to call the Fund Office to verify coverage.

Surgical Expenses - For the performance of an operation or the repair of a dislocation or fracture (excluding assistant surgeon) and for the services of an anesthetist not included in the Hospital charges.

Skilled Nursing Care Facility room and board and miscellaneous charges for a Skilled Nursing Care Confinement.

Home Health Care services for:

- Nursing care provided by a registered nurse or a licensed practical nurse supervised by a registered nurse;
- Medical services;
- Physical, occupational, or speech therapy; and
- Medical supplies and drugs, including home infusion therapy furnished by a Home Health Care Agency in the patient's home and according to a Home Health Care Plan. One home health care visit is equivalent to one visit by a home health agency representative, or a visit of four hours or less by a home health aide.

Benefits will not be paid for:

- Services of a housekeeper, companion, or sitter;
- Services and supplies not included in the Home Health Care Plan;
- Services provided by a person who lives in the patient's home;
- Services that do not involve direct patient contact; or
- Nursing services to administer home infusion therapy that the patient or caregiver can be successfully trained to administer.

Maternity Expenses resulting from a pregnancy are covered immediately for Expenses incurred on or after the effective date of the Covered Individual's coverage under the Plan. Under Federal law, the Plan may not restrict the Hospital stay for childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). The Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay that is less than or equal to 48 hours (or 96 hours). Maternity Expenses do not include charges related to a surrogate pregnancy, childbirth classes, adoption fees, or elective home delivery.

Covered Individuals who are pregnant have access to Blue Cross Blue Shield's *Maternity Management Program,* a voluntary, maternity management program. *Maternity Management* is a telephone-based program designed to assess, educate, and support pregnant Covered Individuals toward optimal childbirth outcomes. Covered Individuals are matched with a registered obstetrical nurse, who will be available throughout the entire pregnancy to answer questions, assess conditions, and to provide educational materials. To the extent possible and with the Covered Individual's consent, the same nurse will be the primary contact from the time of enrollment through six weeks following the baby's delivery. Nurses are available during normal business hours. All conversations with *Maternity Management* nurses are kept confidential. To enroll in the *Maternity Management Program* or to obtain additional information, call (651) 662-1818 or (866) 489-6948, between 8:00 a.m. and 4:30 p.m. (CST).

Nursery care for newborn dependent children.

Treatment for Mental or Nervous Disorders, Alcoholism, Chemical Dependency, or Drug Addiction must be recommended by a Physician and performed by a consulting psychologist, a licensed clinical psychologist, psychiatrist, or Physician. Inpatient treatment must be provided by a licensed or accredited Hospital, a residential primary treatment program licensed by the appropriate state, or a nonresidential treatment program approved or licensed by the appropriate state. Out-of-network inpatient Expenses are only covered in the case of an Emergency Medical Condition.

Office visits and lab charges for annual routine examinations for Covered Individuals.

Immunizations and well child visits for Covered Individuals.

Birth control devices and birth control pills.

Diagnostic Laboratory and X-Ray services provided or recommended by a Physician while not Hospital confined; however, the following services are not covered:

- Dental care or treatment;
- Eye refractions; or,
- Therapeutic X-rays.

Chiropractic services for the detection, treatment, and correction of structural imbalance; subluxation; or misalignment of the vertebral column for alleviating pressure on nerves.

Reconstructive Surgery when necessary because of:

- Injuries received;
- Repair of congenital defects of newborn children;
- Repair of defects that result from surgery for which benefits were paid by the Plan; or,
- For which pre-authorization has been received from the Plan.

Reconstructive Surgery Expenses in connection with a mastectomy, as required by Federal law, are also covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and,
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Hospice Care for a person who has received a prognosis of six months or less to live. Covered Expenses include:

- Part-time or intermittent nursing care provided for up to eight hours a day by a Hospice Care or Home Health Care Agency;
- Medical supplies, drugs, and medicines;
- Medical social services; and,
- Room, board, services, and supplies for pain control and other acute and chronic symptom management in a Hospital or convalescent facility.

Covered Hospice Care does not include:

- Bereavement counseling, pastoral counseling, financial or legal counseling (such as estate planning and drafting of a will), or funeral arrangements;
- Services that are not for the care of the patient, such as sitter or companion services, transportation, house cleaning, or maintenance; and,
- Respite care provided to give the primary caregiver time away from the patient for any reason.

Human Organ Transplant Surgery including human organ acquisition. Acquisition Expenses are limited to:

- Testing to identify a suitable donor;
- Acquisition of organ;
- Transportation of donor, if living;
- Life support for donor; and,
- Transportation of the organ or donor on life support.

Dental Services including orthodontic treatment, the initial replacement or repair of the teeth, and any necessary dental X-rays for an Injury to the jaw or natural teeth. Orthodontic treatment must begin within six months after the Injury and be completed within two years after the Injury.

Other Expenses - including:

- Treatment by a legally qualified Physician;
- Treatment by a physiotherapist (other than a member of the Covered Individual's immediate family);
- X-ray or radium treatment;
- X-ray and laboratory examinations;
- Professional ambulance services for Medically Necessary transportation (limited to roadway transportation) to the Hospital or from the Hospital to the home (limited to 250 miles), if to commence Hospice Care at home; and,
- Human growth hormone injections.

Medical Supplies including:

- Blood and blood plasma;
- Artificial limbs and eyes to replace natural limbs and eyes;
- Surgical dressings;
- Casts;
- Splints;
- Trusses;
- Braces;
- Crutches;
- Oxygen and the rental of equipment for its administration; and,
- Rental or purchase of durable medical equipment prescribed by a Physician, not to exceed the Reasonable and Customary purchase price.

Foot Orthotics (orthopedic shoes or other supportive appliances for the feet) are payable only once every 12 months for adults, and once in a period of six months for children under age 19 when replacement is required due to growth. The annual maximum Plan benefit for foot orthotics is $400.00 per person. This benefit will be paid at 100%, not subject to deductible or copayments. See the *Schedule of Benefits* section for benefits and limits.

Prescription smoking cessation products, only if participating in the Blue Cross Blue Shield *Quit Coach Program*. The Plan pays 80% of the cost of these products.

Please note: If you have an HRA, you may be reimbursed for certain Allowable Medical Care Expenses such as deductibles. For more information, see the *Health Reimbursement Arrangement* section.

PRESCRIPTION DRUG BENEFIT

(ACTIVE EMPLOYEES, RETIREES, AND DEPENDENTS)

The Prescription Drug Benefit covers drugs and medicines legally obtained from a licensed pharmacist only when prescribed by a licensed Physician. The prescription drug out-of-pocket maximum is $4,900/single and $7,550/family. The Comprehensive Medical Expense Benefits deductible and out-of-pocket maximum do not apply to this benefit.

You and your Eligible Dependents obtain prescription drugs through the retail program or mail order program, both of which have a maximum day supply. For generic medications, you pay a copayment for each prescription. For a brand name medication, you pay a coinsurance amount (a percentage of the cost of the prescription); however, there is a minimum and maximum copayment for each prescription. The retail and mail order copayment/coinsurance amounts are shown in the Schedule of Benefits.

Covered prescriptions are included under Covered Charges in the *Comprehensive Medical Expense Benefits* section. Examples of covered prescriptions include birth control devices, birth control pills, and up to 12 pills per month for treating Erectile Dysfunction (such as Viagra). Additionally, prescription smoking cessation products are covered, but only if you participate in the Blue Cross Blue Shield *Quit Coach Program*. See the Schedule of Benefits for more information.

SPECIALTY DRUGS

Express Scripts, will manage the Specialty Drug program. Specialty Drugs MUST be filled through Express Scripts. If you have questions about whether a medication you are taking should be provided by Express Scripts, call (888) 216-6710.

EXCLUSIONS AND LIMITATIONS

Specifically excluded are those drugs or any other form of medication that may be obtained without such a prescription, even though they may be so prescribed. Other exclusions are shown in the *General Exclusions and Limitations* section.

DENTAL BENEFITS

(ACTIVE EMPLOYEES, PRE-MEDICARE RETIREES, AND THEIR DEPENDENTS – REGULAR PLAN ONLY)

Dental Benefits will be paid for covered dental charges. This benefit will not exceed the Calendar Year Maximum shown in the Schedule of Benefits. Expenses in excess of the Calendar Year Maximum shown in the Schedule of Benefits will **not** be covered under the Comprehensive Medical Expense Benefits. It is recommended, but not required, that a plan for dental treatment be submitted before work is done so you will know in advance what benefits the Plan will pay.

A legally qualified practitioner must provide services, including supplies and treatment related to oral examinations; and treatment of accidentally injured or diseased teeth, supporting bone, or tissue. In the event of an accidental Injury to sound and natural teeth, the Comprehensive Medical Expense Benefits will pay first and then Dental Benefits will be considered.

The Plan Administrator may, at its discretion, request supporting proof of loss such as clinical reports, charges, and X-rays.

Covered dental Expenses are considered to have been incurred on the date the dental service is performed.

COVERED DENTAL CHARGES

The following is the Schedule of Covered Dental Services:

COVERED PREVENTIVE DENTAL SERVICES:

- Oral examinations, including scaling and cleaning of teeth, but not more than two examinations or scaling and cleanings in any calendar year.
- Dental X-rays, limited to:
  - Full mouth X-rays (of at least 14 films), once in any 60 consecutive-month period,
  - Supplementary bitewing X-rays, once in any 12 consecutive-month period for Eligible Dependents under age 18, and once in any 24 consecutive-month period for all covered family members age 18 and older; and,
  - Dental X-rays required in connection with the diagnosis of a specific condition requiring treatment.
    - Topical application of sodium or stannous fluoride, once in each 12 consecutive-month period, but only for Eligible Dependents under age 18.
    - Dental sealants, but only for an Eligible Dependent under age 18.
    - Space maintainers.

COVERED BASIC DENTAL SERVICES:

- Restorative services (fillings only) using amalgam, synthetic porcelain and plastic filling materials, and crowns and jackets when teeth cannot be restored with a filling material.
- Oral surgery—including the excision of impacted teeth—and all oral surgery in connection with treatment of periodontal and other diseases of the gums and tissues of the mouth.

- Administration of general and local anesthetics in connection with oral surgery and/or other covered dental services.
- Injection of antibiotic drugs by the dentist.
- Endodontic treatment, including root canal therapy.
- Extractions, except when incurred as a result of orthodontic care.

COVERED MAJOR DENTAL SERVICES:

- Initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures or fixed bridgework.
- Replacement or alteration of full or partial dentures or fixed bridgework that is necessary because of oral surgery.
- Replacement of a full denture where the requirements listed under Exclusions and Limitations under this section are met.
- Replacement or additions of teeth to an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework so long as the requirements listed under Exclusions and Limitations under this section are met.
- Replacement of a crown restoration, provided the original crown was installed more than five years prior to the replacement.
- Repair or re-cementing of crowns, inlays, bridgework, or dentures; or the relining of dentures.

Note: If you have an HRA, you may be reimbursed for certain dental Expenses considered Allowable Medical Care Expenses, such as X-rays, Hospital, and/or surgical fees.

EXCLUSIONS AND LIMITATIONS

In addition to the Exclusions and Limitations to the Comprehensive Medical Expense Benefits as shown in the *General Exclusions and Limitations* section, benefits will not be paid under these Dental Benefits for:

- Expenses incurred after termination of eligibility, except for prosthetic devices that were fitted and ordered prior to termination and that were delivered to an eligible Covered Individual within 30 days after the date of termination.
- Prosthetic services (including bridges and crowns) started or under way prior to the date a Covered Individual became eligible under this Dental Benefit.
- Denture re-basing or relining less than six months from the date of initial placement and not more often than once in any two-year period.
- Replacement of lost or stolen prosthetics.
- Replacement of prosthetics less than five years after placement, except as specifically provided.
- Orthodontic care, treatment, services, and supplies.
- Treatment on or to the teeth or gums for cosmetic purposes (including realignment of teeth).
- The application of dental sealant after the Eligible Dependent's 18th birthday.
- Services for dental implants.

Other exclusions are shown in the *General Exclusions and Limitations* section.

VISION CARE BENEFITS

(ACTIVE EMPLOYEES, PRE-MEDICARE RETIREES, AND THEIR DEPENDENTS – REGULAR PLAN ONLY)

Benefits will be paid for eye examinations and related services performed by a legally qualified ophthalmologist or optometrist, including:

- Dilation of pupils and/or the relaxing of focusing muscles by drops;
- Refraction for vision;
- Examinations for pathology; and,
- Prescribed frames and lenses (including contact lenses).

The maximum amount payable for examinations and vision materials for each Covered Individual per two-year calendar period is shown in the Schedule of Benefits.

An Expense is considered to be incurred on the date on which the service or materials are provided or obtained.

Note: If you have an HRA, you may be reimbursed for certain vision care expenses that are Allowable Medical Care Expenses.

EXCLUSIONS AND LIMITATIONS

No payment will be made under these **Vision Care Benefits** for Expenses incurred for the following:

- Any vision services or vision materials provided as a result of Workers' Compensation or occupational disease law; or
- Any vision service or vision materials for which no charge is made, or which are furnished by or payable under any plan or law of any federal or state government or any political subdivision; or,
- Sunglasses and safety glasses that do not require a prescription to purchase.

Other exclusions are shown in the *General Exclusions and Limitations* section.

HEARING BENEFIT

(ACTIVE EMPLOYEES, PRE-MEDICARE RETIREES, AND THEIR DEPENDENTS – REGULAR PLAN ONLY)

Charges for hearing examinations, the purchase of hearing aids, and the fitting of hearing aids are covered up to the maximum benefit shown in the Schedule of Benefits. Charges in excess of the amount shown in the Schedule of Benefits are your responsibility, and will **not** be considered a covered Expense under any other Plan benefit, including the Comprehensive Medical Expense Benefit.

Note: If you have an HRA, you may be reimbursed for hearing expenses that are Allowable Medical Care Expenses, such as hearing exams or hearing aids.

EXCLUSIONS AND LIMITATIONS

Benefits will **not** be paid for:

- Replacement batteries; or,
- Repair and maintenance of hearing aids.

Other exclusions are shown in the *General Exclusions and Limitations* section.

WEEKLY DISABILITY BENEFITS

(Active Employees—Regular and Reduced Plan Only)

A Weekly Disability Benefit will be paid if you have become Totally Disabled as a result of a non-occupational Injury or Illness, are prevented from working at your regular occupation, and require the regular care of a Physician. Written proof of disability must be submitted to the Plan Administrator.

BENEFITS PAYABLE

The weekly benefit paid is shown in the Schedule of Benefits. You must not be receiving benefits under Workers' Compensation law (or other law of similar purpose). Any absence from work—that starts while you are eligible for this benefit—is considered a disability absence if, during all of the absence, you are prevented from working solely because of Injury or disease.

This benefit will be payable to you beginning the first day of Total Disability due to an accidental non-occupational Injury, or the eighth day of a Total Disability due to a non-occupational Illness. The maximum number of weeks of payment for all absences occurring during a single disability period is 26. Payment information, which is included in the Schedule of Benefits, will be made for as many separate and distinct disability periods as may occur.

During partial weeks of Total Disability, you will be paid a daily rate of one-seventh of the Weekly Disability Benefit amount shown in the Schedule of Benefits.

TOTAL DISABILITY PERIOD

In determining when one Total Disability period ends and a new one begins, all disability absences due to the same or related causes and separated by less than two consecutive weeks of full-time active work will be considered as occurring in a single Total Disability period.

If a new Total Disability period is due to a cause different from the causes of any prior Total Disability, it need only be separated from the prior Total Disability by one day of full-time active work. You will be eligible for payment up to the maximum number of weeks for that new Total Disability Period.

It is not necessary to be confined to your home to collect benefits, but you must have been seen and treated personally by a Physician. A Physician and not a chiropractor must make all certifications of Total Disability. Benefits are not payable for any day on which you are no longer considered Totally Disabled.

In the event an Injury or Illness is, in the opinion of the Trustees, work related and the Workers' Compensation insurance carrier(s) or self-insured Employer(s) involved deny the claim, the Plan will provide the Weekly Disability Benefits, subject to the other requirements being satisfied.

DEATH BENEFIT

(Active Employees—Regular Plan Only)

The Death Benefit is payable to your beneficiary if you die from any cause while eligible for benefits under this Plan. The amount of the Death Benefit shown in the Schedule of Benefits will be paid to your beneficiary in a lump sum after proof of death is submitted to the Plan Administrator. You will be eligible for this Death Benefit as long as you are eligible for all other benefits of the Regular Plan.

BENEFICIARY

Your beneficiary is any person or persons named on a designated form kept on record at the Plan Administrator. You may change your beneficiary at any time by filing a new enrollment card listing your new beneficiary with the Plan Administrator. Consent of your current beneficiary is not required for any change of beneficiary. A change in the choice of beneficiary will become effective upon receipt of the new beneficiary form by the Plan Administrator.

If you have not named a beneficiary or if your beneficiary dies before you, payment will be made by the Plan Administrator in the following order:

- To your surviving spouse, or if none,
- Equally to any children, or if none,
- Equally to your parents, or if none,
- To your estate.

If your beneficiary is a minor or legally incapable of giving valid receipt for any payment due him or her, the Plan may make payment in monthly installments of no more than $50.00 to the person(s) who have been caring for or supporting the beneficiary. This will continue until a claim is made for the remainder of the benefit by a duly appointed guardian or committee of the beneficiary.

ASSIGNMENT

Death Benefits provided by this Plan are not assignable.

GENERAL EXCLUSIONS AND LIMITATIONS

(APPLICABLE TO THE COMPREHENSIVE MEDICAL EXPENSE, DENTAL, VISION CARE, AND HEARING BENEFIT PLANS)

Plan benefits will **not** be payable for Expenses incurred for, or resulting from:

1. Injury, Illness or dental treatment for which Workers' Compensation benefits are paid or that arises out of or in the course of any occupation or employment for wage or profit.
2. An act of declared or undeclared war or armed aggression, or while on active duty in the Armed Forces, National Guard, or Reserves of any state or country.
3. Expenses incurred in an automobile accident, if automobile insurance was not obtained by the Covered Individual as required by State law. Payment will be considered on Expenses that exceed the amount of no-fault coverage.
4. Services or supplies that are:
   a. Out-of-network inpatient Expenses that are not due to an Emergency Medical Condition;
   b. Not recommended by a Physician,
   c. Not Medically Necessary,
   d. Not provided according to generally accepted professional medical standards; or,
   e. Investigative or Experimental treatments, except to the extent required under the Affordable Care Act (see the *Definitions* section).
5. Expenses incurred after eligibility terminates.
6. Expenses in excess of the Reasonable and Customary Charges.
7. Behavioral problems or social maladjustment that are not specifically the result of mental illness.
8. Eye exercises and vision training.
9. Failure to appear for an appointment as scheduled.
10. Completion of claim forms.
11. Sex transformation, or any treatment related to sexual dysfunction.
12. Participation in a riot or in the commission of a felony.
13. Supplies or equipment for personal hygiene, comfort, or convenience such as air conditioning, humidifiers, physical fitness and exercise equipment, home traction units, or waterbeds.
14. Special home construction to accommodate a disabled individual.
15. Speech therapy, unless required because of a physical impairment caused by an Illness or Injury.
16. Maintenance or Custodial Care.
17. Diagnosis and treatment of infertility or any promotion of pregnancy by artificial means.
18. Vasectomy reversal and tubal ligation reversal.
19. Elective abortions.
20. Acupuncture.
21. Wigs.
22. Detoxification, unless part of a treatment program.
23. Smoking cessation products, if not participating in the Blue Cross Blue Shield *Quit Coach Program*.

24. Recreational or Educational services and materials.
25. Expenses for medical or surgical treatment of obesity, including (but not limited to) gastric restrictive procedures, intestinal/gastric bypass and reversal procedures, weight loss services or products, dietary instructions, and any complications caused by these treatments.
26. Services that the Covered Individual is not required to pay, including (but not limited to) services of the clergy.
27. Charges made by a provider for phone consultations.
28. Any Expense or charge for treatment or counseling for behavior associated with compulsive gambling, waging addiction, or gaming.
29. Expenses provided before eligibility begins, even though the Illness began prior to eligibility.
30. Private duty nursing.
31. Marriage counseling or training services.
32. Physical, occupational, and speech therapy that are not expected to make a measurable or substantive improvement within a reasonable period of time.
33. Court-ordered services and confinements that are not Medically Necessary.
34. Any services for or related to autologous, allogeneic, or syngeneic stem cell therapy; or fetal tissue transplants.
35. Growth hormone replacement, except for conditions meeting medical necessity criteria.
36. Routine physical examinations required by a third party for medical research, employment, insurance, or licensing requirements.
37. Services not within the scope or license of a provider.
38. Gene therapy as a treatment for inherited or acquired disorders.
39. Autopsies.
40. Transplanted animal organs or tissue.
41. Liquid nutritional and electrolyte supplements, unless administered by tube feedings.
42. Cosmetic Surgery such as liposuction, except as described under “Reconstructive Surgery,” repair of scars or blemishes on the skin surface.

Please note: If you have an HRA, certain Allowable Medical Care Expenses not covered by the Plan may be reimbursable under the HRA. For more information, see the *Health Reimbursement Arrangement* section.

COORDINATION OF BENEFITS

The purpose of this Plan is to help Covered Individuals meet the cost of needed medical care or treatment. It is not intended that anyone receive benefits greater than actual Expenses incurred. Benefits payable by this Plan and any other group medical plans will not exceed 100% of Allowable Expenses. In no event will payment under this Plan exceed the amount that would have been allowed if no other plan were involved. All medical benefits provided under this Plan are subject to these rules.

DEFINITIONS

Plan as defined by this section, means any plan providing benefits or services for or by reason of medical, dental, or vision care or treatment under:

- Group blanket or franchise insurance coverage;
- Group Blue Cross, Blue Shield, and other group prepayment coverage including HMO's (health maintenance organizations);
- Labor-management trustee plans, or employee benefit organization plans;
- Governmental programs, or coverage required or provided by any statute;
- Any group coverage of a child sponsored by, or provided through any educational institution;
- Group arrangements for members of associations of individuals; and,
- Group or individual automobile no-fault coverage.

The term plan is construed separately as to each policy, contract, or other arrangement for benefits or services, and separately as to any part of a plan that may consider benefits or services of other plans in determining its benefits and any part that does not. To differentiate referring to this Plan specifically and exclusively, "Plan" will be capitalized to refer to this Plan and not capitalized when referring to all plans or any other plan.

Allowable Expense as defined by this section means any necessary, Reasonable, and Customary Charge, at least a part of which is covered under one of the plans covering the person for whom claim is made.

If a plan provides benefits in the form of services and supplies instead of cash, the reasonable cash value of the service provided and supplies furnished (if otherwise an Allowable Expense) will be deemed both an Allowable Expense and a benefit paid.

EFFECT ON BENEFITS

If a Covered Individual is covered by another plan or plans, the benefits under this Plan and the other plans will be coordinated. This means one plan pays its full benefits first, and then the other plan pays.

- The primary plan (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this rule.
- The secondary plan (the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed the greater of:
    - 100% of total Allowable Expenses; or
    - The amount of benefits it would have paid had it been the primary plan.

If a Covered Individual is eligible under another plan, there are rules that determine the order in that benefits are paid:

- When the other plan does not have Coordination of Benefits rules (COB rules), that plan is primary and must determine benefits first.
- When another plan does have COB rules, the first of the following rules to apply governs:
  - If one of the plans covers the claimant as an Eligible Employee, then that plan will be primary.
  - If an Eligible Dependent child's married or unmarried parents live together, the plan of the parent whose birthday anniversary is earlier in the calendar year will pay for Allowable Expenses incurred first; except:
    - If both parents' birthdays are on the same day, the plan that covered the covered Eligible Dependent child (or the parent) longest will be primary and determine benefits first.
    - If the other plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that plan's COB rule will determine the order of benefit payment.
- If an Eligible Dependent child's unmarried parents are not living together, then the following rules apply:
  - The plan that covers the parent who must provide health coverage by court decree will be primary and determine benefits first. If a parent fails to provide court-ordered health benefits, this Plan will **not** pay any benefits.
  - When there is no court decree that requires a parent to provide health coverage to a dependent child, the following rules will apply:
    - When the parent who has custody of the child has not remarried, the custodial parent's plan will be primary and determine benefits first.
    - When the parent who has custody of the child has remarried, then the custodial parent's plan will be primary and determine benefits first, the stepparent's plan will determine benefits second, and the non-custodial parent's plan will determine benefits third.
  - If none of the above rules apply, the plan that has covered the claimant for the longest period of time will pay its benefits first; except when one plan covers the claimant as a laid-off or Retired Employee (or an Eligible Dependent of such an Employee), and the other plan includes this COB rule for laid-off or Retired Employees (or is issued in a state that requires this COB rule by law). In this case, the plan that covers the claimant as other than a laid-off or Retired Employee (or an Eligible Dependent of such an Employee) will pay first."

When part of the plan coordinates benefits and a part does not, each part will be treated like a separate plan.

COORDINATION OF BENEFITS WITH MEDICARE

The Plan is 100% coordinated with Medicare. Any Expense covered by Medicare is an Allowable Expense under this Plan.

For any eligible Medicare Expense, this Plan will first calculate the normal benefit payment for the Reasonable and Customary Charge without regard to the amount paid by Medicare. Such calculated amount will be used to pay any remaining balance of the eligible Medicare Expense up to 100% of the Expense. Any remainder will be held for the payment of other eligible Medicare Expense if no more than 100% of the Expense will ever be paid.

A Covered Individual does not need to retire and begin receiving Social Security retirement benefits in order to be eligible for Medicare. Most people are automatically eligible for Medicare at age 65, even if they are still employed. Some people become eligible for Medicare before age 65, such as people who are disabled as defined by Social Security or people with end stage renal disease (ESRD).

There are two parts to Medicare. Part A covers Hospital Expenses and is generally free. Part B covers other medical Expenses and requires a monthly premium. ***The Plan automatically considers you to be insured under both Part A and Part B whether or not you have actually enrolled. Therefore, it is very important that you enroll in Medicare as soon as you become eligible.***

Services provided by a Physician who directly contracts with Medicare beneficiaries, and therefore opts out of Medicare, will not be covered by the Plan.

This Plan will be primary over Medicare if you:

- Are at least age 65, eligible for Medicare because of age, and are actively employed by an Age Discrimination in Employment Act of 1967 (ADEA) Employer;
- Are considered disabled by Social Security, but are still considered Active by an ADEA Employer; or,
- Have ESRD, but have not completed the required waiting period prior to Medicare becoming primary.

Medicare will be primary over the Plan if you:

- Are eligible for Medicare and are not actively employed by an ADEA Employer;
- Are eligible for Medicare, at least age 65, and retired (however, if you become entitled to Medicare due to ESRD prior to becoming eligible for Medicare due to age or another disability, this Plan will be primary for the required waiting period); or,
- Are disabled, have completed the 24-month waiting period, and are not actively employed by an ADEA Employer.

Following are definitions for this section:

***Medicare Benefits*:** Benefits for services and supplies that the Covered Individual receives or is entitled to receive under Medicare Parts A and B.

Age 65: The age attained at 12:01 a.m. on the first day of the month in which the Covered Individual's 65th birthday occurs.

***ADEA Employer*:** An Employer who:

- Is subject to the U.S. Age Discrimination in Employment Act of 1967 (ADEA); and,
- Has 20 or more employees each working a day in 20 or more calendar weeks during the current or preceding calendar year.

CLAIMS AND APPEALS

If you or your dependents incur an Injury or Illness for which you will make claims, you need to submit a written notice to the Plan Administrator within 90 days after the date that benefits for that Injury or Illness begin, or as soon as reasonably possible, but in no event later than two years after the claim was incurred. Notice given by or on behalf of the claimant to the Plan Administrator, with sufficient information to identify the Covered Individual, will be deemed notice to the Plan.

WHEN BENEFITS ARE PAID

Benefits payable under the Plan for the Weekly Disability Benefit will be paid no later than the end of each two-week period. All claims payable for any other loss will be paid as they accrue upon receipt of due written proof of such loss.

POST SERVICE MEDICAL CLAIM DECISIONS FOR THE COMPREHENSIVE MEDICAL EXPENSE, DENTAL, VISION CARE, AND HEARING BENEFIT PLANS

When you file a post-service medical claim, you have already received the services in your claim.

The following procedures apply to post-service medical claims:

- Obtain a claim form from the Plan Administrator.
- Complete your (the Employee's) portion of the claim form.
- Have your Physician either complete the Attending Physician's Statement section of the claim form, submit a completed Health Care Finance Administration (HCFA) health insurance claim form, or submit an HIPAA-compliant electronic claims submission.
- Attach all itemized Hospital bills or doctor's statements that describe the services rendered to the claim form.
- Submit the claim to the Plan Administrator:
  HEARTLAND HEALTHCARE FUND
  Wilson-McShane Corporation
  3001 Metro Drive – Suite 500
  Bloomington, MN 55425
  (952) 854-0795
  (800) 535-6373
- Reimbursement for covered charges will be made to the provider of service unless the Employee has requested otherwise in writing. If benefits are not paid directly to the provider of service, unpaid benefits for outstanding Hospital, nursing, medical, or surgical claims are payable to you, if living. Otherwise, any outstanding claims will be payable to your estate.

To speed the processing of your claim, check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. If the claim forms have to be returned to you for information, delays in payment will result.

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar-year period. Mail any further bills or statements for any medical or Hospital services covered by the Plan to the Plan Administrator as soon as you receive them.

Ordinarily, you will be notified of the decision on your post-service medical claim within 30 days from the Plan's receipt of the claim. This period may be extended one time by the Plan, for up to 15 days, if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days pass, or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a post-service medical claim and notify you of the determination.

WEEKLY DISABILITY BENEFIT CLAIMS

If you are submitting a claim for the Weekly Disability Benefit, you must submit a claim form that was completed by you and your Physician. This form may be obtained from the Plan Administrator.

For disability claims, the Plan will make a decision on the claim and notify you of the decision within 45 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan Administrator notifies you—prior to the expiration of the first 30-day extension period—of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days pass, or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within 30 days.

DEATH CLAIMS

If your heirs or estate are submitting a claim for the Death Benefit, they must submit a claim form that was completed by them and your Physician. This form may be obtained from the Plan Administrator.

Ordinarily, your heirs or estate will be notified of the decision on your death claim within 90 days from the Plan's receipt of the claim. This period may be extended one time by the Plan, for up to 30 days, if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, your heirs or estate will be notified before the end of the initial 90-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from your heirs or estate, the extension notice will specify the information needed. In that case, your heirs and estate will have 45 days from receipt of the notification to supply the additional information. If your heirs and estate do not provide the information within that time, the claim will be denied. During the period in which your heirs or estate are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days pass, or until the date your heirs or estate respond to the request (whichever is earlier). The Plan then has 30 days to make a decision on the death claim and notify your heirs or estate of the determination.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

You or your dependents, as a claimant, may designate someone to act as your authorized representative. The authorization must be in writing and is valid for one year, although in an acute medical situation a health care professional with knowledge of a claimant's medical condition is allowed to act as the authorized representative without a designation by the claimant. Please contact the Plan Administrator for a Designation of Authorized Representative Form.

NOTICE OF DENIAL OF CLAIM OR ADVERSE BENEFIT DETERMINATION

The Plan must provide you and your dependents, heirs, or estate with a notice of their initial determination about the claim within certain timeframes after they receive the claim. The notice must provide you with the following information, unless your claim involves Weekly Disability and/or Total Disability:

- The specific reason or reasons for the denial of benefits or other Adverse Benefit Determination;
- A specific reference to the pertinent provisions of the Plan upon which the decision is based;
- A description of any additional material or information that is needed to process the claim, and an explanation of why the information is needed;
- A copy of the Plan's review procedures and time periods to appeal the claim; plus a statement that you, your dependents, heirs, or estate may bring a lawsuit under ERISA following the review of the claim;
- A copy of any internal rule, guideline, protocol, or similar criteria that was relied upon; or a statement that a copy is available to you, your dependents, heirs, or estate at no cost upon request;
- A copy of the scientific or clinical judgment; or a statement that it is available to you, your dependents, heirs, or estate at no cost upon request for medical claims that are denied due to:
    - Medical necessity;
    - Experimental treatment; or,
    - Similar exclusion or limit.

NOTICE OF DENIAL OF CLAIM OR ADVERSE BENEFIT DETERMINATION – WEEKLY DISABILITY BENEFITS OR TOTAL DISABILITY

The Plan must provide you and your dependents, heirs, or estate with a notice of their initial determination about your Weekly Disability and/or Total Disability claim within certain timeframes after they receive the claim. The notice must provide you with the following information:

- The specific reason or reasons for the denial of benefits or other Adverse Benefit Determination;
- A specific reference to the pertinent provisions of the Plan upon which the decision is based;
- A description of any additional material or information that is needed to process the claim, and an explanation of why the information is needed;
- A copy of the Plan's review procedures and time periods to appeal the claim; plus a statement that you, your dependents, heirs, or estate may bring a lawsuit under ERISA following the review of the claim;
- A copy of any internal rule, guideline, protocol, or similar criteria that was relied upon; or a statement that such rule, guideline, protocol, or similar criteria does not exist;
- A copy of the scientific or clinical judgment; or a statement that it is available to you, your dependents, heirs, or estate at no cost upon request for Weekly Disability and/or Total Disability claims that are denied due to:
  - Medical necessity;
  - Experimental treatment; or,
  - Similar exclusion or limit.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following information you, your dependents, heirs, or estate provided regarding the views of health care professionals and/or vocational professionals who treated you and/or evaluated your condition;
- An explanation of the basis for disagreeing with or not following the views of medical or vocational experts whose advice was obtained by the Plan in connection with your Adverse Benefit Determination, regardless of whether or not the advice was relied upon in making the benefit determination;
- A statement that you, your dependents, heirs, or estate are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your application for benefits; and
- If the notice is sent to a county in which ten percent (10%) or more of the population residing in the county is only literate in the same non-English language, the written notice will include a statement in the non-English language, which indicates how you can access the language services that are provided by the Plan.

YOUR RIGHT TO REQUEST A REVIEW OF A DENIED CLAIM OR ADVERSE BENEFIT DETERMINATION

You, your dependents, heirs, or estate have the right to a full and fair review by the Board of Trustees if the claim for benefits is denied by the Plan. You or your dependents, heirs, or estate must make a request to the Plan Administrator within 60 days (Death Benefits claim) or 180 days (any other benefit

claim) after receiving notice of denial. You, your dependents, heirs, or estate's application for review must be in writing, and it must include the specific reasons why the denial is felt to be improper. You or your dependent, heirs, or estate may submit any document felt appropriate, as well as all written issues and comments.

You, your dependents, heirs, or estate have the right to review documents relevant to the claim. A document, record, or other information is relevant if it:

- Was relied upon by the Plan in making the decision;
- Was submitted, considered, or generated in the course of making the benefit determination (regardless of whether it was relied upon);
- Demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or,
- Constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you, your dependents, heirs, or estate will be provided with identification of medical or vocational experts (if any) that gave advice to the Plan on the claim—without regard to whether their advice was relied upon in deciding the claim.

A different person will review the claim than the one who originally denied the claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you, your dependents, heirs, or estate.

If the claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, was under Investigation, or was Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Before the Plan can issue an Adverse Benefit Determination on review on a Weekly Disability and/or Total Disability claim based on a new or additional rationale, the Plan shall provide you, your dependents, heirs, or estate with the rationale, free of charge. The rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided under the Plan to give you, your dependents, heirs, or estate a reasonable opportunity to respond prior to that date.

TIMING OF NOTICE OF DECISION ON APPEAL

Ordinarily, decisions on appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of a request for appeal. However, if the appeal is received within 30 days of the next regularly scheduled meeting, then the appeal will be considered at the following regularly scheduled meeting of the Board of Trustees. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the appeal may be necessary. The Plan will notify you in advance if any extension will be necessary. Once the Plan reaches a decision on the appeal, the Plan will notify you of the decision as soon as possible, but no later than five days after the date when the Plan reaches its decision.

NOTICE OF DECISION OF APPEAL

The decision on any appeal of the claim will be given to you, your dependents, heirs, or estate in writing. The notice of a denial of a claim, except for a claim involving Weekly Disability and/or Total Disability, on appeal will provide:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) upon which the determination is based.
- A statement that you, your dependents, heirs, or estate are entitled to receive reasonable access to and copies of all documents relevant to the claim, upon request and free of charge.
- A statement of your, your dependents', heirs', or estate's right to an external review or to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination review.

If an internal rule, guideline, or protocol was relied upon by the Plan, you, your dependent, heir, or estate will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on medical necessity, or because the treatment was Experimental or under Investigation, or other similar exclusion, you or your dependent, heir, or estate will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the claim, or a statement that it is available upon request at no charge.

NOTICE OF DECISION OF APPEAL – WEEKLY DISABILITY BENEFITS OR TOTAL DISABILITY

The decision on any appeal of your Weekly Disability and/or Total Disability claim will be given to you, your dependents, heirs, or estate in writing. The notice of a denial of a claim on appeal will provide:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) upon which the determination is based.
- A statement that you, your dependents, heirs, or estate are entitled to receive reasonable access to and copies of all documents relevant to the claim, upon request and free of charge.
- A statement of your, your dependents', heirs', or estate's right to an external review or to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination review.
- A copy of any internal rule, guideline, protocol, or similar criteria that was relied upon; or a statement that such rule, guideline, protocol, or similar criteria does not exist;
- A copy of the scientific or clinical judgment; or a statement that it is available to you, your dependents, heirs, or estate at no cost upon request for Weekly Disability and/or Total Disability claims that are denied due to:
  - Medical necessity;
  - Experimental treatment; or,
  - Similar exclusion or limit.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following information you, your dependents, heirs, or estate provided regarding the views of health care professionals and/or vocational professionals who treated you and/or evaluated your condition;

- An explanation of the basis for disagreeing with or not following the views of medical or vocational experts whose advice was obtained by the Plan in connection with your Adverse Benefit Determination, regardless of whether or not the advice was relied upon in making the benefit determination;
- If the notice is sent to a county in which ten percent (10%) or more of the population residing in the county is only literate in the same non-English language, the written notice will include a statement in the non-English language, which indicates how you can access the language services that are provided by the Plan.

EXTERNAL REVIEW OF CLAIMS

This External Review process is intended to comply with the Patient Protection and Affordable Care Act of 2010 (ACA) external review requirements as set forth in federal regulations and other guidance issued in connection with the implementation of the ACA.

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

Dental Benefits and Vision Benefits are characterized as excepted benefits under HIPAA for the purpose of external review of claims.

EXTERNAL REVIEW OF STANDARD CLAIMS

Your request for external review of a standard (not urgent) claim must be submitted, in writing, within four (4) months of the date that you receive notice of an initial claim determination or adverse appeal claim determination. For convenience, such a determination is referred to below as an "Adverse Determination," unless it is necessary to address the determination separately.

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

PRELIMINARY REVIEW PROCEDURES

1 Within five (5) business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:

   a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

   b. The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;

   c. You have exhausted the Plan's internal review and appeals process, unless you are not required to exhaust the internal review and appeals process under the federal interim final regulations (which involve certain limited exceptional circumstances); and,

d. You have provided all of the information and forms required to process an external review.

2. Within one (1) business day of completing its preliminary review, the Plan will send you a notice in writing as to whether your request for external review meets the threshold requirements for external review.

   a. If your request for external review is complete but not eligible for external review, the notice will include the reasons for the request's ineligibility and contact information for the Employee Benefits Security Administration (EBSA)—toll-free number (866) 444-EBSA (3272).

   b. If your request for external review is not complete, the notice will describe the information or materials needed to make the request complete. You will be allowed to perfect your request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

REVIEW BY INDEPENDENT REVIEW ORGANIZATION (IRO)

If your request for external review meets the threshold requirements for external review, the Plan will assign the request to an IRO. The IRO will be assigned in accordance with the Plan's rules, which provide an assignment or rotation method that ensures independence and avoids a bias towards the Plan. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits.

Once the claim is assigned to an IRO, the following procedures will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you must submit in writing to the assigned IRO within ten (10) business days following the date you receive the notice from the assigned IRO, additional information that the IRO will consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after ten (10) business days.

2. Within five (5) business days after the date of assignment to the IRO, the Plan will provide to the IRO any documents and any information considered in making its Adverse Determination. Failure by the Plan to provide documents cannot delay the conduct of the external review. If the Plan fails to provide the documents and information within this time, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or the final adverse internal appeal determination. Within one (1) business day after making the decision, the IRO will notify you and the Plan.

3 If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

4. The IRO will utilize legal experts, where appropriate, to make coverage determinations under the Plan.

5. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or

conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law. In addition to the documents and information provided, the assigned IRO—to the extent the information or documents are available and appropriate—may consider additional information (including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer[s]).

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

EXPEDITED EXTERNAL REVIEW OF CLAIMS

You may request an expedited external review if:

1. You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or,
2. You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your

life or health or would jeopardize your ability to regain maximum function; or you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency services (but you have not yet been discharged from a facility).

Preliminary Review
Upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request as soon as possible to determine whether the request meets the reviewability requirements set forth in the Preliminary Review Procedures section above. The Plan will send you a notice as soon as possible informing you as to whether your request for review meets the threshold requirements for external review, along with other information described in the Preliminary Review Procedures section above.

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

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

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

AFTER EXTERNAL REVIEW

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will provide coverage or payment for the reviewed claim as soon as possible in accordance with applicable law. The Plan reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law. The Plan must provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under State or Federal law.

The IRO will maintain records of all claims and notices associated with the External Review process for a minimum of six (6) years. An IRO will make such records available for examination by you, the Plan, or a state or federal government oversight agency, upon request, except where such disclosure would violate state or Federal privacy laws.

LEGAL ACTIONS

You, your dependent, heir, or estate may not start a lawsuit to obtain benefits until after a review by the Plan Administrator is requested and a final decision has been reached by the Board of Trustees or an IRO, or until the appropriate time frame described above has elapsed since the request for review was filed and no final decision or notice that an extension will be necessary to reach a final decision has been received by you, your dependents, heirs, or estate. Any lawsuit based on the denial of an appeal by the Board of Trustees is governed by the applicable statute of limitations. You, your dependents, heirs, or estate and the Plan have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U. S. Department of Labor office or your State Insurance Regulatory Agency.

PRIVACY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice that was distributed to you upon eligibility. The privacy notice is available from the Plan Administrator.

1. The Plan will use and/or disclose Protected Health Information (PHI) only to the extent and according to the provisions of the HIPAA Privacy Rule (the Privacy Rule). The Plan does not perform any treatment activities, but may disclose information to health care providers treating a Participant in order to facilitate the providers' treatment of the Participant. The Plan has a need to use and/or disclose PHI in the course of health care operations and payment activities.
2. The Board of Trustees (the Board), as the Plan Sponsor, is permitted to use and/or disclose PHI for the purpose of making benefit claim determinations on review. The Board will receive and use only the minimum information necessary to decide the appeal, and will avoid making any disclosure of the information unless necessary to the claim determination (such as for the purpose of obtaining medical, legal, or actuarial advice regarding the claim determination that is being reviewed). When disclosing any such information, the Board will obtain adequate assurance from the party to whom the information is being disclosed that the party will protect the privacy of the information. Any Business Associate agreement entered into between the third party and the Plan will protect the Board of Trustees to the same extent it protects the Plan.
3. The Board of Trustees, as the Plan Sponsor, will use and/or disclose PHI when specifically compelled by law (including, but not limited to: court orders and court-ordered warrants, subpoenas, or summons issued by a court, grand jury, a government or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits; and pursuant to requests of the Secretary of Health and Human Services [HHS] or his or her designee(s)). Unless specifically directed by the governing legal document or authority, the Plan Administrator and other Employees of the Plan Administrator will ordinarily respond to legal process compelling the disclosure of PHI, without the necessity of any action on the part of the Plan Sponsor.
4. The Plan will use and disclose PHI as permitted by authorization of the Participant or beneficiary. With an authorization, the Plan will disclose PHI to any plan affiliated with the Heartland Healthcare Fund of benefits or reciprocal benefit plans, for the purposes related to administration of these plans.
5. The Board of Trustees will release PHI to an authorized representative or another representative only upon receipt of a completed written authorization form that can be obtained from the Plan Administrator.
6. The Board of Trustees is further permitted to use and disclose de-identified or summary health information for the following purposes, and is permitted to use and/or disclose individually identifiable health information in connection with the following activities only when the Board is unable to carry out its responsibility to administer the Plan without the particular individually identifiable health information being requested:

- Administering the Plan or amending its provisions, including but not limited to:
    a. Management activities relating to the implementation of and compliance with the requirements of the Privacy Rule;
    b. Customer service, including the provision of data analyses for Participants, participating Unions, and Contributing Employers, provided that PHI is not provided to the Participants, Unions, or Employers;
    c. Resolution of internal grievances;
    d. The sale, transfer, merger, or consolidation of the Plan with another employee welfare benefit plan, and due diligence related to such activity; and,
    e. Creating de-identified health information or a limited data set.
- The Board of Trustees further agrees:
    a. Not to use or further disclose PHI, other than as permitted or required in the documents governing the Plan or as required by law;
    b. To ensure that any agents—including any subcontractor to whom it provides PHI received from the Plan—agree to the same restrictions and conditions that apply to the Board of Trustees with respect to the information;
    c. Not to use or further disclose the information for employment-related actions and decisions;
    d. Not to use or disclose the information in connection with any other benefit or employee benefit plan established pursuant to the Collective Bargaining Agreements that establish this Plan;
    e. To report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
    f. To make available PHI as required by statute or regulation to the extent that the Board of Trustees, rather than the Plan Administrator, has control of any PHI;
    g. To make available PHI for amendment and to incorporate any amendments to PHI as required by statute or regulation—to the extent that the Board of Trustees, rather than the Plan Administrator, has control of any PHI;
    h. To make available the information required to provide an accounting of disclosures as required by statute or regulation—to the extent that the Board of Trustees, rather than the Plan Administrator, has control of any PHI;
    i. To make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for purposes of determining compliance with the Privacy Rule by the Plan;
    j. If feasible, to return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form; and not to retain copies of such information when no longer needed for the purpose for which the disclosure was made (except that, if such return or destruction is not feasible, to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible); and,
    k. To ensure that the adequate separation between the Plan and the Board of Trustees as required by statute or regulation is established.

7. All Employees of the Plan Administrator (also known as Employees of the Plan), including the Plan Administrator, claims processor(s), and customer service representative(s), do and will have access to PHI in the course of the services they perform for the Plan. These individuals are employed by the

Plan itself, and are not Employees of the Board of Trustees, that is the Plan Sponsor. No Employees of the Board of Trustees, or of any member of the Board of Trustees, will have any access to PHI held by the Plan except as noted previously. All Fund Employees will protect the privacy of individually identifiable health information received, created, or maintained in the course of their employment, and will use and/or disclose such information only according to the terms of this Summary Plan Description (SPD).

8. Fund Employees, including the Fund Administrator, will have access to Plan Participants' protected health information only to perform the Plan administration functions that the Fund Administrator provides for the Fund.
9. Any Fund Employee who fails to comply with the preceding information will be subject to the disciplinary procedures and sanctions, up to and including termination of employment or affiliation with the Plan, in appropriate circumstances, as established by the Plan or by the Board of Trustees relating to unauthorized use or disclosure of PHI, for any use or disclosure of Plan Participants' PHI in violation of or noncompliance with the terms and provisions of this Plan.
10. The Plan will develop and distribute to all Participants a Notice of Privacy Practices that will comply with all statutes and regulations, said notice will be approved by the Board of Trustees and will describe the policies and procedures that the Plan will follow with respect to protecting the privacy of PHI.
11. It is expected that the Board of Trustees will not have a need for access to PHI, except in connection with review of an Adverse Benefit Determination or in unusual circumstances. The Board has delegated the daily responsibility for administering the Plan to the Plan Administrator and his or her staff. The Plan Administrator and Plan Administrator's staff will carry out their administrative duties on behalf of the Plan, such as claims processing and regular Plan administration, without disclosing PHI to the Board of Trustees (unless such a disclosure is necessary, and then will disclose only the minimum information necessary to carry out the purpose of the disclosure to the Board of Trustees, and only according to the terms of the Privacy Rule and this SPD).

The following definitions are specific to this Privacy section:

1. Business Associate means a person or entity that provides services to a Plan involving or using PHI, such as consultants, lawyers, network providers, and others.
2. Health Plan means an individual or group health plan that provides or pays the cost of medical care. It also includes health insurance issuers, HMOs, Medicare, and Medicaid.
3. HIPAA means the Health Insurance Portability and Accountability Act of 1996.
4. HIPAA Privacy Rule or "Privacy Rule" means the Code of Federal Regulations promulgated by the Department of Health and Human Services (HHS) according to HIPAA.
5. Protected Health Information or "PHI" means individually identifiable health information that:
    a. Is created or received by a health care provider, health plan, employer, or health care clearing house;
    b. Relates to an individual's past, present, or future physical or mental health or condition; receipt of health care; or payment for health care; and,
    c. Identifies the individual or can be reasonably used to identify the individual that is transmitted or maintained in any form or medium.

RIGHT OF SUBROGATION AND REIMBURSEMENT

If you or your dependent incurs medical expenses as a result of an Injury or accident, a third party may be liable for those expenses. In this case, the Plan may make advance payments to cover your health benefits in accordance with the subrogation and reimbursement rules in this section.

To understand the Plan's subrogation and reimbursement rules, you need to understand the meaning of the terms subrogation and reimbursement.

Subrogation allows the Plan to "stand in your shoes" to recover benefits paid by this Plan from any other plan or person who should have properly paid those benefits. For example, if you are injured in an auto accident due to another driver's fault, and the Plan pays expenses for the treatment of your injuries, the Plan can "stand in your shoes" and make a claim to recover those expenses from either the responsible driver or the responsible driver's insurance company. In subrogation, the Plan is asserting your rights to collect against a responsible party.

With reimbursement, the Plan is not asserting your rights, but instead is requiring repayment of the benefits paid on your behalf. For example, say you are crossing the street and are hit by a car that failed to stop for the crosswalk. The Plan pays expenses for the treatment of your injuries. You hire an attorney and file suit against the driver, eventually arriving at a settlement. Under the Plan's reimbursement provisions, you must use the proceeds of your settlement to repay the Plan for the expenses it has paid for your treatment. With reimbursement, you have asserted your rights to collect against the responsible party, and you must use the money that you collected to repay the Plan.

These rules are explained in greater detail below.

SUBROGATION

- If another plan or person is or may be liable for expenses incurred in connection with a Covered Individual's Injury or Illness, the Covered Individual must complete a subrogation agreement and provide any requested information to the Plan Administrator before the Plan will pay any benefits for such Injury or Illness.

- This Plan shall be subrogated to the extent of benefits paid under this Plan to any monies recovered from any other plan or person by reason of the Injury or Illness, which occasioned the payment of benefits under this Plan. This Plan shall also be subrogated to the extent of benefits paid under this Plan to any claim the Covered Individual may have against any other plan or person for the Injury or Illness, which occasioned the payment of benefits under this Plan. Upon written notification to the claimant, this Plan may (but shall not be required to) collect on the claim directly from the other plan or person in any manner this plan chooses without the consent of the Covered Individual.

- This Plan shall apply any monies collected from any other plan or person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining shall be paid to the Covered Individual as soon as administratively practicable. In other words, if the Plan recovers money in a subrogation action,

the Plan will use the money to cover payments made by the Plan and any reasonable costs and expenses the Plan incurred collecting that money (including attorneys' fees) up to the amount of the award or settlement. If there is any money remaining, it will be paid to you.

- The Plan's rights to subrogation and reimbursement take priority over any other use of monies that a Covered Individual recovers, including payment of attorney's fees and expenses, and regardless of whether the Covered Individual obtains a full or partial recovery for the Injury or Illness. The Plan's subrogation and reimbursement rights under this section are not limited by the "common fund" doctrine. The characterization of any amount recovered by a Covered Individual from another plan or person, whether through settlement agreement or otherwise, shall not affect the Plan's priority right to recover the full amount of benefits paid to or on behalf of such Covered Individual, or to characterize otherwise Covered Charges as excludable expenses pursuant to the provisions of this section. Nor will the amount of the Plan's recovery right be limited simply because the amount recovered by the Covered Individual from the responsible third party is insufficient to reimburse the Covered Individual for all of his damages, including non-medical expense items, such as "pain and suffering" or property damage. This Plan's subrogation and reimbursement rights are not limited by the "make whole" doctrine that is sometimes applicable in other legal contexts. The Trustees or their designee may, within their sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

- This Plan shall not be responsible for any costs or expenses incurred in connection with any recovery from any other plan or person unless this Plan agrees in writing to pay a part of those expenses.

- The Board of Trustees, within its sole discretion, shall determine which of this Plan's rights and remedies is within the best interests of this Plan to pursue. The Trustees may decide to recover less than the full amount of excess payments or to accept less than full reimbursement if:

    - This Plan has made, or caused to be made, such reasonable, diligent, and systematic collection efforts as are appropriate under the circumstances; and

    - Such decision is reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

RECOVERY AND REIMBURSEMENT

- Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount that at any time is in excess of the maximum amount of payment necessary at that time to satisfy the intent of these rules, this Plan shall have a right to recover these payments, to the extent of any excess, in accordance with the Recovery of Overpayments rules set forth below.

- The Trustees may, in their discretion, elect to set-off any amounts paid by this Plan that are in excess of the amounts for which this Plan is liable under this section in accordance with the Recovery of Overpayments rules set forth below. The Trustees, in their discretion, may also elect to set-off any amounts paid by this Plan that are in excess of the amounts for which the Plan is liable under this section against any amount owed by the Plan at that time or in the future, to the same insurance company, or other organization to whom the overpayment was made. The

Trustees have sole and absolute discretion whether to recover or set-off, and from whom to recover.

- If the Plan makes payment of Allowable Expenses incurred for treatment of an Injury or Illness for which another plan or person (a responsible third party) is or may be liable, and in which this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays for treatment of the Injury or Illness, the Plan may elect to set-off any payments in accordance with the Recovery of Overpayments rules set forth below. The Plan may also elect to set-off any excess payments against any amount owed by the Plan at that time or in the future to the same insurance company, or other organization to whom payment was made. If the responsible third party, or such person's insurer (or anyone else on behalf of the responsible third party), makes payment to a Covered Individual, or on behalf of a Covered Individual, as compensation for an Injury or Illness, and this Plan is not subrogated with respect to that payment, this Plan is entitled to reimbursement from the Covered Individual in an amount equal to the lesser of the benefits paid by this Plan for treatment of that Injury or Illness, or the amount paid to or on behalf of the Covered Individual by the responsible third party or its insurer. This section shall not apply when the responsible third party or its insurer is another plan with respect to which this Plan is the primary payer of an Allowable Expense in accordance with the Coordination of Benefits rules set forth above.

- If a responsible third party or its insurer pays compensation to or on behalf of a Covered Individual for an Injury or Illness for which the responsible third party is or may be liable, and the Covered Individual incurs (either before or after payment of such compensation) otherwise Allowable Expenses for treatment of that Injury or Illness, such otherwise Allowable Expenses incurred after the date on which the compensation was paid, or incurred prior to such date but not paid by this Plan as of that date, shall be excluded from coverage to the extent of the excess (if any) of the compensation the Covered Individual receives over the Allowable Expenses which the Plan has already paid for treatment of the Illness or Injury that is the subject of the compensation from the responsible third party, and as to which expenses the Plan has already received reimbursement. This rule shall not apply with respect to Allowable Expenses incurred by a Covered Individual for treatment of asbestosis and/or its related conditions after the Covered Individual's receipt of compensation from a responsible third party or such party's insurer related to the Covered Individual's claim against such responsible third party for compensation on account of having contracted asbestosis.

- The Plan's right to reimbursement takes priority over any other uses of monies recovered, including payment of attorneys' fees and expenses, and regardless of whether the Covered Individual obtains a full or partial recovery for his Injury or Illness, or for other damages sustained as a result of an action by a responsible third party that also resulted in the Covered Individual's Injury or Illness. This Plan shall not be responsible for any costs or expenses incurred in connection with any recovery from any other plan or person unless this Plan agrees in writing to pay a part of those expenses. This Plan's reimbursement rights are not limited by the "common fund" doctrine. The characterization of any amount a Covered Individual recovers from another plan or person, whether through settlement agreement or otherwise, shall not affect the Plan's priority right to recover the full amount of benefits paid to or on behalf of a Covered Individual, or the Plan's right to characterize otherwise Covered Charges as excludable expenses. Nor will the amount of this Plan's recovery right be limited simply because the amount a Covered Individual recovers from another plan or person is insufficient to reimburse

the Covered Individual for all of his damages, including non-medical expense items such as "pain and suffering" or property damage. This Plan's reimbursement rights are not limited by the "make whole" doctrine that is sometimes applicable in other legal contexts.

WORK-RELATED CLAIMS

In general, the Plan does not cover charges relating to any Injury or Illness for which a Covered Individual has received or is entitled to receive compensation under any Workers' Compensation or occupational disease or similar law or program. However, an exception exists if a Covered Individual has a work-related Injury or Illness for which a claim has been filed with a Workers' Compensation insurance carrier or with a federal or state court or agency. In the event that claim was initially denied, then the Plan may pay benefits arising from the work-related Injury or Illness in accordance with this subsection.

A Covered Individual must complete a subrogation agreement and provide any requested information to the Plan Administrator before the Plan will pay any benefits in accordance with this subsection. Benefits paid in accordance with this subsection are subject to the subrogation and reimbursement provisions of this section (i.e. all of the Plan's rights with respect to subrogation and reimbursement shall apply to benefits paid in accordance with this section).

DUTY OF COOPERATION AND THE RIGHT TO OBTAIN AND RELEASE INFORMATION

Each Covered Individual has a duty to cooperate with this Plan and, at the request of the Board of Trustees or its designee and as a condition of receiving benefits under this Plan, a Covered Individual shall take any action, give information and assistance and execute documents required by this Plan to enforce its rights under this section. The Plan will make no payments to or on behalf of a Covered Individual until the Plan is satisfied that the claimant has complied with the requirements of this section. The Board of Trustees or its designee, without the consent of or notice to any person may release to or obtain from any person any information, with respect to any person, which the Board of Trustees or its designee deems necessary to make payment for medical care, to determine and enforce any applicable cost sharing requirements of this Plan and to enforce this Plan's rights to recovery, reimbursement and/or subrogation.

RECOVERY OF OVERPAYMENTS

No person is entitled to any benefit under the Plan except as expressly provided under the Plan. The fact that payments have been made from the Plan in connection with any claim for benefits under the Plan does not establish the validity of the claim, or provide the right to have such benefits continue for any period of time, or prevent the Plan from recovering the benefits paid to the extent the Trustees ultimately determine that in fact, there was no right to payment of the benefits under the Plan.

The Plan shall have the right to recover, by all legal and equitable means, any amounts paid that the recipient was not rightfully entitled to under the terms of this Plan (i.e. overpayments). This right to recovery shall include, but not be limited to, the right to recoup such amounts from the participant, medical provider who received the overpayment, future benefits to be paid to or on behalf of the Participant and his Eligible Dependents, and the right to recoup such amounts from any benefits to be paid to or on behalf of any survivors of the Participant or Eligible Dependent. This right to recovery shall further include the right to collect additional costs incurred by the Plan to recover the overpayment (for example, attorney's fees). For purposes of this section, the term "overpayment" shall include payments made on behalf of an individual who was not eligible for coverage from the Plan.

ADMINISTRATIVE INFORMATION

The following information is provided to help identify this Healthcare Fund and the people who are involved in its operation as required by the Employee Retirement Income Security Act of 1974 (ERISA).

NAME OF PLAN

The Plan is known as the Heartland Healthcare Fund. The Plan document is in the possession of the Trustees and may be inspected by a Covered Individual at any time during business hours at the Plan Administrator.

TYPE OF PLAN

The Plan is maintained for the purpose of providing death, weekly disability, medical, prescription drug, dental, vision, and hearing benefits for Eligible Employees, Retired Employees and their Eligible Dependents according to the Schedule of Benefits and eligibility rules described in this Summary Plan Description (SPD).

The Death, Weekly Disability, Comprehensive Medical Expense, Prescription Drug, Dental, Vision, and Hearing benefits of this Plan are provided on a self-funded basis directly from the Fund's assets.

SUMMARY PLAN DESCRIPTION (SPD)

The SPD document describes the requirements and eligibility for participation, the types of benefits available and the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits.

AGENT FOR SERVICE OF LEGAL PROCESS

Wilson-McShane is designated as the agent for service of legal process. Any legal documents should be served upon the Plan Administrator.

BOARD OF TRUSTEES

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees has the responsibility of determining the eligibility rules for participation by Employees in the benefit Plan and for determining the benefits to be offered. The Trustees will exercise complete discretionary authority to construe, interpret, and apply all of the terms of the Plan. The Board of Trustees is also responsible for reporting to the government agencies and disclosing to Plan Participants and beneficiaries as required by ERISA.

The Board of Trustees intends to continue the Heartland Healthcare Fund indefinitely. The Board of Trustees retains the right to amend the Plan at any time. Any amendment to the Plan will be binding on all Covered Individuals on the effective date of the amendment. The Board of Trustees also retains the right to terminate the Plan if all Contributing Employers are no longer obligated through written agreement to make Required Contributions. In this event, the monies of the Plan will be applied to all existing benefit obligations in effect on the date of termination of the Plan. Termination of the Plan will be binding on all Covered Individuals who were covered under the Plan prior to termination.

Any balance of the Plan that cannot be so applied, will be applied to other uses as—in the opinion of the Board of Trustees—will best serve the intentions of the Plan. Upon the disbursement of the entire Trust assets, the Trust will then terminate.

PLAN SPONSOR AND PLAN ADMINISTRATOR

The Board of Trustees is both the Plan Sponsor and Plan Administrator of the Plan. The Board of Trustees consists of an equal number of Union and Employer representatives, selected by the Union and the Associations and Employers. You can contact the Board of Trustees through the Plan Administrator.

IDENTIFICATION NUMBER

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 02-0656066. The Number assigned to this Plan by the Board of Trustees pursuant to the instructions of IRS is 501.

CONTRIBUTIONS

The Heartland Healthcare Fund receives money from Contributing Employers according to the Collective Bargaining Agreements of the various local unions. Copies of the Collective Bargaining Agreements are available at the Local Unions' Offices and from the Plan Administrator.

FUND ASSETS

All assets are presently invested pursuant to guidelines adopted by the Board of Trustees.

PLAN YEAR

The Fund's fiscal year for the purpose of maintaining records, filing various governmental records, and filing various governmental reports is the annual period January 1 through December 31.

STATEMENT OF ERISA RIGHTS

As a Participant in the Heartland Healthcare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The Plan is required by Federal law to provide you with information about your rights under ERISA. ERISA provides that all Plan Participants will be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

The right to continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA Continuation Coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the documents governing the Plan or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $149.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in

Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the division of technical assistance and inquiries, Employee Benefits Security Administration, U.S. Department of Labor. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ERISA Local Office
Kansas City Regional Office
2300 Main St, Ste 1100
Kansas City, MO 64108
Tel (816) 285-1800
Fax (816) 285-1888

ERISA Main Office
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

DEFINITIONS

Active: A state of employment where the Employee is performing hours of work for a contributing Employer who makes Posted Contributions on the Employee's behalf.

Adverse Benefit Determination or Denial of Claim: Any claim where:

- Payment is denied; reduced, or terminated; or
- There is a failure to provide or make payment (in whole or in part) for a benefit; a beneficiary's eligibility to participate in a plan; an application of any utilization review; or an Experimental, under-investigation, Medically Necessary, or appropriate service.

Cosmetic or Reconstructive Surgery: Any surgical procedure performed primarily to:

- Improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or,
- Prevent or treat a mental or nervous disorder through a change in bodily form.

Covered Individual: Either an Eligible Employee or an Eligible Dependent.

Custodial Care: Any care intended primarily to help a disabled person meet basic personal needs when:

- There is no plan of active medical treatment to reduce the disability; or,
- The plan of active medical treatment cannot reasonably be expected to reduce the disability.

Dollar Bank: The accumulated Posted Contributions for an Employee, less any amount used for eligibility or forfeited according to the eligibility rules for this Plan. A Dollar Bank may be credited with a maximum of six months of the Required Contribution amount; any excess amount(s) will be credited to a Health Reimbursement Arrangement (HRA).

Eligible Dependent: Any of the following persons:

- The spouse of an Eligible Employee if the parties are legally married under State law, regardless of where the parties live and whether the parties are of the same or opposite sex (a common-law spouse is not considered an Eligible Employee's spouse and is not an Eligible Dependent);
- The child or children of the Eligible Employee, including stepchildren, foster children, adopted children, and children placed with the Eligible Employee in anticipation of adoption who are under 26 years of age;
- The grandchild or grandchildren of the Eligible Employee, if that grandchild has been legally adopted or if the grandchild's parents are deceased or mentally or physically incapacitated (proof of death or incapacitation must be furnished before the child will be considered eligible); and,
- The child or children of the Eligible Employee or spouse who are named as alternate recipients in a Qualified Medical Child Support Order (QMCSO).

Age limits may be waived if an unmarried Eligible Dependent child is incapable of self-sustaining employment by reason of mental or physical handicap and became handicapped prior to the termination age stated above. The child may remain covered under the Plan if he/she is chiefly dependent upon the Eligible Employee for support and maintenance, and if the Plan Administrator receives due proof of incapacity within 31 days of the date the child's coverage under the Plan would otherwise terminate. The child's coverage may be continued under the Plan as long as the Eligible Employee's coverage remains in force and the child remains incapacitated. The Plan Administrator may request proof of the continued existence of such incapacity from time to time.

Eligible Employee: Any employee who is covered according to the rules explained under Eligibility.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or,
- Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions, an Emergency Medical Condition is one in which:

- There is inadequate time to effect a safe transfer to another Hospital before delivery; or,
- The transfer may pose a threat to the health or safety of the woman or the unborn child.

In Emergency Medical Condition situations, the Fund will only pay for what is Reasonable and Customary. If the out-of-network provider bills more than what is Reasonable and Customary, the Participant may be balance billed and held responsible for paying 100% of the difference between what the provider billed and what is deemed Reasonable and Customary.

If you or your covered dependent will be admitted to the Hospital or any other facility for any reason, be sure to ask and confirm that the facility is an **"In-Network participating provider" in the Blue Cross network of providers**. Understand that confirmation that a provider "accepts Blue Cross insurance" does not mean the provider is a Blue Cross participating provider. Therefore, inpatient services provided at a facility that states it "accepts" Blue Cross insurance but does not verify that it is an "In-Network participating provider" will not be covered by the Plan.

Examples of non-participating providers that provide inpatient services include Cancer Treatment Centers of American, Passages Treatment Centers, and many other drug rehabilitation centers as well as specialized medical treatment centers. When you or your covered dependents go to receive treatment for which an overnight stay is anticipated, it is always a good practice to call the Fund Office to verify coverage.

Employee: An individual on whose behalf an Employer makes contributions according to a Collective Bargaining Agreement.

Employer: An organization that makes contributions on behalf of Employees according to a Collective Bargaining Agreement.

Expense: The charge incurred for a covered service or supply. A Physician, as described in this Plan, must order or prescribe the service or supply. An Expense is considered incurred on the date the service or supply is received. An Expense does not include any charge for a service or supply that is:

- Not Medically Necessary;
- In excess of the Reasonable and Customary Charge for such services or supplies; or
- Experimental/Investigative.

Experimental/Investigative: Treatment and procedure, meaning a service, procedure, drug, device, or treatment modality for a specific diagnosis that:

- Has failed to obtain final approval for use of a specific service, procedure, drug, device, or treatment modality for specific diagnosis from the appropriate governmental regulatory body;
- Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of the specific service, procedure, drug, device, or treatment modality on health outcomes for a specific diagnosis;
- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function that makes it Experimental or Investigative, or if Federal law requires such review or approval;
    - Reliable evidence shows that the drug, device, medical treatment, or procedure is:
        - The subject of on-going phase I or phase II clinical trials;
        - The research, experimental study, or investigational arm of on-going phase III clinical trials; or
        - Otherwise under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or
    - Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure requires further studies or clinical trials to determine its maximum tolerate dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means 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.

Notwithstanding the above, to the extent required under the Affordable Care Act, the Plan will not deny any qualified individual (as defined below) the right to participate in an approved clinical trial (as defined below); deny, limit, or impose additional conditions on the coverage of routine patient costs (as defined below) for items and services furnished in connection with participation in the approved clinical trial; and will not discriminate against any qualified individual who participates in an approved clinical trial. For purposes of this paragraph, the following definitions apply:

- "Routine patient costs" include items and services typically provided under the Plan for a Participant not enrolled in an approved clinical trial. However, such items and services do not include (a) the investigational item, device, or service itself; (b) items and services not included in the direct clinical

management of the patient, but instead are provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

- "Qualified individual" is a group health plan participant or beneficiary who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition and either the referring health care professional is a participating provider and has concluded that the participant's or beneficiary's participation in the approved clinical trial would be appropriate; or the participant or beneficiary provides medical and scientific information establishing that the individual's participation in the approved clinical trial would be appropriate.
- "Approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either approved or funded by one of the following:
  - The National Institute of Health;
  - The Centers for Disease Control and Prevention;
  - The Agency for Health Care Research and Quality;
  - The Centers for Medicare and Medicaid Services;
  - A cooperative group or center of any of the above entities or the Department of Defense or Department of Veterans Affairs;
  - A qualified non-governmental research entity identified in the guidelines issue by the National Institutes of Health for center support grants; or,
  - The Department of Veterans Affairs, the Department of Defense, or the Department of Energy if certain conditions are met.
    - Conducted under an investigational new drug application reviewed by the Food and Drug Administration; or,
    - A drug trial that is exempt from having such an investigational new drug application.
- "Life-threatening condition" is a disease or condition likely to result in death, unless the disease or condition is interrupted.

If a PPO Provider is participating in an approved clinical trial and the PPO Provider will accept the qualified individual as a participant in the approved clinical trial, the qualified individual is required to use the PPO Provider instead of a Non-PPO Provider.

The Trustees have the authority to determine, in their discretion, whether a service, procedure, drug, device, or treatment modality is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended, or approved the service, procedure, drug, device, or treatment does not, in itself, make it eligible for payment.

Home Health Care Agency: Any agency or organization that:

- Is primarily engaged in providing nursing and other therapeutic services;
- Is federally certified and duly licensed by the state in the care that is given, if such licensing is required;
- Has policies established by a professional group associated with such agency, including at least one Physician and at least one registered nurse, to govern the services provided;

- Provides for full-time supervision of such services by a Physician or by a registered nurse;
- Has its own administrator; and
- Maintains a complete medical record on each patient.

Home Health Care Plan: Continued care and treatment of a Covered Individual:

- Who is under the care of a Physician; and,
- Who would need Hospital confinement without home health care.

A Home Health Care Plan must:

- Be approved in writing and established by the attending Physician with the home health care provider;
- Be provided for the same or related condition that required a Hospital confinement of at least three days or, in cases without a hospitalization, the Physician must certify that without home health care, hospitalization would have been necessary;
- Begin within 14 days following release from a Hospital or Skilled Nursing Care Facility; and,
- Be reviewed at least every 30 days by the attending Physician.

Hospice Care Agency: An agency or organization that:

- Has Hospice Care available 24 hours per day;
- Is licensed or certified by the jurisdiction where it is located;
- Provides skilled nursing services, medical social services, psychological and dietary counseling, and bereavement counseling for the immediate family;
- Establishes policies governing the provision of Hospice Care;
- Assesses the patient's medical and social needs;
- Develops a Hospice Care Program; and,
- Provides or arranges for services to meet those needs.

Hospice Care Program: A plan established by the patient's Physician and outlined in writing. A plan must:

- Be reviewed from time to time by the patient's attending Physician and Hospice Care Agency personnel;
- Provide palliative care to patients and supporting care to patients and their families; and
- Include an assessment of the patient's needs and a description of the care to be provided to meet those needs.

Hospital: An institution approved or licensed by an authorized state agency and lawfully operated in the jurisdiction in which it is located and is included in one of the following descriptions:

- An institution for the care and treatment of sick and injured persons, with organized facilities for diagnosis and surgery and having 24-hour nursing service;
- A residential treatment facility for the treatment of emotionally handicapped children;

- A community mental health center or mental health clinic; or,
- A residential primary treatment facility, for treatment of alcoholism, chemical dependency, or drug addiction.

This does not include institutions operated primarily as rest homes, homes for the aged, or institutions that are primarily custodial in nature.

Hospital, as used by this Plan, also includes a freestanding ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day, seven days a week, that are not part of a Hospital, but that have been reviewed and approved by an authorized state agency to provide health care treatments or services.

Illness: Any bodily Illness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician. Illness also includes pregnancy.

Injury: Any damage resulting from trauma from an external source.

Medically Necessary: A service or supply that the Plan's medical staff and/or an independent review panel believe:

- Is appropriate and consistent with the diagnosis according to accepted standards of community practice; and,
- Could not have been omitted without adversely affecting the person's condition or the quality of medical care.

Participant: A person who is eligible for coverage according to the rules explained under Eligibility, and participating in a Plan offered by the Heartland Healthcare Fund.

Physician: Any individual, including a psychiatrist, consulting psychologist, psychologist, chiropractor, osteopath, podiatrist, optometrist, and doctor of dental surgery, who is licensed to practice by the governmental authority having jurisdiction over such licensure, and who is acting within the usual scope of his/her practice and license.

Plan: The document adopted by the Trustees that describes the benefits to be provided for Covered Individuals, eligibility requirements, termination rules, and the rules and regulations pertaining to Plan administration. The Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

Posted Contribution: The Employer Contribution made to the Fund on behalf of an Employee that has been posted to his or her Dollar Bank. Contributions are posted on the last day of the month following the work month in that they were accrued.

Predecessor Fund: If an Employee covered as an Eligible Employee in another certified multi-employer health fund covering carpenters transfers into this Fund, the transferring Employee will be covered under this Fund if the Trustees determine that:

- The other health fund the Employee is transferring from is a certified multi-employer health fund;
- The transferring Employee was eligible under the other certified multi-employer health fund; and,
- The other certified multi-employer health fund transfers assets on the transferring Employee's behalf within 12 months of the date coverage ends under the Predecessor Fund.

Qualified Medical Child Support Order ("QMCSO"): A QMCSO is a judgment, decree, or order issued by a court of competent jurisdiction requiring that the Fund recognize an eligible child as an Alternate Recipient, as defined by ERISA Section 609(a). Such order must be approved in accordance with procedures adopted by the Board of Trustees. Upon receipt of a Medical Child Support Order or other order designating medical child support, the Fund Office will promptly notify each Alternate Recipient of the receipt of such order and the Fund's procedure for determining whether the order is qualified. Upon review of the order, the Participant and all Alternate Recipients will be promptly notified whether the order has been determined to be a QMCSO. The Fund will provide benefits under the Fund to any Alternate Recipients in accordance with the applicable provisions of any QMCSO. Any payment of benefits made by the Plan pursuant to a QMCSO in reimbursement for Expenses paid by an Alternate Recipient's Custodial Parent or Legal Guardian shall be made to the Alternate Recipient's Custodial Parent or Legal Guardian.

Reasonable and Customary Charges: The Usual and Customary fee or charge for the services provided and the supplies furnished in the area where such services are provided, or supplies are furnished. The complexity of the service will be considered when determining the Reasonable and Customary Charge.

Retired or Totally Disabled Employee: An Eligible Employee who meets the necessary requirements to be considered retired or Totally Disabled outlined under the rules explained under Eligibility.

Required Contribution: The amount required to be granted a month of eligibility under the Regular Plan, Reduced Plan, or Millwright Local 2158 Pre-Apprentice Plan, as applicable, as determined by the Trustees.

Skilled Nursing Care Confinement: Confinement in a Skilled Nursing Care Facility:

- Upon the specific recommendation and under the general supervision of a legally qualified Physician;
- Beginning within seven days after discharge from a Medically Necessary Hospital confinement lasting at least three days for which room and board benefits are paid; and,
- For the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the previous Hospital confinement.

A second Skilled Nursing Care Confinement that begins less than 60 days after a hospitalization or a Skilled Nursing Care Confinement will be considered as part of the first confinement.

Skilled Nursing Care Facility: An institution or that part of any institution that operates to provide convalescent or nursing care and:

- Is primarily engaged in providing to inpatients:
  - Skilled nursing care and related services; or
  - Rehabilitation services;
- Has policies, which are developed with the advice of (and with provisions for a review of such policies by) a group of professional personnel, including one or more Physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;
- Has a medical staff responsible for the execution of such policies;
- Has a requirement that the health care of every patient be under the supervision of a Physician;
- Provides for having a Physician available to furnish necessary medical care in case of Emergency;

- Maintains clinical records on all patients;
- Provides 24-hour nursing service that is sufficient to meet nursing needs according to the policies developed, and has at least one registered professional nurse employed full-time;
- Provides appropriate methods and procedures for the dispensing and administering of prescription medications;
- In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature:
  - Is licensed pursuant to such law; or
  - Is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and,
- Meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof.

Totally Disabled:

The inability of the Eligible Employee to engage in or perform the duties of his or her regular occupation or employment within the first two years of disability. After the first two years of disability, Totally Disabled means the inability of the Eligible Employee to engage in any paid employment or work for which he/she may, by education and training, including rehabilitative training, be or reasonably become qualified.

The Board of Trustees will initially require proof of Total Disability and may require subsequent proof. In addition, the Trustees have the right to require the disabled Covered Individual to submit to a medical examination at his/her expense.

Trustees: The Board of Trustees of the Heartland Healthcare Fund.

HEARTLAND HEALTHCARE FUND
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